



Building Healthy Communities: Should Employers Care?

National Health Leadership Council

Memphis, TN
June 24-26, 2009



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Message from the President



August 2009

The National Health Leadership Council (NHL) of the National Business Coalition on Health (NBCH) brings together leaders from business, health coalitions, and other stakeholders in the health care system to discuss issues at the cutting edge of health care financing, organization, access, and quality. Recent NHL meetings have explored consumer-centered health care and consumer-directed health benefit models, evidence-based benefit design, health information technology (IT), physician performance measurement, physician payment reform, the link between employee health and productivity, consumer financial incentives, strategies for engaging the C-suite in promoting employee health and productivity, and the prospects for health care reform.

In June 2009, the NHL met in Memphis, TN to discuss another timely, critical topic—the employer role in building healthy communities and promoting population health. The meeting focused on the need to manage the overall health status of the population by addressing all the key determinant of health (e.g., individual behavior, the physical and social environment) rather than just focusing on improving delivery of medical care. Two days of rich conversation included presentations by representatives of key stakeholders in building healthier communities, such as employers/ employer coalitions, health insurers, physicians, local departments of health, and others. The meeting served as an opportunity to discuss critical issues and divergent opinions, with the goal of building consensus for moving forward. To that end, the meeting included the following key elements:

- An overview of the multi-dimensional challenge of community health
- A discussion of how to make population health a national priority
- The perspective of city and county health officials on how to make the U.S. a healthier nation
- A discussion of why employers should invest in community health
- A review of the community well-being index and community health intervention strategies
- A review of coalition models for building community health partnerships

This meeting represents the continuation of an effort by NBCH to take a leadership role in promoting employer and employer coalition activity in the area of community/population health. The effort began after NBCH leaders attended a conference sponsored by the Centers for Disease Control and Prevention (CDC)—during this session, former CDC director Julie Gerberding issued a challenge to corporations and the public health community to work together on promoting population health. To that end, NBCH is currently in the middle of a 5-year partnership with CDC to promote a leadership role for business in this area. The first year involved gauging coalition interest and the degree to which coalitions have already built relationships with public health agencies and taken a leadership role in this area. After finding strong interest among coalitions, NBCH spent the second year focusing on “matchmaking”—i.e., bringing together the business and public health communities. Years 3 and 4 will focus on the development of a seed grant program to support coalitions in their work with community partners to put in place evidence-based interventions in community health, while year 5 will focus on evaluation. Key questions to be answered from this work and from the discussion at this NHL meeting include the following:

- Why should employers care about community health? Is there a business case?
- What examples exist of successful strategies, especially where coalitions have been involved?
- Are there good measurement tools to help gauge progress and promote transparency, including shining a light on opportunities for improvement and rallying stakeholders to get more involved?
- How can incentives and rewards be used to motivate improvements in population health?

This report summarizes the presentations and discussions that took place at the meeting. Our hope is that it will help in promoting company- and coalition-led efforts to transform health care community by community.

Sincerely,

A handwritten signature in black ink that reads "Andrew Webber". The signature is written in a cursive, flowing style.

Andrew Webber
President and CEO, NBCH

The National Health Leadership Council (NHLC) of the National Business Coalition on Health (NBCH) is a vehicle for high-level discussions of issues that are important to coalition members and to all major parties in health care, including purchasers, providers, insurers, suppliers, and consumers. The expectation is that NHLC meetings will produce statements of agreement among the stakeholders that will promote the advancement of a more value-based health care system. The goal is to encourage community-based changes founded on market principles.

In June 2009, NHLC met in Memphis, TN to discuss a timely, critical topic—the employer role in building healthy communities and promoting population health. The first day of the meeting included an overview of the issue of population/community health, including a discussion of the various determinants of health and the need to make population health a national priority; a discussion of why employers should care about investing in community health; and a review of a community well-being index and strategies for community health intervention. The second day included a review of how the business community can work with county and city health departments to make the U.S. a healthier nation and a discussion of community-based efforts in Memphis and Virginia to improve population health. This report summarizes and synthesizes the key points from the presentations and discussion that took place during the meeting. It is organized into the following sections:

- **The Multi-Dimensional Challenge of Community Health**
David Kindig, MD, PhD, Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health
- **Making Population Health a National Priority**
Karen Adams, Vice President of National Priorities at the National Quality Forum
- **Making the U.S. a Healthier Nation**
Bobby Pestronk, Executive Director of the National Association of County and City Health Officials
- **Investing in Community Health: Why Employers Care**
Sara Palermo, Vice President of the Mid-America Coalition on Health Care; Holly McCoy, JD, SPHR, Director of Human Resources at the American Academy of Family Physicians
- **Community Well-Being Index and Community Health Intervention Strategies**
Larry Boress, President and CEO of the Midwest Business Group on Health (moderator);
Kurt Schusterman, Vice President and General Manager of the Gallup-Healthways Well-Being Index;
Jake Glover, Director of Health and Wellness Initiatives at America's Health Insurance Plans;
Richard Yoast, M.A., Ph.D., Director of the Department of Prevention and Healthy Lifestyles within the Division of Medicine and Public Health at the American Medical Association
- **Coalition Models of Community Health Partnerships**
Barbara Wallace, President and CEO of the Virginia Business Coalition on Health; Karen Remley, MD, MBA, FAAP Commissioner of the Virginia Department of Health; Cristie Travis, CEO of the Memphis Business Group on Health

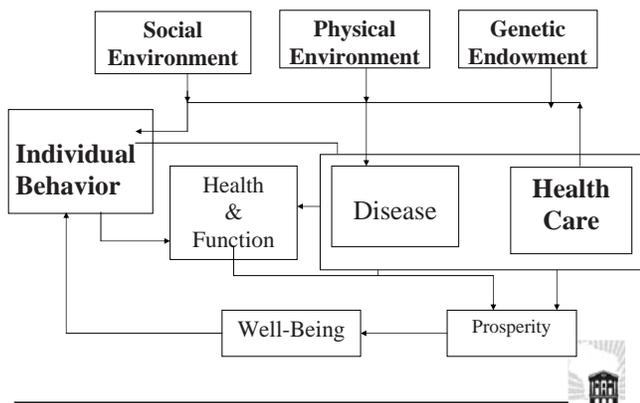
The Multi-Dimensional Challenge of Community Health—Population Health Is Everyone’s Business

David Kindig, MD, PhD, Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health

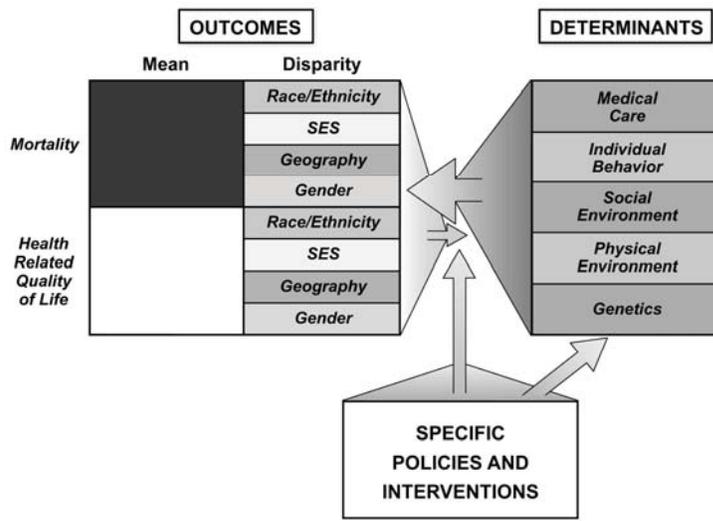
Improving the overall health of the population requires paying as much or more attention to those who do not seek medical care as those who do. Health status is driven by much more than medical care, including factors such as having gainful employment and adequate income, and living an appropriate lifestyle (e.g., diet, physical activity) in a physical and social environment that is conducive to health. While reform of the medical care system is essential, it alone will not produce optimal population health outcomes. Rather, investments must be made across the range of factors that determine health. Success, moreover, requires broad, multi-sectoral partnerships with appropriate financial incentives, including a robust role for corporate leaders that goes beyond employee wellness.

What Is Population Health?

As made clear in the book *Why Are Some People Healthy and Others Not? The Determinants of Health of Populations*, health care focuses primarily on treating disease. But most people want more than just the absence of disease; rather they want full functionality and physical and emotional well-being. As shown in the chart below, outcomes go beyond just medical outcomes, and health depends on more than just



This model of the determinants of health has recently been expanded to incorporate mean (or average) outcomes, including mortality and health-related quality of life, along with disparities in outcomes by race/ethnicity, socioeconomic status, geography, and gender. As depicted on the right side of the chart below, specific policies and interventions can be used to influence each of the major determinants of health.



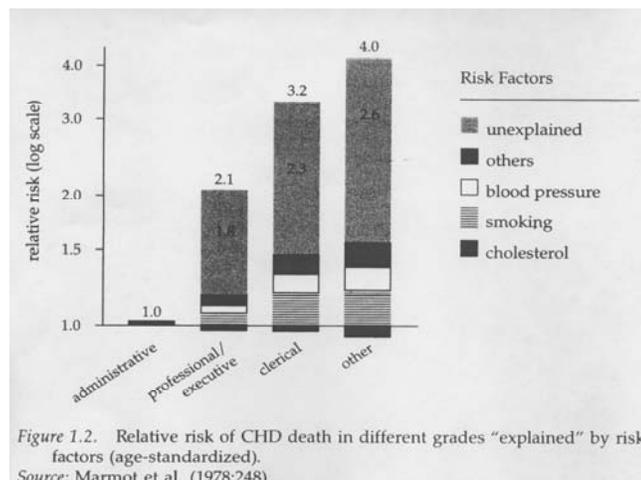
The Relative Importance of the Major Determinants of Health

Debate continues as to the relative importance of the major determinants of health. But nearly everyone agrees that medical care does not play a dominant role in determining health status. The most “bullish” view on the importance of medical care comes from Cutler, who in 2006 estimated that medical care produced roughly half of the gains in life expectancy between 1960 and 2000. Even this “pro-medical care” assessment concluded that the gains in life expectancy due to medical care come at a high cost, and that “the current rise in spending should be balanced by attention to the health benefits gained.” In other words, even those who are the most optimistic about the role of health care in promoting health question the value of further investments, given the high costs. In fact, in 1974 Victor Fuchs raised a fundamental question about how resources should be allocated to promote health. He asked: “How much should go for medical care and how much for other programs affecting health, such as pollution control, water fluoridation, accident prevention, and the like?” He concluded that “there is no simple answer to this question, partly because the question has rarely been asked.”

In 2002, McGinnis questioned the wisdom of placing so much emphasis on medical care versus other determinants of health, and hence advocated a very different kind of balance with respect to the allocation of resources. He estimated the proportional contribution of the various determinants of health to be as follows: behavioral patterns (40%), genetic predisposition (30%), social circumstances (15%), health care (10%), and environmental exposure (5%). *America's State Health Rankings* also places less emphasis on health care (though not as little as does McGinnis), with personal behaviors estimated to account for 36% of overall population health status, followed by community environment (25%), clinical care (21%), and public health policies (18%).

Social Determinants of Health

The social determinants of health have been appreciated by those in public health for a long time, but have only recently become more widely understood. Sir Michael Marmot, a social epidemiologist who studied civil servants over a 20- to 30-year period, has done some of the most important current research in this area. He found (see chart below) that the relative risk of heart disease appears to be driven primarily by unexplained risk factors that have nothing to do with cholesterol, blood pressure, or smoking. He hypothesizes social factors, such as the degree of autonomy one has at work, play a critical role. In 2001, Lantz found that four risk factors only have a modest impact in predicting functional status and self-rated health status in low-income populations, leading him to conclude that "risk behaviors are not the dominant mediating mechanism for health differences across socioeconomic groups." Because of this and other similar work, the social environment has now generally been recognized as a factor that influences health, although the magnitude of that impact remains a matter of debate.



Opportunities for Improvement Everywhere

At present, researchers do not understand the relative size and importance of the various determinants of health, nor do they know which policies and interventions are most cost-effective in affecting health. But researchers do know that improvement is possible, even in relatively healthy areas. As shown in the chart below, even the healthiest states overall lag in some specific areas. For example, while Minnesota is the 2nd healthiest state overall, it ranks 27th in prenatal care, 21st with respect to obesity, and 15th on smoking prevalence. Similar opportunities can be found in every other state.

ALL STATES CAN IMPROVE SINCE NO STATE IS #1 IN ALL DETERMINANTS

Americas Health Rankings 2007

	Wisconsin #12	Minnesota #2	N. Dakota #8
Smoking	28	15	22
Obesity	34	21	27
HS Graduation	4	7	2
Uninsured	2	4	18
Prenatal Care	24	27	39
Immunization	2	7	10



While some factors cannot be modified through state policy (e.g., race, age, gender, rural/urban mix, immigrant status), many factors can be addressed, including the number of uninsured, education and income levels, employment, living alone, physical activity, and rates of smoking and obesity. In fact, even the healthiest states, such as Minnesota and Hawaii, could improve overall health status by 15% to 20% by achieving the highest level of performance in each modifiable area. Low-performing states could improve by 40% to 50%.

Importance of Financial Incentives

Dr. Kindig's book, entitled *Purchasing Population Health: Paying for Results*, makes the fundamental assertion that "meaningful improvements in population health will not be achieved until appropriate financial incentives are designed for this outcome." Yet as Evans and Stoddart point out in a 2003 article,

“redirecting resources means redirecting someone’s income . . . and most students of population health cannot confidently answer the question, ‘well, where would you put the money?’” If Dr. Kindig were “czar,” he would likely reallocate the 25% of current health expenditures thought to be ineffective (equivalent to roughly \$500 billion), putting \$300 billion of it into education (e.g., early childhood education, better K-12 environments, job creation), \$100 billion toward covering the uninsured, and \$100 billion toward prevention. He believes that a multi-sectoral, balanced-portfolio approach works best. This view is supported by a review of the evidence on the effectiveness, potential target populations, and potential decision makers for 400 programs and policies across various aspects of population health, which found that every stakeholder has an important role to play. He has also called for a coordinated effort across the determinants of health between public and private sectors, as well as the financial resources and incentives to make it work.

Critical Roles for the Business Community

The business community has two critical roles to play in promoting population health—one primary and one secondary—as outlined below:

- **Workforce health (primary role):** This role includes building a worksite culture of health, making a sustained commitment to strengthening human capital, and investing in a wide spectrum of evidence-based worksite health and health care management programs.
- **Community health (secondary role):** This role involves using influence and political power to leverage other public and private resources for prevention and the social and physical environment, such as tobacco, early childhood development, economic development, and the design of neighborhoods.

As NBCH CEO Andrew Webber commented in 2009, “business leaders must come to understand that they can do everything right to influence the health and productivity of their captured workforce at the worksite, but if that same workforce lives in unhealthy communities, employer investments can be lost or certainly weakened.”

Moving Forward

The University of Wisconsin School of Medicine is involved in the Robert Wood Johnson MATCH (Mobilizing Action Toward Community Health) grant program, which encompasses two activities:

David A. Kindig serves as Emeritus Professor of Population Health Sciences and Emeritus Vice Chancellor for Health Sciences at the University of Wisconsin-Madison School of Medicine. In this role, he-co-directs the Wisconsin site of the Robert Wood Johnson Foundation Health & Society Scholars Program and also serves as Senior Advisor to the University of Wisconsin Population Health Institute and as co-director of its “Making Wisconsin the Healthiest State” project. Prior to taking on his current position, Dr. Kindig served as Professor of Preventive Medicine/Population Health Sciences at the University of Wisconsin, as Vice Chancellor for Health Sciences at the University of Wisconsin-Madison, as Director of Montefiore Hospital and Medical Center, as Deputy Director of the Bureau of Health Manpower of the U.S. Department of Health, Education and Welfare, and as the first Medical Director of the National Health Services Corps. He has also served as Chair of the federal Council of Graduate Medical Education, President of the Association for Health Services Research, a ProPAC Commissioner, and Senior Advisor to Donna Shalala when she served as Secretary of Health and Human Services. He has received numerous awards and distinctions. Dr. Kindig received a Bachelor of Arts degree from Carleton College in 1962 and M.D. and Ph.D. degrees from the University of Chicago School of Medicine in 1968. He completed residency training in social pediatrics at Montefiore Hospital in 1971.

- Increase awareness of summary measures of population health and the multiple determinants of health by releasing annual *County Health Rankings* across all 50 states. In February 2010, the school will release rankings for every county in the country, using a common methodology and weighting assignments for each major determinant of health.
- Identify and examine alternative, multi-sectoral governance partnership structures that can improve population health, and develop incentive models to stimulate multi-sectoral accountability and action toward community health improvement.

The hope is that this work will help in answering the key question in population health, articulated by Kindig and Milbank in 2007—that is, “what is the optimal balance

of investments (e.g., dollars, time, policies) in the multiple determinants of health (e.g., behavior, environment, socioeconomic, medical care, genetics) over the life course that will maximize overall health outcomes and minimize health inequities at the population level?”

Making Population Health a National Priority

Karen Adams, Vice President, National Priorities Partnership at the National Quality Forum

The time has come to make population health a national priority. In 2008, health care accounted for one quarter of total federal spending, and will account for half of all non-interest federal outlays by 2050. Costs are skyrocketing, value is questionable, disparities are persistent, and the pace of improvement is slow. There is a tremendous need to focus and to establish goals to guide health reform, as the window of opportunity to push for reform is open. The current health care system does not emphasize the health of the population; rather it focuses on addressing acute health care needs as they arise as opposed to preventing them early on. In the long run, this results in more costly care, and a less healthy, less productive workforce.

Background on National Priorities Partnership®

The National Priorities Partnership (NPP) was convened by the National Quality Forum (NQF), whose mission is to improve the quality of American health care by setting national priorities and goals for performance improvement, endorsing national consensus standards for measuring and publicly reporting on performance, and promoting the attainment of national goals through education and outreach programs. The push for national priorities is being driven by the following:

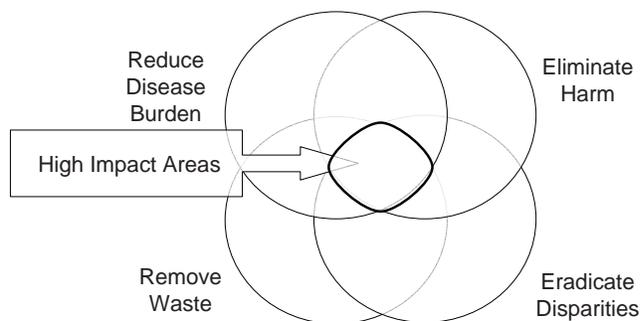
- **Focus:** The NPP seeks to center efforts on high-leverage areas to achieve a high return on investment (ROI).
- **Align:** The NPP seeks to harmonize the efforts of multiple groups around common goals for improvement.
- **Accelerate:** The NPP emphasizes the urgent need to drive fundamental change in the delivery system.

NPP is a group of 28 multi-stakeholder organizations, including consumers, purchasers, quality alliances, health professionals/providers, the public sector, accreditation/certification groups, health plans, and private sector organizations. Four additional organizations recently joined from the supplier, pharmacy, long-term care, and community sectors. Don Berwick, MD, President and CEO of the Institute of Healthcare Improvement, and Margaret O’Kane, President of the National Committee for Quality Assurance (NCQA), co-chair the partnership.

Selecting the Priorities

As shown in the chart below, NPP targets high-impact areas that reduce disease burden, eliminate harm, remove waste, and eradicate disparities. The selection of the priorities was informed by the existing evidence base. For some of the priority areas, the evidence on how to improve quality was more robust than for others. However, due to the collective importance of all the priorities

Selecting the Priorities: Criteria



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to patients and their families, this was not considered a limiting factor, but rather a way to focus needed attention on developing strategies and tools to address gaps in current knowledge as to what works best. Additionally, stakeholder input was also solicited from the NQF membership and others in the field.

Based on these criteria, NPP has identified six priority areas--population health, patient and family engagement, safety, care coordination, palliative and end-of-life care, and overuse. These priorities represent a shift to cross-cutting rather than disease-specific issues that have dominated discussions over the last decade. Each of these areas is described in more detail below, with greater depth provided in the area of population health.

All of the National Priorities have implications for employers and purchasers of health care, and all have the potential to improve the health of the population while reducing the high costs of care. For example:

- Improving safety can reduce the extra costs associated with infections and adverse drug events.
- Improving care coordination and reducing preventable readmissions can reduce the costs of unnecessary hospital stays.
- Increasing the use of palliative care and other end-of-life services can not only result in more satisfied patients and families, but also in the use of less aggressive and less costly care.
- Increasing shared decision-making can result in patients opting for less intensive care.
- Decreasing the use of unnecessary or unwarranted services will result in savings.

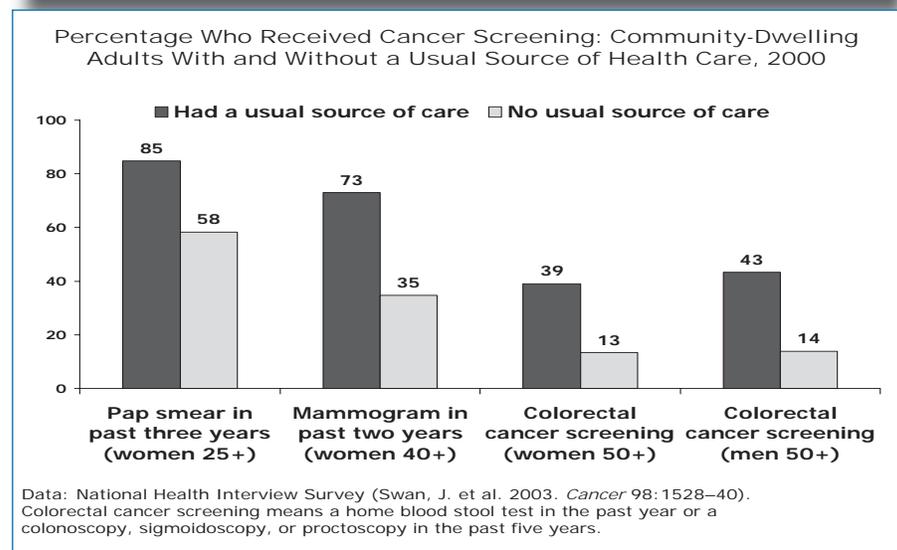
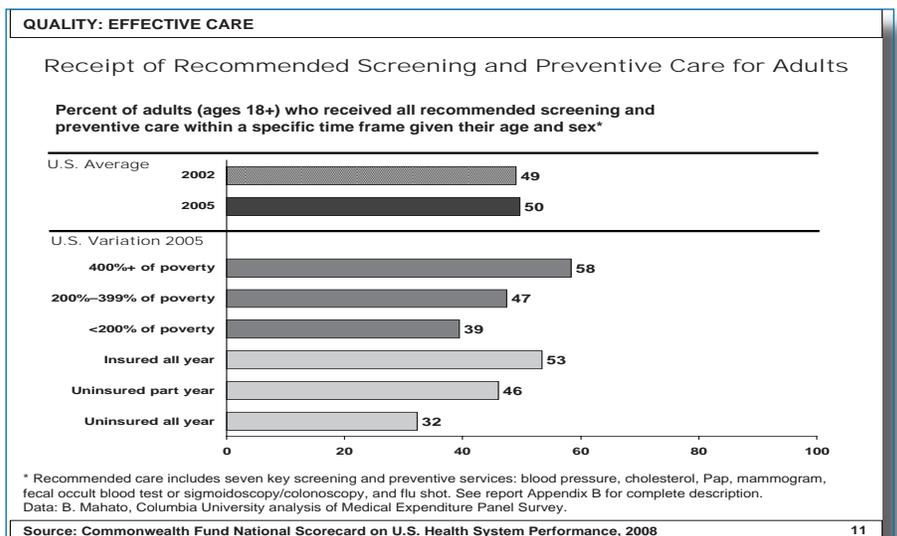
While discussions frequently focus on whether the provision of preventive services actually costs or saves money, population health encompasses much more than that--it aims not only to prevent illness, but to ensure a healthy, vibrant, productive American population.

Population Health

The overarching goal of this National Priority is to improve the health of the

population. To that end, NPP's vision is to create communities that foster health and wellness, as well as national, state, and local systems of care fully invested in the prevention of disease, injury, and disability. This would be accomplished through reliable, effective, and proactive programs to help all people reduce the risk and burden of disease. Areas of focus include widespread use of effective preventive services, adoption of healthy lifestyle behaviors, and the development of a national index to assess health status.

The Partners are working together to ensure that all Americans receive the most effective preventive services recommended by the U.S. Preventive Services Task Force (USPSTF). This is critical since, as shown in the charts below, only about half of Americans get recommended preventive services, with rates being particularly low among those who are poor or without insurance or a usual source of care. Wide variations in performance also exist across states.



Karen Adams, Ph.D., M.T., serves as Vice President of National Priorities at the National Quality Forum (NQF). In this role, she oversees the National Priorities Partnership, a multi-stakeholder initiative establishing priorities and goals for health care quality improvement and public reporting. Immediately prior to assuming her position at NQF, Dr. Adams served as Program Officer of the Commonwealth Fund's State Innovations Program. She has also served on several quality related projects at the Institute of Medicine (IOM). Before joining IOM, she served as Assistant Professor in the Department of Medical and Research Technology at the University of Maryland School of Medicine and as the academic coordinator of the undergraduate medical technology program. Dr. Adams received her undergraduate degree in medical technology from Loyola College, a master's degree in management from the College of Notre Dame, and a doctorate degree in health policy from the University of Maryland. She is also a certified medical technologist with experience in a variety of clinical laboratory settings.

To reach these goals, the NPP will facilitate the development of a composite measure of preventive services that can assess the extent to which each individual in the population and the population as a whole receives the most effective preventive services based on a prioritized list of recommendations of the USPSTF.

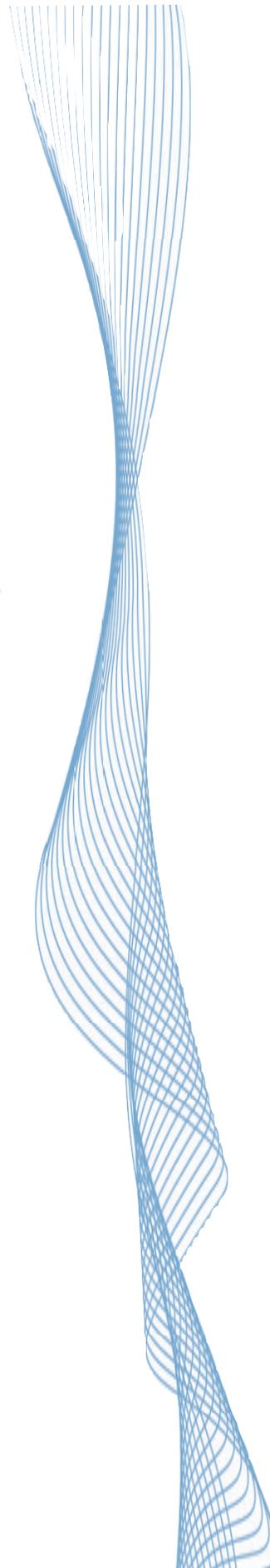
Another important goal is for the Partners to work together to ensure that all Americans adopt the most important healthy lifestyle behaviors known to promote health. For example, physical activity and good nutrition can help in combating the obesity epidemic, which is known to pose significant long-term risks to the population. In addition, smoking cessation counseling works, but is provided only 62 percent of the time. To encourage use of these programs, NPP will ensure or facilitate the development of a composite measure of interventions known to be effective in helping individuals adopt healthy behaviors, and a composite measure that can assess the extent to which each individual in the population and the population as a whole adopts the most important behaviors.

To promote achievement of both of these goals, the NPP facilitates the development of educational campaigns for the general public and health care professionals, and tools to collect data and improve performance on the measure in clinical practices and populations across the country. The NPP will also support individuals and clinical practices in improving the use of these important clinical preventive services, and work to develop and implement benefit designs, payment methods for health care organizations, and incentives for consumers that encourage use of the most effective preventive services and the adoption of healthy lifestyle behaviors.

A final goal related to population health is for the Partners to work together to ensure that health of American communities will be improved according to a national index of health that bridges the gap between the health care delivery system and public/community health. To get there, the NPP will ensure or facilitate the development of a national health index that addresses not only the contribution of health care to good health, but also the health behaviors of individuals, and the socioeconomic and physical environment factors that affect health. This index will be calculated and reported for all counties in the U.S., and the NPP will promote the spread of training and knowledge of interventions known to be effective in improving the health of Americans. NPP will support the efforts of stakeholders to demonstrate annual improvement in the health of their communities (especially for disadvantaged populations), and will promote coordination and cooperation between public and private health entities in working toward improvement in the health of the population.

Patient and Family Engagement

NPP envisions care that honors each individual patient and family, offering voice, control, choice, skills in self-care, and total transparency, and that can and does adapt readily to individual and family circumstances and to differing cultures, languages, and social background. NPP will strive to engage patients and their families in managing health and making decisions about care. Areas of focus



include patient experience of care (as measured on CAHPS surveys and other instruments), patient self-management, and shared decision-making.

Improve Safety and Reliability

NPP envisions a health care system relentless in continually reducing the risks of injury from care, aiming for “zero” harm wherever and whenever possible. Areas of focus include healthcare-associated infections, serious adverse events, and mortality.

Care Coordination

NPP envisions a system that guides patients and families through their health care experience, while respecting patient choice, offering physical and psychological supports, and encouraging strong relationships between patients and the health care professionals accountable for their care. Coordination needs to occur both within the delivery system and between the system and public health. To that end, NPP seeks to ensure that patients receive well-coordinated care within and across all health care organizations, settings, and levels of care. Key areas of focus include medication reconciliation, preventable hospital readmissions, and preventable emergency department (ED) visits.

Palliative and End-of-Life Care

NPP envisions health care capable of promising dignity, comfort, companionship, and spiritual support to patients and families facing advanced illness or dying, fully in synch with all of the resources that community, friends, and family can bring to bear at the end of life. To that end, NPP seeks to guarantee appropriate and compassionate care for patients with life-limiting illnesses. Areas of focus include relief of physical symptoms (pain); help with psychological, social, and spiritual needs; effective communication regarding treatment options and prognosis; and access to high-quality palliative care and hospice services.

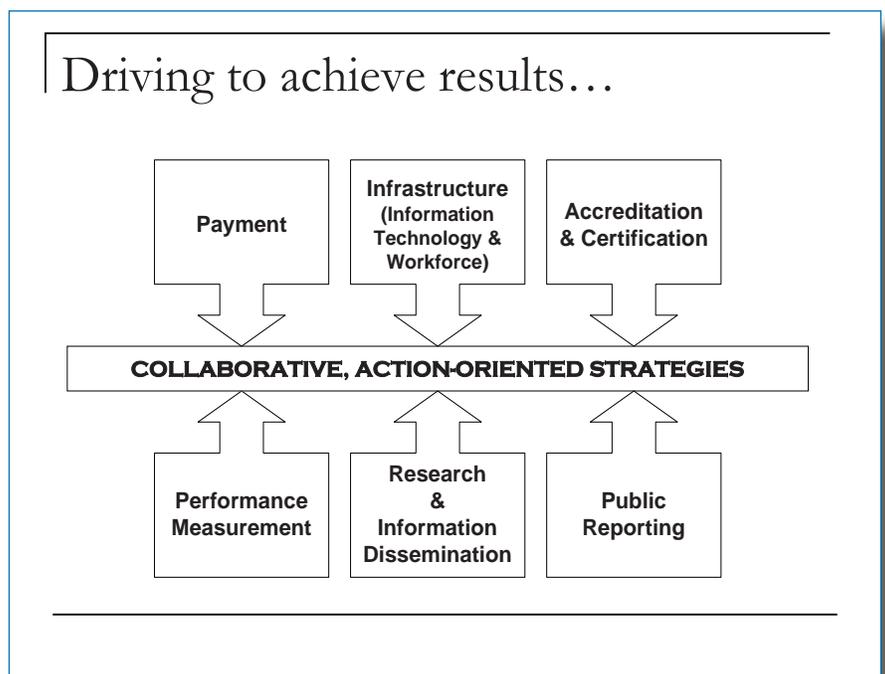
Overuse

NPP envisions a health care system that promotes better health and more affordable care by continually and safely reducing the burden of unscientific, inappropriate, and excessive care, including drugs, tests, procedures, visits, and hospital stays. For this priority in particular, it was critical to bring

stakeholders together who would most likely be affected by any identified targeted areas. To that end, the NPP reached out to specialty societies and others to identify opportunities to eliminate overuse while ensuring delivery of appropriate care. Key areas of focus that were agreed upon include inappropriate medication use; unnecessary laboratory tests; unwarranted maternity care interventions, diagnostic and therapeutic procedures, and consultations; preventable ED visits and hospitalizations; inappropriate non-palliative services at the end of life, and potentially harmful preventive services with no benefit. Many opportunities exist to reduce overuse, but this priority area will be particularly challenging given current payment systems (which generally emphasize volume over value) and the appearance of “rationing” care.

Moving Forward

The NPP continues to bring stakeholders from all sectors of the health care industry together, including national partners, NQF members, affinity groups, and communities, in an effort to make progress in each of these priority areas. As shown in the chart below, a variety of strategies will be used to stimulate development and implementation of collaborative, action-oriented strategies designed to achieve results—particularly those related to payment systems, infrastructure (both IT and workforce), accreditation/certification, performance measurement, research and information dissemination, and public reporting.



The year 2009 has been designated “the year of action” by the NPP. The Partners continue to work collaboratively to align efforts around the National Priorities and the key drivers of change. They are conducting outreach to other stakeholder groups to encourage them to join the effort, as only together can meaningful change occur.

Making the U.S. a Healthier Nation

Robert M. (Bobby) Pestronk, Executive Director, National Association of County and City Health Officials

Why is the U.S. not the healthiest nation in the world? There are many reasons, and stakeholders in every community should be asking this question on a regular basis. Health status improves one person at a time in response to the environment that the community collectively creates. Thus everyone has a responsibility to answer this question and take the steps necessary to do

something about it.

The U.S. is not a healthy nation today. As shown in the chart below, the U.S. trails many nations in health—by a wide margin. The U.S. spends \$7,500 per person, the equivalent of 16.2% of gross domestic product (GDP), which represents twice what other nations spend. Insurance premiums are hyperinflating, and as a result one in three Americans under age of 65 was uninsured during part of 2007 or 2008. Many uninsured are part of working families. In 2007, 50 million Americans reported difficulty paying medical bills, up by 14 million from 2003. With respect to quality, the nation also gets a failing grade, with 98,000 dying of medical errors each year, 40% of those with coronary artery disease receiving incomplete or inappropriate care, and 90% of those with alcohol dependence receiving the same. In addition, tens of thousand die each year due to infections acquired in the hospital, often because someone could not bother to wash hands.

The U.S. Trails Many Nations In Health

Infant Mortality Rate (Deaths/1000 live births)			Life Expectancy at Birth (years)		
Rank	Country	Rate	Rank	Country	Years
1	Singapore	2.30	1	Andorra	83.53
2	Sweden	2.75	2	Japan	82.07
3	Japan	2.80	3	Singapore	81.87
4	Iceland	3.25	4	San Marino	81.86
5	France	3.36	5	Canada	81.16
6	Finland	3.50	6	France	80.87
7	Norway	3.61	7	Sweden	80.74
8	Malta	3.77	8	Switzerland	80.74
9	Czech Republic	3.83	9	Australia	80.73
10	Andorra	4.03	10	Israel	80.61
11	Germany	4.03	11	Iceland	80.55
12	Switzerland	4.23	12	New Zealand	80.24
13	Spain	4.26	13	Italy	80.07
14	Israel	4.28	14	Monaco	79.96
15	Slovenia	4.30	15	Liechtenstein	79.95
16	Denmark	4.40	16	Spain	79.92
17	Austria	4.48	17	Norway	79.81
18	Belgium	4.50	18	Greece	79.52
19	Australia	4.51	19	Austria	79.36
20	Liechtenstein	4.52	20	Malta	79.30
21	Luxembourg	4.62	21	Netherlands	79.25
22	Netherlands	4.81	22	Luxembourg	79.18
23	Portugal	4.85	23	Germany	79.10
24	United Kingdom	4.93	24	Belgium	79.07
25	New Zealand	4.99	25	United Kingdom	78.85
26	Canada	5.0	26	Finland	78.82
27	Ireland	5.14	27	Jordan	78.82
28	Monaco	5.18	28	Bosnia and Herzegovina	78.33
29	Greece	5.25	29	Cyprus	78.15
30	San Marino	5.44	* 30 UNITED STATES	78.14	
31	Taiwan	5.45	31	Denmark	78.13
32	Italy	5.61	32	Ireland	78.07
33	Cuba	5.93	33	Portugal	78.04
34	South Korea	5.94	34	Albania	77.78
* 35 UNITED STATES	6.30		35	Taiwan	77.76
36	Croatia	6.47	36	Kuwait	77.53
37	Belarus	6.53	37	South Korea	77.42
38	Lithuania	6.57	38	Costa Rica	77.40
39	Cyprus	6.75	39	Cuba	77.27
40	Poland	6.73	40	Chile	77.15

Source: World Factbook, Central Intelligence Agency, 2008

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The employer coalition movement, moreover, suggests a growing recognition by employers of a diminished bottom line if employees are not healthy and employers and other stakeholders do not maximize the conditions that lead to health. Success will require the business community to join forces with city and county health officials.

The Challenges Facing Communities

Prospects for Reform

Prior to joining the National Association of County and City Health Officials (NACCHO), Mr. Pestronk served as chief health officer in Flint, MI, and director of the Genesee County Health Department. As a board member and officer for a number of non-profit organizations and businesses, he also helped create a local business coalition. As the health department director, he experienced many challenges and enjoyed some remarkable successes in spite of extreme conditions. In Genesee County, employment at General Motors dropped from 90,000 to 7,000 during his tenure, with an additional 1,000 jobs having been lost since he left six months ago. Recession and resilience were constant features of the county landscape, even as stakeholders worked to build a new future based on education, health care, and small business rather than manufacturing. Despite these challenging circumstances, health improvements did occur, including a reduction in African-American infant deaths and in racial disparities in infant mortality rates. The county also managed to provide medical coverage to nearly everyone under 175% of the federal poverty level, offering a primary care home and other services through a new health plan. In addition, regulations were changed to create conditions that led to some of the earliest tobacco-control measures in an area that is home to many blue-collar workers and single women—typical targets for tobacco promoters. These successes were achieved in partnership with the local business community.

The Structure and Role of Local Health Departments

NACCHO represents the nearly 3,000 local health departments that exist across the country. NACCHO assists these organizations in sharing best practices, tools, and models that work. NACCHO's national perspective draws on various permutations of state and local law. Thanks to its 100 employees (mostly knowledge managers and creators), NACCHO shares

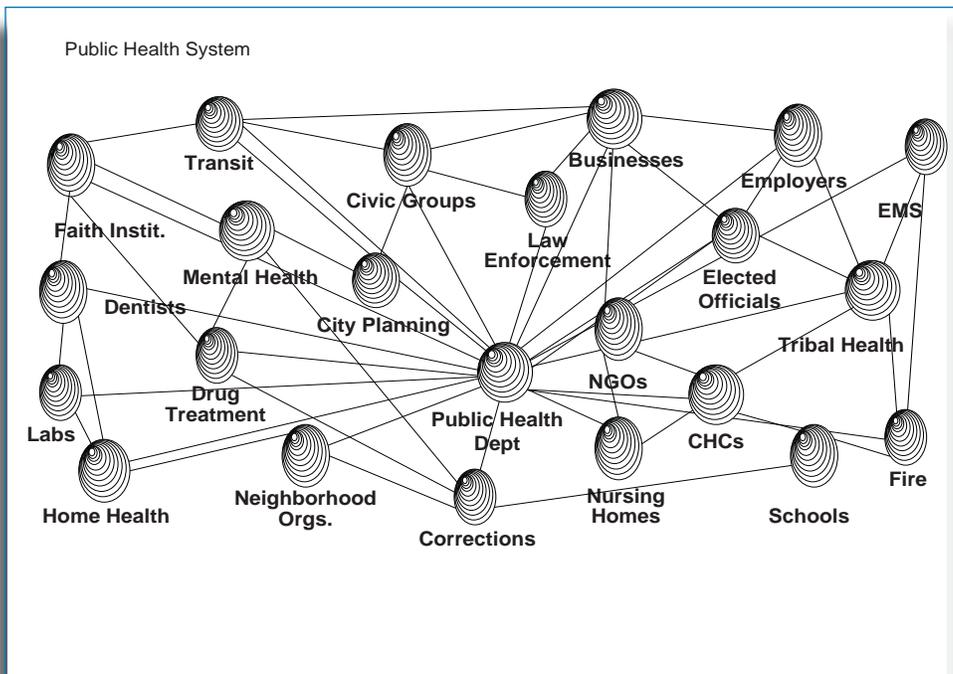
Robert Pestronk serves as Executive Director of the National Association of County and City Health Officials (NACCHO) in Washington, D.C. In this role, Mr. Pestronk represents local health departments and their staff in their efforts to protect and promote health, prevent disease, and establish the social foundations for wellness in communities across the United States. Prior to joining NACCHO in November 2008, he served as Health Officer in Genesee County, Michigan for 22 years, achieving successes in a number of areas, including setting up the 26,000 member Genesee Health Plan, putting in place tobacco control regulations, and reducing infant mortality rates (and racial disparities in those rates). He has held numerous leadership positions in various organizations, including being Past President and a board member of the Michigan Health Officers Association and the Michigan Association for Local Public Health, and serving on the board of NARSAD (the Mental Health Research Association), the Greater Flint Health Coalition, the Rotary Club of Flint, Priority Children, and Temple Bethel. He is a Primary Care Policy Fellow through the United States Department of Health and Human Services and trained as a Scholar through the Public Health Leadership Institute. He is Past President of the Primary Care Fellowship Society and the Public Health Leadership Society Council. He was a member of the IOM Public Health Roundtable and of the National Advisory Committee for Turning Point: Collaborating for a New Century of Public Health. He was the first President of the Public Health Law Association. He has received numerous awards and recognition, and has published many articles and book chapters. Mr. Pestronk received a Masters in Public Health degree from the University of Michigan School of Public Health and an Bachelor of Arts degree in politics from Princeton University.

products and tools, including written reports and publications, meetings, webinars, and the like. NACCHO works with hundreds of federal, state, and local agencies as well as domestic and international ones, all with the goal of improving the performance of local health departments, which range in size from having a few staff to employing tens of thousands. Whether large or small,

however, each of these departments has enthusiastic staff members who deliver and/or coordinate a range of services for those in the community.

As shown in the chart below, local health departments are part of a larger web known as the “public health system.” Depending on the type of jurisdiction involved, some public health departments are actively engaged in the delivery of services and/or managing hospitals or other sites. Other agencies may limit their activities to regulatory functions, such as licensing and inspection. Still others may create law, knowledge, and processes to address the social determinants of health.

decision-making on their part. Collectively, the nation has created the conditions that have led to it being ranked in the middle of the pack with respect to health status. To address this issue, communities need to create the conditions to make people healthy, and that is what public health departments are trying to do. To that end, public health departments use their limited resources to deliver the following essential services:



- Assessing and monitoring health status, including creating plans for improvement; business coalitions often tap into this knowledge and in some cases help to create it.

- Diagnosing and investigation health problems.
- Informing, educating, and empowering people.
- Mobilizing community partnerships.
- Developing policies, plans, regulations, and rules for the marketplace in the interest of community health. Health departments are part of the local governance structure, and hence give voice to collective desires.
- Enforcing laws and regulations.
- Linking people to needed health services.
- Assuring a competent workforce.

The governance structure for local health departments also varies, with 59% being run by county boards, 14% by city-county boards, 9% by a town or township, 10% by a multi-county district or region, and 7% by a city.

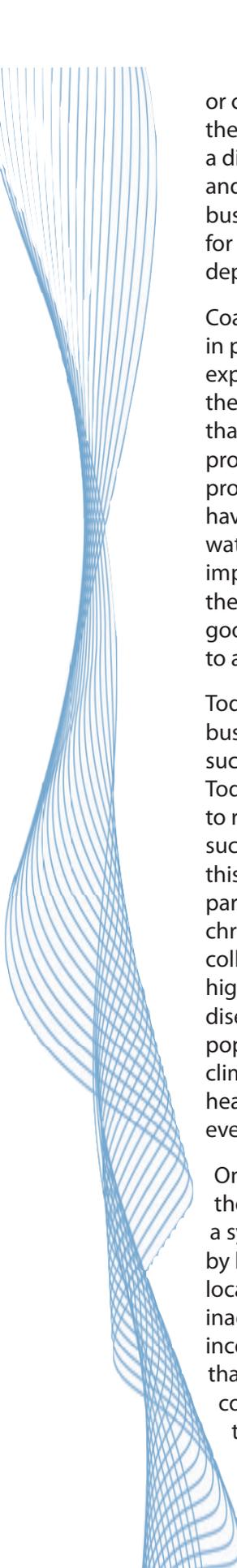
The work of local health departments generally involves helping area practitioners and residents see the conditions that account for present health status through a larger lens than they can see themselves. This knowledge helps them to understand why change in these conditions is necessary, and what work can and should be done for this change to take place. Local health departments also provide tools to help execute that change.

Healthy people do not happen by accident, and unhealthy people are not just the result of bad

- Evaluating health services.
- Conducting research for new innovations.

How the Business Community Can Work with Public Health

Local business and coalition leaders should introduce themselves to the local health department director, and both parties should seek to learn about each other’s activities and how to work together for the good of the community. Businesses rely on the services of public health departments, yet these departments lost 7,000 jobs collectively during 2008 and will likely lose twice that many in 2009 (the equivalent of an entire state’s public health department). These losses put the public at risk, creating problems with the food supply



or causing a community to focus resources on the wrong problems. These problems could have a direct, negative impact on the local workforce and corporate profits. As a result, coalition and business leaders should speak up and advocate for preserving funding and staffing for local health departments.

Coalitions also have an important role to play in promoting health, equity, and fairness. The explicit recognition of these principles has made the U.S. an attractive place to live historically, but that attraction is under threat today. To ensure promotion of these principles, four questions, promoted internationally by Rotary Clubs (which have had success world-wide assuring potable water, nearly eradicating polio and working to improve literacy), are important ones to ask: Is it the truth? Is it fair to all concerned? Will it build goodwill and better friendship? Will it be beneficial to all concerned?

Today more than ever, public health and the business community need to join forces. Rotary's success illustrates how this may be accomplished. Today's business and public health leaders need to respond to the current challenge and be just as successful. Public health officials would welcome this kind of partnership with business leaders, particularly as the nation faces new and emerging chronic and infectious diseases. The nation has collectively created the conditions that lead to high rates of heart disease, asthma, and infectious disease. Given the challenges of an aging population, health disparities, budget deficits, climate change, influenza, and the like, public health and business need each other more than ever to successfully negotiate these challenges.

One of the biggest current challenges is to reform the jumble of American health care, which is not a system at all. Today's health care is dominated by high (unaffordable) costs; huge regional and local variations in access, cost, and quality; an inadequately prepared workforce; and poor incentives that reward the wrong things. Rather than being a system, the nation has a random collection of activities that have accreted over time. Employees use this system, so it is up to employers to work with public health to fix it. The first task is to begin to focus on prevention and chronic disease management rather than fixing acute health problems.

The second task is to create the environmental conditions that promote health, including better access to high quality primary care, dental care, and mental health services built on the foundation of prevention. Today's allocation of resources—with an excess focus on treatment and relatively little attention paid to prevention—needs to be reversed.

While the public should theoretically be “up in arms” about the quality of today's health care disorganization, most consumers have no basis for comparison with other ways of organizing and delivering care, and no way to know how poorly the current jumble performs. But the business community should know better and should insist on major change rather than “tinkering around the edges.” The business community needs to demand organized systems of care with appropriate financial incentives that reward outcomes, as the system will not get better unless those stakeholders paying directly for care demand that it does. The goals of government and business are aligned in this area. While some protest reform because they fear it will lead to rationing, rationing already exists. In addition, the current system is dominated by huge variations driven by medical and professional guilds. As a result, the value of investments in health has eroded, and cost increases have become unsustainable. While reform efforts over the past 60 years have failed, failure is no longer an option, as community health must be put at the core of a new system.

The Alliance to Make US Healthiest

The Alliance to Make US Healthiest is a partnership between governmental public health organizations and the private and non-profit sectors. Its goal is to achieve better health by engaging Americans in conversation (e.g., through coalitions) so that they understand what needs to be done, helping people stay healthy, finding partners, leveraging innovations in technology (those that work best), improving health equity, and placing health in all policies. More information on the alliance is available at www.healthiestnation.org.

For example, while health care has historically focused on fixing what is broken, the placement of health considerations into all policies seeks to prevent things from breaking in the first place. These policies not only relate to health

care, but also to the environment, transportation, agriculture, housing, and education. Access to high quality education, early childhood development, and safe and decent housing affects health. But they each depend in part on income. To maximize the health of the population, communities need to construct conditions that make health the likely outcome of decision-making, so that other priorities do not take precedence. For example, the conditions that promote obesity (e.g., lack of fruits and vegetables in neighborhood grocery stores, an excess supply of fast-food chains in low-income neighborhoods, poor or unsafe options for supervised exercise) should not be allowed to occur in the first place. To help communities enact these kinds of policies, NACCHO promotes the conclusions and recommendations of the Robert Wood Johnson Foundation Commission on a Healthier America, the World Health Organization (WHO), and others, which can be adopted and adapted in local communities to make health and wellness (rather than care for illness) a priority.

Success will require an increased awareness of the decisions that have been made and the problems communities presently face. Success will also require community organizing, with strong business voices doing this organizing. Businesses need to recognize that a profit can be made from health (not just from illness and death), and should organize campaigns, advocate for policy changes, and confront through dialogue issues of race, gender, and class disparities. The focus should be on transportation, housing, employment, education, and financial market policies, as these are also health policies. Health impact assessments should be required and available for public inspection whenever policies in these areas are under consideration.

Conclusion

The present conditions that create poor health are not natural, fixed, or inevitable, but rather the result of decisions that have been collectively made by society. Society can collectively change them, just as society decided to end slavery and let women vote. The time has come to re-engage and learn from these experiences, and to address current inequities and problems. While this is a tall order, it can be done. The key question becomes—where to begin? To that end, the following activities should occur:

- Speak out, asking why the U.S. is not the healthiest nation.
- Seek more value from investments in health care.

- “Walk the talk” by taking at least one more specific action to improve health and model positive health behavior in the home, community, organization, school, or jurisdiction.
- Share successes by joining the Alliance to Make US Healthiest; tell others about programs and the difference they have made, and encourage colleagues to do the same.
- Hold each other accountable for success.
- Get to know the director of the local health department, as he or she shares the same goals. Local health departments represent attractive partners for the business community, and together these stakeholders can work to create the conditions that make people healthy.

Why Should Employers Care About Investing in Community Health?

Sara Palermo, MBA, Vice President, Mid-America Coalition on Health Care

Holly McCoy, JD, SPHR, Director of Human Resources at the American Academy of Family Physicians

Employers and employer coalitions benefit from improving the health of the local community, and have an important role to play in creating public-private partnerships to do so

Background on Mid-America Coalition on Health Care

The Mid-America Coalition on Health Care (MACHC) is not a purchasing coalition. Rather, it focuses on bringing partners together to improve the health of employees and their families, promote employee and community wellness, develop strategies to contain health care costs, and serve as a community resource in generating and communicating health care information. Founded in 1978 as a 501(c)3 organization, MACHC is the fourth oldest employer coalition in the nation, with 60 members responsible for 500,000 lives. The coalition operates in two states (Kansas and Missouri), which creates challenges with respect to state laws, taxes, etc. With 4 employees and a budget of \$500,000 (split between dues and donations), MACHC is run by a board of employers and all regional stakeholders, including health care organizations and public and private employers.

In 2000, U.S. Surgeon General David Satcher came to Kansas City, noting that the city was on the cutting-edge of building true public private partnerships to address major, community-wide public health issues. Such partnerships are critical, since, as the IOM and others have noted, the determinants of health remain beyond the capacity of any one practitioner or discipline to manage. As shown in the chart below, community health comes from the collaborative, combined work of employees, clinicians, and public health.



Public-private partnerships to build healthy communities provide value to each of the key stakeholders; examples of the kind of value that can be created include the following:

- **For public health:** The creation of a new setting to reach populations and the development of a better understanding of how to work with employers
- **For private partners:** The creation of credible, evidence-based tools and resources and the provision of technical assistance with the data (e.g., from public health epidemiologists)
- **For community health:** Better integration of programs, more consistent messaging across settings, and increased collaboration that generates innovative solutions

What is MACHC Doing to Promote Community Health?

MACHC is active in three distinct areas related to building partnerships for community health.

• **Facilitating public-private partnerships:** MACHC hosts monthly conference calls that bring together the public sector (e.g., local and state health departments, CDC, NBCH, and Region VII Health and Human Services) and the private sector (e.g., MACHC, NBCH, and their member organizations). MACHC also secures support from public health for employers, including programming to meet identified needs, technical assistance with assessments, analytics, etc., and financial support for community initiatives.

• **Translating tools and practices:** MACHC is very active in this area, including being engaged in the following activities:

- Using employer data to identify priority areas, such as cardiometabolic risk factors.
- Identifying and implementing programs and tools to address needs, such as intervention grid cards for each key risk factor, a chronic disease self-management program, and an ROI tool developed by the National Association of Chronic Disease Directors.
- Communicating employer needs back to public health, including evaluation and feedback for the CDC Heart Healthy, Stroke Free Worksites Toolkit and the CDC LEAN-Works! Study (which employers are currently evaluating).

• **Leading community health initiatives:** MACHC is leading initiatives on depression and cardiovascular health and disease, and overseeing the *Building a Healthier Heartland* initiative.

- The depression initiative, launched by the U.S. Surgeon General in 2001, included 15 employers and 140,000 lives. This Institute of Medicine-recognized program sought to decrease the stigma associated with depression and to create an infrastructure for the appropriate diagnosis and treatment of depression.
- The cardiovascular initiative, also recognized by CDC as a leading “promising practice”, seeks to improve community awareness of cardiovascular risk factors and secondary prevention, and to reduce related health care and productivity costs. The stakeholder partnership for this initiative includes 14 employers with over 400,000 covered lives, the CDC, the Kansas and Missouri Depart-

ments of Health, the American Heart Association, the Sunflower Foundation, the Kansas Health Institute, and three pharmaceutical companies. The initiative has brought together all the key stakeholders to identify where during the many patient touch points and handoffs the process breaks down. These discussions identified delays in seeking treatment as a key factor in low survival rates for cardiovascular events; delays were found to be driven by low bystander activation/response, low use of cardiopulmonary resuscitation (CPR), delays in calling 911, and lack of access to automatic external defibrillators or AED (and low use when they are available). To address this issue, the initiative put in place training sessions on CPR with AED and developed an evaluation plan and a response plan to further the goal of saving the lives of those experiencing cardiac arrest.

➤ The *Building a Healthier Heartland* initiative seeks to improve the health of the community by aligning stakeholders around nutrition, physical activity, and smoking cessation. MACHC is the lead partner with HHS Region VII and the Kansas City, MO Health Department. The program has been developed in response to a growing employer need to address weight management. At present, the program is engaged in development and capacity-building activities. In the fall of 2009, a partner kickoff meeting will take place. In February 2010 (which is National Heart Month), a highly visible community launch will occur with employees and others.

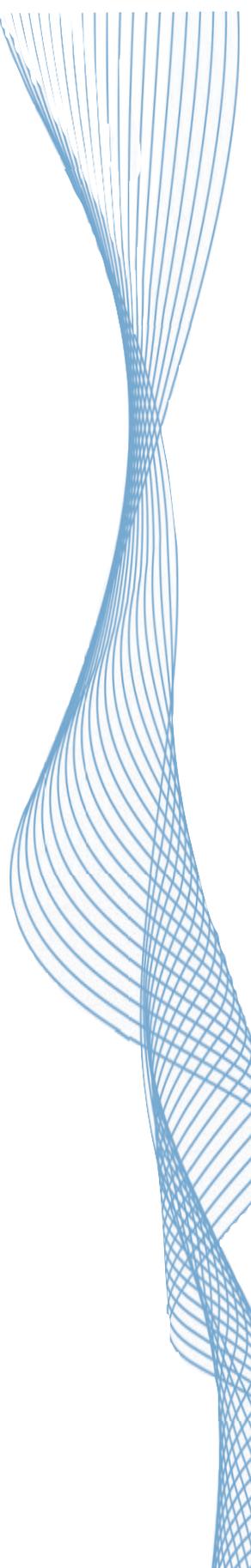
MACHC is just starting to look at the social determinants of health. The coalition hopes to make the case to employers on the importance of these factors by quantifying their impact on health. The first step, however, is to understand the current social environment in which people live, such as whether there are sidewalks, grocery stores, and the like, and the degree to which behavioral health risks exist in the community. Much of this information is not yet known.

Sara Palermo, MBA, is Vice President at the Mid-America Coalition on Health Care in Kansas City, Missouri. The Coalition is a non-profit organization of 60 large employers (covering 300,000 lives regionally and 1.5 million world-wide) and stakeholders in Kansas City's bi-state regional health care delivery system; coalition members work together to improve the health and wellness of the region's citizens. In her position, Ms. Palermo has primary responsibility for managing the Coalition's Value-Based Benefits initiative, The Kansas City Collaborative, and initiatives related to public-private partnerships linking employers with organizations such as state departments of health, CDC, and Region VII Health and Human Services. She also provides leadership to the Missouri and Kansas Departments of Health Heart Disease and Stroke Prevention State Advisory Boards. She is also a member of NBCH's Community Health Partnerships Committee and Marketing and Communications Committee, the National Transitions of Care Coalition Advisory Board, and the American Heart Association's Community Strategies Council. Ms. Palermo received a bachelor's degree in Psychology from Avila University and an MBA from Keller Graduate School.

Holly D. McCoy, JD, SPHR joined the American Academy of Family Physicians (AAFP) in 2004 as Director of Human Resources. In this role, she oversees all AAFP human resource functions, including employee benefits, development, recruiting, employee relations, and administration. Prior to joining the AAFP, she served 13 years as Vice President of Human Resources for Farmland Industries, Inc. Before moving into the human resources field, Ms. McCoy practiced law as in-house counsel for Farmland as well as in private practice. An active participant with MACHC since 1991, Ms. McCoy served on the Coalition Board of Directors and participated as an employer representative on a number of MACHC initiatives, including the Kansas City Collaborative on Value-Based Benefits, the Community Initiative on Cardiovascular Disease, the Community Initiative on Depression, and the Kansas Employer-Provider Taskforce. Ms. McCoy earned an MBA from Rockhurst University in Kansas City, MO, a JD from University of Missouri – Columbia, and an undergraduate degree in sociology and history from Drury University in Springfield, MO.

Perspective of the American Academy of Family Physicians

The American Academy of Family Physicians (AAFP) is a not-for-profit, professional organization for family physicians with 94,000 members. Key activities include advocacy, education, medical publications, and public



health initiatives. As an employer, AAFP has 380 employees and 665 covered lives in a fully insured plan. Primarily working in an office environment, AAFP staff are primarily female (75%), with an average age of 42.

AAFP has been involved with MACHC as a member since 2004. Bruce Bagley, MD, the Medical Director of Quality Improvement with AAFP, sits on MACHC's board of directors. In addition, AAFP's human resources staff actively participates in MACHC initiatives from an employer's point of view.

Employers such as AAFP care about building healthy communities for a variety of reasons. First and foremost, health care issues are systemic, and systemic changes cannot be made alone. Better solutions come from the sharing of ideas and perspectives. In addition, because employees frequently move between employers and/or are recruited from the community, everyone has an interest in community health. In fact, the children who live in the community will likely one day be employees of local companies. Thus, it is critical for the entire community to support health promotion and prevention, to develop resources to assist in this work, and to provide a consistent message to the community. To that end, AAFP has been actively working with MACHC on its key initiatives as well as coordinating with community entities directly, as outlined below:

Depression Initiative

Described earlier, this program began in 1998 with 8 Kansas City area employers, and grew to 15. Ms. McCoy was involved with the early years of this initiative with a previous employer, Farmland Industries, Inc. Employers used the CDC's *Behavioral Risk Factor Surveillance Survey*, administered by the Kansas City Department of Health and Environment to 45,000 employees. The results identified depression as a critical area, given the large costs of anti-depressant medications (even though less than 1% of claims related to depression). The group chose depression because it is one of most prevalent yet undiagnosed and untreated diseases in the workplace. It also tends to

occur with other chronic conditions and has a significant impact on productivity and disability costs. Stakeholders felt they needed to raise awareness of the illness in the medical community and among the population at large, and to encourage individuals to seek treatment. The overall goals were to destigmatize depression, identify its direct and indirect costs, and create the community infrastructure required to support appropriate and timely diagnosis and treatment. To that end, employers administered an employee attitude survey (this survey was not seen as threatening by employees, since they knew that all major employers were participating), developed educational materials, worked with the physician/provider community, and shared information with other employers and the community at large. The survey found that two-thirds of employees felt that their employers had few resources to help with depression and/or did not know how to access those that were available. Yet most, if not all, of the employers had employee assistance programs and provided mental health benefits, suggesting a strong need to educate employees.

The program truly represented a community-wide effort, with 15 employers (representing 140,000 lives) participating, along with health plans, clinicians, local health departments, community/civic organizations, and the media. The AAFP was involved in the initiative starting in 2004 with an effort to educate employees and managers about depression.

Community Initiative on Cardiovascular Health (CICV)

The aforementioned CICV initiative is now in its fourth year. The program, which includes 14 employers, providers, and public health agencies, focuses on health, lifestyle, and behavioral issues related to modifiable cardiovascular risk factors. The initiative provides worksite activities to promote cardiovascular health; data to identify needs, evaluate the effectiveness of various interventions, and calculate the ROI; coordination of care for those with acute coronary syndrome; and value-based benefit design through participating employers.

Kansas Cardiovascular & Stroke Advisory Council

This council includes state and local public health officials, employers, and other community representatives. The council is responsible for development of key documents and action plans for the CDC, including the statewide burden document and cardiovascular state plan. A public education subgroup has created a toolkit for identifying signs and symptoms and the “Chain of Survival” (911-CPR-AED-Sustained Treatment). The goal is to make sure Kansans know the signs and symptoms of a stroke and heart attack. The kit is being distributed through employers, churches, and community organizations. The participants are also working to achieve a “Heart Safe Community” designation.

Pandemic Flu

Pandemic flu and other crisis management is a community-wide issue. Employers cannot create plans to deal with these types of crises in a vacuum. Rather, what the schools, public health, emergency personnel, and others do will affect whether employees come to work during a crisis.

While not an MACHC initiative, AAFP staff coordinated with local public health agencies in developing a plan in 2006-2007. Staff participated in a task force made up of public health, emergency management, and business representatives to figure out how to respond to a pandemic, including whether worksites could become vaccination sites for the community. AAFP also participated in a Citizen Engagement Study done by the Metropolitan Area Regional Council. This study involved 23 focus groups conducted in churches, neighborhood groups, councils, community centers, and other venues to find out how citizens would likely respond to a pandemic flu situation. The goal was to gauge the preparedness of individual citizens and institutions, and to identify the barriers in a pandemic flu situation. Key findings were that people know little about the pandemic flu; that the need for a paycheck represented the biggest barrier to keeping people at home and isolated; that few businesses have plans to let people work from home in the event of a pandemic; that neighborhood, church, and school leaders could be vital, but few are presently involved; and that people are likely to disregard public health advisories if they need to care for children or parents. The focus groups helped the stakeholders to figure out how to address these issues and to improve the community’s overall level of preparation for an epidemic.

AAFP developed its own employer pandemic flu plan based on WHO classifications. The plan includes a “containment leave” policy that allows staff to not come to work without using vacation or sick leave. While the area has not yet seen many H1N1 cases, AAFP has been active in educating staff about prevention (e.g., through thorough and regular hand washing) and have instructed managers not to make people who are sick come to work. Thus far, AAFP has not yet recommended that managers send people who are coughing home from work, nor has it activated its containment leave policy.

Community Well-Being Index and Community Health Intervention Strategies

Larry Boress, President and CEO of the Midwest Business Group on Health (Moderator)

Kurt Schusterman, Vice President and General Manager of the Gallup-Healthways Well-Being Index

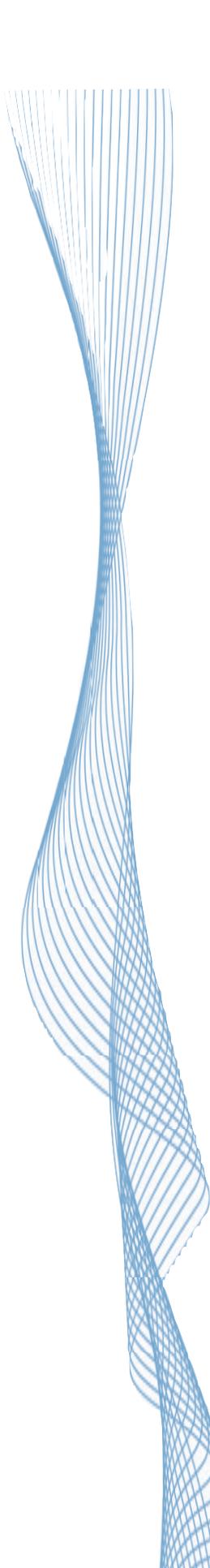
Jake Glover, Director of Health and Wellness Initiatives at America’s Health Insurance Plans

Richard Yoast, M.A., Ph.D., Director of the Department of Prevention and Healthy Lifestyles within the Division of Medicine and Public Health at the American Medical Association

Employers and other stakeholders need to understand if the money they spend to improve population health yields dividends. The key is to have metrics by which to measure whether people are in fact improving their health status. This section includes a discussion of one possible metric for measuring population health, along with a review of specific community health intervention strategies that appear to have been successful in improving population health.

Gallup-Healthways Well-Being Index™

Current estimates suggest that the U.S. spent \$2.2 trillion on health care in 2007, with annual increases of 6.2% expected over the next decade. The share of GDP accounted for by health care spending is expected to rise from 17.6% today to 20.3% in 2018. The U.S. spends twice as much as Europe on chronic care, yet the population appears to be twice as sick. At present, roughly two-thirds of the working population has more than one chronic condition; in fact, chronic diseases are expected to cost \$6 trillion by the middle of the century. The more conditions an individual has, the more days that he or she



misses work. In short, if present trends continue, today's economic situation will appear mild compared to the economic disaster the nation will face due to rising health care costs. Addressing this problem is everyone's business, and will require having the right financial incentives and creating some accountability for a definitive outcome—i.e., improved population health.

Background on Healthways

Healthways is a \$700 million public company that sells services through health plans and directly to larger employers. The company's stated mission is to create a healthier world, one person at a time. The strategy is to start with the individual, then branch out to the workplace and the community. The organization has embraced the WHO definition of health—i.e., a "state of complete physical, mental, and social well-being, and not merely absence of disease or infirmity."

The company began its efforts in diabetes care, then moved to a wider array of disease management interventions. Through the acquisition of Axia, the company moved into corporate wellness, and now continues to expand its offerings by providing a comprehensive range of programs to improve workplace well-being. Two years ago, the company's leadership put a "stake in the ground" by embracing the WHO definition of health and targeting a person's overall well-being. To fulfill its mission, Healthways has many different lines of business, including technology and fulfillment operations, care enhancement centers, coaching centers, home-based nurses/coaches, fitness center networks (e.g., local YMCAs, Curves), and an alternative medicine network.

The underlying value proposition behind these services is that by improving physical, emotional, and social well-being, Healthways can help to reduce total health care costs and improve the performance of employees, thus creating a relative national and local competitive advantage from an employer's health investments.

Creating a Measure to Gauge Progress

Noting the long-held adage that "what gets measured gets improved," Julie Gerberding,

MD, former director of the CDC, has long advocated the development of a community health index that would allow local communities to measure the health status of the population, and then work to improve it. Accepting that challenge, Healthways has worked with the Gallup organization to develop the Healthways-Gallup Well-Being Index™. The primary goal of this effort is to create a shared vision of improved well-being, which should help to change the debate and expand the focus from health care delivery to overall health and well-being. By creating a measure that can credibly assess the state of health and well-being, Healthways and Gallup hope to stimulate improvements in health status, reduce costs, and improve productivity and business results through the development and implementation of known-to-be-effective interventions and programs that help people to stay healthy by mitigating health-related risk from lifestyle behaviors and optimizing care for those with health conditions.

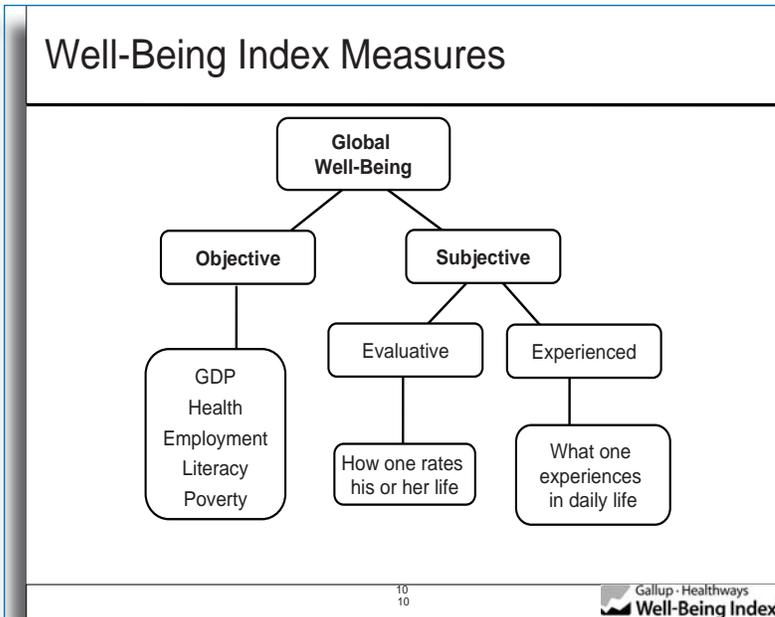
Multiple industry stakeholders have come together with the government in this effort, including America's Health Insurance Plans (AHIP), pharmaceutical companies, hospitals, labor unions, and others. Collectively, these stakeholders have pledged to lower the rate of growth in health care spending by 1.5% a year over 10 years, yielding an estimated \$2 trillion in savings. To reach this goal, they have pledged to work to curb obesity, promote wellness, coordinate care, manage chronic illnesses, standardize insurance claims forms, and increase use of EMR and other IT. But to realize this goal, there is a strong need for a definitive statistic that everyone can use to gauge progress.

How the Measure Works

Gallup and Healthways have made a 25-year commitment, initiated January 2, 2008, to track the well-being of Americans using an index with six domains—life evaluation, emotional health, physical health, healthy behavior, work environment, and basic access. Results are being measured through a telephone-based "community" survey, with 1,000 surveys completed every day (7 days a week). In 2008, 355,334 surveys were completed; by the end of May 2009, over 500,000 will have been

completed. The survey is being administered with design support and oversight from leading behavioral economists, psychologists, and experts in psychometric survey design and statistical analysis. The survey targets individuals in a way that replicates the demographics of the overall U.S. population.

As shown in the chart below, global well-being is a function of objective measures such as GDP, health, employment, literacy, and poverty, and subjective measures, including evaluative ratings (how one rates his or her life) and everyday experiences.



More details on the individual components of the index are provided below:

- Life evaluation:** The life evaluation component uses the Cantril “self-anchoring striving scale,” a measure first developed in 1965 by Hadley Cantril and his colleagues at Princeton. The survey questions ask Americans to evaluate their lives by imagining a ladder with steps numbered from 0 to 10, with “0” representing the worst possible life and “10” the best. Participants rate both their present life situation and anticipated situation in five years. Results are grouped into three categories—those who are thriving (with a current rating of 7 or higher and an outlook of 8 or higher), struggling (with a present rating above 4 and below 7), and suffering (with a present rate below 4). Results suggest that those who thrive tend to have higher incomes, more education, and good health and social support. Strugglers tend to worry about making ends meet on a day-to-day basis, while those who are suffering tend to have lower income and less edu-

cation and access to basic needs such as food, shelter, and health care. One’s life evaluation can have a profound impact on overall health care costs—for example, a comparison of two women with similar demographics and one chronic disease shows that one who is thriving costs roughly \$5,000 less than others in her cohort, while one who is struggling costs \$1,300 more. As shown in the chart below, life evaluation scores dropped significantly as the economic crisis unfolded in the fall of 2008, but have since rebounded somewhat.

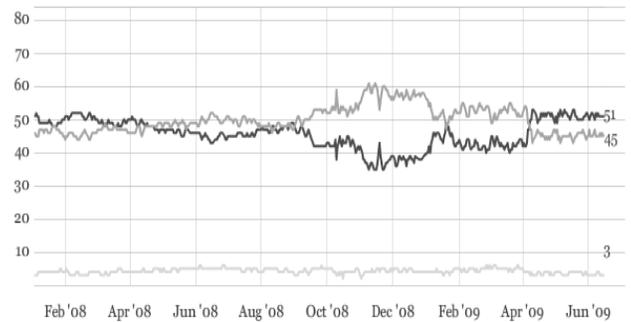
Daily Pulse - Thriving-Struggling-Suffering

Gallup Daily: U.S. Life Evaluation

Three-day trailing average through June 12, 2009

Based on the Gallup-Healthways Well-Being Index

■ % Thriving ■ % Struggling ■ % Suffering



13 Gallup - Healthways Well-Being Index

- Emotional health:** The emotional health index is a composite of individual’s daily experiences. Respondents are asked to think about yesterday from the morning until the end of the day, including who they were with, what they did, and how they felt. The index is based on responses to 10 items, including smiling or laughter, learning or doing something interesting, being treated with respect, enjoyment, happiness, worry, sadness, anger, stress, and diagnosed depression.
- Physical health:** The physical health index is comprised of a composite of nine items that combine history of disease with daily health experiences, including estimates of body mass index, disease burden, sick days in the past month, health problems that get in the way of normal activities, obesity, feeling well-rested, daily energy, daily colds, daily flu, and daily headaches
- Healthy behavior:** The healthy behavior index includes items that measure lifestyle habits with

established relationships to health outcomes, including smoking, diet, and physical activity. Sample questions include:

- Do you smoke?
 - Did you eat healthy yesterday?
 - In the last seven days, how many days did you eat five or more servings of fruits and vegetables, and how many days did you exercise for 30 minutes or more?
- **Work environment:** The survey asks workers the following questions:
 - Are you satisfied or dissatisfied with your job or the work you do?
 - At work, do you use your strengths to do what you do best every day, or not?
 - Does your supervisor at work treat you more like he or she is your boss or your partner?
 - Does your supervisor always create an environment that is trusting and open, or not?

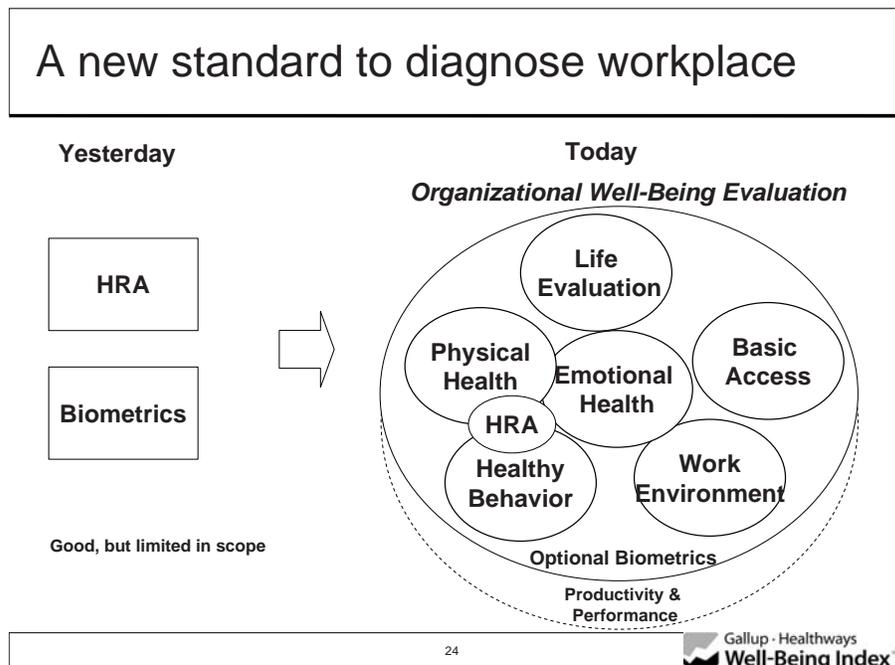
- **Basic access:** This index measures 13 items related to an individual's access to food, shelter, health care, and a safe and satisfying place to live, probing whether the individual has enough money for food, shelter, and health care; whether they have health insurance and a doctor; whether they have visited a dentist recently; satisfaction with the area or community; availability of clean water, medicine, and affordable fruits and vegetables; and whether they feel safe walking alone at night and have a safe place to exercise.

not been able to re-invent themselves, and hence are losing population.

Going Forward

Phase one of the project has been completed with the launch and establishment of the Gallup-Healthways Well-Being Index™, with a focus on communities. Phase two, scheduled for 2009, will focus on launching a survey to measure well-being of sub-populations at an organizational level. Phase 3, which will begin in 2009 and continue in future years, will focus on demonstrating a quantifiable impact on costs and productivity through evidence-based interventions.

Gallup and Healthways will use two models of well-being surveys in this work—the Gallup-administered telephone-based survey described earlier and a Healthways-administered web-based survey that will be benchmarked against the community survey and will target specific populations. In addition to covering the six domains described earlier, the focus of this survey will expand to include health risk appraisals (HRA), productivity, and absenteeism. The goal of this effort, as shown in the chart below, is to create a new standard to diagnose the workplace that goes beyond HRAs and biometrics to incorporate overall organizational well-being.



Results to Date

Survey responses thus far show wide variations in the index across the country, with the west generally enjoying higher well-being than the rest of the country. Results broken down by Congressional district (which have been shared with members of Congress) demonstrate wide variations across areas and states. City-specific results suggest that those cities with the highest well-being tend to attract new residents, while those with lower well-being tend to be industrial towns that have

To that end, Healthways has developed a *Well-Being Report*, which benchmarks an organization's population

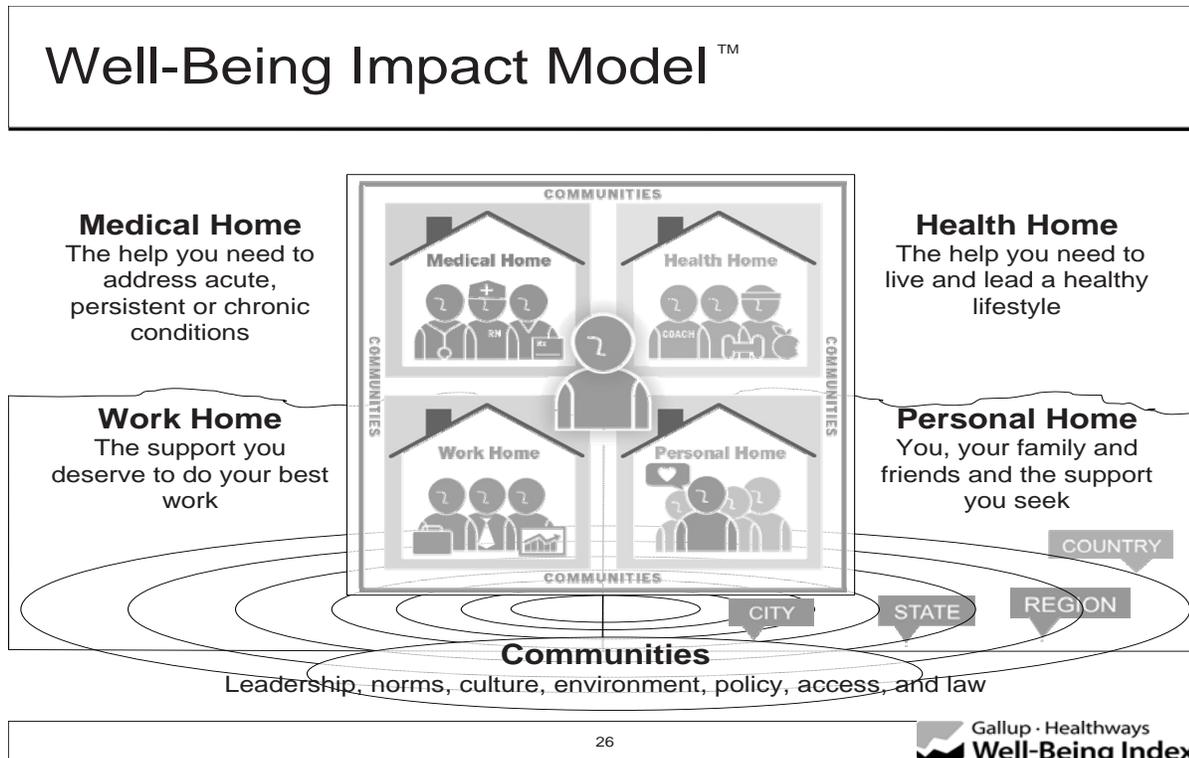
against the national *Well-Being Index* scores; provides an embedded NCQA-certified HRA; and offers analysis around the culture of health and productivity within the organization.

As shown in the chart below, Healthways has also developed a Well-Being Impact Model™ that evaluates well-being in four areas—medical home (to address acute, persistent, or chronic conditions), health home (help in leading a healthy lifestyle), work home (to support one in doing the best work possible), and personal home (support for the entire family).

of resources to those areas where the largest impact can be made.

- Participation demonstrates innovative thought-leadership.

A coalition or corporation can conduct the survey in its own population for a relatively modest cost—under \$5,000 for a 1,000-person corporation. And as noted, rankings from counties, cities, Congressional districts, and the like are already available free of charge.



Why Employers Should Care

Employers are responding positively to, and engaging in, this new well-being index, for several reasons:

- They have to give up nothing to advance to this new standard.
- The index provides benchmarks against an official, definitive national statistic; participating employers can get years of trend data and insight before anyone else.
- The index provides insights into barriers to higher productivity and lower health care costs.
- The index helps to prioritize the allocation

Summary

The Gallup-Healthways Well-Being Index™ provides a comprehensive picture of well-being that can be used to do the following:

- Develop benchmarks for well-being at a national, regional, and local level, and by job classification, disease, condition, and the like.
- Gain insight into the health of the population within a community, employer, union, military unit, etc.
- Evaluate the effectiveness of programs and interventions on overall well-being.

- Identify the drivers of well-being for specific groups.
- Understand the relationship between physical and emotional health.
- Tailor health solutions for employers by profiling their unique employee population.

Community Health Intervention Strategies

Several organizations have put in place health intervention strategies at the community level that are designed to improve the well-being of specific populations by using the well-being index described in the previous section.

America's Health Insurance Plans (AHIP)

Since recruiting Mr. Glover as Director of Health and Wellness Initiatives, AHIP has been working to promote adoption by corporations of wellness programs and other techniques that have been proven to work in professional sports and adapted for use in schools. After having talked about the importance of wellness and prevention for decades, AHIP's leadership believes that now is the time to act to make a difference.

Background: Effectiveness of School-Based Programs

Mr. Glover's past work includes working with a school district where 63% of children were obese; this year there are no obese children in the district. How did this happen? The program began with every child being given a heart rate monitor and being told to engage in 30 minutes of physical activity within their target heart range each day; graduate students download data from the monitor on a daily basis to gauge levels of physical activity.

To reach the 30-minute goal, children were encouraged to engage in novel forms of physical activity, such as roller blading (a grant provides roller blades to the children). Parents were engaged as well—for a child to participate, one parent had to come to a session and try to roller blade. Eventually every parent came. Parents also had to participate in group-exercise programs such as hip-hop dancing. (A local John Deere plant signed on to the program and realized a 43% reduction in obesity.) Each day the children learned new

principles about physical activity, but remained free to get their 30 minutes of activity in any way they would like. Coaches taught the children novel ways to meet the requirement, such as doing dynamic warm-up exercises on the treadmill, participating in an interactive dance video game, and the like.

The U.S. Secretary of Education came to the school to learn how the district eliminated obesity, and how the model could be replicated elsewhere. Mr. Glover initiated a similar program in Brooklyn, where he initially did not get a warm reception. Over time, however, he was able to develop novel programs, such as a "muscle and joint hip-hop rap" song, that engaged the children. Thus far, the program has reduced the rate of obesity from 52% to 36% in one year.

Adopting the Model in Corporate America

After AHIP recruited Mr. Glover, he began working with member health plans and employers to adopt similar kinds of physical activity programs within corporations. The goal is to go outside of traditional health care and to go beyond the statistical reporting of data to actually get something accomplished.

The typical program works very similarly to the school-based programs described above. Employees receive heart rate monitors that allow for data to be downloaded to a common site. (The cost of such monitors range from \$30 to \$180.) Within companies, participants are assigned to be on different "professional football teams," with levels of physical activity being translated into yards on the football field, which in turn are tied to incentives. Individuals and teams can track their daily, weekly, and monthly activities, and receive incentives based on performance. At the end of the "season," participants can cash in their points for products. To date, the program has been highly successful at a number of companies (e.g., Cox Communications), with employees quickly becoming very engaged.

The program has partnered with the Gallup-Healthways Well-Being Index™, which is helping to analyze the data. AHIP, moreover, has purchased the rights to host the Congressional district ratings, which can be sorted by income and other factors and used as a research tool.

American Medical Association (AMA)

Part of the AMA's mission is to promote the health of

Larry Boress serves as President and CEO of the Midwest Business Group on Health (MBGH), one of the nation's leading non-profit business coalitions. Founded in 1980, Chicago-based MBGH is composed of over 90 major, self-funded, public and private employers having headquarters or employee populations in the Chicago metropolitan area. MBGH member firms provide health benefits to over 2 million lives, spending close to \$2.5 billion on health benefits annually. Mr. Boress oversees all of MBGH's educational, networking, group purchasing, research, and advocacy activities. He assists member companies in formulating benefit designs, measuring the performance of providers and health plans, and sharing benefit management strategies. In this role, he conducts employer roundtables on onsite clinics, consumer engagements, consumer-directed health plans, pharmacy benefits, wellness strategies and union benefits. Prior to joining MBGH in 1991, he spent 17 years at the Illinois State Medical Society. During that time, he assisted physicians in their practices and represented the medical profession in its relationships with hospitals, regulatory agencies, and affiliated professional organizations. Mr. Boress currently serves on the NCQA Health Promotion Program Advisory Council and the Coalition for Quality and Patient Safety in Chicago, and is co-chair of the Illinois Partnership to Fight Chronic Disease. He received a Masters in Public Administration from Roosevelt University and a Bachelors of Arts degree from Northern Illinois University, and is also a Certified Association Executive.

Kurt Schusterman serves as Vice President and General Manager of the Gallup-Healthways Well-Being Index. He has spent his career building brands and divisions within Fortune 500 companies as well as growing smaller emerging enterprises. Previously, Mr. Schusterman served as Chief Marketing Officer for Hands-On Video Relay Service, a niche telecommunications company that provides video relay services for the deaf community. He has also worked with a private equity firm to build a chain of medical spas around the nation called Sona MedSpa, and led the re-branding effort of the Mail Boxes Etc. franchise network (with over 4,500 locations) to The UPS Store, one of the largest re-branding efforts in retail history.

Mr. Schusterman holds a bachelor's degree in marketing from Miami University (Ohio) and a master's degree in advertising from Northwestern University.

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Richard A. Yoast, PhD, serves as Director of the American Medical Association (AMA) Department of Prevention and Healthy Lifestyles, which addresses issues related to alcohol, tobacco, nutrition, exercise, drug abuse, and health promotion. Prior to taking on this role, Dr. Yoast directed two RWJF National Program Offices at the AMA addressing alcohol policy. He currently serves as the lead AMA science staff for alcohol, tobacco, and other drug abuse issues. Other positions held by Dr. Yoast include the following: principal investigator for several research projects; director of Tobacco Control for the State of Wisconsin and the Wisconsin ASSIST Project (with one statewide and 32 local coalitions); director of the Wisconsin Clearinghouse and Prevention Resource Center on Alcohol and Other Drugs (at the University of Wisconsin-Madison); and university lecturer. He has published numerous articles, presented at many national and international conferences, and consults on community and university alcohol policy and advocacy strategies.

the public. To that end, the AMA is engaged in several projects designed to support environmental policies that have a positive impact on health.

Benefits of Environmental Policies

Environmental policies can serve a variety of functions, including protecting individuals from risk; limiting exposure; reducing the magnitude of risks (e.g., frequency, duration, impact); prohibiting behaviors;

encouraging or reinforcing healthy behaviors; regulating, controlling, and guiding; and improving the allocation of resources. Environmental policies create a standard of behavioral expectations, making it easier to engage in healthy behaviors and harder to engage in unhealthy, high-risk activities. They keep sending the same messages and thus create new norms. For example, long-term use of no smoking rules and signs has created an environment where few if any people

smoke in areas designated as “no smoking,” with little enforcement required.

The advantages of pursuing environmental policy approaches include the following:

- They reflect community will and views, not only what one person decides to do.
- They reach entire populations and communities.
- They tend to stay in place over long periods of time, with little or no revisiting unless a controversy arises.
- They typically require minimal maintenance.
- They tend to be cost-effective.
- Implementation requires relatively easy tasks related to community education and awareness, with the involvement of the whole community.

Example #1: “Matter of Degree” Initiative to Curb Binge Drinking in Colleges

The AMA has been involved in several environmental change coalitions. The first (1996-2007), called A Matter of Degree, was a national effort funded by the Robert Wood Johnson Foundation to reduce binge drinking in college communities through policy and environmental changes. The focus was on creating the characteristics of successful coalitions and collaborations for community change, and to get away from blaming the individual. The program was implemented in 10 college communities of various sizes, the smallest being Newark, DE (a town of 30,000) and the largest being Atlanta, GA. Many program activities have continued now that grant funding has ended.

The health issues targeted by the program included heavy student binge drinking, extensive neighborhood disruption, and injury and violence. Colleges wanted to participate because students were suffering harm, because they had become desperate for new ideas to curb binge drinking, and because local communities had become fed up with the problem, with many downtown businesses suffering. The program involved the formation of a top-level collaboration between the city, campus, and other partners to conduct a needs assessment and develop an action and media plan. Structures (e.g., the composition of the formal coalition, action teams, committees, etc.) and decision-making processes varied across sites. Typical volunteer partners,

most of which stayed with the program for the entire 10-year grant period and afterwards, include university presidents, city or campus police chiefs, mayors and/or city council members, city economic development staff, local business owners, community associations, school system representatives, health care providers, concerned citizens, and students. Each site had one paid coordinator.

Changes strategies used within each community included the following:

- Changing and strengthening policies at the campus, city, and organizational/institutional level.
- Improving enforcement and awareness of existing policies and services.
- Actively using the mass media to create awareness of problems, identify effective solutions, and advocate for support and change.
- Using targeted awareness and education campaigns that acknowledge that the problem is not all the student’s fault (for example, because the community sells alcohol to college students). Campaigns focus on how the problem affects individuals and how individuals can change their own behavior.

Several dynamics were supportive of change in all 10 coalitions, including the presence of the following:

- Long-term voluntary commitments, as everyone wanted to live in cleaner, safer, healthier communities.
- Key organizations that see themselves as active change agents; this view represents a big change for universities traditionally focused on research.
- A shift from individual-only to more environmental approaches (although general education about drinking was not used, as leaders knew this approach is not effective).
- Ongoing use of communications and data, with constant references back to the data on binge drinking.
- Constant high-level organizational administrative support and shared leadership.

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A midpoint evaluation found that five communities had engaged in high levels of activity, with the remaining five having initiated a fairly low level. The high-activity sites had launched roughly three times more interventions (157 versus 46) and achieved positive outcomes in a wide range of areas. The low-activity sites had realized relatively few positive changes. For comparison purposes, a

review of 32 communities where no changes were made showed steady or even worsening problems with binge drinking. These differences, moreover, have persisted over time.

A more in-depth evaluation revealed the presence of the following in the high-activity sites as compared to the low ones:

- More formal structures and processes that members knew
- More member involvement in discussions and decisions
- More consensus-driven decision-making, as the power resides in the coalition
- More positive views of leadership, which was seen as “trusted” and “responsible”
- Less directive and more facilitative staff that focuses on organizing and keeping the program going
- A clear, limited role for the coalition spokesperson
- More data-driven plans and activities
- A broader, more diverse membership
- Well-defined action plans that are known to members and perceived as doable
- High levels of satisfaction with the effort, which was generally seen as worthwhile and enjoyable
- A more positive view of the responsiveness and controllability of the environment
- A greater sense of efficacy on campus and in the community

While it is hard to tell if success bred satisfaction and optimism (or vice versa), it is clear that success depends on the satisfaction and commitment of long-term volunteers and on clear, facilitative, responsive, and organized leadership. In fact, the characteristics of an effective community coalition-based effort include the following:

- Strong, clear, consistent leadership
- Use of intentional organizing to recruit members and reach goals
- Ongoing efforts to help members understand and participate in the coalition, and to reach consensus on processes, decisions, and action plans
 - Strategic use of the media and media advocacy to build support
 - Use of data and research to drive

decisions and planning

- A focus on policy-centered analysis and action
- A constant flow of information to keep everyone informed

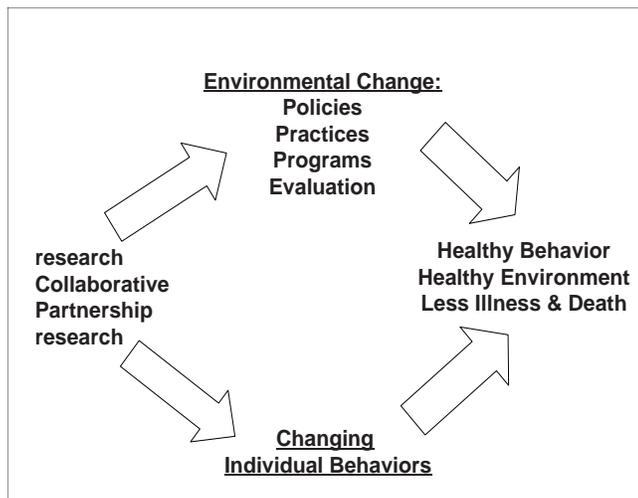
Example #2: Building a Healthier Chicago

The *Building a Healthier Chicago* (BHC) initiative (more information can be found at www.healthierchicago.org), launched in early 2008, is designed to improve the health of Chicago’s residents and employees through the integration of existing and new public health, medicine, and community health promotion activities. BHC is a joint program of the AMA, Chicago Department of Public Health, and the U.S. Department of Health and Human Services (DHHS) regional office, with the participation of the Chicago Medical Society and hundreds of other collaborating organizations. The program seeks to create an integrated, effective, and sustained community-wide partnership for health promotion that can be replicated nationwide. The objective is to do the following:

- Build synergy by promoting, coordinating, and tracking adoption of optimal programs, practices, policies, and supportive environments in health care organizations, worksites, schools, and neighborhoods.
- Develop and maintain a system of interventions that complement and reinforce each other to maximize reach and effectiveness.

Like the *A Matter of Degree* program model, the BHC model for change, depicted in the chart below, focuses on using research and collaborative partnerships to enact environmental changes (policies, practices, programs, and evaluation) intended to encourage healthy behaviors and thus create a healthy environment, leading to less illness and death. Specific strategies being used include the following:

- Development of effective action collaborations (and communications) among the community, academia, health care organizations, and government, with the goal of improving health for all
- Increasing the level of community resources dedicated to health and well-being
- Integrating community resources with health



care systems

- Improving access to health promotion and health care

Working committees have been set up in a number of areas, including worksite wellness, schools and youth, academic partnerships, community outreach and support, and metrics. In addition, advisory councils have been set up at the federal level and for students and physician leadership; a CEO advisory council is currently being developed. Specific objectives being pursued include supporting partners in increasing levels of physical activity; improving dietary habits; preventing, detecting, and controlling hypertension; and supporting physician efforts in reducing smoking and excessive/risky alcohol use. (This latter effort is being done through the AMA.)

At a recent meeting of the collaborative, participants highlighted the creation of healthy neighborhood environments, networking, collaboration (both citywide and in specific neighborhoods), and model programs for specific neighborhoods as being the most valuable activities of the collaborative. Partners' objectives include putting in place activities in schools (e.g., assessments and model developments), workplaces (e.g., education, assessments, conferences, award recognition, toolkits), parks, residences, and communities. To that end, partners have been actively recruited to develop model programs, including programs in high-rise residential and office buildings, elementary schools, corporations, and federal agencies (e.g., the Federal Aviation Administration). Major partners, such as the Chicago Department of Public Health, have put in place multiple initiatives, while the AMA has worked to get local physicians, hospitals, and health programs involved, including educating

physicians on prevention and how to integrate program activities into their practice in a viable way. For evaluation purposes, the initiative is developing metrics that use available data and is creating other data-gathering opportunities (e.g., through product sales, worksite assessments) to gauge program impact.

Coalition Models of Community Health Partnerships

Barbara Wallace, President and CEO of the Virginia Business Coalition on Health

Karen Remley, MD, MBA, FAAP Commissioner of the Virginia Department of Health

Cristie Travis, CEO of the Memphis Business Group on Health

This section reviews two community health partnerships that involve local or regional business coalitions.

The Virginia Business Coalition on Health-Department of Health Partnership

The Virginia Business Coalition on Health (VBCH) and the Virginia Department of Health (VDH) have partnered with each other and other stakeholders to promote community health.

Background on Virginia Business Coalition on Health

VBCH was founded in 1983 under the name Hampton Roads Health Coalition. Originally serving eastern Virginia, VBCH has expanded throughout the state, and now represents 70 members in the public and private sectors with approximately 300,000 employees and dependents. VBCH is a "mixed-model" coalition, with both providers and purchasers as members, although only "pure" employers sit on the governing board. VBCH participates in a number of national and state activities. At the national level, VBCH participates in The Leapfrog Group initiative for hospital patient safety, NBCH's eValue8 RFI (Request for Information) Tool for health plan evaluation, the Health Map Rx program for diabetes management, and the National Diabetes Education Program. Virginia activities include:

- Stroke and cardiovascular disease (CVD) prevention project sub-grant from VDH and 6

employers (2007 to present)

- State planning grants for covering the working uninsured
- Annual Wellness in the Workplace awards, with 20 employers having been named winners since 1997 for exemplary wellness programs in the workplace
- Annual business and health summit (400 attendees, co-sponsored with state patient safety organization)
- Quarterly business roundtables on topics of interest to members
- Annual health economics forum with Old Dominion University (250 attendees came to the most recent session)
- Square One Children's Health and School Readiness Initiative (a regional initiative founded by VBCH in 1998)
- CVD risk reduction and stroke prevention project with the City of Virginia Beach, which employs 16,000 individuals (2004)

Background on Virginia Public Health System

The Virginia public health system operates at the state, county, city, and local level. The system is divided into 35 health districts that report to the overall director with physicians leading each district. These districts are further divided into 120 health departments. Virginia is one of the few states to still follow the "Dillon Rule"—this means that a locality can only put forth new laws, regulations, etc. at the pleasure of the General Assembly. For example, the General Assembly had to approve local smoking bans in restaurants. Given that tobacco dominated the Virginia economy for decades (and remains important today), success in getting these bans passed required the hard, collaborative work of coalitions of stakeholders. The Virginia public health system also relies on a unique, complicated array of funding streams from the federal government, state general budget, and directed funds.

The VBCH-VDH Partnerships

VDH and VBCH partnerships typically focus on areas of common purpose and focus, including the actionable application of data, joint grants, coordinating with

multiple stakeholders, and leveraging VDH's history with the community.

One partnership involves a four-year collaboration known as the *Heart Disease and Stroke Prevention Project*, part of a cooperative agreement between VDH and CDC that began in 1988. While for many years VBCH participated in this program on a voluntary basis, in 2006 the organization became formally involved as a recipient of a sub-grant. The major focus for VBCH is primary and secondary prevention of CVD and stroke, distribution of an emergency protocol, and health benefit design for worksite wellness.

In year one of the four-year partnership (fiscal year 2006-2007), VBCH and member employers became a distribution point for CDC materials, including for the *Act in Time (Heart Attack)* and *Know Stroke* kits, heart attack and emergency protocols, 9-1-1- brochures, and signs and symptoms key tag cards. In year two, VBCH formed a workgroup of 7 Hampton Road employers, conducting face-to-face meetings, phone conferences, informal surveys, and the like in order to create an inventory of existing programs. In the current year (year 3), VBCH has continued to convene the worksite group (adding one employer) and will develop a toolkit, including pilot testing a 150+ page, six-module kit on stroke and CVD reduction at one worksite. FY 2010 will involve evaluation and distribution of the toolkit to all VBCH members. VBCH also plans to provide "mini-grants" for implementation of the *CVD and Stroke Tool Kit*. (VBCH recently learned that the sub-award grant has been renewed for the July 2009 to July 2010 period.)

Other VBCH activities include the following:

- *How's Your Health, Hampton Roads?*, an HRA for ages 2 to 99, has been distributed on 30,000 card discs to employees and general public.
- The Regional Consortium for Infant and Child Health (CINCH) was formed with 200 partners, including an affiliation with Eastern Virginia Medical School and Children's Hospital. VBCH has held leadership positions and jointly sponsored educational programs with CINCH.
- The City of Norfolk conducted employee lung health screenings and wellness program.
- Chesapeake Public Schools and Chesapeake Regional Medical Center enrolled in the Health Map Rx program for diabetes.

- The City of Virginia Beach has consolidated benefits and committed wellness program leaders and staff to participate in the *CVD Risk Reduction Study*.
- The fourth edition of *Diabetes Resource Directory* for Hampton Roads has been released.

Barbara Wallace serves as President and CEO of the Virginia Business Coalition on Health (VBCH), a state-wide, not-for-profit, employer-focused organization founded in 1983 in eastern Virginia. Since its founding, VBCH has sought approaches to worksite wellness and affordable, high quality health care for its 70 member employers, which represent more than 300,000 covered lives in the public and private sectors. Dr. Wallace currently sits on the Board of NBCH, where she also serves as Secretary/Treasurer of the Executive Committee, Chair of the Finance Committee, and on the Board of the Community Coalition on Health Institute. She also represents NBCH on the Business Health Strategy Group of the National Diabetes Education Program. Prior to joining VBCH, Dr. Wallace served as higher education administrator and development officer for Illinois State University and as an adjunct faculty member in the College of Education. Previous roles include director of Continuing Professional Education for the College of Sciences and Health Professions at Old Dominion University, and as extension specialist at Virginia Tech. Dr. Wallace started her career in education teaching in Head Start, followed by several years in public secondary education. During her career, she has written, managed, and implemented state and federal grants awards exceeding 3 million dollars. Dr. Wallace is a graduate of James Madison University, Virginia Tech, and The College of William and Mary.

Karen Remley, MD, serves as state health commissioner, directing the Virginia Department of Health, which is celebrating 100 years of service in 2009. In this role, she manages the state's public health system, which includes 35 local health districts that protect and promote the well-being of the Commonwealth's residents. Throughout her career, Dr. Remley has been involved in many aspects of health care. Recent positions include Vice President of Medical Affairs at Sentara Leigh Hospital in Norfolk, Virginia; Medical Director of External Quality at Anthem Blue Cross and Blue Shield of Virginia; CEO of Physicians for Peace, an international medical education organization; and Chief Medical Officer for Operation Smile, Inc., a worldwide children's medical charity. Dr. Remley also serves as Assistant Professor in the Division of Health Professions at the Eastern Virginia School of Medicine. She has professional certifications from the American Board of Medical

Examiners and the American Board of Pediatrics and Pediatric Emergency Medicine, and is a member of the American Academy of Pediatrics. Throughout her career, she has continued to practice as a pediatric emergency physician. Dr. Remley received a Doctor of Medicine degree from the University of Missouri-Kansas City and completed a Pediatrics Residency at St. Louis Children's Hospital. She holds a Master of Business Administration (in Health Services Management) from Duke University's Fuqua School of Business.

Cristie Upshaw Travis serves as CEO of the Memphis Business Group on Health (MBGH), a business coalition with 20 employer members and affiliates providing health care benefits to over 300,000 residents of the MidSouth and Tennessee. Since joining the organization in December 1994, Ms. Travis has spearheaded the development of a new MBGH philosophy statement, developed the quality measurement strategy, facilitated publication of the Memphis Health Plan Report Card and Memphis Hospital Report Card, led the roll-out of The Leapfrog Group hospital survey and improvement initiative in Memphis, recruited health plan and hospital participation in the Leapfrog Hospital Reward Program, engaged physicians in practice pattern evaluation and quality improvement, helped prepare physicians for performance measurement and reporting and pay-for-performance, and identified specific strategies to advance MBGH on its path to value-based purchasing. Prior to joining MBGH, Ms. Travis served as a health care consultant for over 15 years, working with clients on planning and marketing. She currently serves as Chair of the Board of NBCH and the Healthy Memphis Common Table and is a former Chair of the Board of The Leapfrog Group. She also serves on the National Commission on Prevention Priorities in Washington, D.C. and the National Transitions of Care Coalition in Little Rock, Arkansas. She is former Project Director for the Healthy Memphis Common Table's "Aligning Forces for Quality: Memphis Regional Market Project", a pilot project of the Robert Wood Johnson Foundation's national initiative to dramatically improve care for all people across all settings of care. Ms. Travis has a Master of Science in Hospital and Health Administration from the University of Alabama at Birmingham.

Lessons Learned and Observations from Coalition Perspective

Key lessons that have been learned by VBCH as a result of its partnership with VDH include the following:

- Relationship-building takes time, as participants need to build trust and establish an understanding of what each party can bring to the relationship.
- Staff changes can affect the relationship by increasing understanding of what the initiative means in terms of implementation tasks, and by developing roles and responsibilities appropriate for each stakeholder.
- Public health funding helps support resources needed by the coalition.
- The mission of VBCH engages employers, providers, and consumers toward a classic public health agenda, including emphasis on prevention and education, chronic disease intervention, community integration, and the prevention of complications.

For employer coalitions in general, partnerships with public health departments are valuable in replicating best practices and working toward value-based benefits (e.g., through eValue8 and Leapfrog) that encourage a focus on outcomes (quality) rather than insurance premium discounts (costs). Partnerships also help to secure the engagement of all community stakeholders and maintain a focus on population-based health.

The Public Health Perspective: Endless Potential for Partnerships with Business

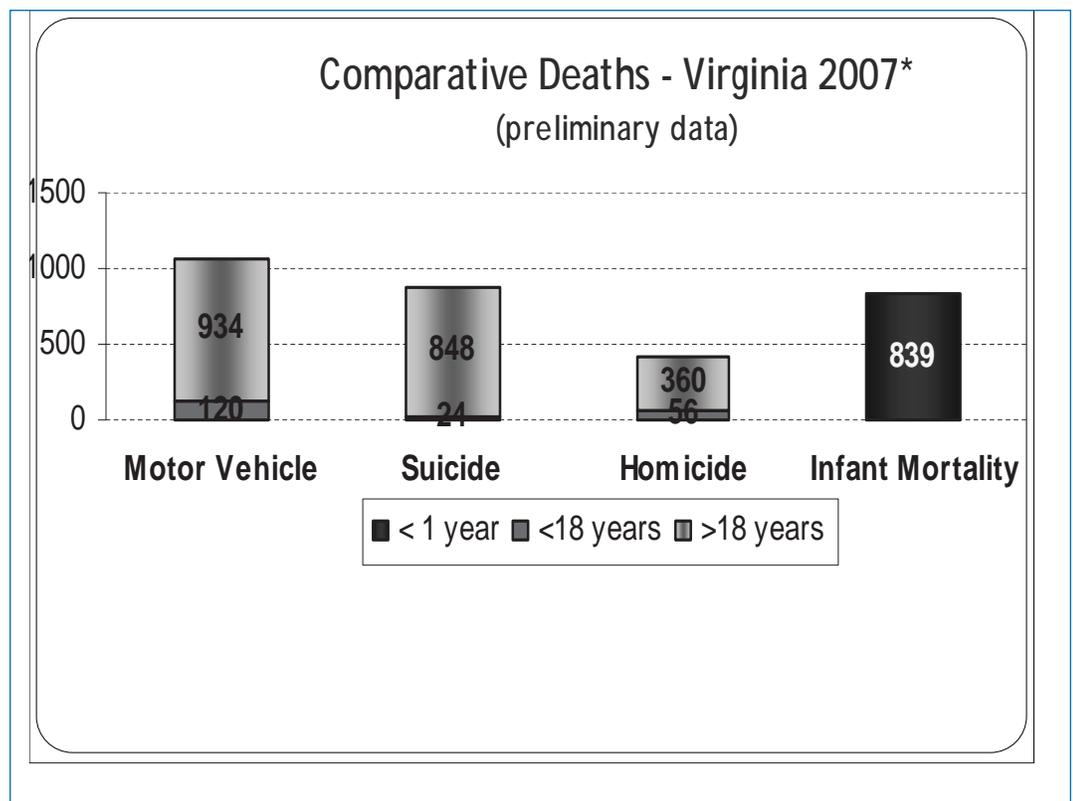
From the perspective of VDH, the potential for partnerships with business to improve population health seem almost limitless. While the two stakeholders may seem likely unlikely “bed fellows,” there is much to be gained from collaboration. While at times the

Commissioner of Health has to explain to the public, legislators, and executive staff why VDH works with the business community, the effort is worthwhile. Mayors and county supervisors at the local level generally “get it,” but those higher up in state government often must be educated, as they view the two stakeholders as having disparate goals, and do not understand how making money and improving community health go together.

From VDH’s perspective, the business community can play an important role in addressing both unseen and visible epidemics facing Virginia, as outlined below:

The Unseen Epidemic of Infant Mortality

Virginia and many other states face a largely invisible epidemic with respect to infant mortality, especially in the African-American population. While rates are well below where they were in the 1940s, further improvement is needed, as rates in the U.S. remain higher than in Europe. Even though infant mortality claims as many lives as do suicide and motor vehicle accidents (see chart below), the issue receives relatively little attention.



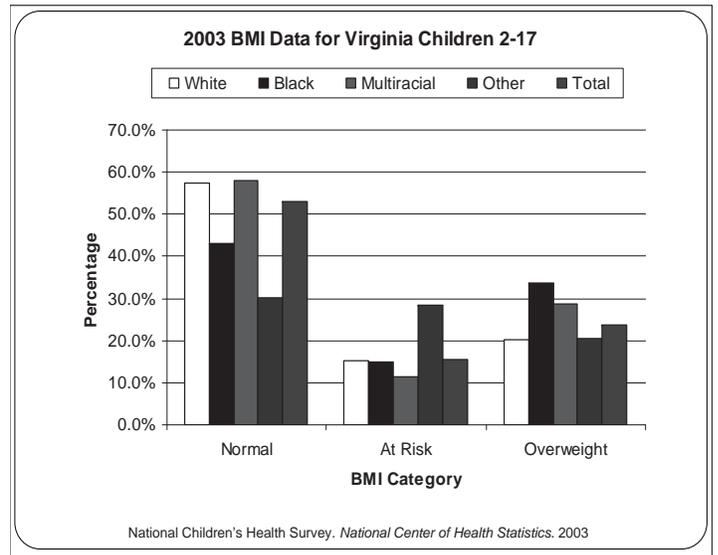
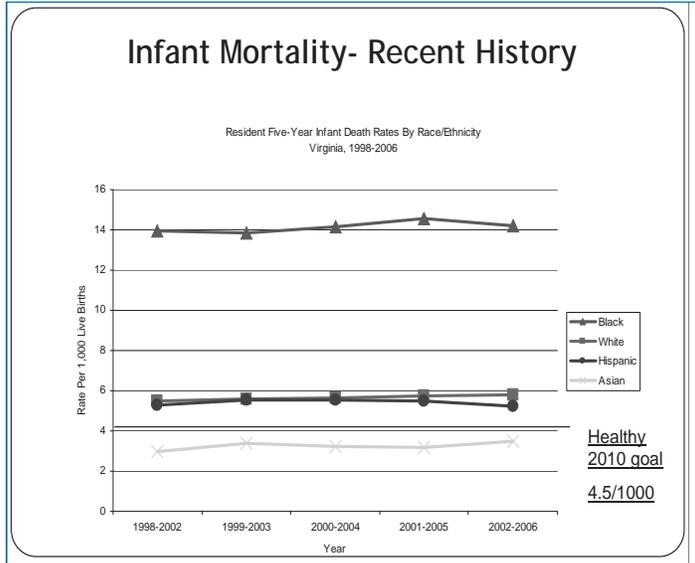
The true costs of the problem, moreover, go beyond infant deaths, as many babies who are born prematurely survive, but require tremendous amounts of costly care. Giving high-risk pregnant women access to high-quality prenatal care and other support could reduce both

death rates and overall costs of premature deliveries. The problem is especially acute among African Americans, where death rates are more than double those of other ethnicities (see chart below). This disparity, while very complex, may partly reflect the legacy of having segregated health care systems until 30 years ago. The system remains segregated in some respects, with low-income and certain ethnic groups having a much more difficult time accessing care.

resistance to antibiotics due to overuse.

The Seen Epidemic: Obesity

Obesity represents a visible epidemic in Virginia and many other states. While obesity remains a complex issue to address in adults, childhood obesity represents a more “doable” issue for public health departments. As shown in the chart below, roughly half of grade-school children are overweight, or at risk of becoming overweight.



While many factors account for the disparity, much of it comes down to having access to good basic health care, such as taking a daily vitamin with folic acid. This vitamin, which costs 10 cents a day, can reduce the risk of premature birth considerably. In fact, VDH provides these vitamins free of charge to its clients.

An Emerging Epidemic: Rising Rates of C-Sections

The growing popularity of C-sections represents an emerging epidemic in Virginia. At present, roughly 65% of deliveries are vaginal, down from 78.2% in 1998. If current trends continue, the number of C-sections will equal the number of vaginal deliveries by 2016. This trend is dangerous, as women who choose to schedule an elective C-section are taking a natural event and turning it into an elective surgical procedure, with all of the associated risks. In addition, because due dates cannot be known with precision, scheduled C-sections may occur too early, thus having a big impact on the baby’s health. A baby’s brain is very different at 35 weeks than at 39 weeks. In fact, babies born at 35 weeks have twice the risk of having a learning disability. Yet pregnant woman are being induced on a routine basis today, as elective C-sections have almost become an expectation in society. To address this issue, an education and awareness campaign is needed on the risks involved, much as was done to educate the public on the dangers of developing

Over the last decade, the percentage of overweight kindergartners rose from 7% to 14%; children who are overweight in kindergarten are likely to remain so all of their life, putting them at higher risk of diabetes, heart disease, and many other problems. The key to success is to target interventions early in life. In fact, a study looking at height and weight of babies found that children often “tip” to being overweight very early in life (within the first two years). To that end, VDH has formed a partnership with the American Academy of Pediatrics, with the goal of encouraging pediatricians to counsel parents during the first two years of life (when they come in for visits quite frequently, usually every few months). In addition, the WIC (Women, Infant, Children) program food basket this year has been changed to include more healthy foods, including salmon, tortillas, brown rice, and fresh fruits and vegetables; in addition, juice (which causes weight gain and cavities) will not be provided for those under two years of age.

The Ongoing Epidemic: Heart Attacks and CVD

Virginia continues to fight to prevent heart attacks and CVD. The good news is that death rates from CVD have declined, and those who have a heart attack in Virginia are less likely to die from it. While improvements have occurred in many geographic regions within the state, pockets of areas remain where the risk of death

remains high. These high rates are mainly the result of a lack of primary screening and interventions, including diet changes and use of lipid-lowering medications. Employers can play a valuable role in encouraging employees to take the steps necessary to reduce their risk of CVD, and to know the warning signs of a heart attack.

A New Epidemic: Novel Influenza

After planning for this type of outbreak for 7 years, it has emerged, but differently than was anticipated. Public health has historically planned for an avian flu type of outbreak that disproportionately affects the elderly and those with underlying health conditions. But the H1N1 (swine) flu is a seasonal flu that appears to affect children and women of child-bearing age more frequently and spares the elderly. Employers (who employ many in the target population) could end up bearing huge costs, both in terms of direct health care expenses and absenteeism. As a result, H1N1 represents a great opportunity for businesses to work with local and state health departments to get the message out about vaccination and the need to develop plans to allow employees who feel sick to stay home (working if possible) without giving up pay or sick leave. Without such plans, sick employees may come to work and spread the disease. Programs should be set up and communicated this summer, in advance of the impending flu season. Employers can also partner with local health departments to offer on-site vaccinations, or give time off to parents to get children vaccinated. Education efforts should also focus on how individuals can minimize spread of the disease, such as by washing hands thoroughly and regularly. VDH and other health departments would welcome any ideas the employer community may have to deal with this issue. Due to recent budget cuts, many public health departments are “lean and mean,” and therefore are looking for partners to get the message out about the upcoming influenza season.

Advantages of Participating in the Partnership

The advantages of having a business coalition involved in a partnership with public health include the following:

- Coalitions speak the right language to secure buy-in from the employer sector.
- Coalitions can build the case for health promotion and improvement by estimating an ROI for these activities, thus establishing employee health as a sound business decision and the right thing to do.

- Coalitions can create a bridge-trusted partnership.
- Coalitions allow for grant-writing relationships.
- Coalition participation increases the chance of success in improving overall community health status.
- Coalition participation helps to ensure collaboration with all employer stakeholders, including public and private sector organization, for-profits and not-for-profits, large and small, fully insured and self-insured.

On the flip side, the advantages that public health brings to the table include the following:

- A data-driven, evidence-based perspective
- An understanding of the paradigm shift from process to outcomes
- A mission focused on education, chronic disease prevention and intervention, chronic disease control, reduction of complications, and community integration.
- Relationships with faith-based, non-profit, and minority-based organizations at the community level
- Credibility and expertise from the public health perspective

Memphis: A City Learning to Work Together

The city of Memphis has developed a community-wide collaboration to improve the health of the population. Tremendous room for improvement exists, with Memphis having been named the least healthy city for women in 2002 by Self magazine, and the least healthy city for men by Men’s Health magazine a year later. In 2002, Memphis women ranked in the bottom 6% with respect to exercise and generally did not follow healthy diets, leaving to average body mass index of 27.3 (with anything over 25 being considered overweight). Not surprisingly, diabetes rates in Memphis ranked among the highest in the nation.

Background on Memphis Business Group on Health (MBGH)

Established 24 years ago (making it one of the oldest coalitions), MBGH represents 20 members and affiliates

with 300,000+ covered lives. Members include the State of Tennessee, which works with MBGH on TennCare (the state Medicaid program), statewide health planning, and other issues and programs, as well as employee benefits. MBGH focuses on improving health and health care for employees of member organizations and their families. The coalition's mission is to facilitate the purchase of effective and efficient health care in the Memphis community by focusing on what the purchaser (employer) can do, including adopting proven and promising national initiatives at the local level, and collaborating locally to spread good ideas and enhance effectiveness.

Healthy Memphis Common Table: Take Charge for Better Health

After being named the unhealthiest city in the nation, local government (including the mayor) and community organizations decided to come together to do something about it. In 2002 and 2003, Healthy Memphis Common Table (HMCT) was formed to support and encourage people in working together to improve the health of everyone in the community. The focus is on mobilizing the entire community to achieve excellent health for all, leaving no one (or group) behind. With half of the population being African American, HMCT has made addressing health disparities a central focus. Major initiatives sponsored by the collaboration (often with the support of grant money) include the following:

- **Obesity Diabetes Initiative (ODI):** Obesity is an underlying condition that frequently leads to diabetes, CVD, and other problems. Tackling this issue requires getting at fundamental behavioral issues, such as physical activity, nutrition, and smoking.
- **Memphis Quality Initiative:** This hospital-based quality improvement collaborative brings hospitals together to look at inpatient care. The initiative is also being expanded to outpatient care and physician offices. One major success story involved all hospital campuses going smoke free on the same day 1.5 years ago.. Current efforts include an initiative to promote appropriate hand washing by providers.
- **Alliance to Reduce Disparities in Diabetes:** With support from the Merck Foundation,

HMCT is working with faith-based centers to address diabetes.

- **Chartered Value Exchange:** HMCT has been designated a Chartered Value Exchange by DHHS, providing it with access to technical assistance.
- **Aligning Forces for Quality (AF4Q):** HMCT participates in this RWJF program; more details are provided later in this section.

While most collaborative activities are funded through grants, the hospital community has also provided unrestricted donations, including money to support the salary of the HMCT executive director, who joined the organization in January 2009. While no donations have yet come from the corporate world, HMCT leaders plan to approach the business community soon, once they have developed a convincing case for support (since there will likely be only one opportunity to get an audience with corporate leaders). The need for a convincing case is especially important, given that the one time Memphis area corporations stepped up to the plate in the past (by supporting a program designed to reduce infant mortality), they saw little impact from their investment.

How MBGH Supports the Collaborative

MBGH is involved in HMCT at many levels. Ms. Travis, CEO of MBGH, sits on the HMCT board of directors, having served three terms as chair (a new chair will take over next year). She also serves on the AF4Q leadership team, including co-chairing the Performance Measurement Public Reporting Steering Committee and until recently managed the AF4Q project in Memphis (a time-consuming endeavor that has now been taken over by the HMCT director). MBGH has also developed collaborative projects with HMCT, including the following:

- The NCQA Physician Recognition Program Project, which is part of the aforementioned ODI, in partnership with 11 other organizations.
- The NBCH/AHRQ Diabetes Treatment Improvement Project (also part of ODI).
- The Value-Based Benefit Project (part of AF4Q), which focuses on an area that employers can directly control (benefit design). This program directly meets the consumer engagement aims of AF4Q.

An Example of Collaboration: How MBGH/HMCT Work Together on AF4Q

The AF4Q program in Memphis, formally known as *Aligning Forces for Quality: Improving Health & Health Care in Communities Across Greater Memphis*, is a collaboration that goes across communities and stakeholders, with the goal of improving care for all patients across all settings by:

- Helping physicians improve the quality of care for patients
- Giving people information that helps them be better partners in managing health and making informed decisions
- Improving care in hospitals, with a focus on the central role of nurses
- Reducing inequalities in care for patients of different races and ethnicities

While prevention is not a stated goal (because AF4Q money is not intended for prevention), the focus has evolved to incorporate primary and secondary prevention. Key principles that have been adopted in the

15 participating communities include the following:

- Involve all stakeholders in the community; while the group tends to be consensus-driven, at some point a leader may have to emerge to make decisions not based on consensus.
- Create a shared vision for quality care for Memphis.
- Place the individual patient at the center, supporting them in understanding and demanding quality care, receiving quality care (e.g., by providing information on comparative quality), and taking care of themselves.
- Create a culture of quality improvement and excellence in care.

The leadership team includes representatives from the business community (e.g., MBGH, FedEx), physician organizations, health plans, public health, consumer advocates, and local quality improvement organizations. Overlapping work groups have been formed in performance measurement and reporting, physician engagement and quality improvement, and consumer engagement. These groups produce measures, reports,

Integrated Strategies

Behavioral Target:
Understand what quality care is

Strategy: Quality Care is the Right Care				
	Employers	Providers	Health Plans	Community Leaders/Organizations
Specific Stakeholders	Memphis Business Group on Health member employers FedEx Other interested employers identified through: ADA, Novo Nordisk, Chamber of Commerce	Memphis Medical Society & its members Bluff City Medical Society & its members Health Choice & its members Baptist Health Services Group & its members	Health Plan Advisory Committee members including: CIGNA, Aetna, BCBST, Humana, TLC	The Commercial Appeal (daily newspaper) WREG-TV (CBS affiliate) Memphis Healthy Churches Methodist Congregational Health Network Memphis-Shelby County Regional Health Council
Activities	Educate employees on essential health care and age & disease appropriate prevention, screening & treatment recommendations through condition-specific brochures (KB, NS) Provide employees "take to your Doctor" material that incorporates disease appropriate prevention, screening & treatment recommendations (SE, M, NS) Educate employees on how to read provider performance reports and why these reports are important (KB) Offer employees a benefit design which provides incentives to use high performing providers (M, NS)	Educate patients on essential health care and age & disease appropriate prevention, screening & treatment recommendations through condition-specific brochures in waiting rooms, exam rooms (KB, NS) Use the "take to your Doctor" material provided by employers and health plans to help deliver age & disease appropriate care (SE) Actively engage patients through quality visit goals (KB, NS) Refer patients to high performing providers (NS, SE)	Educate enrollees on essential health care and age & disease appropriate prevention, screening & treatment recommendations through condition-specific brochures (KB, NS) Partner with employers to develop and provide "take to your Doctor" material for enrollees (NS, SE, M, S) Post providing ratings as well as link to HMCT public reporting website (KB, NS) Educate enrollees on how to read provider performance reports and why these reports are important (KB) Offer benefit designs that provide incentives to use high performing providers (M, NS)	Distribute age & disease appropriate prevention, screening & treatment recommendations through condition-specific brochures to agencies, coalitions, and organizations for distribution to their constituencies & incorporate into their own messaging (KB, NS) Incorporate condition-specific brochure information into Family-Health Take Charge articles & WREG news bites (KB, NS) Repurpose condition-specific brochure information for broad distribution through Commercial Appeal distribution channels (KB, NS)

and other educational tools and resources. For example, physician performance data on diabetes care has recently been released to the public. In July, individual physician performance data on patient experience (as reported in surveys) will be released, with additional information coming in the fall of 2009. These data are critical to “shaking things up,” as consumers need information to make better decisions and providers need information to guide quality improvement activities.

The Memphis AF4Q project has developed new partnerships in the area of consumer engagement, measurement and reporting, and quality improvement. Organizations that have never come together before are now working together. For example, weekly columns now run in the newspaper on issues relevant for consumers, and a comfort care coalition has formed to address end-of-life and palliative care issues. Schools and churches have also become involved, including the development of a congregational health network.

Strategies are being integrated across stakeholders, with an overall behavioral target being set (e.g., getting people to understand what quality care is), and then each stakeholder—including employers, providers, health plans, and community leaders/organizations—developing specific strategies aimed at achieving the target. As shown in the chart below (an example of an early framework for consumer engagement), the idea is to have each stakeholder tackle what is in its sphere of influence. In addition, Memphis AF4Q leaders are trying to find common strategies and messages that can be used across stakeholders, such as distributing a quality-of-care checklist for consumers in newspaper, public reports, physician practices, and employer sites. This type of common messaging through a common tool across stakeholders is at the core of what is meant by “aligning forces.”

How MBGH Is Involved

MBGH is taking an active role in adopting the AF4Q framework. MBGH recruited employers to adopt value-based insurance designs that encourage employees to use high-value health services and not use services that provide no value. This effort supports both of the consumer engagement behavioral targets within AF4Q. Results from this year long-project found that people often do not take diabetes medications properly; more work is needed to figure out why. If not, employers will still end up bearing the cost of diabetes-related complications.

Within the performance measurement and public reporting arena, MBGH has traditionally been the only organization in Memphis focusing on public transparency. MBGH’s experience in this area has provided a strong foundation for the AF4Q work. MBGH has incorporated AF4Q goals into eValue8 site visits; recruited health plans to collaborate on data aggregation; and leveraged health plan and purchaser-plan relationships to conduct a physician-level patient experience-of-care survey. This latter initiative “popped up” unexpectedly; MBGH had to mobilize employers to pressure plans to participate in the survey. One national plan took a lot of convincing, with Memphis being the only big city in which the plan took part. The plan was concerned about push-back from physicians, and only agreed to participate when MHCT agreed to “take the heat” and promised to publicly praise plans for participating.

Why Is MBGH Involved in AF4Q?

MBGH participates in AF4 in order to do the following:

- **Solidify transparency as community strategy:** As noted, MBGH was the sole public voice in the community for 23 years. Now that voice has been magnified with the support of stakeholders; without such support, physician performance reporting would not be nearly as far along.
- **Influence transparency products:** Participation helps to ensure the employer-purchaser’s voice is heard loud and clear. Employers need to push back against the temptation to make everyone look good in these reports, and to ensure that people are held accountable for performance. To that end, the labels attached to performance should not be “good, better, and best.”
- **Educate stakeholders:** Participation helps other stakeholders to better understand the position of the employer/purchaser, and provides opportunities to identify common ground and promote the spread of best practices.
- **Broaden health impact across community:** Participation is the “right thing to do” as a non-profit coalition with an obligation to the entire community. A healthier community results in a healthier, more productive labor pool, both today and in the future.

The Benefits and Challenges of Collaboration

Employers and other stakeholders benefit from collaborating with each other, although challenges exist as well.

Why Should Employers Participate?

Employers should participate in community collaborations because community-based, multi-stakeholder initiatives engage people (including employees and dependents) in the place they live, play, worship, and work. If employees work in a healthy environment but go home to an unhealthy one, employers will feel the effects. Other reasons for employers to participate include the following:

- Developing integrated strategies across stakeholders and places can maximize program impact and reduce “noise.”
- Employers can play a critical role, as they have influence over employees through benefit design and worksite wellness programs, and can influence plans through contracts and benefit designs.
- Economic development and growth depends on improving the health of the community.

How Do Other Stakeholders in HMCT Benefit?

HMCT benefits directly from its partnership with MBGH, which brings the following to the table:

- An established organization with a credible track record in addressing broader health care issues, including cost, quality, measurement, and outcomes
- Access to major insurers, which represent a vehicle to provide and support collection of key data elements
- A proven track record with value-based purchasing concepts
- Employer connectivity
- A history of performance measurement and public reporting through Leapfrog principles
- A strong commitment to the mission of the regional health improvement collaborative
- A key resource for national policy issues

What are the Challenges?

Collaboration, of course, is not easy, and it takes time to get to “true” collaboration, as depicted in the chart below.

INSERT CHART #26 FROM TRAVIS, ENTITLED “WHAT ARE THE CHALLENGES? GETTING TO TRUE COLLABORATION:

Developing the trust that can reduce “turf wars” takes time. Ultimately the goal is to get to the place where “your success means my success.” Memphis has not reached this stage yet; in fact, stakeholders in Memphis have probably reached a point somewhere between coordination and cooperation. Remaining challenges include reducing tension between organizational and community priorities (which have to be balanced), focusing on a few priorities (needs and opportunities are numerous and cannot all be addressed), and creating accountability in a voluntary initiative with multiple participants. With respect to this latter issue, no one works for someone else in a collaborative partnership, so no one can be fired for missing a deadline. As partnerships mature and relationships become stronger, organizations and individuals will begin to become accountable to each other, and will not want to let each other down.

Summary of Key Themes and Lessons

Key lessons and themes from the two-day NHLC meeting include the importance of the following:

- Considering all the determinants of health; those who are serious about improving the health of the population need to take a broad view that incorporates social determinants as well as personal behavior and other drivers of health.
- Developing financial incentives to encourage the achievement of population health; the business community believes in aligning incentives.
- Developing effective policies and interventions to promote population health.
- Thinking creatively and expansively about making the business case for improved population health, particularly for the business community. In particular, there is a need to explore the link between healthy communities and business expansion and consumer demand for services.
- Developing partnerships among stakeholders by bringing groups together to find a common agenda (a very difficult task). An independent, trusted convener (such as a coalition and/or NBCH) that does not have its own agenda can play this role.
- Using and learning from existing case studies that provide examples and lessons on how to build that common agenda.
- Amplifying the common agenda and messaging throughout the community by providing a consistent message at churches, schools, worksites, and the like.
- Setting priorities based on the evidence about what does and does not work with respect to community health intervention strategies, particularly in the context of scarce, limited resources. This evidence can help determine where to make investments. Better science and evidence, however, may be needed in some areas to inform these decisions.
- Continuing work on the development of transparent measures for population health as a motivator, accountability tool, and call to action. Multiple efforts are underway, including the several measures highlighted during this NHLC meeting. While there is a risk of having too many measures, the goal should be to develop easily used measurement tools that hold stakeholders accountable for improvement over time.

National Health Leadership Council Attendees

Karen Adams
Vice President
National Quality Forum

Sharon Albert
Vice President, Marketing and New Market Development
URAC

Gary Allen
Executive Director
Hawaii Business Health Council

Paul Antaya
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Bayer HealthCare Pharmaceuticals

Monda Barlow
Human Resources
Community Counseling Services, Inc.

Marilyn Bell
Executive Director
Michigan Purchasers Health Alliance

Denise Bianchini
Senior Manager
Abbott

Larry Boress
President & CEO
Midwest Business Group on Health

Jerry Burgess
President & CEO
Healthcare 21 Business Coalition

Don Creveling
Executive Director
Montana Association of Health Care Purchasers

Jim Cummings
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Jerry Custer
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Heartland Healthcare Coalition

James Dempster
Executive Director
MedEncentive, LLC

Susan Dorsey
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Wichita Area Technical College

Mike Evans
Director of Benefits
OK Foods

Tewan Fair
Director, Special Projects
Memphis Business Group on Health

Renee Frazier
Executive Director
Healthy Memphis Common Table

Susan Gibson
Associate Director
Genentech, Inc.

Lisa Gish
Executive Director
Tri-State Business Group on Health

Jake Glover
Director
America's Health Insurance Plans

Christopher Goff
President and CEO
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Rhonda Grabow
Senior Vice President Strategic Planning
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Jeff Greene
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National Committee for Quality Assurance

Tom Hare
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Triumph Fabrications - Hot Springs

Rick Heine
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Caryol Hendricks
Executive Director
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National Business Coalition on Health

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Gregory Kraupa, OD
American Optometric Association

Trisha Kurtz
Director, Federal Relations
The Joint Commission

Douglas Libby
Executive Director
Maine Health Management Coalition

Keith Lockwood
National Account Manager
Reckitt Benckiser Pharmaceuticals

Holly McCoy
Director
American Academy of Family Physicians

Carly McKeon
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Employers' Health Coalition

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Karen Remley
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Larry Stepnick
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Steve Stitt
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Cristie Travis
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Michael Vittoria
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Rhode Island Business Group on Health

Jerry Vuocolo
Director, Healthcare Systems Strategy
Merck & Co., Inc.

Barbara Wallace, EdD
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