Childhood Obesity:
Harnessing the Power of Public and Private Partnerships
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ASTHO is the national non-profit organization representing the state and territorial public health agencies of the United States, the U.S. Territories, and the District of Columbia. ASTHO’s members, the chief health officials of these jurisdictions, are dedicated to formulating and influencing sound public health policy and assuring excellence in state-based public health practice.

NIHCM Foundation is a non-profit organization whose mission is to promote improvement in health care access, management and quality, and to foster dialogue and cooperation between the private and public sectors to find creative and workable solutions to American health system problems.

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Childhood Obesity: Harnessing the Power of Public and Private Partnerships

EXECUTIVE SUMMARY

In just two decades, the number of children and adolescents in the U.S. who are either overweight or obese has tripled. The recent rise in childhood obesity is due largely to complex changes occurring in the social and physical environments of children. Reversing the trend in childhood obesity requires engaging stakeholders who can improve the quality of these environments in successful collaborations.

In this report the National Institute for Health Care Management Foundation (NIHCM) and the Association of State and Territorial Health Officials (ASTHO) focus on selective, exemplary collaborations between state health agencies and health plans to reduce overweight and obesity in children. The idea of collaboration is simple. Partner A agrees to work with Partner B on a project of shared interest. However, collaboration is more complicated in practice. Partners may experience cultural conflict, competition, and lack of trust.

Nevertheless, as this report demonstrates, collaborations have the potential to produce significant value in the prevention of health problems associated with obesity. A successful collaboration can lead to better outcomes than either partner could produce on their own.

This report profiles three case studies of collaborative obesity prevention programs that involved both organizations’ key clients. As entities interested in promoting the health of the populations they serve, health plans and public health agencies arelogical partners in the fight against childhood obesity. In addition, research revealed several unique collaborations between stakeholders other than health plans and state health agencies, such as academic institutions, state education agencies, businesses, and others. To illustrate the scope such broader partnerships can achieve, a fourth case is presented briefly in this report.

For each case study, we conducted in-depth interviews with key representatives from a large health plan in the state and the state health agency to learn about the factors that contributed to the success of these collaborations, as well as the challenges that were encountered. Our objective is not to draw broad, generalized trends, but instead to use detailed accounts of three disparate partnerships to provide a nuanced understanding of how these collaborations were initiated and sustained and the impact they had on obesity in their communities.

Although the lessons learned from each case study differ, analysis revealed that the following were critical factors:

1. Collaborations often develop once stakeholders realize their shared interests.
2. A primary benefit of collaboration is that resources and skills can be shared among partners, allowing for a broader and stronger initiative than either could carry out alone.
3. Understanding and adapting to the differences in operational cultures between the public and private sectors is critical to a successful public-private collaboration.
4. Partners must be realistic about the initiative’s duration and funding commitments to produce a program that is sustainable.

INTRODUCTION

The purpose of this report is to describe leading collaborations between state health agencies and private health plans in addressing childhood obesity. The report profiles three distinct cases of such partnerships and briefly discusses a fourth case involving different, but related public and private collaborators.
Recognizing the importance of collaborations as a means to effectively address childhood obesity, the Centers for Disease Control and Prevention’s (CDC) Division of Partnerships and Strategic Alliances funded a joint project by the Association of State and Territorial Health Officials (ASTHO) and the National Institute for Health Care Management (NIHCM) Foundation to examine specific examples of partnerships between state health agencies and private health plans in obesity prevention. The idea behind the analysis was to understand the ways in which partnerships between these two stakeholders developed, the successes and challenges encountered, and the lessons learned.

ASTHO is the national non-profit organization representing the state and territorial public health agencies of the United States, the U.S. Territories, and the District of Columbia. ASTHO’s members, the chief health officials of these jurisdictions, are dedicated to formulating and influencing sound public health policy and assuring excellence in state-based public health practice.

NIHCM Foundation is a non-profit organization whose mission is to promote improvement in health care access, management and quality, and to foster dialogue and cooperation between the private and public sectors to find creative and workable solutions to American health system problems. NIHCM member plans are widely acknowledged industry leaders, providing coverage to over 30 percent of all privately insured individuals under 65 years of age.

The Impact of Childhood Obesity on the Lives of America’s Children

The growing epidemic of childhood obesity is one of the most serious public health concerns facing America today. Over the past 25 years, the prevalence of overweight in children and adolescents has tripled, reaching 17.1 percent in 2003-2004. This epidemic is occurring in both boys and girls, across all states and socioeconomic lines, and among all racial and ethnic groups, though specific subgroups including Hispanics, African Americans, and Native Americans are disproportionately affected.

Childhood overweight is related to numerous chronic diseases that typically manifest in adulthood. Examples include type-2 diabetes, cardiovascular disease, and certain cancers. The metabolic precursors for many of these diseases may begin in childhood. For example, findings from the Bogalusa Heart Study indicate that 60 percent of overweight five-to ten year-old children had at least one additional risk factor for cardiovascular disease (high cholesterol, triglycerides, insulin, or blood pressure), and 25 percent had two or more. In some locations, diagnosis of type-2 diabetes in adolescents now accounts for almost as many new cases of type-1 diabetes. Overweight children are also at increased risk for lower self-esteem, depression, self-blame, and social rejection by both peers and adults.

The Importance of Collaborations in Tackling Childhood Obesity

Home, work, school, and clinical environments all influence the choices that children make regarding food and physical activity. Therefore, strategies that engage stakeholders across these contexts offer more promise of delivering an effective response to the obesity epidemic than efforts made by a single entity. Consequently, public-private collaborations targeting obesity prevention are increasingly being pursued as they have the potential to bridge resources and reach a greater number of individuals than either partner could alone.

Successful collaborations can affect program, policy, and health outcomes through a number of means. The type of resources each partner can bring to the table, including funding, leadership, and staff-support can greatly influence the shape, reach, and outcomes of an initiative. For example, partnering with schools is becoming increasingly common as they have the ability to reach large numbers of children. With the help of other stakeholders, many schools have recently implemented policies to create healthier environments that not only improve children’s weight, but also their self-esteem and academic performance.
Other benefits of collaboration include creating widespread awareness of an issue, sharing accountability for implementation, and acquiring broad recognition for a program.

The following case studies provide in-depth examples of how such public-private partnerships can occur and thus help inform the discourse on best practices in collaborations targeting childhood obesity. These cases serve as models that other stakeholders may find helpful in designing their own collaborations to reduce childhood obesity.

**Approach**

The NIHCM Foundation and ASTHO conducted an “environmental scan” of various obesity prevention activities that resulted from collaborative efforts between a state health agency and a health plan. Several criteria were considered for case study selection, including the extent of collaborative efforts in the partnership, diversity in the kinds of partnerships, and the scope of the obesity prevention program. Using these criteria, three case studies in the following states were selected: Massachusetts, Pennsylvania, and Tennessee. One additional state, North Carolina, was included in the paper to serve as an example of a collaboration that involved partners other than the state health agency and a health plan.

Information for each case study was gathered through a series of interviews with representatives from the state health agency and the health plan, as well as a review of the documentation related to the prevention program. To guide interview questions, a structured instrument with a set of core questions was developed and used for each case study (see Technical Appendix).
HEALTHY CHOICES — MASSACHUSETTS

Introduction

The Massachusetts Department of Public Health (MDPH) partnered with Blue Cross Blue Shield of Massachusetts (BCBSMA) to implement Healthy Choices, a school-based initiative focused on childhood overweight prevention across the state. Although not explicitly based on it, the program follows the Obesity Care Model, a theoretical framework for implementing obesity interventions in the medical system and the broader environment in which children develop. (See Figure 1). The objective of Healthy Choices is to increase opportunities for young people to participate in physical activity programs and increase knowledge regarding the health benefits of proper nutrition and increased physical activity.

Separate Initiatives, Common Interests, & Complementary Strengths Lead to Collaboration

Prior to the creation of Healthy Choices, both BCBSMA and MDPH ran separate obesity prevention programs. In 1998, BCBSMA began the Jump Up and Go! (JUG) initiative after conducting a statewide community assessment process to identify gaps and unmet needs in children’s health. Targeting childhood obesity, JUG offered its program in several settings, including clinics, schools, communities, and the media. At the start, JUG focused its efforts on community organizations such as YMCAs and the Boy Scouts.

In 1994, MDPH developed and piloted Healthy Choices. The program improved school meals and increased student nutrition, physical activity knowledge, and behaviors. School-wide activities promoted improved nutrition and physical activity, and before and after-school programs aimed at enhancing awareness of nutrition and physical activity. Results from the pilot evaluation showed decreased rates of tardiness, increased rates of physical activity, and improved breakfast and lunch eating habits among students. Based on the findings, MDPH wanted to expand the program. At a cost of $20,000 per school per year, however, Healthy Choices was not financially sustainable.

Through a meeting on the issue of childhood obesity in the state, BCBSMA and MDPH realized their common interests and initiated discussions to join efforts. The health plan brought staffing and financial backing to the table. MDPH provided access to schools, a promising intervention, and a program coordinator to oversee the expansion. Together they determined that schools needed:

1. Clear and transparent incentives to adopt curricular materials targeting obesity.
2. A financial commitment.
3. A sustainable model.

By 1999, the two organizations decided to apply together for a grant to evaluate the expansion of Healthy Choices. The new initiative had a similar focus as the original MDPH Healthy Choices on before- and after-school programming and promotional activities, but further focused on implementing elements that were low-cost and could be integrated in schools on a sustainable basis. BCBSMA provided three-year diminishing grants of $5,000, $3,000, and $1,000 to participating schools. Schools developed and implemented programs tailored to their needs with help from a MDPH-directed coordinator and program evaluators. During each year of the grant, schools increased engagement with local area businesses to obtain continued funding. The evaluation from the expansion demonstrated a positive intervention effect for girls both in body mass index (BMI) and nutrition knowledge. In addition, process data provided invaluable information about program implementation. Having a school-based coordinator, a unified team, support from administration, adequate resources and technical assistance from MDPH were predictors of whether the program reported successes during the intervention.
Healthy Choices: Upward and Onward

5-2-1

In support of their collaborative efforts in the schools, key BCBSMA staff coined the “5-2-1” Daily Prescription for Health, which has since gained wide popularity around the country. 5-2-1 simplifies the CDC evidence-based guidelines for childhood obesity prevention into a functional concept that can be used across the environments in which children learn and develop. 5-2-1 encourages children and their parents to eat five or more servings of fruits and vegetables, limit television and screen-time to two hours, and participate in at least one hour of physical activity daily. The result has been an evidence-based, multi-dimensional, broad-based social marketing campaign that connects JUG childhood obesity initiatives across schools, community, homes, and clinics.

Planet Health and CDC’s School Health Index

By 2004, Healthy Choices expanded to include the Harvard School of Public Health’s Planet Health curriculum, an evidence-based interdisciplinary curriculum designed to integrate health and wellness habits with core school subjects such as language arts, math, science, social studies, and physical education. The program also instituted the requirement that grant recipients improve school health polices through use of CDC’s School Health Index (SHI). SHI is a formalized self-assessment and planning guide to help schools evaluate and improve health, safety, and wellness policies. Under the program, schools are required to select and implement at least one policy change for each year that they receive funding under a Healthy Choices grant. Examples of such policy changes include improving the nutritional quality of foods provided by school cafeterias and vending machines, and increasing opportunities for physical activity during the school day.

Current Status of the Collaboration

The current model, considered the enhanced Healthy Choices model, is a grant-making program that includes a flexible interdisciplinary educational curriculum, a school health policy improvement program, a before-and-after school component, and the 5-2-1 community-wide social marketing campaign.

The initiative has also established a collaboration with Framingham State College. Teachers can earn continuing education credits for taking the Web-based Planet Health training in addition to other graduate courses, Web-based courses, and Web-based modules and curricula.

With the support of regional coordinators funded by BCBSMA and supervised by MDPH, Healthy Choices has been implemented in over 125 Massachusetts schools with plans for further expansion. The technical assistance provided by the regional coordinators was critical for program implementation. Program evaluators monitor program progress, document program barriers and assess school policy changes and changes in youth attitudes and behavior. In addition, evaluators provide annual updates on school status and guidance on how schools can use the data to improve their programs and market their initiatives to the school community.

Lessons Learned

Collaborating partners can share resources and create a better product than either one could alone.

In the enhanced Healthy Choices model, resources converged to produce more successful and sustainable impacts than either partner could have accomplished on their own. Resources include different skill sets and expertise, financial backing, access to other partners, ideas and innovation, and prior experiences. Both partners stated that Healthy Choices was easier to implement and became more widespread based on the different resources and contacts that each partner was able to bring to the collaboration. BCBSMA brought access to plan members, participating physicians, financial resources, and an experienced marketing and press relations department. MDPH brought programming and evaluation expertise and connections to government agencies, public health organizations across the state, and community-based groups. In addition, statewide advocacy efforts by BCBSMA for obesity prevention resources were beneficial to MDPH and other organizations in Massachusetts.

Both organizations also felt that collaborations between public and private entities are viewed more positively than initiatives driven by a single entity. Partnerships establish an environment of shared accountability which can...
help the public perceive their efforts to be mutually focused on the general public good. As a result, buy-in among stakeholders involved in the collaboration (e.g. parents, teachers, school administrators, clinicians) may be higher.

**Recognizing and understanding differences in culture between participating partners is key to successful collaboration.**

For a collaboration to achieve a measure of success, public and private partners must accommodate the differences among their respective work cultures. As Maria Bettencourt, Director of the MDPH Nutrition and Physical Activity Unit, commented, “Even though there are challenges, we absolutely have to work with the private sector. We have different organizational cultures and languages, and our organizational goals are different, but we need to figure out how to understand each other better and work together to accomplish our collective goal to reduce childhood obesity. It is a win-win situation.”

Private and public sector organizations often have different data and evaluation requirements, which can affect aspects of a collaboration. For example, although MDPH and the Harvard School of Public Health are currently collecting five-year data on Healthy Choices effectiveness, BCBSMA needed immediate evaluation information in order to prioritize Healthy Choices relative to other BCBSMA goals and activities. To meet this need, MDPH evaluators provided annual data as part of the ongoing evaluation. In addition, the health plan conducted their own surveys to determine the initiative’s efficacy and progress.

Working with schools and communities adds an additional layer of complexity in a public-private collaborative effort. Initiatives must be designed and implemented with the specific needs and requirements of the participating organizations in mind. For example, BCBSMA and MDPH had to operate on the school year timeline, carrying out the majority of work when school is in session in order to receive cooperation from school administrators and teachers.

**A targeted audience needs both structure and flexibility.**

The regional coordinators provided school staff with ideas, resources and guidance on implementing Healthy Choices. Schools used the information and training and implemented the various components of Healthy Choices using available resources and tailored the program to meet their needs. Tools and resources were provided, but no specific protocols of change were mandated and schools responded positively. At the same time, BCBSMA and MDPH provided structure by evaluating school initiatives. The presence of regional coordinators and program evaluators in the initiative also made it easier for schools to receive adequate training and correctly report results.

**Define and formalize roles and responsibility.**

Both partners stated that at times it was unclear who had responsibility and control over different aspects of the collaboration. Both stated that a memorandum of understanding would have helped eliminate any misunderstandings about respective responsibilities and more clearly define the conditions of the collaboration.

**Being realistic about cost and time is critical for sustainability.**

Looking back at the original Healthy Choices pilot, the partners recognized that: 1) costs associated with the initial implementation of a program are higher than the ongoing costs of continuing the program; 2) after-school programs can be expensive if not well coordinated with local resources; and 3) short-term grants do not typically lead to sustainable programs. This desire to improve program stability with the long-term goal of achieving sustainability was the impetus behind the creation of the three-year pared down grants ($5,000, $3,000, and $1,000) with increasing financial and in-kind support from local area businesses. Because Healthy Choices involves schools, it is critical to acknowledge their involvement and the time commitment required to implement and sustain such a program.

**Simple, multi-dimensional approaches for childhood obesity are most effective.**

The 5-2-1 message brings together multiple evidence-based strategies across different dimensions of a child’s environment to implement obesity prevention strategies in a simple and clear way. Sylvia Stevens-Edouard, Director of Community Relations, BCBSMA, highlighted the effectiveness of 5-2-1 as a marketing tool in the fight against childhood obesity in discussing community feedback. “Many parents know their children have to lose weight, but don’t know specifically what to do. Now they’re thinking, ‘what do we have to do? 5-2-1’.” The success of the 5-2-1 marketing tool is evidenced by its widespread adoption in childhood obesity initiatives across
the country. The *Healthy Choices* program seeks to reach families through a multitude of education and behavior change strategies by integrating messages and policy change into settings where parents and children already are.

**Figure 1: The Obesity Care Model and Related JUG Initiative Supports**

Adopted from Wagner’s Chronic Care Model, the Obesity Care Model provides a framework to guide the development of comprehensive, multi-component obesity interventions focusing equally on the medical system and the broader environment outside the clinic walls.

Under the Obesity Care Model, self-management is the core determinant of reduced weight. In pediatric settings, engagement of the family is essential to the child’s ability to achieve and sustain weight control. Thus, self-management among children requires family management.

As the model indicates, improved health outcomes depend not only on effective delivery of care by the medical system but also on complementary changes in schools and communities to support evidence-based strategies.

Through its multi-component approach targeting children across different environmental settings, *JUG* addresses many of the key aspects outlined in the Obesity Care Model:

1. **Clinician Support** - To support childhood obesity efforts in the clinical setting, BCBSMA developed a clinician toolkit. Each kit contains information from the CDC on childhood obesity, BMI growth charts, information on the 5-2-1 message, and checklists that parents and children can use in conjunction with adapting the 5-2-1 lifestyle.

2. **Parent and Family Support** - BCBSMA also designed and distributed parent toolkits to equip parents with educational resources and activities that help parents understand the impact of proper nutrition and physical activity on children’s development and facilitate communication and implementation of healthy practices espoused by *JUG* at home.

3. **School Support** - The MDPH and BCBSMA *Healthy Choices* initiative includes a school grant-making program, a school health policy improvement program utilizing the CDC School Health Index (SHI), and an interdisciplinary wellness curriculum.

4. **Community Support** - BCBSMA partnered with CBS-4 and Shaw’s/Star supermarket to sponsor a “5-2-1 Jump Up and Go!” on-air television campaign. Programming includes regular reports and features on childhood nutrition and fitness and a tips series that runs within the newscast and at various times throughout the day on CBS-4 and other affiliates. The campaign is also linked to the *JUG* Web site ([www.jumpupandgo.com](http://www.jumpupandgo.com)), a kid-friendly site that contains healthy eating and fitness tips, and related links.
HIGHMARK HEALTHY HIGH 5 HEALTH eTOOLS FOR SCHOOLS – PENNSYLVANIA

Introduction

Highmark Healthy High 5 Health eTools for Schools is a leading edge program that harnesses technology with best practices to improve nutrition and physical education and increase physical activity in schools throughout the state. The program, funded through Highmark Healthy High 5, an initiative of the Highmark Foundation, was created after meeting with representatives from the Pennsylvania Department of Health (PADOH) and the Pennsylvania Department of Education (PDE) and determining the specific needs of state agencies and schools. Highmark Healthy High 5 Health eTools for Schools (https://www.healthetoolsforschools.org) is a secure Web-based portal that enables school nurses to electronically input, track, and communicate student’s health and fitness information (including body mass index (BMI)) through an electronic version of the PADOH’s required School Health Record for all students. The portal provides educators and principals access to a research-based, evidence-driven curriculum for better nutrition and physical activity planning. Health eTools is based on CDC’s Coordinated School Health Program (CSHP) model, a multi-component approach designed to encourage schools, families, and communities to work together to improve students’ health and their capacity to learn. (For more on CSHP, see Figure 2).

How Did The Private-Public Strategic Partnership Begin?

In February 2005, at the request of Pennsylvania Governor Ed Rendell, the Secretary of Health, Calvin B. Johnson, MD, composed a small workgroup of experts from PADOH, PDE, the Department of Agriculture, and others to develop a children’s wellness initiative. Building off of the statewide obesity plan, the state Maternal and Child Health Block Grant application, and other state efforts, the workgroup developed 29 options for review, including the idea of a Web-based portal for a children’s wellness initiative. The workgroup wanted the initiative to support CDC’s CSHP model, include school nurses, and teach parents how to make good choices at home. Prior to this, Highmark, Pennsylvania’s largest health insurer, had several grant and other initiatives in place to provide schools with the resources necessary to address health risk through obesity prevention. Consistent with the state workgroup’s idea of a school-focused, Web-based portal, Highmark was intrigued with advancing the concept of a student electronic health record to improve health services in schools. While, at the committee level, the state was considering its options, Highmark leadership met with Secretary Johnson and Secretary of Education Dr. Gerald Zahorchak to discuss shared priorities for reducing childhood overweight in the state. In discussing their respective ideas and the state’s recent mandate for BMI screening and reporting by schools—as well as pressures to meet academic standards imposed by No Child Left Behind legislation—Highmark realized that its vision for reducing children’s health risk and commitment to supporting schools set the stage for meaningful collaboration to support the state’s mandate.

“It was that ‘Ah Ha!’ moment when we realized our common goals with the state departments of health and education,” said Janice Seigle, Highmark Director of Corporate Strategic Initiatives. Meetings and discussions ensued with partners making verbal commitments to align as closely as possible their efforts and move in tandem. In September 2006, Highmark Inc. announced Highmark Healthy High 5, a five-year, $100 million initiative of the Highmark Foundation, to improve children’s health and wellbeing. Health eTools for Schools became a core component under the initiative and is now funded through the Highmark Foundation.

The Pennsylvania Department of Health made a deliberate decision not to sign a memorandum of understanding (MOU) with Highmark Foundation to allow flexibility and to ensure that the project develop quickly and implementation be facilitated without state administrative policy hindrance. Planning and implementation continues to progress through regular discussions between Highmark Foundation, PADOH, and PDE.

In order to be assured of its effectiveness and to feel comfortable in endorsing Health eTools, the PADOH requested it review the finished product. It also asked that Health eTools be made available statewide, including to schools located in counties outside the Highmark Foundation 49-county service region. In turn, Highmark Foundation requested the Department’s public endorsement of Health eTools to encourage schools to adopt the program and assure its sustainability.
Technology partner InnerLink, was contracted in early 2005 to develop Highmark Foundation’s vision of an evidence-based, best practice strategy to promote student wellness under the framework of the CSHP model. The resulting product, Health eTools for Schools, evolved through substantial collaboration with professional and advocacy groups in the state including representatives from PADOH and PDE as well as the following:

- Pennsylvania State Association for Health, Physical Education, Recreation and Dance (PSAHPERD)
- Pennsylvania Association of School Nurses and Practitioners (PASNAP)
- Pennsylvania Advocates for Nutrition and Activity (PANA)
- Pennsylvania School Boards Association (PSBA)

The portal serves as an online resource and information management solution that equips school nurses, food service providers, educators, administrators, and school wellness coordinators with interactive tools designed to accomplish federal and state mandates that include:

- Measuring, recording, and reporting changes in student health indicators.
- Improving physical activity and nutrition policies.
- Improving student attitudes and knowledge regarding nutrition and physical fitness.

**PADOH-Mandated Screenings and BMI Report Cards**

In Pennsylvania, school nurses are required to complete several screenings for each student to report to the Pennsylvania Department of Health: hearing, vision, screening for curvature of the spine, dental checkup, and BMI. (See Figure 3). In the 05-06 school year, schools were also required to begin sending annual BMI report cards to parents for all students in kindergarten through fourth grade. The report cards provide the child’s BMI, an explanation of how this measurement is related to the range of measurements for their child’s age and gender, and encourage parents to share the information with their family physician. BMI report cards will be added for grades five through eight in the 06-07 school year and then required for all grades kindergarten through 12 in the 07-08 school year.
The Health eTools initiative provides school nurses with personal digital assistants that record a student’s height and weight, which can then be synced with the Health eTools Web site where BMI is calculated and CDC’s Growth Screening chart captures the student’s BMI on a per grade basis. The program generates a customized letter to be sent home to the parents communicating the results of the BMI screening and a health report for submission to the Pennsylvania Department of Health. PADOH receives the data in aggregate form to use for surveillance, program planning, and evaluation. Records are password protected. The school nurse is the only person within a school who has access to the entire student health record. Fitness health assessment protocols can be generated for each student and provided to physical education teachers. Other educators can access a host of nutrition-relevant curricular materials (discussed below) using Health eTools. A third party provider performs data management and security functions in compliance with federal and state privacy laws.

**Federal Requirements**

The federal *Child Nutrition and WIC Reauthorization Act of 2004* required all schools participating in the National School Lunch Program to: 1) apply nutrition guidelines for food service providers aimed at promoting student health and reducing childhood overweight and 2) create wellness policies designed to improve children’s nutrition education and physical activity. To facilitate implementation of the first of these requirements, the Pennsylvania Department of Education provided schools detailed information in their *Guidelines for Nutritional Standards for Competitive Foods*. To assist implementation of the second, Health eTools provided interdisciplinary wellness templates for administrators, food service providers, and educators for efficient, best practice approaches to wellness policy creation and implementation. Many of these templates were initially developed by the Pennsylvania Advocates for Nutrition and Activity (PANA), a statewide coalition established by PADOH and funded by CDC to promote policies and programs that support healthy eating and physical activity in the state. PANA also provides materials to assist in the evaluation of school wellness policies, which are reviewed by the state every five years.
Educational Materials

An important feature of Health eTools is the on-line availability of downloadable lesson plans, student worksheets, assessments, and other curricular materials that classroom educators and physical education instructors use to teach healthy behaviors across the curriculum. Health eTools participating schools commit to incorporating 75 minutes of nutrition education content into class time at each grade level per marking period. These materials are consistent with the Pennsylvania Department of Education and PADOH standards for nutrition education, physical education, and activity designed to foster learning in core subject areas. Educational materials available through Health eTools include content drawn from three evidence-based sources:

- **WE CAN (Ways to Enhance Children's Activity & Nutrition)** – a national program led by the National Heart, Lung, and Blood Institute designed for parents and caregivers to help children 8-13 years old stay at a healthy weight. The program focuses on three important behaviors: improved food choices, increased physical activity and reduced screen time (http://wecan.nhlbi.nih.gov).

- **CATCH (Coordinated Approach to Teaching Children's Health)** – a national program developed by university researchers to promote healthy eating and physical activity behaviors among elementary school children to last a lifetime. The program includes four components: a classroom curriculum, physical education program, school food service planning, and family program (http://www.catchinfo.org).

- **SPARK (Sports Play & Active Recreation for Kids)** - a national program developed by a research-based organization dedicated to creating, implementing, and evaluating programs that promote lifelong wellness. SPARK provides evidence-based physical activity and nutrition programming for Pre-K through 12th grade students (http://www.sparkpe.org). (See Figure 4).

![Figure 4: Screenshot of Health eTools Sample Curriculum](image)
Current Status of Health eTools and the Vision for the Future

Highmark provided the start up and development costs for Health eTools (with partners providing significant in-kind resources), and it is available to school districts statewide. Beginning in Fall 2006, through Highmark Healthy High 5, the Highmark Foundation has committed to funding Health eTools within its 49-county service area with the possibility of continuing funding beyond the initial term. As of July 2007, over 200,000 students were enrolled in 86 school districts that had adopted Health eTools through a Highmark Foundation subsidy program. InnerLink has subsequently engaged in discussions with 150 additional school districts and parochial schools in order to achieve a student enrollment of 400,000 by December 2007.

Most recently, the addition of immunization records and health alerts to the electronic health record has enabled school nurses to more quickly identify children at risk. The long-term vision for Health eTools is to provide schools with evidence-based tools and technology and other resources to play a central role in improving children’s health and reducing obesity. By having the capability to provide a longitudinal view of a student's health, fitness, nutrition knowledge, and healthy lifestyle behaviors, Health eTools can also contribute to comprehensive case management for students from kindergarten through high school.

Lessons Learned

Recognizing and understanding differences in culture between participating partners is key to successful collaboration.

Given the difference in speed at which Highmark made decisions regarding the initiative’s development and the pace and probability of getting the program funded and implemented solely through the state government, the health department had to be willing to sacrifice some decision-making authority so Health eTools could progress, or progress in a timely manner. As Special Assistant to the Secretary of Health, Brian Ebersole, explained, “We had to be willing to let go in order for Highmark to move ahead.”

At the same time, it was important for PADOH to stay informed and that the private sector understood and addressed the existing infrastructure, laws and regulations, and met specified quality standards. Aware that creating a formal MOU had the potential to bog down the initiative in state administrative requirements, a conscientious decision was made to take a more flexible approach to the collaboration by defining roles, assessing progress, and making changes through regular phone calls.

PADOH’s requirement that Health eTools be available to schools statewide added an additional layer of complexity for the initiative. The size and organization of the local health departments in Pennsylvania vary by area, with some organized by county and others in regional groups.

Solely responsible for Health eTools marketing, InnerLink must work with all types of school districts to implement Health eTools, which has been challenging. Highmark Foundation serves 49 counties, leaving 18 Pennsylvania counties without access to the program. To facilitate the statewide rollout and adoption of Health eTools, Highmark Foundation has provided for licensing the program to neighboring Blue Cross plans, Independence Blue Cross and Northeastern Pennsylvania Blue Cross, through InnerLink. The efficiency and swift manner in which Health eTools is being implemented in Pennsylvania is considered a major achievement of the collaboration.

Strong leadership and support at the highest levels is critical to ensuring a successful partnership.

Respondents in both sectors agreed that leadership support at the highest levels is essential for successful collaboration. The initial meeting between Highmark and health agency leadership to specifically discuss avenues for collaboration and the potential of the student electronic health record concept and systemic obesity prevention was key to forging partnerships. Health eTools continued its progress under high-level leadership at PADOH, PDE, and Highmark. Previously established relationships at the secretary level among the state agencies were felt to be an important point of leverage that contributed to the success of the collaboration.
Being realistic about cost and funding is critical for long-term sustainability.

Health eTools is intended to be a long-term investment in child wellness in Pennsylvania. Sustainability of the initiative remains an item of concern to all partners who are actively seeking solutions to assure its viability. Highmark Foundation and the other Blues plans have committed to funding the program for a minimum of three years with the intent that school districts and the state will assume minimal maintenance costs when subsidies end and initial development costs have been absorbed. So far, firm commitments from the state regarding the willingness to fund the program’s ongoing costs and its ultimate sustainability are still pending. Particularly, PDE is encouraged by cost models under development that demonstrate potential benefit and return on investment to Health eTools user schools. Demonstrating value—such as improved absenteeism, increases in student performance, and more efficient data capturing and reporting—is seen as the best way to assure Health eTools longevity.

Collaborating partners can share resources and create a bigger and better product than either one could alone.

Health eTools is a collaboration in which the public and private sectors worked together, bringing their unique resources, skills, expertise, and prior experiences to the table to develop an ambitious initiative to address childhood wellness and obesity across the state. With both federal and state policy levers being directed at schools, the Health eTools initiative is designed to help schools meet these mandates through tools, resources, and financial backing while using CDC’s evidence-based Coordinated School Health Program model as a framework for development. Highmark Foundation support and commitment has afforded speed and efficiency. It has acted as the catalyst to incorporate significant input from leadership among school boards, school nurses, and health and physical education experts. PADOH and PDE brought technical expertise and have been critical in ensuring that the initiative is in line with the complex needs of schools and in supporting the product’s use in schools statewide.

Understanding each partner’s strengths and weaknesses is critical to defining roles for successful collaboration.

A key point from PADOH’s perspective regarding the collaboration’s success was the importance of understanding their organization’s strengths and limitations and defining what their role in the partnership’s success could be. Despite the concept of a Web-based portal coming out of a state level workgroup, PADOH knew that the state could not develop and implement the initiative as fast as the private sector. PADOH had to be willing to make the difficult decision of letting go of some authority over the project to see the initiative completed. However, for PADOH to endorse Health eTools adoption by the schools, they are ensuring that the program’s development complies with federal and state regulations and are requiring that the initiative be offered statewide and include counties not covered by the health plan.

Despite the challenges, partners are optimistic about the progress of Highmark Healthy High 5 Health eTools for Schools thus far. In describing her State department partners, Seigle said, “Underneath all of the bureaucracy and mandates, it was the hard work of dedicated individuals at the health and education departments willing to battle away and get through the red tape to make a difference.” Ebersole agreed, “We couldn’t ask for a better opportunity than with Highmark to get a sense of accomplishment.”
Figure 2: The Coordinated School Health Program Model

According to CDC, a coordinated school health program consists of eight interactive components, with schools providing a critical facility in which many agencies may work together to improve the health of young people (see http://www.cdc.gov/HealthyYouth/CSHP/).

1. **Health Education**: A planned, sequential K-12 curriculum that addresses the physical, mental, emotional and social dimensions of health. The curriculum is designed to motivate and assist students to maintain and improve their health, prevent disease, and reduce health-related risk behaviors.

2. **Physical Education**: A planned, sequential K-12 curriculum that provides cognitive content and learning experiences in a variety of activity areas that promotes each student’s optimum physical, mental, emotional, and social development in activities and sports that all students can enjoy and pursue throughout their lives.

3. **Health Services**: Services provided for students to appraise, protect, and promote health.

4. **Nutrition Services**: Access to a variety of nutritious and appealing meals that accommodate the health and nutrition needs of all students.

5. **Counseling and Psychological Services**: Services provided to improve students’ mental, emotional, and social health.

6. **Healthy School Environment**: The physical and aesthetic surroundings and the psychosocial climate and culture of the school.

7. **Health Promotion for Staff**: Opportunities for school staff to improve their health status through activities such as health assessments, health education and health-related fitness activities.

8. **Family and Community Involvement**: An integrated school, parent, and community approach for enhancing the health and well-being of students. School health advisory councils, coalitions, and broadly based constituencies for school health can build support for school health program efforts. Schools actively solicit parent involvement and engage community resources and services to respond more effectively to the health-related needs of students.
BLUECROSS WALKING WORKS FOR SCHOOLS – TENNESSEE

Introduction

In 2004, the Tennessee Governor’s Council on Physical Fitness and Health, administered by the Tennessee Department of Health (TDH), initiated a partnership with BlueCross BlueShield of Tennessee (BCBST) to encourage physical activity in Tennessee elementary schools. BlueCross Walking Works for Schools is a straightforward program that helps classroom teachers incorporate walking into each school day. The program is designed to instill a culture of physical activity in young children grades K-5 that will hopefully persist throughout their lives.

How did the private-public partnership begin?

Collaboration with TDH and BCBST was the result of a shared interest in the prevention of childhood obesity. The Governor’s Council, administered by TDH, is charged with promoting healthy lifestyles for all Tennessee citizens. In 2004, the Governor’s Council approached BCBST with an idea for funding a program that increased physical activity in schools. Over the course of a series of meetings between the Governor’s Council, TDH, and BCBST, a program for walking in school emerged—BlueCross Walking Works for Schools.

TDH and BCBST agreed to implement the program with a memorandum of understanding to guide the process. The respective strengths of all entities involved facilitated implementation of the project. TDH assisted in promoting the program through regional health department health educators working in local communities encouraging their schools to undertake the program. The Department of Education took the lead in implementing the program among the coordinated school health pilots. Once initial contacts with schools had been established, BCBST organized demonstration days and distributed promotional t-shirts. BCBST funded and has continued to fund the materials required for the programs administered in each classroom.

BlueCross Walking Works for Schools

BlueCross Walking Works for Schools is a straightforward program that requires teachers to incorporate a minimum of five minutes of walking into each school day for a period of 12 weeks each semester. To help teachers achieve this goal, the program provides each class with some basic materials, including a pedometer to record the number of steps taken, tracking posters to chart the progress of the class, and informational packets for teachers to become familiar with the benefits of daily physical activity. Additional materials, such as wristbands and achievement certificates (signed by Governor Phil Bredesen and Vicky Gregg, President and CEO of BCBST), were also distributed to help increase enthusiasm and participation in the program.

Schools that have 90 percent participation from students, staff, and administrators and walk an average of 40 minutes per week or 7.5 minutes per day during the semester will receive an “Extra Mile School” banner to recognize their outstanding effort and encourage continued program participation. Teachers can obtain program materials and provide program feedback by accessing the following Web site: http://www.WalkingWorksForSchoolsTN.com.

Though initially a partnership between BCBST, the Governor’s Council, and TDH, the BlueCross Walking Works for Schools partnership grew to include other public agencies and professional groups in the state, including:

- Tennessee Department of Education
- Tennessee Association for Health, Physical Education, Recreation, and Dance (TAHPRD)
- Belmont University
- FedEx

Each collaborator was key to some aspect of the program’s successful implementation. For example, the Tennessee Department of Education, because of its widespread contacts and credibility with schools, played a crucial role in helping BCBST and TDH gain access to the school system. However, once access to the schools had been acquired, the other partners adopted important roles in advancing the program’s implementation. For
example, TDH could use the Governor’s endorsement of the program to promote adoption. Meanwhile, the financial resources available to BCBST enabled them to distribute promotional *BlueCross Walking Works for Schools* teacher kits with the volume of materials necessary to cover all schools and children and to publicize the program. Belmont University provided critical administrative support during the first year of the program’s implementation, and FedEx provided in-kind support with the shipping and distribution of program materials during the statewide launch for the 2006-2007 school year.

**Evaluation**

*BlueCross Walking Works for Schools* was launched in 2005 as a pilot in 30 schools for grades kindergarten through four. Schools that had school health coordinators were selected for the pilot because the coordinators could assist with the oversight of the program’s implementation and evaluation. By spring 2006, during the second phase of the pilot, the program had expanded to include 121 schools grades K-5 with participation from nearly 50,000 students, 2,410 teachers and 2,566 administrators and staff.

To assess the effects of *BlueCross Walking Works for Schools* on student behavior, teachers were asked to complete a 10-question survey every 12 weeks. In the survey, teachers were asked about their daily routine, including how many minutes were devoted to walking, difficulty experienced with incorporating the program into their lessons, and any observed changes in students’ behavior. During the 05-06 pilot, a total of 452 teachers from 80 schools completed the survey. The results from these surveys are displayed in Figures 5 and 6.

### Figure 5: Percentage of classes that walked the corresponding minutes per day.

<table>
<thead>
<tr>
<th>Percentage of classes</th>
<th>5 min (minimum)</th>
<th>Between 6 to 10 min</th>
<th>More than 10 min</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>35%</td>
<td>44.2%</td>
<td>15.5%</td>
</tr>
</tbody>
</table>

### Figure 6: Percentage of teachers who reported changes in students’ behavior and weight.

<table>
<thead>
<tr>
<th>Types of Changes Observed</th>
<th>Percentage of Teachers Reporting Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved Classroom Behavior</td>
<td>70%</td>
</tr>
<tr>
<td>Improved Attention Span</td>
<td>62%</td>
</tr>
<tr>
<td>Increased Energy Levels</td>
<td>54%</td>
</tr>
<tr>
<td>Improved Learning Readiness</td>
<td>44%</td>
</tr>
<tr>
<td>Increased Physical Endurance</td>
<td>42%</td>
</tr>
<tr>
<td>Weight Loss</td>
<td>6%</td>
</tr>
</tbody>
</table>

**Current Status of BlueCross Walking Works for Schools and Vision for the Future**

On July 20, 2006, after *BlueCross Walking Works for Schools* had completed its second pilot year, the Tennessee legislature passed a bill mandating that all schools integrate a minimum of 90 minutes of physical activity per week into the school day by the 07-08 school year. Since the law’s requirements exceeded those of *BlueCross Walking Works for Schools*, there was concern that it would reduce demand for the program. Instead, participation in *Walking Works for Schools* increased in the fall of 2006, enrolling 377 schools and more than 160,000 students statewide, with even more enrollees expected for the fall of 2007. The increase in program participation has been due, in part, to the statewide release of the program in 2006 up to grades K-5, but also because schools view *BlueCross Walking Works for Schools* as a program that they can build upon to help satisfy the new state requirements.
Lessons Learned

Collaborating partners can share resources and create a better product than either one could alone.

One of the primary benefits of a cross-sector collaboration is that it allows for resources and expertise to be pooled, which helps translate ideas into action, making for a better overall product. As Sandy Bunting of BCBST said, “No one functions in a vacuum. We need help from the public sector to get support for an initiative, as we are just one piece of the community.”

Much of the success of BlueCross Walking Works for Schools can be attributed to the unique contributions that each partner made towards some key aspect of the program’s implementation. Despite the detailed attention that BCBST and the Governor’s Council gave to the planning of BlueCross Walking Works for Schools, the program might not have been implemented without the assistance of the Tennessee Department of Education to gain access to the school system and navigate through its regulations. Equally important were the promotion of the program within Tennessee schools and the provision of program materials. These could not have occurred without the support of other partners, BCBST and TDH, in particular. The pooling of respective resources and expertise in this way helped ensure the launch of BlueCross Walking Works for Schools and its subsequent success.

Programs that are simple in design are easier to implement and can have far-reaching effects.

Relative to other programs, the core appeal of BlueCross Walking Works for Schools is its simplicity. The program sets a realistic goal for teachers and students: incorporate a minimum of just five minutes of walking into each school day. Setting a small goal has two indirect consequences. First, an achievable goal helps participants maintain motivation for the program. An attainable goal also emboldens participants to surpass it, as most classrooms did. Second, students begin to view the daily walking as an important part of their day, which supports a culture of daily physical activity that students will hopefully retain (and seek) even after they leave school premises. Evidence that students had, in fact, imbibed a culture of daily physical activity is reflected most clearly by one teacher who said, “I was able to find time [for the students] to walk, and found that the whole class became dependent upon our walking time.” Once the program began, students began to expect to walk each day and were disappointed if walking did not occur. Thus, although the duration of the activity itself is short-term, the message imparted to students is intended to have a long-term impact.

Being realistic about cost and time is critical for sustainability.

BlueCross Walking Works for Schools requires minimal materials and time commitment from teachers, enhancing the program’s feasibility to replicate and sustain, even with little funding and support. The core component of the program—walking—does not require any special materials or equipment. A few simple and inexpensive accessories, such as wristbands, pedometers, charts, and informational material help build enthusiasm for the activity. It is this important characteristic that the partners hope will encourage all schools statewide to participate in BlueCross Walking Works for Schools.
### Featured Obesity Prevention Programs

<table>
<thead>
<tr>
<th>Program Name</th>
<th>State</th>
<th>Partners</th>
<th>Program Description</th>
<th>Results</th>
</tr>
</thead>
</table>
| Healthy Choices       | Massachusetts        | • BlueCross BlueShield of Massachusetts  
• Department of Public Health | • Three-year grant program to help schools develop and implement obesity prevention programs with assistance from regional coordinators and program evaluators.  
• Schools integrate Harvard’s *Planet Health* curriculum into existing courses and through a “School Health Index” assessment, select a nutrition policy to improve.  
• 5-2-1 community-wide social marketing campaign promoting evidence-based guidelines for childhood obesity prevention. | • Over 125 Massachusetts schools have implemented *Healthy Choices*; further expansions are being planned.  
• Program evaluators are collecting data about program effectiveness, which will be shared with families and communities. |
| Health eTools for Schools | Pennsylvania       | • Highmark Foundation  
• Department of Health  
• Department of Education  
• Innerlink, Inc. | • Secure Web-based portal (similar to an electronic health record) for school nurses to electronically input, track, and communicate student’s health and fitness data.  
• Provides educators access to research-based, evidence-driven curriculum for better nutrition and physical activity planning.  
• Based on CDC’s Coordinated School Health Program model. | • As of July 2007, 200,000 students were enrolled in 86 school districts.  
• Enrollment goal for December 2007 is to reach 400,000 kids. |
| BlueCross Walking Works for Schools | Tennessee          | • BlueCross BlueShield of Tennessee  
• Department of Health  
• Governor’s Council on Physical Fitness and Health  
• Department of Education  
• Tennessee Association for Health, Physical Education, Recreation and Dance  
• Belmont University  
• FedEx | • A program that helps teachers incorporate at least five minutes of walking into each school day.  
• Designed to instill a culture of physical activity in children that will persist throughout their lives.  
• Schools are provided with pedometers, walking logs, wristbands, certificates, and information on the benefits of physical activity. | • Surveyed teachers noted positive changes in energy levels, physical endurance, attention span, overall classroom behavior, learning readiness, and weight.  
• More than 160,000 kids were enrolled in the program as of fall 2006. |
PLURAL PARTNERSHIPS: SUCCESSFUL COLLABORATIONS IN NORTH CAROLINA

The chapters in this report focus on direct collaborations between state health departments and health plans. However, these stakeholders often work in collaboration with other partners as well. North Carolina offers a rich example of the kinds of collaborations that can occur when a state agency and a health plan engage in multiple partnerships and their own relationship is less direct. The state of North Carolina merits discussion because a unique set of collaborations led to a result that is attracting the attention of federal and state policymakers around the country.

In 2005, North Carolina became the first state in the nation to mandate at the State Board of Education level that K-8 students receive 30 minutes of physical activity per day. In addition, the state’s General Assembly passed legislation requiring rigorous nutrition standards for all school meals and after school snack programs. Further, school vending machine restrictions passed into law in 2005 are among the strictest in the nation. The adoption of such measures is an outcome many want to accomplish. Therefore, examining the collaborative dynamics that gave rise to North Carolina’s successes yield important insight into how alternate partnership structures can be utilized to effect widespread changes.

A pivotal engine driving North Carolina’s obesity prevention activities is an organization called the Health and Wellness Trust Fund (HWTF) Commission. In 2000, the General Assembly created the HWTF and allocated 25% of North Carolina’s share of the tobacco Master Settlement Agreement to the Commission. Chaired by Lt. Governor Beverly Perdue, the Commission addresses four core aspects of North Carolina’s health: (1) teen tobacco use (2) prescription drug access and safety for low-income populations, (3) health disparities and (4) obesity. When the rates of obesity among young adults in North Carolina climbed to a record high in 2003, Lt. Governor Perdue responded by reaching out to multiple stakeholder groups - including BlueCross BlueShield of North Carolina (BCBSNC) and the North Carolina Division of Public Health (NCDPH) - to initiate a series of obesity prevention efforts. These efforts are coordinated through two core components of the HWTF’s obesity prevention work:

1. Fit Families NC: A Study Committee for Childhood Overweight/Obesity

The Study Committee serves as the policy arm of the HWTF’s obesity prevention efforts. Comprising a broad range of professionals, including representatives from the state legislature, the Study Committee formulates policy recommendations based on input from various stakeholders, as well as evidence-based research. Fit Families NC recommendations directly resulted in the three statewide policy changes, mentioned above, to improve healthy eating and physical activity opportunities in NC schools.

2. Fit Together

FitTogether serves as the educational and activity arm of HWTF. Formed in collaboration with BCBSNC, FitTogether is highlighted by three main obesity prevention efforts: (1) Grants – a variety of school and community grants were awarded by HWTF to help with the implementation of physical activity and healthy-eating interventions; (2) Social Marketing – a content-rich Web site and significant media coverage help spread awareness of the risks associated with unhealthy weight and provide individuals with the knowledge and tools necessary to effect appropriate changes to their lifestyles; and (3) Fit Workplace – a workplace wellness campaign designed to make healthy behaviors part of the business environment in North Carolina.

The above described prevention efforts form part of a multidimensional approach to addressing obesity. Given the complexity of factors that contribute to the obesity epidemic, a comprehensive response involving multiple stakeholders coordinated through a single entity like the HWTF offers a promising approach to controlling obesity. Although, the impact of the HWTF’s policy recommendations have not yet been evaluated, preliminary results from their grant-funded programs in schools have yielded positive results with 93% of the 1,683 surveyed students reporting either a maintained or decreased Body Mass Index (BMI) and 44% reporting increased physical activity. Thus, North Carolina serves as an example of how the core components of fruitful collaborations, discussed elsewhere in this report, need not be restricted to only direct partnerships between state health departments and health plans; rather, these components are transferable and can be applied to a range of collaborative entities. North Carolina has led the way in demonstrating how broad partnership structures can be effective. Other states may feel encouraged by this example to pursue similar partnerships.
CONCLUSION

The cases profiled in this report represent a sampling of the kinds of collaborations between public agencies and private stakeholders in childhood obesity prevention that are possible. Although the number of cases presented in this report is too few to draw general conclusions about the key components of successful collaborations, certain core themes did emerge.

1. Collaborations often develop once stakeholders realize their shared interests.
2. A primary benefit to collaborating is that resources and skills can be shared between partners, allowing for a broader and stronger initiative than either could carry out alone.
3. Understanding and adapting to the differences in operational cultures between the public and private sectors are critical to successful public-private collaboration.
4. Partners must be realistic about the initiative’s duration and funding commitments to produce a program that is sustainable.

With an epidemic as complex as childhood obesity, addressing the problem effectively may depend on the extent to which efforts are made to bring different sectors of society together to ensure that children (and adults) are given the knowledge, tools, and environments necessary to make healthy choices. Partnerships lie at the core of such efforts. Massachusetts, Pennsylvania, Tennessee and North Carolina serve as early examples of how such cross-sector partnerships may be formed, sustained, and achieve significant impact in communities. By learning from the successes and challenges that each of these cases experienced in their respective collaborations, it is hoped that other public and private stakeholders will be encouraged to support and actively engage in obesity prevention initiatives in their own communities.
TECHNICAL APPENDIX

Structured Instrument

1. Introduction and Purpose
   - CDC funded partnership between NIHCM and ASTHO examining private-public partnerships in the prevention and control of obesity and overweight.

2. Initial Question
   - Describe the partnerships of your health plan/health agency concerning obesity that involves the public/private sector, especially with the health agency/health plan?

   For each partnership that is mentioned in the initial description, probe the following questions:

3. Description of programs
   a. How was this partnership formed?
      (Probe: How were partners chosen? What is each partner’s role?)
   b. What are the goals of the partnership?
      (Probe: Coincide with existing goals?)
   c. How are the activities of the partnership funded or supported?
   d. Were there any resources, such as memoranda of understanding, or guidelines for working with the public/private sector that you used or developed?
      (Probe: Would (any / others) have been helpful?)

4. Evaluation of the program
   a. Was there an evidence base for the strategy chosen in this partnership?
   b. Is the program being evaluated or are there plans to evaluate it?
   c. What is the main success from this partnership?
   d. What were the challenges in forming and maintaining this partnership?
   e. What have you learned about collaborating with public/private sector partners?

5. Sustainability and replicability of the program
   a. Do you think this program is sustainable?
      (Probe reasons.)
   b. Do you see this program as replicable?
      (Probe reasons and suggestions / recommendations for other partnerships.)
REFERENCES


7 Based on unpublished studies discussed in communication with Maria Bettencourt, Director, Nutrition and Physical Activity Unit, Massachusetts Department of Public Health, August 9, 2006.


11 Ibid.

12 Ibid.

Acknowledgement

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ASTHO is the national non-profit organization representing the state and territorial public health agencies of the United States, the U.S. Territories, and the District of Columbia. ASTHO’s members, the chief health officials of these jurisdictions, are dedicated to formulating and influencing sound public health policy and assuring excellence in state-based public health practice.

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