Introduction

Northern Virginia is one of the most prosperous areas in the nation. And by many accounts, the health of its residents is quite good: Seven Northern Virginia communities ranked in the top ten of all Commonwealth jurisdictions for health outcomes, according to the 2013 County Health Rankings report published by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

But as a new report from the Northern Virginia Health Foundation shows, dig a little deeper and you see a different picture of the region’s health. According to How Healthy is Northern Virginia?, more than one million adult residents and more than one quarter of all youth in the region are overweight or obese. One quarter of youth admit that they have felt sad or hopeless for two or more weeks in a row and roughly 35 percent of all kindergarten to 12th grade students are eligible for free or reduced lunch. About one in four adults and one in five children go without regular dental care.
While Virginia’s leaders are working to tackle these and other health problems in their individual counties and cities, there is little regional collaboration. Rather than sharing ideas and leveraging resources, organizations are often “working in silos.”

How can we coordinate our efforts—as a region—to make a meaningful difference in the health of Northern Virginia?

**Coming Together to Tackle Northern Virginia’s Health Challenges**

On May 31, 2013, the Northern Virginia Health Foundation convened the first-ever Northern Virginia Health Summit, bringing together more than 130 of the region’s health leaders, nonprofits, businesses, and policymakers—including various state representatives—to take a close look at the region’s health problems and think creatively about how to work together to address them.

The Summit opened with an introduction from Verdia Haywood, Chairman of the Board of the Northern Virginia Health Foundation, and then four speakers presented:

- **Patricia N. Mathews,** President and CEO of the Northern Virginia Health Foundation, highlighted findings from the Foundation’s new health indicators report;
- **Len Nichols,** PhD, Director of the Center for Health Policy, Research, and Ethics at George Mason University—joining via Skype—summarized the state of health reform in the Commonwealth;
- **Steven Woolf,** MD, MPH, Director of the Virginia Commonwealth University Center for Human Needs, described how social determinants—social, environmental, behavioral, and other factors—influence our health; and
- **Gloria Addo-Ayensu,** MD, MPH, Director of the Fairfax County Department of Health, provided case examples of how Fairfax County has worked “across silos” to address health challenges.

Speaker presentations were followed by a “Question and Answer” period with the audience and small group breakout sessions where attendees were asked to brainstorm ways to work “across silos” toward improving public health.

The following report provides an overview of speakers’ remarks and ideas generated by attendees during the breakout sessions.
Where Are We? A Review of Northern Virginia Health Indicators

Patricia N. Mathews, President and CEO of the Northern Virginia Health Foundation (NVHF), started the day with a call for collaboration across the region’s nine jurisdictions: Arlington, Fairfax, Loudoun, and Prince William counties and the cities of Alexandria, Fairfax City, Falls Church, Manassas, and Manassas Park.

Highlighting findings from the new NVHF health indicators report, *How Healthy is Northern Virginia?*, Mathews made it clear why action is needed: While some folks are doing well, many Northern Virginia residents are struggling:

- **Over half of adult residents**—more than one million people—are overweight or obese, and more than one quarter of all youth are overweight or obese;
- **One in five adults**—more than 340,000 people—are at risk for binge drinking;
- **More than one in four youth**—in every city and county studied—reported feeling sad or hopeless for two or more weeks in a row;
- **Close to one in four adults** has not had a dental visit in the last two years; one in five children hasn’t seen a dental provider in the last year;
- **Roughly 35 percent of all kindergarten to 12th grade students** are eligible for free or reduced lunch; and
- **More than 5,000 pregnant women** are going without early prenatal care.

Race and income are not driving these findings, Mathews noted. And it’s about more than access to medical care. More than 175,000 Northern Virginians live in census tracks that rank in the bottom 20 percent of the Health Opportunity Index statewide. Populations in these census tracks are considered to be more vulnerable for adverse health outcomes. This includes people who live in some of the region’s wealthiest communities—Alexandria, Arlington, and Fairfax. The Health Opportunity Index assigns a value to a county or city based on factors that influence health such as affordability, education, environment, and economic opportunities.

Mathews then introduced the next three speakers whose remarks set the context for the audience brainstorming sessions that followed.
Health Care Reform in the Commonwealth

Len Nichols, Director of the Center for Health Policy, Research, and Ethics at George Mason University, told the story of how Virginia arrived at its current state of health reform and where it’s headed. While painting a picture of Virginia’s political climate in vivid color—that is, purple—Nichols described how this state, whose attorney general was the first to file suit against the Affordable Care Act, later came around to passing Medicaid expansion after lawmakers became convinced of its “fiscal prudence.”

Nichols described how the Commonwealth is moving ahead in quasi-partnership with the federal government, whereby the federal government will run the insurance exchange for Virginia, but the Commonwealth will take on “plan management,” or coordination with the health plans in the exchange.

Medicaid expansion passed in May, but certain requirements built into the law could leave its future uncertain. A new Medicaid Innovation and Reform Commission made up of 12 legislators was established to monitor the state’s progress and will vote on proposed reforms. Whether expansion moves forward will depend on how they vote and who is elected Governor in November.

But reform is happening in Virginia, said Nichols. The federal exchange has the potential to expand coverage for thousands of Northern Virginians, and the Commonwealth is already moving ahead on delivery reforms and generating ideas through the newly established Virginia Health Innovation Center. The Center is currently considering ideas for 400 different and new programs, including different models of the patient-centered medical home and a “bundles for babies” program to improve care for young Virginians from before birth throughout childhood.

Noting Mathews’ earlier call for the region to work together in Virginia, Nichols added that, “Collaboration has a major role to play in improving our pursuit of the triple aim [of improving people’s health and the quality of their care, while lowering health care costs].”
Beyond Health Care

While expanding access to insurance and making care affordable is critical, we have to look beyond medical care to really improve health outcomes, said Steven Woolf, MD, MPH, Director of the Virginia Commonwealth University (VCU) Center for Human Needs.

Woolf described how many health problems are related to unhealthy behaviors, such as smoking or alcohol use, but that these aren’t just matters of personal responsibility. They have to do with the environment in which we live.

Downstream determinants—such as access to healthy foods and our ability to maintain physical activity and safe neighborhoods—influence our ability to be healthy, according to Woolf. “But there are even more important ‘upstream’ determinants, such as education, income, and economic growth that are very important drivers of health,” he said.

Citing VCU research, Woolf described the dramatic link between income and health. For example, 25 percent of deaths would be averted if everyone in Virginia had the household income of people who live in the wealthiest counties. “I’m a doctor and there’s nothing I can do at the bedside or the hospital that can produce numbers like that,” he said.

In the policy world, these social factors are addressed by non-health related entities making policies related to education reform and the economy, seemingly non-health related. But taking a more holistic view, it’s clear that these policies are also health policies, said Woolf. More and more lawmakers are taking this “health in all policies” approach.

“There are important ‘upstream’ determinants, such as education, income, and economic growth that are very important drivers of health.”

Steven Woolf, Director of the Virginia Commonwealth University (VCU) Center for Human Needs

Looking at the links between social factors and health also matters to the bottom line. Woolf described how trying to balance their budgets, policymakers will cut education programs or food stamps without realizing the impact on health outcomes and increased health care costs. In a recent example, federal lawmakers proposed cutting Supplemental Nutrition Assistance Program benefits to save money. This move would not only send more people into poverty, but the intended savings would have been lost completely by higher health care costs, Woolf said.
Mobilizing Community Partners to Improve Community Health

Gloria Addo-Ayensu, MD, MPH, Director of the Fairfax County Department of Health, shared examples of collaboration in action that began only when the Health Department was forced to break out of its “comfort zone” and work in partnership with other departments and jurisdictions.

The events of September 11, 2001 and the Anthrax attacks one week later required the Health Department to act swiftly to address a surge in public health needs and work closely with non-traditional partners, engaging many for the first time. Health care providers, public safety partners, schools, and leaders from all over the region were relied on to share information, dispense medication, and work with Fairfax County to put emergency preparedness plans in place, said Addo-Ayensu.

Since then, Fairfax County hasn’t looked back. Today they call on various partners to address an array of public health challenges—from engaging clergy in community HIV/AIDS prevention to partnering with movie theaters to educate the public about getting vaccines.

Developing cultural competence has played a key role in their building successful partnerships. Health Department staff members have learned not just about distinctions in ethnicity or race, but about the cultures of different sectors. Addo-Ayensu described how they enlisted a consultant to advise them on working with the faith-based community before ever approaching clergy leaders of color to discuss HIV/AIDS issues with their congregants.

Addo-Ayensu also shared her guiding principles for effective partnership:

- Build on what already exists and leverage existing resources to minimize the need for additional costs initially.
- Look for opportunities for early successes and set realistic goals.
- Listen to partners and be flexible.
- Find ways to collaborate on priorities that further each other’s mission.
- Allow sufficient time for partnership to develop and scale up gradually.
- Make capacity-building and sustainability a core strategy of the partnership.
- Partnership-building is work, but rewarding!
What Are Our Ideas?

Following the speaker presentations and a Question and Answer session, attendees were asked to turn to each other—at assigned tables—to come up with ideas based on two questions (below). A mix of participants representing different sectors and jurisdictions were put together at each table. Groups were asked:

1. Where are there opportunities for collaboration across specific silos that might yield improved health for Northern Virginians?
2. What can I do—in my work and where I live—to improve the public’s health?

After 30 minutes of discussion, every table was asked to report out. Ideas put forward by representatives from each table are grouped into common themes (provided on page 8).
Themes that Emerge from Participant Discussions

Many ideas were generated, and those that recurred across conversations are grouped in these themes:

1. We need a regional effort in Northern Virginia to help break down silos, share ideas, build trust, work together, and share resources. There are many individual partnerships and programs, housed in individual counties and cities, but nothing that is regional. Many public health problems we’re working to address individually concern us all region-wide.

2. There are many good examples of what’s working, but we’re not sharing ideas. We need a mechanism by which we can share best practices and find opportunities to collaborate that have been missed. For example, free clinics and other health centers could connect with employers of people using clinics’ services and ask them for support. This is something that has worked elsewhere in the state.

3. People aren’t getting directed to the resources they need, to resources that are available. We need to improve communication with health care providers and others about these resources.

4. To be effective advocates for our region, voices need to come from all sectors. For example, in the case of Medicaid expansion, policymakers heard from nonprofit and faith-based groups saying that “it’s the right thing to do,” while businesses made the economic case for expansion.

5. We have to frame issues using language other sectors speak. For example, we could communicate better with certain entities like the departments of transportation or housing by explaining how their work could have a positive impact on health outcomes.

6. Technology could be used more effectively as a resource for those seeking services. For example, there could be patient education “apps” that direct people to information about the nearest safety-net provider or social service resource.

7. We can do more to harness the power of philanthropy and business to improve health. We can leverage relationships with board members to move an issue forward, especially on social and economic factors that influence health outcomes (called social determinants of health). We should also encourage long-term investments in programs. Most grants are short-term and focus on outcomes, but changes in health outcomes don’t always come in the short-term.

8. We should do more to engage non-traditional partners in thinking about the health of the region. Examples include: law enforcement, the federal military, faith-based communities, schools, and the media.

9. There isn’t enough data being shared. Let’s work to make sure that the right data is being shared with policymakers and other stakeholders.
What Are Our Next Steps?

Thanking participants for their inspiring ideas, Patricia N. Mathews, President and CEO of the Northern Virginia Health Foundation, asked the group to consider themselves “impatient optimists.”

Mathews asked attendees to keep the new sobering statistics about the region’s health in mind, but to also stay optimistic that they can improve people’s health and the conditions that cause the need for health improvement—and take action.

In addition to addressing many of the ideas generated during the Summit, there are simple things that can be done right away. “You can call or send an email to someone you know that’s not working in your ‘silo’... and figure out how you might be able to work together,” said Mathews.

Looking ahead, the Foundation will review all the ideas generated during the Summit’s brainstorming sessions and will continue in-depth conversations with organizations later this fall, as they consider their role in advancing health in the region.