

# Let's Get Healthy California Task Force Final Report

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December 19, 2012



### Letter from Task Force Co-Chairs

It is with great pride and enthusiasm that we present the “Let’s Get Healthy California” Task Force report.

Over the past six months, California’s leaders in health and health care have come together to share their expertise, passion, and creativity to develop this vision to improve the health of all Californians. The Task Force’s charge was ambitious—envision what California will look like in ten years if we commit to becoming the healthiest state in the nation.

We know that time is of the essence. Californians are experiencing an unprecedented increase in chronic disease. In addition, racial and ethnic disparities across many health outcomes are widening and health care costs continue to surpass the rate of inflation.

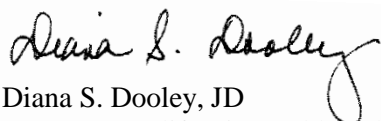
Yet faced with these challenges, this report recognizes that opportunities abound. California has a strong track record of utilizing our world-class talent and diversity to spur innovation and improve health, including being an early implementer of the federal Affordable Care Act. Building on these successes, this report looks forward at ways we can work together to achieve dramatic and critically necessary changes that will result in better health, better care, and lower health care costs for all Californians.

The report provides a framework for assessing Californians’ health across the lifespan, with a focus on healthy beginnings, living well, and end-of-life. The Task Force also identified three areas that most profoundly affect the health and health care landscape: redesigning the health care delivery system, creating healthy communities and neighborhoods, and lowering the cost of care. Importantly, the report makes clear that eliminating health disparities is an over-arching goal. We will not see improvements in health without viewing changes through a health equity lens.

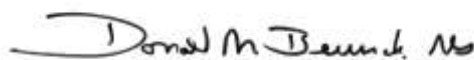
Within each of six goals, the Task Force identified a set of priorities. To track progress within these goals 39 health indicators were selected that, taken together, paint a picture of the state's overall level of health; nine additional indicators were identified that don’t yet have a data source. We have created a Dashboard that contains the 39 indicators, the data behind them, and ten-year targets. We will use the Dashboard to follow whether Californians are becoming healthier, or not, over time. The Dashboard reflects priorities and indicators at this point in time and will likely change as our needs and our ability to measure them evolve. It is our hope that by tracking these indicators, we will stimulate actions to collectively make a measurable difference.

Some such actions are highlighted in the first two appendices of the report (see Appendix I., II.). In myriad ways, Californians are already working together to build a healthier state through innovative, evidence-based projects and practices. It is these catalysts for change that will enable us to move forward on improvements in health.

We are indebted to the members of the Task Force, the Expert Advisors, staff, and the wide-range of organizations and individuals who have given so generously of their time and talent to develop this report. We are grateful for their commitment and leadership as we work toward our call-to-action---Let's Get Healthy California!



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### **Acknowledgements**

We would like to express deep appreciation to The California Endowment (TCE) for supporting the “Let’s Get Healthy California” Task Force. We also would like to acknowledge and thank the leadership of the Service Employees International Union – United Healthcare Workers West (SEIU-UHW) for their role in the initial planning and development of the “Let’s Get Healthy California” Task Force.

Special thanks to TCE, Kaiser Permanente, the Sutter Center for Health Professions, and their talented staff for hosting our three in-person meetings.

We extend our gratitude to the California Department of Health Care Services information technology team which made our many webinars possible.

We are grateful to the many organizations that lent expertise and provided information on various priority areas and indicators. Where appropriate, such contributors are noted in footnotes and listed in an Appendix.

Finally, we are indebted to the members of the public who attended and contributed to Task Force webinars and meetings, and submitted written comments. Your feedback greatly helped to improve this report.

## Executive Summary

On May 3, 2012, Governor Jerry Brown issued Executive Order B-19-12 establishing the Let's Get Healthy California Task Force to “develop a 10-year plan for improving the health of Californians, controlling health care costs, promoting personal responsibility for individual health, and advancing health equity.” The Executive Order directed the Task Force to issue a report by mid-December, 2012, with recommendations for how the state can make progress toward becoming the healthiest state in the nation over the next decade.

Co-chaired by California Health and Human Services Secretary Diana S. Dooley and Dr. Don Berwick, Founder and former President and CEO of the Institute for Healthcare Improvement and former Administrator of the Centers for Medicare and Medicaid Services (CMS), the Task Force brought together 23 California leaders in health and health care, supported by an equally distinguished group of 19 Expert Advisors. The Task Force's charge was to lay out a course to address two questions:

*What will it look like if California is the healthiest state in the nation?  
&  
What will it take for California to be the healthiest state in the nation?*

With the Triple Aim as a foundation, and informed by extensive and wide-ranging feedback—collected through a series of webinars, online surveys, and meetings—the Task Force developed an overarching Framework. The Framework identified six goals, organized under two strategic directions.

The first strategic direction, Health Across the Lifespan, sets out key milestones and markers of health and well-being in three critical life stages:

*Health Across the Lifespan*  
*Goal 1. Healthy Beginnings: Laying the Foundation for a Healthy Life*  
*Goal 2. Living Well: Preventing and Managing Chronic Disease*  
*Goal 3. End of Life: Maintaining Dignity and Independence*

The second strategic direction, Pathways to Health, covers the practice and policy changes needed to improve the quality and efficiency of the health care system and to make community environments more conducive to being healthy.

*Pathways to Health*  
*Goal 4. Redesigning the Health System: Efficient, Safe, and Patient-Centered Care*  
*Goal 5. Creating Healthy Communities: Enabling Healthy Living*  
*Goal 6. Lowering the Cost of Care: Making Coverage Affordable and Aligning Financing to Health Outcomes.*

The Task Force identified a total of 30 priorities within these six goals; a Dashboard was developed, with 39 measurable indicators that, taken together, convey the state of California's health—at both the population and system levels; nine additional indicators were identified that don't yet have a data source behind them.

Furthermore, the Framework makes clear that health equity should be fully integrated across the entire effort. Health outcomes vary dramatically by demographics, geography and a host of socio-economic conditions. For California to be the healthiest state in the nation, health disparities must be reduced and, ultimately, eliminated. The underlying principle guiding the establishment of ten-year targets is that these gaps can be closed.

With the Framework and Dashboard finalized, the challenge going forward is to identify evidence-based interventions and quicken the pace of uptake across the state. The report identifies a range of private sector efforts and public sector programs that seek to improve one or more of the priorities. This list is just a start, however. Although the Let's Get Healthy California Task Force officially ends, a website will be created and housed at the California Health and Human Services (CHHS) Agency. It will serve as a repository of the report, the Dashboard and the inventory of change strategies, and as a way to promote information sharing, facilitate collaboration, and enable progress to be collectively tracked.

The high level of participation and enthusiasm expressed throughout this process by more than three-dozen Task Force members and Expert Advisers, along with countless others, is a testament to the strong desire and commitment to make California the healthiest state in the nation. The Task Force encourages stakeholders, policymakers, and the public to join together to advance the goals and priorities identified in this report and create a statewide culture of health. The CHHS Agency will play a convening role to advance this agenda going forward.

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## I. Introduction

As the Golden state, California prides itself as a place where people can enjoy a high quality of life, be healthy and pursue their dreams. The state is home to outstanding educational institutions and medical facilities, has a reputation for creativity and innovation, and attracts the best and the brightest from all over the country and the world. It is one of the most diverse states in the country in terms of its people, geography, and economy. California's vast resources and assets have propelled the state's economy to be the eighth largest in the world.

Maintaining a healthy population is key to California's future prosperity. Healthy children learn better, healthy adults are more productive, and healthy seniors can enjoy more active years. A healthy population attracts prospective employers looking to establish in the state and ensures that local and state budgets are not consumed by health care costs.

Several trends in population health and health care present both opportunities and challenges:

- Chronic conditions and an aging population. Although California's population is slightly younger than the rest of the nation's, it is aging. Moreover, California, like the rest of the country, is experiencing unprecedented levels in chronic disease. The alarmingly high rates of obesity and resulting conditions, such as diabetes, may reverse the progress in increasing life expectancy made over the last 100 years. For the first time ever, this generation of children may not live as long as their parents.
- Transformation in health care delivery. The health care delivery system is undergoing a period of rapid transformation to address a trio of problems—it is fragmented, uncoordinated, and financially unsustainable. Private and public initiatives abound that are changing the way the health care system operates and performs.
- Significant health disparities. California is the most populous and diverse state in the country. Significant health disparities, or differences in health outcomes, exist by race/ethnicity, income, educational attainment, geography, sexual orientation and gender identity, and occupation. These disparities relate to differences in social, economic and environmental conditions, as well as to issues within the health care system itself.
- The Affordable Care Act. The passage of the federal Affordable Care Act (ACA) in 2010 offers the country, for the first time, a vehicle for providing health care insurance to a vast majority of the population. The Act also recognizes the important role that prevention and public health play in improving health outcomes, and makes an unprecedented investment in prevention both inside and outside the health care system.
- Health care costs and the state fiscal challenges. The cost of health care continues to surpass the rate of inflation, causing increasing strain on the budgets of families, employers and the government.

California has made great strides in many of these areas. For example, California has led the nation in reducing smoking, implementing managed care, and creating innovative payment mechanisms to hold down Medi-Cal costs. More recently, it has aggressively begun implementation of the Health

Benefit Exchange under the ACA. However, the state's fiscal situation, the increase in chronic disease, and the waste and inefficiencies in the health care system demand more robust action.

The time is ripe to build on what California has already accomplished to set ambitious goals for the next ten years and develop a plan to systematically collect, prioritize, and share information. With California's talent, expertise, and history of innovation, we can bring stakeholders, employers, and diverse communities together to catalyze action that will reduce the burden of disease and stem the rise in health care costs. By promoting a culture of health in our homes, our workplaces, our schools, and our communities, as well as reforming the medical care delivery system to place health promotion at its core, we can succeed in making California the healthiest state in the nation.

## II. Background, Strategic Directions, and Goals

### A. Background

On May 3, 2012, Governor Jerry Brown issued Executive Order B-19-12 (see Appendix III.) establishing a Let's Get Healthy California Task Force (hereinafter referred to as the Task Force) to "develop a 10-year plan for improving the health of Californians, controlling health care costs, promoting personal responsibility for individual health, and advancing health equity." The Executive Order identified a number of issues to be considered by the Task Force, including asthma, diabetes, childhood obesity, childhood vaccinations, and hypertension, as well as hospital readmissions and sepsis-related mortality. The Executive Order further directed the Task Force to issue a report by mid-December, 2012, with recommendations for how the state can make progress toward becoming the healthiest state in the nation over the next decade.

Co-chaired by California Health and Human Services Secretary Diana S. Dooley and Dr. Don Berwick, Founder and former President and CEO of the Institute for Healthcare Improvement and former Administrator of the Centers for Medicare and Medicaid Services (CMS), the Task Force brought together 23 California leaders in health and health care, supported by an equally distinguished group of 19 Expert Advisors who jointly participated in all aspects of this process. Dr. Robert Ross, president and CEO of The California Endowment, served as Honorary Chair of the Expert Advisors. (See Appendix IV. for full listings of Task Force and Expert Advisors members.) For purposes of this report all Task Force and Expert Advisor members are collectively referred to as the Task Force or Task Force members.

As the Executive Order stated, the Task Force was charged to help California track progress toward improving the health of the state by "establishing baselines for key health indicators...[and] establishing a framework for measuring improvements." Therefore, the first overarching question guiding the Task Force was:

*"What will it look like if California is the healthiest state in the nation?"*

In addition, the Secretary charged the Task Force to address a second overarching question:

*"What will it take for California to be the healthiest state in the nation?"*



To ground its work, the Task Force first developed a set of guiding principles (see Appendix V.) and agreed that the “Triple Aim”—articulated by Task Force Co-Chair Dr. Don Berwick during his tenure at CMS—should serve as the foundation for developing the goals, priorities, and indicators.

**The Triple Aim of Health Improvement**

- Better Health
- Better Care
- Lower Costs

Several recent national and state reports were reviewed, including the Department of Health and Human Services’ 2011 National Strategy for Quality Improvement in Health Care, the National Prevention Council’s 2011 National Prevention Strategy, and the State Health Data Assistance Center’s 2011 Framework for Tracking the Impacts of the Affordable Care Act, developed for the California HealthCare Foundation. In addition, a variety of scorecards, such as the County Health Rankings and the Commonwealth Fund on Local Health System Performance, were examined, along with similar efforts undertaken by other states around the country.

Based on this review, the Task Force identified several broad issue areas to investigate further: prevention and population health, quality improvement, coverage and access, and affordability and costs. Using available national standards as a starting place, options for setting priorities and selecting or developing indicators were considered for inclusion in the Task Force report. Task Force members and other stakeholders provided significant input through a series of webinars, surveys, in-person meetings and direct communications. (See Appendix VI. for process map.) For example, following webinars in which proposed priority areas and indicators were shared and discussed, more than 600 participants, including Task Force members and a wide range of stakeholders, ranked them through online surveys.

## **B. The Triple Aim**

The Triple Aim sets forth three overarching – and interdependent – goals. Because they must ultimately align with each other, it is critical to tackle all three simultaneously.

- **Better Health:** Helping people achieve optimal health at all stages of life is the ultimate goal. As described in the Centers for Disease Control and Prevention Healthy People 2020, a range of personal, social, economic and environmental factors influence health status in addition to health care services. To achieve this element of the Triple Aim, prevention—especially preventing chronic disease—must be put front and center, and the role of non-medical sectors, which some believe can contribute to more than 50 percent<sup>1</sup> of a population’s health status, must be fully considered and integrated into the strategies for change.
- **Better Care:** Although there are many institutions and areas of excellence within California’s health care system, overall, it is inefficient, opaque, and provides variable clinical outcomes.<sup>2</sup> By becoming truly patient-centered and striving for consistently high quality of care, Californians can obtain better value for each health care dollar spent.

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<sup>1</sup> Tarlov, A.R., “Public Policy Frameworks for Improving Population Health.” (Annals of the New York Academy of Sciences, 1999 p. 281-293.), and <http://www.cdc.gov/socialdeterminants/FAQ.html>.

<sup>2</sup> “A Mixed Bag: Clinical Quality in California.” (California HealthCare Foundation, October 2012).

- **Lower Costs:** Today's health care financing system is not aligned with the first two goals of the Triple Aim. It incentivizes inefficiencies and rewards volume of services, not quality or health. With better alignment, we can moderate the current rate of increase in health care costs, while achieving better quality, value and health outcomes.

### **C. Strategic Directions and Goals**

With the Triple Aim as a foundation, and informed by extensive and wide-ranging feedback, the Task Force Framework identifies six goals, organized under two strategic directions.

The first strategic direction, Health Across the Lifespan, addresses the question of *"What will it look like if California is the healthiest state in the nation?"* The Task Force believes that we should aspire to be a state where Californians at all ages and stages of life can thrive and are afforded choices at the end of life. Under this strategic direction, the Task Force identified three goals, each relating to a critical life stage:

#### **Health Across the Lifespan**

Goal 1. **Healthy Beginnings:** Laying the Foundation for a Healthy Life

Goal 2. **Living Well:** Preventing and Managing Chronic Disease

Goal 3. **End of Life:** Maintaining Dignity and Independence

The second strategic direction, Pathways to Health, addresses the question of *"What will it take for California to be the healthiest state in the nation?"* The Task Force identified three goals, which relate to the practice and policy changes needed to improve the quality and efficiency of the health care system and to make community environments more conducive to being healthy.

#### **Pathways to Health**

Goal 4. **Redesigning the Health System:** Efficient, Safe, and Patient-Centered Care

Goal 5. **Creating Healthy Communities:** Enabling Healthy Living

Goal 6. **Lowering the Cost of Care:** Making Coverage Affordable and Aligning Financing to Health Outcomes.

With collective, comprehensive effort by diverse stakeholders, including those who may not have been included in such activities in the past, the Task Force believes that California can become the healthiest state in the nation. It will take, however, working on multiple fronts simultaneously—from making very technical but important changes in the health care delivery system and protecting our public health infrastructure, to inspiring every single Californian to take more responsibility for his/her own health. By taking this comprehensive approach, we will not only improve the health of our people, but also the fiscal health of the state by slowing the rise in health care costs.

This report is the result of six months of deep analysis, discussion, and debate among the Task Force members ably supported by a state staff team. It sets forth six goals, priorities within each goal, and indicators to measure progress as well as provides synopses of a variety of strategies that Task Force members, as the catalysts for change, are currently undertaking. To be clear, however,

this report is just the first step, and it should be seen as a “work-in-progress.” As we collectively undertake the hard work of change, we will continue to innovate and experiment, learn from our experiences, assess new data and evidence as it emerges, and make modifications as necessary.

One final note: In putting together this report, the Task Force sought to reflect the voices—and the actual words—of Task Force members who shared their passion for California and gave so generously of their time and expertise. Sprinkled throughout the report are “Six-Word Stories” created by Task Force members at the September 28, 2012 meeting that describe their personal visions for the state.

### III. A Framework for Measuring Health

The Task Force Framework depicts the two strategic directions—Health Across the Lifespan and Pathways to Health—and six goals. Each of the six goals encompasses a broad range of issues; therefore, the Task Force identified a select number of priorities to focus on, which collectively will enable the State and interested parties to monitor California’s progress toward becoming healthier over time. Moreover, the Task Force believes that a defined set of priorities can galvanize all Californians—from health care stakeholders, to policymakers, to residents themselves—to prioritize programs, policies, and strategies to advance common goals.

In order to track progress toward becoming the healthiest state in the nation, it is critical to know where California currently stands, stake out clear and measureable ten-year goals, and have reliable and meaningful data to monitor improvements over time. By establishing baseline data today, this set of indicators provides a powerful tool for assessing how the State is doing—both where it is succeeding and where it is falling short—which can help draw attention and resources to where they are needed most.

For each priority, specific indicators were identified, with baseline data and ten-year targets, broken down by race, ethnicity and gender, to the extent data are available. With literally hundreds of potential measures from which to choose, the Task Force sought to select those priorities and indicators that would best represent the critical issues facing California and balance many competing needs.

- We seek to be aspirational over the long term, but also need to be practical to make progress in the short-term.
- We would like to be able to compare ourselves with the rest of the country and also account for California’s leadership in developing additional data sources.
- We aspire to be comprehensive, but also need to limit the number of goals and targets in order to focus our efforts to make a difference.
- We desire to measure “what’s most important and has heart,” and also ground our targets in metrics for which data currently exist.

**Living Well. Dying Well. Sharing. Caring.**  
—Co-Chair Diana Dooley  
CA Health and Human  
Services Secretary

- We recognize the significant role played by broad determinants of health, such as poverty, but as a Task Force comprised primarily of health and health care professionals, we focused on what is within our own areas of expertise and where we can have the greatest influence.

Although the majority of indicators included in the Dashboard have readily-available data sources or available data, we also included a select number of indicators that do not currently have good measures, but are, nevertheless, critical to tracking the state's progress. By including them in the Dashboard, the Task Force hopes to stimulate their development.

The Framework makes clear that health equity should be fully integrated across the entire effort. Health outcomes vary by population, geography, race/ethnicity, and socioeconomic status and educational attainment, as well as by gender, sexual orientation and gender identity. The Task Force recognizes that as the most diverse state in the country, in order to make California the healthiest state in the nation, one of the central goals of this effort must be to reduce and, ultimately, eliminate those disparities. Therefore, the underlying principle that guided the establishment of the ten-year targets is that we can only close the gaps, focusing on race and ethnicity to start, by raising *everyone's* health to the best outcomes that we know can be achieved.

**Healthy California: Courageous leadership stands up!**

—Bruce Bodaken  
Blue Shield of California

The Task Force identified a total of 30 priorities within the six goals described in the Framework, as well as developed a Dashboard, with measurable indicators for each of the priorities. They are organized as follows:

2 Strategic Directions → 6 Goals → 30 Priorities → 39 Indicators.

Section IV describes each of the priorities, as well as specific indicators for tracking them. Dashboards with all of the relevant data for the indicators are also included for each goal. The complete Dashboard, along with detailed information on the methodology for selecting indicators and targets can be found in Appendix VII.; Appendix VIII. provides the data sources for each of the indicators.

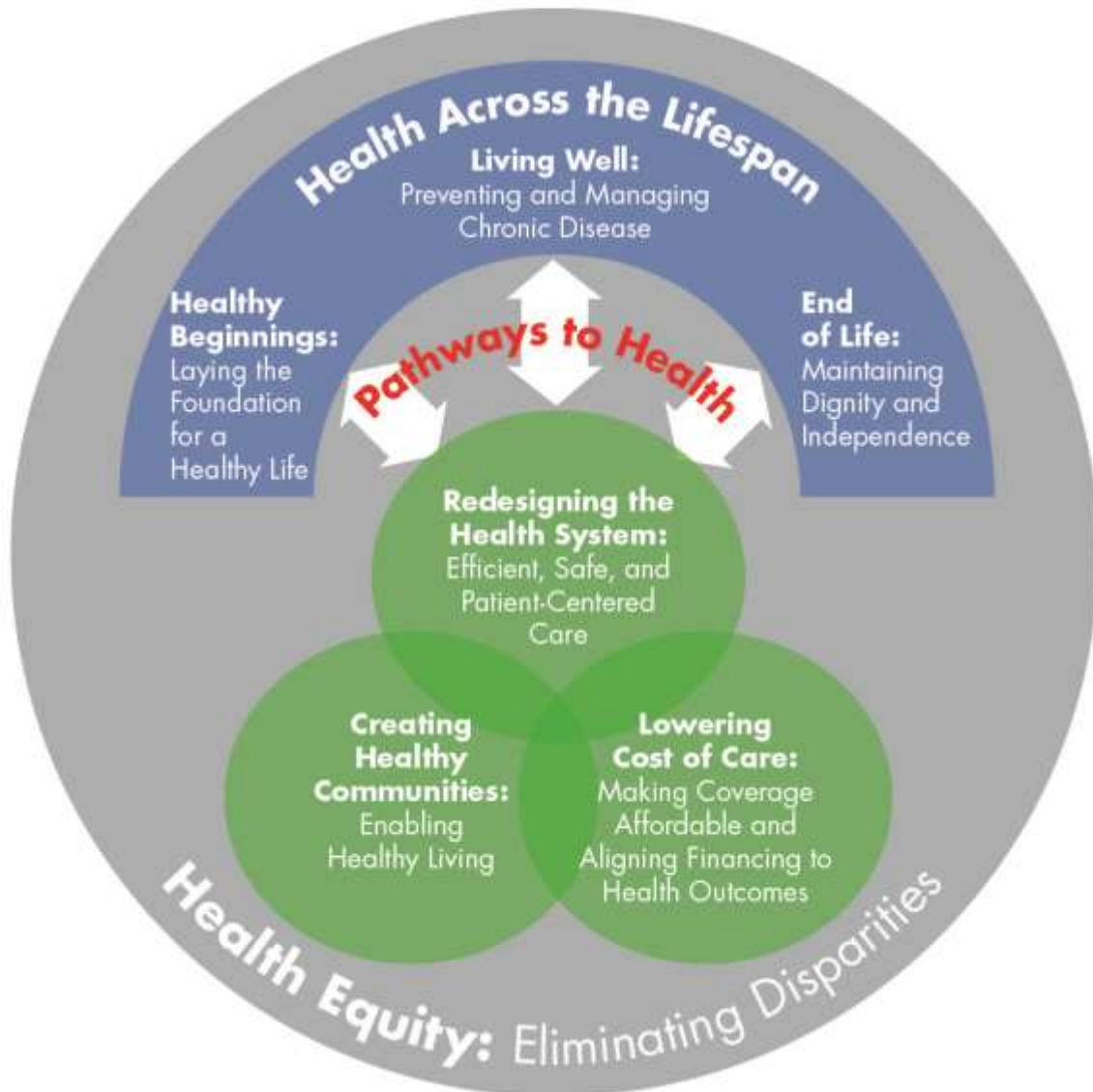
For each indicator, the Dashboard displays:

- A description of the specific indicator
- Current California data (CA Baseline)
- Target for California in 2022
- Current national data (National Baseline), where available
- Target for the nation in 2020, where available
- The range of best and worst current outcomes by Race/Ethnicity for California data where available. In a few instances gender, age/grade, geography, income or health plan type differences are shown.

# Let's Get Healthy California Task Force Framework

## The Triple Aim:

Better Health • Better Care • Lower Costs



## IV. Priorities and Indicators

### A. Health Across the Lifespan: All Californians Enjoy Optimal Health

Being the healthiest state in the country means that Californians throughout the lifespan—from our children to our seniors—are healthy. This strategic direction focuses on three goals related to key stages of life: Healthy Beginnings, Living Well, and End of Life. It is important to stress, however, that these stages of life exist on a continuum without clearly defined boundaries, and that health conditions and behaviors that begin in one stage of life can influence health status throughout the lifespan. In particular, the priorities identified under the Living Well goal are intended to encompass all of adulthood, including aging, whereas the End of Life goal refers to a stage of life but applies across the age spectrum.

**Healthy beginnings: Equity, proactive, collective wellness**  
— America Bracho,  
Latino Health Access

#### Goal 1. Healthy Beginnings: Laying the Foundation for a Healthy Life

Getting a healthy start sets the stage for health and well-being for a person's entire life. The nine priorities and thirteen indicators, along with two that need to be developed, represent a spectrum of important dimensions of children's health and well-being from infancy to the teenage years. There is increasing evidence that a number of adult health and medical conditions have their origins in early childhood, which is why tracking a range of issues in childhood is critical. Table 1 displays an overview of the priorities and indicators, while Table 2 identifies the baseline and 2022 target for each indicator. In addition, racial/ethnic data, to the extent they are available, are included, demonstrating the significant disparities that exist between racial and ethnic populations in California.

Table 1: Priorities and Indicators for Healthy Beginnings

Priority	Indicator
↓ Infant deaths	1. Mortality rates
↑ Vaccinations	2. Doses of vaccines for children 19-35 months
↓ Childhood trauma	3. Adverse Childhood Experiences score 4. Nonfatal child maltreatment incidents
↑ Early Learning	5. Proportion of 3 <sup>rd</sup> graders who read at or above proficiency level <i>Indicator Development Needed: School Readiness</i>
↓ Childhood asthma	6. Emergency Department visit rates for asthma
↑ Childhood fitness and healthy diets	7. Physical fitness assessments of children 8. Adolescents who meet physical activity guidelines 9. Soda and sugary sweetened beverage consumption 10. Fruit and vegetable consumption



Priority	Indicator
↓ <b>Childhood obesity and diabetes</b>	11. Obesity rates for children and adolescents <i>Indicator Development Needed: Diabetes rates for adolescents</i>
↓ <b>Adolescent tobacco use</b>	12. Smoking rates
↑ <b>Mental health and well-being</b>	13. Frequency of feeling sad within last 12 months

*Infants and Vaccinations.* There are a wide range of indicators to select from that relate to both positive and negative outcomes of birth, from level of maternal prenatal care to prematurity and birth-weight. Recognizing that the Dashboard sought to include representative indicators for each priority, infant mortality rates are included. Although California's infant mortality rate is better than the national average, there are significant disparities, with African American babies dying at more than twice the rate of other groups. Achieving the 2022 target of 4 deaths per 1,000 live births will take concerted efforts to address the high African American infant mortality rate. With regard to vaccinations, California rates are slightly below those of the nation. The ten-year target for this indicator is 80 percent, in line with the national target.

*Childhood Trauma.* Because of the growing literature about the impact childhood trauma has on the future health and social development of children as they become adults, this topic is included as a priority. The Adverse Childhood Experience<sup>3</sup> (ACE) score refers to the number of traumatic events in a child's life, including verbal, physical or sexual abuse, an alcoholic parent, or mental illness. The higher the score, the greater the risk for a range of diseases and disabilities. Although the ACE score is determined in adulthood, this tool is also used in pediatric populations to evaluate risk and perform early interventions. It is possible to assess whether Californians' overall exposure to childhood trauma is being reduced over time using the ACE measurement. Another indicator, Nonfatal Child Maltreatment incidents, provides current information on reported children maltreatment at the county level.

**Everyone trying to reproduce  
California's results**  
—Nadine Burke-Harris  
Center for Youth Wellness

*Early Learning.* The Dashboard includes one non-health priority and two indicators on early learning because of the critical link between education and future health. Education is associated with longer life expectancy, as well as improved health, quality of life and health-promoting behaviors.

The first indicator relates to reading proficiency. Third grade reading levels are a strong predictor of future academic success, individual earning potential, global competitiveness, and general productivity.<sup>4</sup> The good news is that between 2006 and 2011, third grade reading levels in California jumped from 36 to 44 percent, a roughly 22 percent increase.<sup>5</sup> The bad news is that fewer than half of our children still do not meet proficiency standards for this determinant of health.

<sup>3</sup> The Adverse Childhood Experiences Study [Accessed October 2012] <http://acestudy.org/home>.

<sup>4</sup> Lesnick, J., George, R., Smithgall, C., & Gwynne J. (2010). "Reading on Grade Level in Third Grade: How Is It Related to High School Performance and College Enrollment?" Chicago: Chapin Hall at the University of Chicago

<sup>5</sup> California Department of Education, "Standardized Testing and Reporting (STAR) Results." [Accessed October 2012] <http://star.cde.gov>.

**All kids helping each other improve.**

— Joe Silva, Tuolumne Co.  
Office of Education

One of the Dashboard's widest disparities exists in the metrics for 3<sup>rd</sup> grade reading proficiency. Only 33 percent of Hispanic/Latino 3<sup>rd</sup> graders read at or above the proficiency level, while 69 percent of Asian American children do. That is a gap that must be reduced for all of California's children to succeed.

The second indicator concerns overall school readiness, which refers to how prepared a child is to succeed in school cognitively, socially, and emotionally. Because young children's early experiences actually influence brain development that can set the stage for future development and success in school and life, tracking readiness is a good representative for many other non-health determinants. Although an indicator has not yet been identified, it is included in the Dashboard to signify the importance of this measure. (See Appendix VII.)

*Childhood Asthma.* Childhood asthma has become a pressing issue in recent years—nearly 1.5 million children in California have asthma, the most prevalent chronic condition for kids ages 0 to 17.<sup>6</sup> Asthma can result in higher school absenteeism and lead to lower levels of physical activity, in addition to the other effects of the condition. There are significant disparities in asthma prevalence and in the utilization of health services resulting from asthma. For example, African American children utilize the Emergency Department more than eight times as frequently as Asian American children for asthma.

*Childhood Fitness and Healthy Diets.* Many unhealthy behaviors with a life-long impact on health—smoking, poor diet, and inactivity—begin in childhood and adolescence; therefore, several priorities are devoted to these issues. Only 20 percent of California's adolescents report consuming fruits and vegetables five or more times per day. A target goal of 32 percent is proposed based on geographic disparities.

Surprisingly, the percent of adolescents in California who drank two or more glasses of a sugary beverage within the past day is much higher than the national rate (27 percent, 20 percent respectively). Also, California's rate of teenagers who meet physical activity guidelines is less than the national rate, and African American teenagers' rate is the highest. Asian Americans rank relatively high in terms of school fitnessgram scores for grades 7 and 9.

**Educated, active children moving California forward**

—Joy Melnikow, Center for  
Healthcare Policy and Research,  
UC Davis

*Obesity and Diabetes.* Because of the rise in overall weight and diabetes in children, it will be important to track these conditions. The Dashboard sets ambitious targets for childhood obesity. It is not enough to simply stem the rising rates of obese children. To become the healthiest state in the nation, California must reverse the epidemic and begin to lower the rates of obesity, given the impact of these conditions on the long-term health and well-being of the population and society. Therefore, the Task Force recommends that the 2022 target rates of obesity for children be under 10 percent and that the adolescent rate be set at 12 percent, representing a reduction of about one-third from their baselines. Although there is no indicator to measure the prevalence of diagnosed diabetes in children/adolescents at this time, it is recommended that one be established.

<sup>6</sup> "Chronic Disease in California: Facts and Figures." (California HealthCare Foundation 2006). [Accessed October 2012] <http://www.chcf.org/publications/2006/10/chronic-disease-in-california-facts-and-figures#ixzz2Aheur300>.



*Tobacco.* California has been a national leader in efforts to reduce smoking. While California performs quite well in comparison to most states with respect to tobacco use—14 percent of adolescents smoked cigarettes in the past 30 days compared to 20 percent nationally—the Task Force aims for further reductions by 2022. A target goal of 10 percent is proposed.

*Mental Health and Well-being.* One often under-reported issue is adolescent mental health. There are two measures that track adolescent mental health. The first, included in Table 2, found between one-quarter and one third of 7<sup>th</sup>, 9<sup>th</sup>, and 11<sup>th</sup> graders experienced feelings of sadness within the last 12 months. These numbers increase by grade and show gender disparities. Gender disparities were used to set targets in place of racial/ethnic disparities because such data are not available by grade level. In the next section, a second metric for adolescent depressive episodes is also included.

Table 2: Dashboard for Healthy Beginnings

Leading Indicator			CA Baseline	2022 CA Target	National Baseline	2020 National Target	Disparities
1	Infant Mortality, Deaths per 1,000 Live Births		5	4	7	Not Available	White/Asian: 4 Af. Am.: 11
2	All doses of recommended vaccines for children 19-35 months		68%	80%	70%	80%	Not Available
3	Respondents indicating at least 1 type of Adverse Childhood Experience		59%	45%	Not Available	Not Available	Other: 45% White: 62%
4	Incidents of nonfatal child maltreatment (including physical, psychological, neglect, etc.) per 1,000 children		9	3	9	8	Asian/P.I.: 3 Af. Am.: 25
5	Proportion of third grade students whose reading skills are at or above the proficient level		46%	69%	Not Comparable	Not Comparable	Asian: 69% Hisp/Lat.: 33%
6	Emergency department visits, 0-17 years due to asthma per 10,000		73	28	103	Not Available	Asian/P.I.: 28 Af. Am.: 236
7	Percentage of “physically fit” children, who score 6 of 6 on the required California school Fitness-gram test	5 <sup>th</sup> graders	25%	36%	Not Available	Not Available	White: 36% Hisp./Lat.: 19%
		7 <sup>th</sup> graders	32%	46%	Not Available	Not Available	Asian: 46% Hisp/Lat, P.I.: 25%
		9 <sup>th</sup> graders	37%	52%	Not Available	Not Available	Asian: 52% P.I.: 27%
8	Proportion of adolescents who meet physical activity guidelines for aerobic physical activity		15%	24%	18%	20%	Af. Am.: 24% Asian: 9%
9	Adolescents who drank 2 or more glasses of soda or other sugary drink yesterday		27%	17%	20%	Not Available	Asian: 17% 2+ Races: 38%
10	Adolescents who have consumed fruits and vegetables five or more times per day		20%	32%	Not Comparable	Not Comparable	Placer County: 32% Orange County: 15%
11	Proportion of children and adolescents who are obese	2-5 yrs.	12%	9%	11%	10%	White: 9% Hisp./Lat: 15%
		6-11 yrs.	12%	8%	17%	16%	2+ Races: 8% Hisp./Lat.: 16%
		12-19 yrs.	18%	12%	18%	16%	Asian: 12% Hisp./Lat.: 24%
12	Proportion of adolescents who smoked cigarettes in the past 30 days		14%	10%	20%	16%	Asian/P.I.: 10% White: 15%
13	Frequency of sad or hopeless feelings, past 12 months	7 <sup>th</sup> graders	28%	25%	Not Available	Not Available	Male: 25% Female: 31%
		9 <sup>th</sup> graders	31%	24%	Not Available	Not Available	Male: 24% Female: 36%
		11 <sup>th</sup> graders	32%	27%	Not Available	Not Available	Male: 27% Female: 37%

## Goal 2. Living Well: Preventing and Managing Chronic Disease

The World Health Organization (WHO) defines health as a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”<sup>7</sup> The six priorities and ten indicators, along with one that still needs to be developed, represent key aspects of living well. A particular focus is placed on preventing and managing chronic disease, given the rising prevalence of chronic diseases and the impact they have on the state’s residents. Nearly 14 million adults (38 percent) in California live with at least one chronic condition and more than half of them have multiple chronic conditions.<sup>8</sup>

Table 3 displays an overview of the priorities and indicators, while Table 4 identifies the baseline and 2022 California target for each indicator.

Table 3: Priorities and Indicators for Living Well

Priority	Indicator
↑ Health status	14. Self-reported health status as good, very good or excellent
↑ Fitness and healthy diets	15. Adults who meet physical activity guidelines 16. Sugary sweetened beverage consumption 17. Fruit and vegetable consumption
↓ Tobacco use	18. Smoking rates
↑ Controlled high blood pressure and high cholesterol	19. Percent of adults with hypertension who have controlled high blood pressure 20. Percent of adults with high cholesterol who are managing the condition
↓ Obesity and diabetes	21. Obesity rates 22. Diabetes prevalence
↑ Mental health and well-being	23. Proportion of adults and adolescents with a major depressive episode <i>Indicator Development Needed: Effective treatment of depression</i>

**Health Status.** In order to assess the overall health of the population, the first priority under this goal is health status. For California to be the healthiest state in the nation, California’s residents should first and foremost believe that they are healthy, so the Dashboard sets a 2022 target for reported health status as good, very good, or excellent at 90 percent, up from today’s 85 percent.

**Fitness and Healthy Diets.** As much as 80 percent of heart disease, stroke and diabetes—and over 30 percent of cancers—could be prevented by increasing healthy behaviors, including physical activity

**Engaged,  
individualized,  
energized, thriving,  
tennis at 85!**  
—Kerry Tucker  
Nuffer, Smith, Tucker, Inc.

<sup>7</sup> World Health Organization, “Preamble to the Constitution” as adopted by the International Health Conference, New York, 19-22 June, 1946 and entered into force on 7 April 1948.

<sup>8</sup> “Chronic Disease in California: Facts and Figures.” (California HealthCare Foundation 2006). [Accessed October 2012].  
<http://www.chcf.org/publications/2006/10/chronic-disease-in-california-facts-and-figures>

levels.<sup>9</sup> Californians already engage in more physical activity than people in other states in the country, but as a state that prides itself on being active, the Dashboard sets a very ambitious goal for 2022. In ten years, two-thirds of adults should meet the physical activity guidelines—more than 25 percent higher than the national target of 48 percent.

**For lifelong health  
accelerate prevention now.**

—Neal Halfon, Center for  
Healthier Children, Families and  
Communities, UC Los Angeles

With regard to healthy diets, two indicators are included: consumption of sugary sweetened beverages and the percentage of Californians who eat the recommended amount of fruits and vegetables eaten. Currently, 28 percent of Californians meet the standard of eating fruits and vegetables five times a day. The ten-year target is set at 34 percent based on income level disparities. The Dashboard also seeks to cut in half the proportion of Californians who

drink two or more sugary sweetened beverages a day.

*Tobacco Use.* As a major contributor to a range of chronic diseases, reducing smoking is a priority for living well. The Task Force believes that California should continue to be a leader in efforts to lower smoking rates. The Dashboard's 2022 target would bring the state's overall rate to 9 percent—a 30 percent reduction from the current rate of 12 percent. To achieve this goal, particular attention will need to be paid to smoking among African Americans, who currently smoke at a rate two times higher than Californians of Asian descent.

*Controlled High Blood Pressure and Cholesterol.* Two conditions—high blood pressure and high cholesterol—if uncontrolled, can be precursors to other more serious health issues. Effective, prevention-oriented, patient-centered clinical care can ensure that people monitor and treat their disease and, ultimately, slow its progression. In addition, management of chronic disease, particularly for seniors, requires a range of supports outside of the clinical setting.

Data available for these indicators come from health plan surveys and do not represent all Californians. Depending upon plan type, the range of adults diagnosed with hypertension who have controlled high blood pressure is from 50-79 percent. Similarly, for adults diagnosed with high cholesterol who are managing the condition the range is from 50-76 percent. Targets for 2022 were set to improve and significantly exceed national targets, in particular for persons enrolled in preferred provider organizations (PPOs).

**Collectively creating a  
culture of health.**

— Sophia Chang  
California HealthCare Foundation

*Obesity and Diabetes.* Bringing obesity rates down is essential to improving the overall health of the population. Although California's current adult obesity rate—nearly one in four—is one of the lowest in the country, it could increase substantially by 2030 if current trends continue.<sup>10</sup> Obesity-related health costs in California could similarly increase by nearly 16 percent by 2030.

There is a strong correlation between obesity and many diseases, including diabetes. Both diabetes and obesity have significant racial and ethnic disparities. African American adult rates are about 50

<sup>9</sup> "Ten Leading Causes Of Death, Death Rates, Age-Adjusted Death Rates And Percent Changes By Sex - Hispanic - California" (2008-2009), [Accessed October 2012] <http://www.cdph.ca.gov/data/statistics/Documents/VSC-2009-0510A.pdf>.

<sup>10</sup> "F as in Fat." (Trust for America's Health, Washington, D.C., September 2012).

percent higher than the overall state baseline. Reaching the 2022 targets will require paying particular attention to addressing myriad issues—from the lack of access to care to the lack of access to healthy food. The Dashboard sets a particularly ambitious 2022 target for obesity. Consistent with the obesity target for children and adolescents, the Task Force believes that California should reverse the obesity epidemic in a significant way and, therefore, has set the target for adults at 11 percent—a reduction of more than half from the current baseline and one-third of the national target.

Currently an average of 9 of every 100 adults in California are diagnosed with diabetes, ranging from 7 to 14, depending on racial/ethnic group. A target of 7, tied to the lowest current racial/ethnic group rate, is the 2022 target.

*Mental Health and Well-being.* As the WHO indicates, good health is not limited to physical health issues; mental health and well-being are also essential. Therefore, screening and treatment for depression is an important priority for this goal. Task Force members struggled with finding good measures for effectively diagnosing *and treating* depression in adolescents and adults. A placeholder indicator that focuses on people who experience a major depressive episode was selected, with hopes that better measures will be developed over time. Targets for this indicator are to reduce the proportion of adolescents who experience a major depressive episode from the current 8 percent to 7 percent, and adults from 6 percent to 5 percent over the next ten years. These targets are in line with those set nationwide.

Table 4. Dashboard for Living Well

Leading Indicator			CA Baseline	2022 CA Target	National Baseline	2020 National Target	Disparities
14	Overall health status reported to be good, very good or excellent		85%	90%	83%	91%	2+ Races: 90% Am In/AK Nat: 75%
15	Proportion of adults who meet physical activity guidelines for aerobic physical activity		58%	66%	44%	48%	MultiRacial: 66% Hisp./Lat.: 50%
16	Adults who drank 2 or more sodas or other sugary drinks per day		20%	10%	Not Available	Not Available	Asian: 15% Latino: 26%
17	Adults who have consumed fruits and vegetables five or more times per day		28%	34%	24%	Not Available	\$35,000 – \$50,000: 34% < \$20,000: 24%
18	Proportion of adults who are current smokers		12%	9%	21%	12%	Asian/P.I.: 9% Af. Am.: 17%
19	Percent of adults diagnosed with hypertension who have controlled high blood pressure		Medicare 79% PPOs 50% HMOs 78%	Medicare 87% PPOs 70% HMOs 86%	46%	65% by 2017	N/A
20	Percent of adults diagnosed with high cholesterol who are managing the condition		Medicare 76% PPOs 50% HMOs 70%	Medicare 91% PPOs 70% HMOs 84%	33%	65% by 2017	N/A
21	Proportion of adults who are obese		24%	11%	34%	31%	Other: 11% Af. Am.: 33%
22	Prevalence of diagnosed diabetes, per 100 adult		9	7	9	Not Available	White: 7 Af. Am.: 14
23	Proportion of adolescents (12-17 years old) and adults (18 years and older) who experience a Major Depressive Episode	Adolescents	8%	7%	8%	7%	N/A
		Adults	6%	5%	7%	6%	N/A

### Goal 3. End-of-Life: Maintaining Dignity and Independence

End-of-life is one of the most difficult stages of life and, yet, in great need of attention to improve the care and experience of individuals who are dying. Survey data reveal that the majority of Californians prefer to spend their last months in a non-hospital setting, free of pain, and making sure their family is not burdened by their care. Although 70 percent of Californians indicate they would prefer to die a natural death at home, only 32 percent of deaths occurred at home, while 42 percent of Californians die in hospitals.<sup>11</sup> In addition, care provided at the end of life consumes a disproportionate share of costs. Although much is covered by Medicare, there are also significant Medi-Cal and out-of-pocket expenses associated with end of life.

The Dashboard includes three priorities and three indicators, along with one indicator to be developed, to track whether patients are obtaining the kinds of services that would enable them to maintain independence and dignity, to the greatest degree possible, during advanced illness, consistent with their wishes.

Table 5: Priorities and Indicators for End of Life

Priority	Indicator
↓ Hospitalization during the end of life	24. Percent of decedents admitted to (Intensive Care Unit/Critical Care Unit) ICU/CCU during the hospitalization in which death occurred
↑ Palliative care and hospice care	25. Proportion of acute care hospitals that provide specialty palliative care 26. Enrollment in hospice care prior to death
↑ Advance care planning	<i>Indicator Development Needed: Advance care planning.</i>

*Hospitalizations During the End of Life.* Monitoring utilization of intensive care services at the end of life is one indicator of the degree to which the care that is delivered is aligned with patient preferences. As such, the Dashboard tracks the number of hospitalizations that ended in death where the patient spent some time in a critical care unit. In 2010, California's rate was 22 percent compared to a national average of 17 percent.<sup>12</sup> The 2022 target is 17 percent.

*Palliative Care and Hospice Care.* Palliative care is specialized, team-based care that focuses on relieving symptoms and improving quality of life for both the patient and family. It can be provided at any stage in a serious illness, and can be provided together with curative treatment. Hospice care is a form of palliative care for patients who have a prognosis of six months or less to live. Because adults with serious illness are often hospitalized, specialty palliative care programs in hospitals can play an

**Communication among caregivers, informed active patients.**  
—Bob Margolis  
HealthCare Partners

<sup>11</sup> "Final Chapter: Californians' Attitudes and Experiences with Death and Dying." (California Health Care Foundation, February 2012).

<sup>12</sup> The Dartmouth Institute for Health Policy and Clinical Practice, The Dartmouth Atlas of Health Care, 2010.

important role in helping patients understand their choices while receiving medical care for pain and other symptoms, emotional and spiritual support, and appropriate referrals to hospice care following discharge. In order to increase access to such care, the Task Force believes that 80 percent of hospitals should offer palliative care programs – up from 53 percent currently.

Many studies have shown that the needs of seriously ill patients and their families are best served by hospice.<sup>13, 14, 15</sup> Patients who are enrolled in hospice receive better symptom control, are less likely to receive aggressive care in the final days of life, and their families are more likely to be satisfied with the care they received. Though hospice services are widely available, in 2010 only 39 percent of Californians<sup>16</sup> were enrolled in hospice prior to death, a slightly lower level of utilization than the 42 percent seen nationally.<sup>17</sup> The Task Force has set a goal of increasing hospice utilization to 54 percent by 2022. It will also be important to monitor the duration of these services to ensure that they are not under-utilized for a given patient.

*Advance Care Planning.* Advance care planning is the process of systematically ensuring that every individual determines and documents their preferences for treatment to guide decision-making, if they cannot speak for themselves. Fewer than one in 10 Californians report having discussed end-of-life care with their physician, including just 13 percent of those 65 or older. Although efforts are already underway to measure utilization of Physician Orders for Life Sustaining Treatments (POLST) among nursing home residents, other measures that monitor patient preferences for care and the processes for documenting and complying with those wishes are needed—and will be critical additions to the dashboard in the coming years.

Table 6: Dashboard for End of Life

	Leading Indicator	CA Baseline	2022 CA Target	National Baseline	2020 National Target	Disparities
24	Terminal hospital stays that include intensive care unit days	22%	17%	17%	Not Available	N/A
25	Percent of California hospitals providing in-patient palliative care	53%	80%	Not Available	Not Available	N/A
26	Hospice enrollment rate	39%	54%	42%	Not Available	White: 54% Hispanic: 10%

## B. Pathways to Health: Systems and Environments Prioritize and Support Health

Tracking health improvements across the lifespan will enable the state to know where progress is being made and where additional effort is needed. As a complement, the Task Force identified three major goals, grounded in the Triple Aim, that represent key pathways to health. These three goals—Redesigning the Health System, Creating Healthy Communities, and Lowering the Cost of Care—

<sup>13</sup> Emanuel EJ, et al. “Understanding economic and other burdens of terminal illness: the experience of patients and their caregivers.” *Annals of Internal Medicine*. (2000); 132: 451-459

<sup>14</sup> Teno JM, et al. “Family perspectives on end-of-life care at the last place of care.” *Journal of the American Medical Association (JAMA)* (2004); 291: 88-93

<sup>15</sup> Miller SC, Mor V, Teno J. “Hospice enrollment and pain assessment and management in nursing homes.” *Journal of Pain and Symptom Management*. (2003); 26: 791-799

<sup>16</sup> 2010 Medicare claims data, analyzed by the California Hospice and Palliative Care Association

<sup>17</sup> “NHPCO Facts and Figures: Hospice Care in America.” (National Hospice and Palliative Care Organization, January 2012). [Accessed October 2012] [http://www.nhpc.org/files/public/statistics\\_research/2011\\_facts\\_figures.pdf](http://www.nhpc.org/files/public/statistics_research/2011_facts_figures.pdf)



also relate to the core disciplines of public health, health care delivery, and financing. Critical to our success over the long term will be the collective ability of leaders to bridge across the three disciplines and align these pathways with the population health goals and priorities described in the previous section. It will take changing practices, incentives, and cultures to drive the integration and re-orientation of the health and health care systems to make optimal health the ultimate goal.

#### Goal 4. Redesigning the Health System: Efficient, Safe, and Patient-Centered Care

Being the healthiest state in the nation will require the health care system to be better aligned toward population health goals and outcomes. The system should be focused on health, not just illness, and become truly patient-centered. To achieve these goals, health care systems and plans across the state are already innovating ways to redesign the health delivery system—which is currently fragmented, geared toward acute services, and at times unsafe. For example, under the state's Section 1115 Medi-Cal (Medicaid) Waiver, A Bridge to Reform, public hospitals are undertaking efforts to address a number of priorities described below, including integrating their systems, developing medical homes, and reducing avoidable errors in hospital inpatient care. The five priorities and five indicators, along with three that need to be developed, will enable the state to monitor improvements in key aspects of health system access and quality. Table 7 displays an overview of the priorities and indicators, while Table 8 identifies the baseline and 2022 target for each indicator.

Table 7: Priorities and Indicators for Redesigning the Health System

Priority	Indicator
↑ Access to primary and specialty care	27. Percent of patients receiving care in a timely manner <i>Indicator Development Needed: Percent of patients who had difficulty finding a provider</i>
↑ Culturally and linguistically appropriate services	<i>Indicator Development Needed: Linguistic and cultural engagement</i>
↑ Coordinated outpatient care	28. Percent of patients whose doctor's office helps coordinate their care 29. Preventable hospitalizations
↑ Hospital safety and quality of care	30. 30-day all-cause unplanned readmissions 31. Incidence of hospital acquired infections
↓ Sepsis	<i>Indicator Development Needed: Sepsis related mortality</i>

*Access to Primary and Specialty Care.* Access to and the availability of timely primary and specialty care (including behavioral health) varies tremendously across the state, across income levels and health status of patients.<sup>18</sup> Overall, with the implementation of the ACA, which will provide health insurance coverage to millions more Californians, the primary care system especially will be stretched thin. It will be critical for the health system and the health professional training

<sup>18</sup> "Speaking Their Minds: Californians Perceptions of Health Care." (California HealthCare Foundation March 2012.)

programs to develop creative solutions to meet the coming demand. Currently approximately three-quarters of enrollees in health plans (i.e., people with coverage) receive care from primary care physicians or specialists in a timely manner. Targets for 2022 are slightly higher and tied to today's highest racial/ethnic group score.

*Culturally and Linguistically Appropriate Services.* For California's diverse populations, ensuring that providers can engage with their patients in a culturally and linguistically competent way is essential to meaningful access. Although the indicators for this priority have not been developed yet, they will be critical to be able to track how well patients are able to find a provider, particularly with the significant expansion of health insurance in 2014 through ACA implementation.

**Continuously improving care—optimal health.**

—George Halvorson  
Kaiser Permanente

*Coordinated Outpatient Care.* Moving the system toward integrated and coordinated care allows patients to receive care in the most appropriate setting, reduces duplication, and enhances quality. Therefore, a measure to track the percent of patients whose doctors' offices help coordinate care with other providers and services is included. Current care coordination ranges from 67 percent for children/adolescents to 75 percent for adults. The indicator reflects Californians enrolled in a health plan; therefore the rates are likely higher than for the overall population. A target of 94 percent was set based on expert advice.

**55 percent is not good enough!<sup>19</sup>**

—Elizabeth McGlynn  
Center for Effectiveness and  
Safety Research, Kaiser  
Permanente

A second indicator of an effective and efficient outpatient system—or lack thereof—is the rate of preventable hospitalizations. Prevention Quality Indicators (PQIs), developed by the federal Agency for Healthcare Research and Quality, are

based on hospital discharge data and identify hospitalizations that are potentially preventable with timely and effective outpatient care. PQIs can be used as a “screening tool” to help flag potential health care quality and access issues and identify community needs. Approximately \$31 billion is spent annually nationwide on hospital admissions that are potentially preventable with improved access to outpatient care.<sup>20</sup>

*Hospital Safety and Quality of Care.* Approximately 33 percent of all health care spending in 2009 in California went to hospital care. Although California's per capita spending for hospital care is less than the national average, systemic improvements are nevertheless needed. Billions of health care dollars could be saved and patient outcomes enhanced through system-wide quality improvement efforts. For example, \$25 billion is spent on preventable hospital readmissions that result from medical errors and complications, poor discharge procedures, and integrated follow-up care,<sup>21</sup> and between \$38 and \$45 billion nationwide is spent on hospital-acquired infections (the Healthcare

**Transformative quality, cost & convenient access.**

—Richard Levy  
Varian Medical Systems

<sup>19</sup> The Quality of Health Care Delivered to Adults in the United States, *New England Journal of Medicine*, 2003, [Accessed October 2012] <http://www.nejm.org/doi/pdf/10.1056/NEJMsa022615>

<sup>20</sup> “Bend the Curve: A Health Care Leader's Guide to High Value Health Care.” (NEHI, 2011).

<sup>21</sup> Ibid



Associated Infections Program of the California Department of Public Health estimates that such infections at California's acute care hospitals cost \$3.1 billion a year<sup>22</sup>).

**California Gold. Wealth through your health.**

—Pam Kehaly, Anthem Blue Cross of California

The Dashboard includes two indicators related to hospital care. They track conditions that result from lapses in patient safety or adherence to the highest quality improvement standards: a) unplanned readmissions within 30-days of hospital discharge and b) hospital-acquired conditions. While available data for the latter is limited, it is useful to include at this time. The Task Force recommends that a more complete and robust composite

safety measure for hospital-acquired conditions be developed within the next few years. With sustained and system-wide quality improvement efforts in hospitals, safety and quality of care for patients can be enhanced and billions of dollars saved.

*Sepsis* (blood poisoning). Although sepsis can be a hospital-acquired infection, it is most often present upon admission. Therefore, it is included as a separate priority. There is no consensus definition nationally or within California for sepsis, and the Task Force recommends that this be a priority for California to develop.

Table 8: Dashboard for Redesigning the Health System

Leading Indicator			CA Baseline	2022 CA Target	National Baseline	2020 National Target	Disparities
27	Percent of patients receiving care in a timely manner	Primary Care Physicians	76%	78%	Not Available	Not Available	White/English Speaking: 78% Asian/Non-English Speaking: 72%
		Specialists	77%	79%			White/English Speaking: 79% Asian/Non-English Speaking: 68%
28	Percent of patients whose doctor's office helps coordinate their care with other providers or services	Child/Adolescent	67%	94%	69%	Not Available	N/A
		Adult HMO	75%				
29	Preventable Hospitalizations, per 100,000 population		1243	Top 5 counties: 727	1,434	Top 3 states: 818	Top 5 Counties: 727 Worst 5 Counties: 1853
30	30-day All-Cause Unplanned Readmission Rate (Unadjusted)		14%	25% reduction per hospital	14%	12% by 2013	N/A
31	Incidence of measureable hospital-acquired conditions		1 per 1,000 discharges	See footnote #40, p. xxiv	Not comparable	Not comparable	N/A

## Goal 5. Creating Healthy Communities: Enabling Healthy Living

Numerous studies have demonstrated that where we live plays a major role in our health. A variety of community conditions, sometimes called physical or environmental determinants, enhance or create barriers to health, from the level of air pollution, to the availability of parks and green space, as well as access to fresh produce. Communities that are safe and provide opportunities for active living and healthy eating are needed to support people in developing and maintaining healthy

<sup>22</sup> Weinberg, M. and L. Wellington Haase. "California Task Force on Affordable Care: Creating a High Value Healthcare System for California." (New America Foundation, May 2010).

behaviors, especially those related to two of the main contributors of chronic disease—diet and physical activity. There are a wide range of priorities and indicators that relate to this goal, and the Task Force encourages public and private stakeholders to review a forthcoming report by the Health in All Policies (HiAP) Task Force that will include dozens of healthy community indicators, and consider how this Dashboard can best link with their recommendations.<sup>23</sup>

**Creating conditions to lead healthy lives.**

—Ed Moreno, Fresno Co. Department of Public Health

The HiAP Task Force, which is located within the Strategic Growth Council and coordinated by the California Department of Public Health Office of Health Equity, works with departments and agencies throughout state government, as well as the public and private sectors, to identify critical changes needed in transportation, housing, land use and agriculture, among other issues, to promote healthy living.<sup>24</sup> HiAP is taking a leadership role, along with many other efforts, to comprehensively promote programs and policies to advance healthy communities. It will take reaching beyond the boundaries of traditional health care and public health sectors—including housing, transportation, and agriculture, to name a few—to make lasting improvements in this goal.

The Dashboard includes three priorities and four indicators to track how well the community environment supports children and adults in making healthy choices with regard to food and activity.

Table 9. Priority and Indicator for Creating Healthy Communities

Priority	Indicator
↑Healthy food outlets	32. Retail Food Environment Index
↑Walking and biking	33. Annual number of walk trips per capita 34. Percentage of children walk/bike to school
↑ Safe communities	35. Perception of neighborhood safety

*Healthy Food Outlets.* According to Healthy People 2020, more than 23 million Americans, including 6.5 million children, live in “food deserts”—neighborhoods that lack access to stores where affordable, healthy food is readily available.

**Prevention works! Invest in your community**

—Mary Pittman  
Public Health Institute

The Retail Food Environment Index (RFEI) is a ratio describing the relative presence of healthy total retail food outlets in a given area. The highest rate is in Santa Cruz County, where 21 percent of the food outlets are healthy. The Dashboard includes that rate as the target for the state in 2022. Although it is a stretch goal from today’s baseline of 11 percent, there is significant attention being placed on this issue and

<sup>23</sup> “Healthy Communities Indicators”, under development by the California Department of Public Health. [Accessed October 2012] [http://www.sgc.ca.gov/hiap/docs/publications/Healthy\\_Community\\_Framework.pdf](http://www.sgc.ca.gov/hiap/docs/publications/Healthy_Community_Framework.pdf)

<sup>24</sup> “HiAP Task Force Report to the Strategic Growth Council.” (December 3, 2010.) [Accessed October 2012.] [http://www.sgc.ca.gov/hiap/docs/publications/HiAP\\_Task\\_Force\\_Report.pdf](http://www.sgc.ca.gov/hiap/docs/publications/HiAP_Task_Force_Report.pdf)

the Task Force believes that this indicator represents progress toward healthier communities throughout the state.

*Walking and Biking.* Two indicators are included in the Dashboard regarding the extent to which both children and adults walk, bike or use alternative transport. In addition to these indicators tracking individual behavior, they also signal the degree to which community infrastructure supports these activities. The first indicator measures the total number of walks people take annually to commute, exercise, or for other purposes. In addition, because the Dashboard places a high priority on children getting a healthy start in life, a second indicator is included that focuses on the percentage of children who walk and bike to school. This indicator also indirectly signifies the degree to which there are safe routes to schools and overall safe school environments, which often act as hubs for communities. For both of these indicators, the 2022 target represents between a 19 and a 26 percent increase in the amount of biking and walking.

*Safe Communities.* In order for residents to be able to be active in their communities, they must feel that they can do so without fear of violence. Currently, although only nine percent of Californians do not perceive their communities to be safe, there are significant racial disparities. For example 15 percent of Latinos do not feel safe in their neighborhoods.

Table 10. Dashboard for Creating Healthy Communities

	Leading Indicator	CA Baseline	2022 CA Target	National Baseline	2020 National Target	Disparities
32	Number of healthy food outlets as measured by modified Retail Food Environment Index	11%	21%	10%	Not Available	Santa Cruz: 21% Sutter: 9%
33	Annual number of walk trips per capita	184	233	186	Not Available	Urban: 233 Town/Rural: 121
34	Percentage of children walk/bike/skate to school	43%	51%	Not Available	Not Available	Latino: 51% White: 33%
35	Percent of adults who report they feel safe in their neighborhoods all or most of the time	91%	96%	Not Available	Not Available	White: 96% Latino: 85%

## Goal 6. Lowering the Cost of Care: Making Coverage Affordable and Aligning Financing to Health Outcomes

Lowering the overall cost of care is critical for all Californians to be able to have access to affordable coverage and care as well as for the fiscal health of the state. Total spending on health care in California in 2009 exceeded \$230 billion. Although California's per capita spending on health care is the 9<sup>th</sup> lowest in the country, it is still growing at a faster pace than inflation or than the growth of the economy.<sup>25</sup> The rise of health care costs places financial burdens on families, businesses and the state, making reining in costs an important goal. Even though California's Medi-Cal spending per enrollee is the lowest in the country, given the fiscal challenges facing the state, more needs

**Optimize Wellness  
Provide Cost-Effectively  
To Everyone**  
—Steven Packer, Community  
Hospital of Monterey Peninsula

<sup>25</sup> "California Health Care Almanac: Health Care Costs 101: California Addendum." (California HealthCare Foundation, May 2012)

to be done. As described earlier with regard to the Triple Aim, the ability to control costs is integrally related to efforts to achieve Goals 1-5. In particular, preventing and better management of chronic disease and redesigning the health delivery system to be more efficient and effective are critical to efforts to control costs.

The six priorities and four indicators, along with two additional ones that need to be developed, provide a snapshot of the state's progress in this goal. Table 11 displays an overview of the priorities and indicators, while Table 12 identifies the baseline and 2022 target for each indicator.

Table 11. Priorities and Indicators for Lowering the Cost of Care

Priority	Indicator
↓ People without insurance	36. Uninsurance rate
↑ Affordable care and coverage	37. Health care cost as percent of median household income
↓ Rate of growth in health spending in California	38. Compound annual growth rate
↑ People receiving care in an integrated system	39. Percent of people in managed health plans
↑ Transparent information on cost and quality of care	<i>Indicator Development Needed: Transparent information on cost and quality</i>
↑ Payment policies that reward value	<i>Indicator Development Needed: Most care is supported by payments that reward value</i>

**Everybody in: Improving our health together**

—Anthony Wright  
Health Access

*People Without Insurance.* With nearly seven million uninsured—21 percent—California has one of the highest rates of people without health coverage. The ACA provides a much-needed foundation for expanding health insurance coverage and reforming the financing system to make this goal a reality. The Health Benefit Exchange is set to begin implementation in 2013, providing California with an enormous opportunity to make

significant progress in getting millions of Californians covered. With more people “in the system,” they will be better able to connect to a regular source of primary and preventive care, rather than rely on the use of more expensive emergency and acute care.

Because of the disproportionately high rates of uninsurance among the state's African American, Hispanic/Latino, and Native American populations, expansion of coverage through the Health Benefit Exchange and Medi-Cal will be an important step toward reducing health disparities. Tracking progress regarding coverage must include breakouts of individuals who are uninsured at some point in the year—which are nearly double the number of people who are uninsured for a year or more—to develop a full picture of who is obtaining insurance and who is still without. Based on expert advice, a target 5 percent uninsurance rate overall was set for 2022.

The Dashboard includes several measures to assess progress in restraining health care costs at both the macro and the individual level.

*Affordable Care and Coverage.* Rising health care costs have contributed to the rapid increase in health insurance premiums for employer-sponsored family coverage, which has increased on average 53 percent from 2005 to 2011, in contrast to the 7 percent growth in median family income during the same time.<sup>26</sup> Lack of affordable care and coverage is one of the primary reasons people are uninsured and unable to access health care when they need it. In order to track individual affordability, the Dashboard includes an indicator on average spending for health care insurance coverage and care for individuals or families, as a percent of median household income. It includes out of pocket payments (OOP) plus total premiums (employee + employer shares).

*Rate of Growth in Health Care Spending.* As described earlier, health care costs have grown at a rate far in excess of general inflation. With the implementation of the ACA and the expansion of health insurance coverage to millions more Californians—many of whom have foregone critical preventive and health care services—health care expenditures will continue to rise. The goal, therefore, is to restrain the rate of increase over time by focusing on creating more value, efficiency, and effectiveness.

**California Health: Both a right and a responsibility.**

—Kelly Traver  
Healthiest You Corporation

To track overall spending, the Dashboard uses as an indicator California's Annual Growth Rate (CAGR) of total health expenditures and per capita costs, with a goal of being in line with the rate of growth in GDP by 2022.

*Integrated Delivery Systems.* The health care delivery system continues to experiment with various models that will facilitate greater integration in order to improve quality and constrain costs. Managed care is the most prominent one, but new models, like Accountable Care Organizations are now being tested with encouragement of the ACA. Consistent with these systems are new mechanisms to align financing to care coordination, including but not limited to capitation and global budgeting. Believing that systems which promote coordinated, integrated and aligned care will support the goals and priorities described throughout the Dashboard, the Task Force believes that a priority to track system-level change is critical. Although there is no perfect indicator, enrollment in population managed care plans is included as a proxy for this priority.

**Rewarding value via payments and market share**

—Arnold Milstein, Clinical  
Excellence Research Center,  
Stanford University

*Transparent Information on Cost and Quality.* Providing consumers with more information can aid in their decision-making and integrate more cost-consciousness into the system. Consumers need to understand what information is the most relevant, as well as basic data on cost and quality in order to become active participants in the decision-making process to

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<sup>26</sup> Premium data is for employer-sponsored insurance only. Out of Pocket (OOP) spending is derived from the Medical Expenditures Panel Survey (MEPS), which generally provides lower spending estimates than the CMS National Healthcare Expenditures Accounts (NHEA) mainly because MEPS includes a more limited scope of services than the NHEA. If a MEPS household is composed of one person, the OOP is considered to be for an "individual". If the MEPS household is composed of more than one person, the OOP is considered to be for a "family." The Berkeley Forum, University of California, Berkeley School of Public Health, October 2012.

determine choice of procedure and provider. There are no metrics yet, but the Task Force places a high priority on developing them.

*Payment Policies that Reward Value.* The ACA will enhance California's ability to implement payment reforms that reward value and health outcomes, rather than volume. To take hold, such payment reforms will need to be accompanied by culture change among providers and patients regarding the notion that more service—and more costly services—are synonymous with high quality and increased health outcomes. Alignment of health care financing with health goals is crucial to maximizing the utilization of health care dollars. Although this indicator is currently difficult to measure, like transparency, the Task Force flags it for future development.

Table 12. Dashboard for Lowering the Cost of Care

Leading Indicator			CA Baseline	2022 CA Target	National Baseline	2020 National Target	Disparities
36	Uninsurance rate	Point in time	15%	5%	15%	Not Available	2+ Races: 8% Am In/AK Nat: 23%
		Some point in the past year	21%	10%	20%	Not Available	White: 14% Am In/AK Nat: 31%
		For a year or more	11%	4%	11%	Not Available	White: 6% Am In/AK Nat: 21%
37	Health care cost (Total premium + OOP) as % of median household income	Families	22%	23%	26%	Not Available	N/A
		Individuals	13%	13%	20%		
38	Compound Annual Growth Rate (CAGR) by total health expenditures and per capita costs. For comparison, CAGR by Gross State Product is included		Total: 7% Per Capita: 6% GSP: 4%	No greater than CAGR for GSP	Total: 7% Per Capita: 6% GDP: 4%	Not Available	N/A
39	High numbers of people in population managed health plans		48%	61%	23%	Not Available	Af. Am: 61% Am In/AK Nat: 41%

## C. Health Equity: Eliminating Health Disparities

Given the diversity of California, the Task Force believes differences by geography, race/ethnicity, and gender, as well as socioeconomic status, sexual orientation and gender identity should be tracked where data are available. Such data are crucial to eliminating health disparities and informing which strategies and interventions are prioritized.

**Equity and social responsibility are fundamental.**

—Ellen Wu, California Pan-Ethnic Health Network

**California gets healthy through engaging social determinants.**

—Jim Mangia, St. John's Well Child and Family Center

As previously mentioned, California's African American population has an infant mortality rate of 11 per 1,000, more than twice the state's average. Only looking at the state's average would mask this very critical issue. Similarly, smoking rates vary considerably by gender, race/ethnicity, income, and geography. In California, 9 percent of adult women are smokers, compared to 15 percent for men. Asian Californians have the lowest rates of smoking – 9 percent overall, while African Americans are twice as high.



By focusing on where the disparities are the greatest and those populations and communities with the poorest health outcomes, California can lead the way in improving the overall health of the state.

That said, it will take more than the health system to fully achieve health equity. Poverty, education, and economic opportunity are major social determinants of health. Efforts to address many of the goals and indicators described above, such as infant mortality, asthma or obesity, will need to reach beyond the boundaries of the traditional health and health care sectors and take a multi-sectoral approach.

Although the Task Force's efforts are focused primarily on those issues where the health and health care sectors can make the greatest difference, our framework explicitly identifies the important role of community environments in achieving our goals. Moreover, the framework links the work of this Task Force to the Health in All Policies (HiAP) project within the California Department of Public Health Office of Health Equity, since it is addressing many of the social and environmental determinants of health. Finally, as a Task Force, we can each commit to continue building bridges with other sectors in order to tackle these issues in new, innovative and collaborative ways over the long term.

**Understanding root causes leads to results.**

—Steve Fields  
Progress Foundation

## V. Conclusion and Next Steps

The Let's Get Healthy California Task Force was constituted for six-months, concluding in December 2012. It is our hope that the product of the Task Force's work—the Framework and Dashboard—will serve as an organizing source of information and influence for stakeholders, policymakers, and the public to engage in efforts across the state to make California the healthiest state in the nation.

**Number one in health is fun!**

—Steve Shortell, UC Berkeley  
School of Public Health

To that end, we are committed to creating a website, to be housed at the California Health and Human Services Agency that will serve as a repository of the report, the Dashboard and the inventory of change strategies, the beginnings of which are collected here. We hope that individuals and

organizations will readily avail themselves of this rich collection of data and information to learn from each other, identify opportunities for collaboration, and continue to contribute new ideas. The Secretary is also committing the Agency to serve in a convening role for work groups to develop implementation strategies and periodically bring experts and stakeholders back together to share progress, assess and highlight strategies that are having the greatest impact, and facilitate their spread. It will be critically important to regularly review priorities and indicators and, to the extent necessary, update the Dashboard as measurement capabilities evolve and new priorities emerge.

As Co-Chair Dr. Don Berwick stated during the November 13, 2012, Task Force meeting, “Nothing happens until it happens on the ground.” This report is a good start, but it will only be meaningful

if each Task Force member, along with stakeholders and community leaders throughout the state, assess how his/her organization can take concrete steps to advance the goals and priorities outlined in the report, including developing the means and methods for determining those interventions likely to have the greatest impact. It

is only through such distributed leadership at all levels and sectors of society, as well as with the broad engagement of the public, that we can collectively advance change.

**Cataclysm imminent. Renew.  
Remake. Relapse? Choose!**

—Dave Regan. SEIU-UHW

The high level of participation and enthusiasm expressed by more than three-dozen Task Force members, along with countless others, throughout this process is a testament to the strong desire and commitment to make California the healthiest state in the country. We are particularly heartened by the interest of SEIU-UHW and so many others to think big about how to create a statewide culture of health that engages Californians up and down the state to change everyday behaviors and become healthier. SEIU-UHW's proposal to focus on schools and advance our priorities within the Healthy Beginnings goal is an excellent starting point.

While the work of the Task Force is done, we look forward to continuing the relationships forged during the last six months and to work together—as well as to engage new partners and the public—to make progress toward achieving the ambitious goals set forth in this report.

**The best place to be alive!**

—Co-Chair Don Berwick  
Former Administrator of the Centers for  
Medicare and Medicaid Services



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## Appendix I: Catalysts for Change: Task Force Exemplary Interventions

There are numerous evidenced-based solutions for each of the six goal areas identified by the Task Force, and in fact, for nearly every priority/indicator included in the Dashboard. August institutions, such as the Centers for Disease Control and Prevention and the Institute of Medicine, issue papers and books with recommendations ranging from best practices for reducing infant mortality to best practices for making hospitals safer. The challenge now is *how* to apply and then quicken the pace of uptake of these solutions in a state as large and diverse as California.

**Join together: the race for better health!**  
—Deborah Freund  
Claremont Graduate University

Fortunately, California is blessed with many and varied efforts that build upon the evidence base, attempting to resolve or at least make inroads into seemingly intractable health problems. This section of the report provides examples of interventions undertaken by Task Force members. Although the many dozens of submitted interventions cannot all be included here, the examples provide a sense of the caliber of leadership, spirit of collaboration, and sense of innovation that define California. Some interventions focus broadly on community or health care system change, while others target a specific population, disease/condition, or race/ethnicity. Together, these efforts serve as a launching pad for success over the next decade.

While interventions are organized by goal area, many may apply to multiple goals. In addition, many interventions target particular populations or geographies that will reduce disparities while improving health, addressing an overarching Task Force theme.

### Goal 1: Healthy Beginnings: Laying the Foundation for a Healthy Life

Many Task Force member organizations are devoted to improving the health of infants and children. For example, the Fresno County Department of Public Health is working on several fronts to ensure that its residents receive appropriate vaccinations. A Task Force member local youth center is garnering national attention around the importance of childhood trauma and its correlation to subsequent adult chronic conditions. Also showcased here are two Task Force members' efforts that focus on children's fitness levels and healthy diets, which will help reduce childhood obesity and diabetes rates.

**Vaccinations:** The **Fresno County Department of Public Health (FCDPH)** is involved in two initiatives to improve the immunization rates. First, the *Immunization Education of Health Care Providers* program offers education to health providers on how to talk to parents who are undecided or have concerns about vaccination. To increase immunization rates, physicians should clearly communicate vaccine benefits and risks while understanding the factors that affect a parent's acceptance and perception of the benefits and risks. The program offers education opportunities to physicians and medical assistants. For example, in conjunction with the Central Valley Immunization Coalition, an immunization update training was developed, promoted and coordinated in Fresno, Madera, Tulare and Kings Counties that reached over 100 medical assistants; in addition a physician education opportunity was provided to 25 local physicians.

**Prevention equals fewer healthcare visits.**  
—Pat Crawford, Atkins  
Center for Weight and Health,  
UC Berkeley

Ninety percent of attendees found the information beneficial for their practice. This intervention has only recently been implemented and, therefore, the impact in the local immunization rate for children 19-35 months has not been measured.

The FCDPH has also participated in an Immunization Registry that can interface with Electronic Medical Records in order to collect and consolidate vaccination data from providers. The Task Force on Community Preventive Services recommended Immunization Registries as a means of increasing vaccination rates, and studies indicate that electronic systems are associated with such increases. Client reminder and recall interventions involve reminding parents that vaccinations are due (reminders) or late (recall). Since the implementation of the reminder/recall strategy, the FCDPH Immunization Clinic demonstrated that immunization rates have steadily increased. Between 2010-2011, the immunization rate of children between the ages 24-35 months for series 4(DTaP)3(Polio)1(MMR)3 (Hib)3(HepB)1(Varicella) increased from 67 to 82 percent. For series 4(DTaP)3(Polio)1(MMR)3 (Hib)3(HepB) 1(Varicella) 4 (PCV) the increase jumped from 65 to 81 percent at 24 months of age.

**Childhood Trauma: The Center for Youth Wellness (CYW)** is pioneering the development of provider-level interventions to mitigate the impacts of Adverse Childhood Experiences as a risk factor for chronic diseases and other conditions. Although there is a significant body of evidence about the impacts of Adverse Childhood Experiences, there is no consensus about the “right” intervention. CYW is doing work on several levels: the provider level nationally – providing expertise for the American Academy of Pediatrics; the county level, providing technical assistance for several county youth probation offices as part of the Positive Youth Justice Initiative; and at the local level in Bayview Hunters Point neighborhood of San Francisco. CYW is currently in the process of developing a platform and protocol that can be used as a framework for individuals and organizations wanting to replicate the model.

**Childhood Fitness and Healthy Diets: Anthem Blue Cross** is partnering with the Alliance for a Healthier Generation (founded by the American Heart Association and the William J. Clinton

**Californians set pace for national reform.**

—Wells Shoemaker, CA  
Association of Physician Groups

Foundation) and San Fernando Valley-based Facey Medical Group to conduct a pilot in the San Fernando Valley area to provide children who have a high body mass index with comprehensive benefits for the prevention, assessment and treatment of childhood obesity. As part of the program, eligible children have access to four visits with their primary care provider and four visits with a registered dietitian per year. Three pediatrician

“champions” participate in the pilot. The involved health care professionals work with children and their families to establish and maintain a healthy lifestyle. Anthem reimburses these services with no cost to the patient. This program currently enrolls 40 children (members) via 3 physician champions and is scheduled for re-evaluation/re-negotiation in March 2013.

Anthem Blue Cross is also supporting a second initiative through a grant to HealthCorps®, a program co-founded by renowned heart surgeon and talk show host Dr. Mehmet Oz. The grant supports eight schools in low-income communities and will target 600 students in each school who are at high risk for obesity. A full time coordinator is placed at each school to integrate peer mentors with other aspects of the school-based curriculum. The program’s goal is to see changes

in Body Mass Index (BMI) in at least 16 percent of the student population, increase in fruit and vegetable consumption, changes in fitness activity, and changes in test scores on health related information. The project is awaiting first year results. Ultimately, the program hopes to increase its reach four-fold by engaging students' family members, school employees, and others.

The **California Department of Public Health** and the **Public Health Institute's** Network for a Healthy California is overseeing a social marketing campaign, called the *Children's Power Play Campaign* to increase the proportion of low-income children aged 9-11 who get the recommended amounts of physical activity and fruit and vegetable consumption. In addition, the *Youth Empowerment Initiative* aims to foster peer leadership and educate youth about nutritious and active lifestyles, and empower youth to create community change, such as installing hydration stations to provide clean drinking water, or making healthy food choices the easy choice in schools. This multi-channel, community-based approach engages children in activities at schools, homes, community youth organizations, farmers' markets, supermarkets, school foodservice, and local media promotions. A combination school and community-based program has been found to be more successful than a school-based program alone. Several changes in the school environment have been made as a result of the *Youth Empowerment Initiative*, including upgrades and menu changes in school cafeterias, increased access to clean drinking water, eating and physical activity behavior changes among youth, their peers, and families, and the acquisition of new skills and exposure to new experiences for involved youth/students.

**Cooperative Extension (CE) Nutrition, Family and Consumer Science Advisors and 4H Advisors** are currently piloting a new obesity prevention program in California, the first of its kind in the nation. Utilizing Cooperative Extension's deep roots in communities, including low income communities at high risk for obesity and diabetes, Extension is mobilizing an effort to redirect resources to address obesity prevention in two California communities located in Butte and Shasta Counties. The new program includes a comprehensive set of nutrition and physical activity messages with 4H youth playing leading roles as peer guides and youth ambassadors for the program. This 2-year community based intervention, emphasizes four key messages delivered in a variety of venues: 1) reducing consumption of sugar-sweetened beverages, (2) limiting fast food consumption, (3) increasing fruit and vegetable intake, and (4) decreasing time spent in sedentary pursuits. The overall goal is to change student attitudes, knowledge and behaviors in ways that are conducive to healthier dietary and physical activity patterns. If this approach is shown to be effective in lowering children's BMI, Cooperative Extension's reach and long-standing relationships could enable it to be a vehicle for engaging communities throughout the state.

## **Goal 2: Living Well: Preventing and Managing Chronic Disease**

Reducing chronic disease in California will require a multi-faceted approach. The initiatives below touch upon virtually all of the priority areas within this goal.

**Kaiser Permanente** is involved in two efforts, both focused on wellness. Kaiser Permanente's program, *Every Body Walk!* promotes walking as an easy, cost effective way for Californians to achieve real health benefits. While walking and other forms of physical activity are not innovative, *Every Body Walk!* is a creative online

**Let us get healthy,  
California. Walk!**  
—Bill Monning  
California State Assembly

educational campaign aimed at getting Americans up and moving. The program is working to spread the message that walking 30 minutes a day, five days a week really can improve your overall health and prevent disease. It provides news and resources on walking, health information, walking maps, how to find walking groups, a personal pledge form to start walking, as well as a place to share stories about individual experiences with walking. The website includes downloadable apps and links to other important information and programs. The program targets 30 minutes of walking per day, 5 days per week for adults; another measure is 10,000 steps per day.

**Get up and enjoy the coast!**

—Anne Stausboll. CA Public  
Employees Retirement System

The Total Health wellness program is a joint project of **Kaiser Permanente** and the **Coalition of Kaiser Permanente unions**. It addresses the Task Force goal of preventing and managing chronic disease by aiming to reduce the proportion of adults who are obese and the proportion of adults who smoke; and to increase the percentage of adults with hypertension who have

controlled high blood pressure and the percentage of adults with high cholesterol who are managing their condition. The goal of Total Health is to create the healthiest workforce in the health care industry by improving the quality and length of employees' lives and enhancing the effectiveness and productivity of the organization.

The Total Health approach seeks to create programs and a workplace environment and culture in which employees in each Kaiser hospital, medical office building, and other facility collectively take responsibility for reducing their health risks. The program additionally seeks to reduce occupational injury and illness. Total Health is innovative in three primary ways: First, instead of focusing exclusively on individual responsibility, employees' progress will be measured as a group, and they will collectively take responsibility for their success. Second, the program uses pay bonuses as incentives for employees to improve their health, rather than the financial penalties used in many other employee wellness programs. Third, the program is a labor-management partnership, and that collaboration is fundamental to its success. The Total Health goal is a 5 percent improvement in key biometric risk indicators over a three-year period (2013-2016). Those indicators are body mass index, smoking rates, cholesterol, blood pressure, and workplace injuries. Currently, Kaiser and the union coalition are jointly creating the health assessment tools as a prelude to launching the program system-wide.

**Healthy California means  
invest in yourself.**

—James Hay  
California Medical Association

Three years ago, **Blue Shield of California** initiated a new workplace wellness program, *Wellvolution* which sought to improve employee health, including tobacco cessation, physical activity, healthy diet, weight management, blood pressure/cholesterol/glucose control, and emotional wellbeing, to name just a few. Taking a comprehensive approach grounded in best practices and research, Blue Shield is utilizing behavioural economics, social media and “gaming” activities with a variety of activities and strategies from cafeteria design to walking workstations and mobile applications. Early results show:

- 26 percent improvement in health status due to transition from “at risk” to “healthy.”
- 48 percent decrease in smoking prevalence. Smoking prevalence of 6 percent represents

- one of the lowest rates in the nation.
- 32 percent increase in regular physical activity; 48 percent decrease in sedentary behaviour
- Over the course of two years, disability costs fell 18 percent among Wellvolution participants but increased 57 percent among those not engaging in wellness.
- Non-participant medical claims are increasing at a rate 1.5 times that of wellness participants.

This effort is now being expanded to Blue Shield members and providers.

The Right Care Initiative, a public-private partnership led by **UC schools (Berkeley and Los Angeles) of Public Health** and the **California Department of Managed Health Care** works to improve heart attack, diabetes and stroke-correlated metrics, particularly blood pressure control for hypertensive patients, lipid control for patients with heart disease, and blood sugar control for patients with diabetes. In 2009, this statewide initiative launched an NIH-funded pilot to reduce heart attacks, strokes and diabetic complications in San Diego that has extended to Sacramento as of 2012. Monthly colloquia bring together metro-area medical, quality, and pharmacy directors from each medical group and health plan, community clinics, the Veteran's Administration Medical Center, and the Navy. While the Initiative's impact on clinical outcomes has not yet been formally evaluated, statewide trends are in the right direction and indicate that the metrics of focus are improving faster than the nation, as observed in California Health Care Quality Report Cards and National Committee for Quality Assurance (NCQA) data. The statewide goal is that all health plans and medical groups meet the national 90th percentile ("A Grade" performance) on heart attack, stroke and diabetic complication prevention measures that serve as proxies for care management quality.

### **Goal 3: End-of-Life: Maintaining Dignity and Independence**

The priorities for Living Well (Goal 2) also apply to seniors. The End-of-Life goal here acknowledges the importance of providing quality care at the end of life when desired. The **California Association of Physician Organizations (CAPG)** showcases a case study in excellence from a member medical group that created a comprehensive model for advanced illness care. Another Task Force member, the **California HealthCare Foundation (CHCF)**, recently began planning for the launch of a new community based palliative care model in early 2013.

**CAPG's Case Studies in Excellence** call attention to the **Sharp Community Medical Group and Sharp Rees-Stealy in San Diego**. Sharp Rees-Stealy is an integrated, multispecialty medical group located in the San Diego community. Implemented in 2011, Sharp's Concurrent Palliative Care Model in End of Life Care works to provide interdisciplinary care to patients with advanced chronic conditions, such as congestive heart failure, chronic obstructive pulmonary disease, and dementia, to benefit from a high level of care coordination. Care is team-based; hospice workers, primary care providers, specialists, nurses, social workers, pharmacists and spiritual care providers come together to deliver comprehensive care. The team works with patients and families to assess their preferences, and develop a treatment and support plan. A palliative care team interacts with patients and family through home visits, family conferences, and spiritual support and guidance. Together a treatment and support plan, complete with an advanced care plan respecting the patient's preferences, is developed. The team supports the



patient through the illness progression, and when appropriate, transition into hospice. Key outcomes to date include a high level of patient and family satisfaction, improvements in quality of life as measured by the Patient Quality of Life Index, and reductions in the total cost of care through enhanced coordination/communication and reduced Emergency Department (ED) visits and hospitalization/ICU days.

In partnership with providers, **CHCF** is launching an effort to implement new models of community-based palliative care primarily in ambulatory care settings. If these demonstration pilots prove successful, then CHCF is prepared to work with a range of adopters and promoters to spread this model of community-based palliative care.

#### **Goal 4: Redesigning Health Care: Efficient, Safe, and Patient-Centered**

Task Force purchasers, payers, and providers are working hard to redesign the continuum of care. Below are examples of providing improved case management for people with chronic conditions in rural and urban areas, as well as mental health settings. Other examples address improvements in hospital safety.

**The California Public Employees' Retirement System** (CalPERS) is partnering with the Pacific Business Group on Health (PBGH) to implement a high intensity case management program through the Humboldt Independent Practice Association. CalPERS' members participating in the project are in the top 20 percent in terms of risk profile and represent an estimated 80 percent of predicted health care costs in the selected geographic areas. Claims data were used to identify high-risk members to target for recruitment and enrollment is occurring. Nurse case managers supervise the care and facilitate access to the primary care physician and specialists, as well as help patients engage in self-care. A shared savings financial model is also being implemented with 50 percent of the savings going to CalPERS and 45 percent to the IPA. There is a five percent administrative recovery fee to Anthem Blue Cross.

A Task Force physician leader from the Humboldt IPA moved south to expand upon this case management model in the new **Stanford Coordinated Care** clinic. This innovative clinic delivers health care to employees of self-funded employers who are most likely to have the highest health care expenditures in the coming year based on risk factors, such as at least two visits to the ED in the previous six months, seeing at least three specialists, or taking at least five chronic disease medications. Care is delivered by teams of a physician, nurse, social worker, physical therapist, clinical pharmacist, and care coordinator and is designed to respond to individual patient needs. A registry has been developed to track clinical data. As the program is only a few months old, there are no data to report, though rigorous evaluation is being planned. The current evidence from similar efforts in Humboldt, Atlantic City and Boeing indicates that 20 percent savings can be achieved, along with improved patient outcomes and satisfaction.

**Business. Opportunity. Free.  
Anything. Everything.  
Greatest.**

—Ann Boynton, CA Public  
Employees Retirement System

Similar efforts for greater coordination and integration of primary care are seen in the **Progress Foundation's** approach to providing treatment for individuals with "serious mental illness." Progress Foundation, in partnership with the University of California at San Francisco School of Nursing, endeavors to bring primary care services into the 24-hour residential treatment

programs settings, taking a proactive approach to ensuring those who are in the midst of an acute psychiatric episode receive necessary preventative care. Over 90 percent of these patients are dually diagnosed with “serious mental illness” and “serious substance abuse treatment needs;” their chronic health conditions are often overlooked and can go undetected. The work of the Progress Foundation and other institutions like it is critically important as the rates of morbidity and mortality from chronic conditions such as diabetes and obesity are rising among the seriously mentally ill population due in part to the increased use of newer generations of psychotropic medications. Progress Foundation’s internal measurements and objectives include a goal that 100 percent of the clients in their residential treatment settings receive a screening, assessment, and initial facility based treatment plan for addressing any existing chronic conditions. Integrating behavioral health and primary care interventions can prevent, diagnose and treat health conditions which, if are allowed to go undetected, could result in unnecessary hospitalizations for both psychiatric and physical health care conditions.

Two major payers, Anthem Blue Cross and Kaiser Permanente, as well as a major hospital system, Dignity, are working to make hospitals safer by reducing hospital-acquired conditions, reducing early elective deliveries, and creating a culture of safety. **Anthem's Patient Safety First (PSF)** initiative is in its third year with more than 175 California hospital participants. Borrowing from the Institute for Healthcare Improvement Breakthrough Series Collaborative Model, PSF leverages peer-to-peer regional learning networks to share and spread best practices. Patient education components are included where appropriate. At the close of year two in 2011, tangible results have been documented, including: saving more than 973 lives as a result of reduced sepsis mortality; reducing ventilator associated pneumonia from 2.32 per 1000 ventilator days to 1.2; and dramatically reducing perinatal gestational age deliveries under 39 weeks from 10.36 percent in 2009 to 3.6 percent. Estimated total population savings exceed \$19 million. Opportunities for future collaboration with other sectors may include business coalitions to ensure incentive alignment and consumer advocacy groups to build broad based awareness.

**Health Caring for All!  
Investing in California.**

—Jane Garcia,  
La Clinica de La Raza

As an integrated delivery system of doctors, hospitals, and a health plan, **Kaiser Permanente** is able to identify best practices and standardize them across medical centers. An example of this is in their Northern California Region's response to septicemia, or sepsis. Because the majority of sepsis cases are patients who already contracted the infection prior to arriving at the hospital, the Kaiser initiative *Saving Lives Through Better Sepsis Care*, focuses on several elements ideally achieved within the first six hours after a patient with sepsis arrives at the hospital. This approach involves comprehensive training, teamwork, and coordination of care delivered in the emergency department, operating rooms, and all other hospital units. Combined efforts to build awareness of the signs for sepsis, and increasing the amount of diagnostic testing led to a 102 percent increase in the rate of sepsis detection in the first year of the program. Early detection can then be followed by aggressive treatment. An innovative screening program developed in 2008 targeting patients at risk for sepsis resulted in Kaiser Permanente Northern California mortality reductions for patients admitted to hospitals with sepsis by more than 40 percent - saving more than 1,400 lives. Another unique feature of the program is the use of mannequins to train emergency physicians and ensure that patients with sepsis will have safe and timely central line placement in the emergency department. Next steps for this initiative include introducing a single standard of sepsis care to all Kaiser Permanente hospitals, extending the approach to all



adults, children, and inpatients. Further, novel approaches to case identification and prediction using clinical and laboratory data are being explored.

Another hospital-related effort to reduce early elective deliveries (EEDs) is underway with **Dignity Health**. In light of the growing evidence base regarding the potential harm of EEDs Dignity undertook an initiative to eliminate or substantially reduce EEDs among its network hospitals offering maternal and child health services in 2011. Key interventions include a standardized list of accepted, evidence-based medical indications for an EED; widespread education of staff, physicians, and patients; and a "hard stop" for scheduling EEDs without a documented indication. In less than six months the rate of EEDs before 39 weeks dropped from a baseline rate of seven percent to one percent, or a system-wide rate of about 75 to 15 EEDs per month. Dignity collaborated with other health systems in the development of the EED initiative and has shared its successes and insights with other systems and CMS.

### **Goal 5: Creating Healthy Communities: Enabling Healthy Living**

Task Force members are involved in a variety of efforts designed to make community environments safer and healthier. Health is linked to employment, education, economic opportunity, housing, the environment and more. These interrelated issues require interrelated solutions.

**The California Endowment** is working across all systems that impact community health – schools, human services, economic development, transportation, and land use – through its Building Healthy Communities initiative, a ten-year, comprehensive community initiative. Begun in 2010 and running until 2020, this effort is creating a revolution in the way Californians think about and support health in their communities. In 14 places across California, residents are engaging in advocacy and projects that prove that they have the power to make health happen in their neighborhoods, schools and with prevention. They're doing this by improving health care and coverage, employment opportunities, education, housing, neighborhood safety, unhealthy environmental conditions, access to healthy foods and more. This is a community driven effort so that each community leads the vision and how to get there. Success is being measured by reaching specific milestones in decreasing childhood obesity and youth violence and increasing school attendance and access to quality health care in our target communities.

Like many of the initiatives described under other goals, the *Health Homes* initiative by **St. John's Well Center** is one that addresses two goals and several priorities. Because the intervention is a community intervention that directly addresses the social determinants of health, it is listed under this goal. The comprehensive approach to asthma combines medical care, coordination, case management, in home community health promotion and assessment, community organizing and legal services. When a patient is identified, diagnosed and treated for asthma symptoms at one of St. John's community health centers, a medical evidence form is filled out with the child, their family and the physician. They are then referred to a case manager, who coordinates the system of care and referrals necessary for the comprehensive intervention. Community health promoters are then dispatched to the home to assess the in-home environmental conditions and triggers (mold, cockroach infestation, rat or rodent infestation, cracking or peeling paint, leaky pipes, temperature, etc.) and to teach the family how to use low-cost, low-tech barriers and cleaning products to alleviate some of the housing conditions besieging the family. If the conditions are structural, a physician writes a letter to the landlord

informing them that the dwelling is harmful to the health of the children living there. If the landlord does not respond, the family is referred to the Center's medical/legal clinic and tenant organizers to provide more pressure on the landlord to make necessary repairs. This strategy has been tremendously effective at alleviating housing conditions that lead to asthma. The progress made includes: a 100 percent reduction in asthma hospitalizations; a 95 percent reduction in blood lead levels; a 100 percent reduction in emergency room use due to asthma; a 96 percent reduction in missed school days, a 93 percent reduction in missed work days for caregivers, and a 159 percent increase of patients with well-controlled asthma per ACT score.

### **Goal 6: Lowering the Cost of Care: Making Coverage Affordable and Aligning Financing to Health Outcomes**

Much of the work to expand the availability and affordability of health insurance coverage will be ramping up over the next two years as the California Health Benefit Exchange becomes operational and various provisions of the ACA take effect. At the same time, many of the preceding exemplary interventions have either an explicit goal or added benefit of reducing costs, in addition to improving the health of the Californians served.

These examples illustrate how California leaders are influencing costs by: (1) maximizing prevention and wellness principles, within the community, schools, health care system, and other settings; (2) identifying patient needs early on and tailoring approaches to meet them; (3) emphasizing primary care; (4) leveraging community workers and promotoras; (5) leveraging new technologies, such as telemedicine; (6) adopting an integrated, team-based approach; (7) and measuring results.

**Healing healthcare,  
affordable to all.**

—Mitch Katz, LA Co. Department  
of Health Services

An exciting opportunity on the horizon comes from a federal initiative for payment reform. The **State of California, led by the Health and Human Services agency**, applied for a Centers for Medicare and Medicaid State Innovation Model (SIM) grant to design an innovative payment solution. Many of the stakeholders represented on the Task Force will be involved with this effort as a key next step in advancing Californians' health. Collectively, these and other interventions can help slow the rate of growth in health care costs, making care and coverage more affordable over time.

## **Appendix II: Catalysts for Change: Public Sector Programs**

In addition to the range of interventions being implemented by private and non-profit organizations described in Appendix I, numerous state agencies are also leading efforts to address many of the goals and priorities identified in this report.

### **Asthma**

California Breathing is dedicated to improving the lives of people with asthma in California by leading the implementation of the Strategic Plan for Asthma in California (the Plan). California Breathing is housed in the California Department of Public Health's Environmental Health Investigations Branch. Consistent with the priorities of the branch, California Breathing focuses on disease surveillance, increasing capacity of a broad network of partners to achieve goals in the Plan, and developing interventions that improve environmental conditions that cause or exacerbate asthma in the most vulnerable populations.

For more information, visit <http://www.californiabreathing.org/about-us>

### **Child Maltreatment (Child Abuse and Neglect) Prevention**

There are multiple systems designed to address different aspects of child maltreatment in California: child welfare, law enforcement and the courts, health care, and community-based organizations. A specific example is the California Child Welfare Council.

The California Child Welfare Council was established by the Child Welfare Leadership and Accountability Act of 2006 (Welfare and Institutions Code Sections 16540 – 16545) and serves as an advisory body responsible for improving the collaboration and processes of the multiple agencies and the courts that serve the children in the child welfare system. The Council is co-chaired by the Secretary of the California Health and Human Services Agency and the designee of the Chief Justice of the California Supreme Court, and membership is comprised of state departments, county departments, nonprofit service providers, advocates, parents and former foster youth. The Council is charged with monitoring and reporting on the extent to which the agencies and courts are responsive to the needs of children in their joint care.

For more information, visit

<http://www.chhs.ca.gov/INITIATIVES/CACHILDWELFARECOUNCIL/Pages/default.aspx>

### **Diabetes**

The California Diabetes Program works in partnership with organizations in California and nationwide to: improve the quality of care in Health Care Delivery Systems; provide communications to increase awareness about diabetes; offer leadership, guidance, and resources for Community Health Interventions; conduct Surveillance to monitor statewide diabetes health status and risk factors; and guide Public Policy to support people with and at risk for diabetes.

For more information, visit <http://www.cdph.ca.gov/programs/diabetes/Pages/default.aspx>

### **Heart Disease and Stroke**

The mission of the California Heart Disease and Stroke Prevention (CHDSP) Program is to reduce premature death and disability from heart disease and stroke among Californians. The CHDSP Program fills a unique niche at the California Department of Public Health, targeting

Californians at risk for heart disease and stroke, including persons with high blood pressure, high cholesterol, and multiple risk factors as well as persons with prior heart attack or stroke. Interventions with these populations directly address Healthy People 2020 objectives for heart disease and stroke.

For more information, visit <http://www.cdph.ca.gov/programs/cvd/Pages/default.aspx>

### **Immunization**

The Immunization Branch of the California Department of Public Health provides leadership and support to public and private sector efforts to protect the population against vaccine-preventable diseases. Immunizations are one of public health's greatest achievements. Vaccines help prevent diseases and help keep Californians of all ages healthy. Making sure all kids get their routine shots on time gives them a healthy start in life.

For more information, visit <http://www.cdph.ca.gov/programs/immunize/pages/default.aspx>

### **Infant Mortality**

Infant Health programs cover a range of activities. One exemplary program is the California Black Infant Health Program, which focuses on the primary disparity in infant mortality. The California Black Infant Health (BIH) Program aims to improve health among African American mothers and babies by empowering pregnant and mothering African American women to make healthy choices for themselves, their families, and their communities.

Within a culturally affirming environment and honoring the unique history of African American women, the BIH Program uses a group-based approach with complementary client-centered case management to help women develop life skills, learn strategies for reducing stress, and build social support. BIH clients participate in weekly group sessions (10 prenatal and 10 postpartum) designed to help them access their own strengths and set health-promoting goals for themselves and their babies. In addition to helping clients reinforce the skills and knowledge they develop in the group sessions, one-on-one case management ensures that clients are connected with the appropriate community and social services to meet their needs. Each woman culminates her participation in the program by developing her own individual Life Plan to guide her continued progress after BIH.

To learn more about the breadth of programs in California, please see:

<http://www.cdph.ca.gov/programs/mcah/Pages/InfantHealth.aspx>.

<http://www.cdph.ca.gov/programs/bih/Pages/default.aspx>

### **Insurance Coverage**

The vision of the California Health Benefit Exchange is to improve the health of all Californians by assuring their access to affordable, high quality care. The mission of the California Health Benefit Exchange is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value. The Exchange will begin enrollment in the fall of 2013.

For more information, visit [www.hbex.ca.gov](http://www.hbex.ca.gov)

## **Medi-Cal**

MediCal is California's Medicaid program. This program pays for a variety of medical services for children and adults with limited income and resources. MediCal is supported by federal and state taxes. The California Department of Health Care Services administers the program which will be covering new populations effective 2014 as enacted under the Affordable Care Act.

For more information, visit [www.dhcs.ca.gov](http://www.dhcs.ca.gov)

## **Nutrition/Obesity Prevention**

California Project LEAN (Leaders Encouraging Activity and Nutrition) works to advance nutrition and physical activity policy in schools and communities in order to prevent obesity and its associated chronic diseases. Our efforts are centered on youth and parent empowerment approaches, policy and environmental change strategies, and community-based solutions that improve nutrition and physical activity environments.

California Project LEAN recognizes that health inequities exist in communities and that specific racial and ethnic minorities experience higher rates of overweight/obesity because of certain social conditions. With this in mind, we focus much of our efforts in low-resource, high-need communities whose members are adversely impacted by such social conditions.

For more information, visit <http://www.californiaprojectlean.org/doc.asp?id=89&parentid=88>

California Women, Infants, and Children's Program (WIC) is a federally funded health and nutrition program for women, infants, and children. WIC helps families by providing checks for buying healthy supplemental foods from WIC-authorized vendors, nutrition education, and help finding health care and other community services. Participants must meet income guidelines and be pregnant women, new mothers, infants or children under age five. In California, 84 WIC agencies provide services locally to over 1.45 million participants each month at over 650 sites throughout the State.

For more information, visit <http://www.cdph.ca.gov/programs/wicworks/Pages/default.aspx>

The Network for a Healthy California (the Network) seeks to create innovative partnerships that empower low-income Californians to increase fruit and vegetable consumption, physical activity, and food security with the goal of preventing obesity and other diet related chronic diseases. Since 1997, the Network has led a statewide movement of local, state, and national partners collectively working toward improving the health status of 7 million low-income California parents and children. Multiple venues are used to facilitate behavior change in homes, schools, worksites, and communities to create environments that support fruit and vegetable consumption and physical activity.

For more information, visit <http://www.cdph.ca.gov/programs/cpns/Pages/default.aspx>

## **Physical Activity**

California Active Communities creates community-wide opportunities for safe, everyday physical activity through behavioral, environmental and policy change for Californians of all ages and abilities. Projects of California Active Communities cover the lifespan and help children through older adults become active and stay active – and have fun while they're at it! Our efforts benefit:

- Children through our [California Walk to School](#), [Safe Routes to School](#), and [School Siting](#) projects;
- All Californians by addressing the built environment and its impact on physical activity through our [Healthy Transportation Network](#), [Joint Use](#), and [Walkable Community Workshops](#);
- Older adults through our [California Active Aging Network](#) and [Walkable Neighborhoods for Seniors](#) projects;
- California's county public health agencies by providing focused [built environment training, mini-grants and resources](#).

All of the projects include a walking component since walking is one of the simplest forms of everyday physical activity that requires no fitness club membership and no special — or expensive — equipment other than a comfortable pair of tennis shoes. Plus, walking — whether for transportation, recreation or leisure — can be one of the easiest ways for individuals to meet

For more information, visit <http://www.caactivecommunities.org>

## **Reading Literacy**

The purpose of the William F. Goodling Even Start Family Literacy Program (Even Start) is to help break the cycle of poverty and illiteracy by improving educational opportunities for low-income families. For fiscal year 2009-10, 57 Even Start projects are operational in California.

Even Start was first authorized in 1989 as Part B of Chapter 1 of Title I of the Elementary and Secondary Education Act of 1965 (ESEA). Even Start legislation was amended in July 1991 when Congress passed the National Literacy Act (Public Law 102-73), lowering the age of children served from age one to birth and allowing community-based organizations to receive grants. The Literacy Involves Families Together Act of 2000 (LIFT) renamed Even Start to the William F. Goodling Even Start Family Literacy Program. It was reauthorized as Title I, Part B, Subpart 3, of the No Child Left Behind Act of 2001.

For more information, visit <http://www.cde.ca.gov/sp/cd/op/evenstart.asp>

## **Tobacco Program**

The mission of the California Tobacco Control Program (CTCP) is to improve the health of all Californians by reducing illness and premature death attributable to the use of tobacco products. Through leadership, experience and research, CTCP empowers statewide and local health agencies to promote health and quality of life by advocating social norms that create a tobacco-free environment.

For more information, visit <http://www.cdph.ca.gov/programs/tobacco/Pages/default.aspx>



## Appendix III: Executive Order B-19-12

WHEREAS all Californians have a stake in making the healthcare system more cost-effective and efficient, and everyone, including doctors, hospitals, healthcare workers, employers, insurance companies, and patients themselves, can contribute to improving quality and reducing costs; and

WHEREAS the State of California, in partnership with the federal government, is taking steps to improve the healthcare system by expanding coverage, realigning payment incentives, providing consumer protections, reducing health disparities between Californians, and distributing wellness and nutritional information; and

WHEREAS preventable and chronic health conditions are detrimental to every Californian's quality of life, cause disproportionate social and economic burdens, and result in California spending 80% of the state's total healthcare dollars on just 20% of the population; and

WHEREAS the incidence and treatment of preventable and chronic conditions is well documented, but California lacks a statewide strategy for collecting, prioritizing, and sharing this information to help people make informed decisions about their own health and healthcare; and

WHEREAS California is home to innovative and world leaders in healthcare, technology, research, and philanthropy and has a strong record of developing successful prevention and wellness strategies, like California's groundbreaking tobacco-control efforts and innovative "health in all" policies; and

WHEREAS the State is uniquely positioned to bring together the talent, resources, experience, and innovations of California's healthcare workforce, diverse communities, employers, technology and healthcare industries, universities, and others, to develop a plan to reduce the burden of disease and improve the health of all Californians.

NOW, THEREFORE, I, EDMUND G. BROWN JR., Governor of the State of California, do hereby issue this Order to become effective immediately:

IT IS HEREBY ORDERED that reducing the individual, social, and economic burdens of preventable and chronic conditions and improving the health of Californians is a priority for California.

IT IS FURTHER ORDERED that the Secretary of the Health and Human Services Agency establish a Let's Get Healthy California Task Force to develop a 10-year plan for improving the health of Californians, controlling health care costs, promoting personal responsibility for individual health, and advancing health equity by establishing baselines for key health indicators, identifying obstacles to better care, making fiscally prudent recommendations, and establishing a framework for measuring improvements.

IT IS FURTHER ORDERED that the Secretary appoint the members of the Let's Get Healthy California Task Force, including individuals representing patients and consumers, healthcare providers, health plans, employers, community-based organizations, foundations, and organized labor. The task force shall first meet by June 15, 2012.

IT IS FURTHER ORDERED that by December 15, 2012, the Let's Get Healthy California Task Force provide to the Secretary a written report that includes the baseline data and sets targets for:

- (1) Reducing diabetes, asthma, childhood obesity, hypertension, and sepsis-related mortality;
- (2) Reducing hospital readmissions within 30 days of discharge; and
- (3) Increasing the number of children receiving recommended vaccines by age three.

The report shall also include recommendations for achieving these targets without additional government spending and standards for measuring improvement over a 10-year period.

IT IS FURTHER ORDERED that agencies under my direct executive authority cooperate in the implementation of this Order, and it is requested that entities of State government not under my direct executive authority assist in its implementation as necessary.

This Executive Order is not intended to create, and does not create, any rights or benefits, whether substantive or procedural, or enforceable at law or in equity, against the State of California or its agencies, departments, entities, officers, employees, or any other person.

I FURTHER DIRECT that as soon as hereafter possible, this Order shall be filed with the Office of the Secretary of

## LET'S GET HEALTHY CALIFORNIA TASK FORCE REPORT

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State.

IN WITNESS WHEREOF I have hereunto set my hand and caused the Great Seal of the State of California to be affixed this 3rd day of May 2012.

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EDMUND G. BROWN JR.  
Governor of California

ATTEST:

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DEBRA BOWEN  
Secretary of State

## Appendix IV: Task Force Members and Expert Advisors

### Co-Chairs

**Don Berwick**, MD, MPP, FRCP, Former President and CEO of the Institute for Healthcare Improvement, and former Administrator of the Centers for Medicare and Medicaid Services

**Diana Dooley**, Secretary, California Health and Human Services Agency.

### Members

**Bruce Bodaken**, Chairman and CEO, Blue Shield of California

medicine, Department of Family and Community Medicine, University of California, Davis

**Dr. America Bracho**, MPH, CDE, Executive Director, Latino Health Access, Santa Ana

**Arnold Milstein**, MD, Professor, Stanford University's Clinical Excellence Research Center

**Lloyd Dean**, President and CEO, Dignity Health (formerly Catholic Healthcare West)

**Bill Monning**, Assembly Member, Chair of the Assembly Committee on Health

**Susan Desmond-Hellmann**, MD, MPH, Chancellor, University of California, San Francisco

**Ed Moreno**, MD, MPH, Director and Health Officer, Fresno County Department of Public Health and President, Health Officers Association of California

**George Halvorson**, Chairman and CEO, Kaiser Permanente

**Steven Packer**, MD, President and CEO, Community Hospital of the Monterey Peninsula, and Board Chair, California Hospital Association

**James T. Hay**, MD, President, California Medical Association

**Dave Regan**, President, Service Employees International Union – United Healthcare Workers - West

**Ed Hernandez**, O.D., State Senator, Chair, Senate Committee on Health

**Mitch Katz**, MD, Director, Los Angeles County Department of Health Services

**Joe Silva**, Superintendent, Tuolumne County Office of Education and past president, California County Superintendents Education Services Association

**Pam Kehaly**, President and General Manager, Anthem Blue Cross of California

**Anne Stausboll**, JD, CEO, California Public Employees Retirement System (CalPERS)

**Kenneth W. Kizer**, MD, MPH, Director, Institute for Population Health Improvement, University of California Davis Health System and Distinguished Professor, UC Davis School of Medicine and Betty Irene Moore School of Nursing

**Kelly Traver**, MD, Founder and CEO, Healthiest You Corporation and the author of The Program

**Richard Levy**, PhD, Chairman of the Board, Varian Medical Systems, Inc.

**Kerry Tucker**, Principal, Nuffer, Smith, Tucker, Inc., Member, California State Board of Food and Agriculture

**Bob Margolis**, MD, Managing Partner and CEO, HealthCare Partners

**Antronette “Toni” Yancey**, MD, MPH, Professor of Health Services and Co-Director, UCLA Kaiser Permanente Center for Health Equity within the Fielding School of Public Health

**Joy Melnikow**, MD, MPH, Director, Center for Healthcare Policy and Research and professor of

**Expert Advisors to the Let's Get Healthy California Task Force**

**Honorary Chair**

**Robert K. Ross**, MD, President and CEO, The California Endowment

**Members**

**Ann Boynton**, Deputy Executive Officer for Benefit Programs, Policy and Planning, California Public Employees Retirement System (CalPERS)

**Nadine Burke Harris**, MD, MPH, Founder and CEO, Center for Youth Wellness

**Sophia Chang**, MD, MPH, Director, California HealthCare Foundation's Better Chronic Disease Care program

**Molly Coyle**, MD, MPH, Chief Innovation Officer, UCLA Health System

**Patricia "Pat" Crawford**, DrPH, RD, Co-founder and Director, Atkins Center for Weight and Health, CE Nutritional Specialist, and Adjunct Professor, University of California, Berkeley

**Steve Fields**, MPA, Executive Director, Progress Foundation

**Deborah "Debbie" Freund**, PhD, MPH, President, Claremont Graduate University

**Jane Garcia**, MPH, CEO, La Clinica de La Raza

**Alan Glaseroff**, MD, Director, Stanford Coordinated Care

**Neal Halfon**, MD, MPH, Director, UCLA Center for Healthier Children, Families and Communities, and Professor of Pediatrics, Health Services and Public Policy

**Richard "Dick" Jackson**, MD, MPH, Professor and Chair, Environmental Health Sciences, UCLA School of Public Health

**Jim Mangia**, MPH, President and CEO of St. John's Well Child and Family Center

**Elizabeth "Beth" McGlynn**, PhD, Director, Kaiser Permanente's Center for Effectiveness and Safety Research

**Lenny Mendonca**, MBA, Senior Partner, McKinsey & Company, San Francisco

**Mary Pittman**, DrPH, President and CEO, Public Health Institute (PHI)

**Wells Shoemaker**, MD, Medical Director, California Association of Physician Groups and co-chair California Quality Collaborative

**Steve Shortell**, PhD, MPH, MBA, Blue Cross of California Distinguished Professor of Health Policy and Management and Dean, School of Public Health at the University of California, Berkeley

**Anthony Wright**, Executive Director, Health Access

**Ellen Wu**, MPH, Executive Director, California Pan-Ethnic Health Network

## Appendix V: Guiding Principles

1. All recommendations shall be based on the best available evidence.
2. Addressing the challenges will require recognition of policies emphasizing the important roles that education, housing, transportation, the workplace and other sectors play in promoting healthy individuals living in healthy communities.
3. Particular focus should be given to reducing the inequalities in health status and health care focusing on vulnerable populations and communities in the state.
4. The recommendations should aim to control health care costs and be fiscally prudent.
5. The recommendations should include opportunities to promote personal responsibility for individual health.
6. The recommendations should consider the strategies for implementation, sustainability over time, and diffusion and spread throughout the state.
7. All recommendations should have associated with them performance indicators to assess the degree of achievement over time.
8. The recommendations should serve as a long-run agenda for the state that transcends changes in public and private sector leadership while taking into account that as some of the objectives are achieved and sustained, they may be replaced by other objectives, and that changes in leadership also bring fresh new perspective for making California the healthiest state in the nation.

Appendix VI: Process





## Appendix VII: Dashboard

To select the indicators, the availability of national data was first assessed, since national data would enable California's progress to be compared to other states. Where such data are not available, or where California data are superior, state data sources were identified. While several key indicators<sup>27</sup> do not have ongoing funding sources at this time, recent baseline data are available and the Task Force recommends them for inclusion in the Dashboard.

To select the ten-year targets, the Task Force first reviewed baseline data for California and the nation for the chosen indicators. In many cases California's current baseline is the same as or exceeds the national baseline, and in some instances already exceeds national 2020 targets for improvement. Because California is striving to be the healthiest state in the country, the Task Force believes that we should set goals that match our ambition; thus, in most cases California targets exceed national targets.

The underlying principle that guided the establishment of the ten-year targets is that California can only become the healthiest state in the nation if we close the race and ethnicity gaps by raising *everyone's* health to the highest outcomes that we know can be achieved. Thus, each indicator was analyzed by race and ethnicity, to the extent data are available, and the best rating was chosen for the 2022 target. For example, California's current infant mortality rate is 5 per 1,000 live births—two percentage points lower than the national average. Within that rate, however, there is great variation. African Americans in California have an infant mortality rate of 11 while Whites and Asian Americans' rates are 4. Therefore, the state target for 2022 is 4 with the aim of improving outcomes overall and closing the disparity gap.

If data by race and ethnicity are not available, national targets were assessed for their potential. Lastly, where no pre-established targets exist, the Task Force relied on the expertise of the state staff team, in conjunction with Task Force members who co-chaired webinars, to recommend 2022 targets.

The 39 total indicators represent a full range of issues that, taken together, will paint a picture of whether Californians are becoming healthier or not over time. It is not an exhaustive list by design. Rather, these select indicators will spur actions that will collectively make a measurable difference.

In addition to the 39 indicators, nine indicators have been identified for which data are not yet available, but which are integral to the Dashboard. The last table in this Dashboard identifies them. The Task Force strongly encourages public, private and philanthropic partners to prioritize efforts to advance the development and collection of these data.

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<sup>27</sup> Adverse childhood experiences and childhood mental health and well-being

## LET'S GET HEALTHY CALIFORNIA TASK FORCE REPORT

### Health across the Lifespan: Indicators, Baselines, and Targets

Leading Indicator			CA Baseline	2022 CA Target <sup>28</sup>	National Baseline	2020 National Target	Disparities <sup>29</sup>
Healthy Beginnings: Laying the Foundation for a Healthy Life							
1	Infant Mortality, Deaths per 1,000 Live Births		5	4	7	Not Available	White/Asian: 4 Af. Am.: 11
2	All doses of recommended vaccines for children 19-35 months		68%	80%	70%	80%	Not Available
3	Respondents indicating at least 1 type of Adverse Childhood Experiences <sup>30</sup>		59%	45%	Not Available	Not Available	Other <sup>31</sup> : 45% White: 62%
4	Reduce Incidents of nonfatal child maltreatment (including physical, psychological, neglect, etc.) per 1,000 children		9	3	9	8	Asian/P.I.: 3 Af. Am.: 25
5	Proportion of third grade students whose reading skills are at or above the proficient level		46%	69%	Not Comparable	Not Comparable	Asian: 69% Hisp/Lat.: 33%
6	Emergency department visits, 0-17 years due to asthma per 10,000		73	28	103	Not Available	Asian/P.I.: 28 Af. Am.: 236
7	Percentage of “physically fit” children, who score 6 of 6 on the required California school Fitness-gram test	5 <sup>th</sup> graders	25%	36%	Not Available	Not Available	White: 36% Hisp./Lat.: 19%
		7 <sup>th</sup> graders	32%	46%	Not Available	Not Available	Asian: 46% Hisp/Lat, P.I.: 25%
		9 <sup>th</sup> graders	37%	52%	Not Available	Not Available	Asian: 52% P.I.: 27%
8	Proportion of adolescents who meet physical activity guidelines for aerobic physical activity		15%	24%	18%	20%	Af. Am.: 24% Asian: 9%
9	Adolescents who drank 2 or more glasses of soda or other sugary drink yesterday		27%	17%	20%	Not Available	Asian: 17% 2+ Races: 38%
10	Adolescents who have consumed fruits and vegetables five or more times per day		20%	32%	Not Comparable	Not Comparable	Placer County: 32% Orange County: 15%
11	Proportion of children and adolescents who are obese or overweight	2-5 yrs.	12%	9%	11%	10%	White: 9% Hisp./Lat: 15%
		6-11 yrs.	12%	8%	17%	16%	2+ Races: 8% Hisp./Lat.: 16%
		12-19 yrs.	18%	12%	18%	16%	Asian: 12% Hisp./Lat.: 24%
12	Proportion of adolescents who smoked cigarettes in the past 30 days		14%	10%	20%	16%	Asian/P.I.: 10% White: 15%
13	Frequency of sad or hopeless feelings, past 12 months	7 <sup>th</sup> graders	28%	25%	Not Available	Not Available	Male: 25% Female: 31%
		9 <sup>th</sup> graders	31%	24%	Not Available	Not Available	Male: 24% Female: 36%
		11 <sup>th</sup> graders	32%	27%	Not Available	Not Available	Male: 27% Female: 37%

<sup>28</sup> Proposed 2022 CA targets for improvement are the score for the best ranking race/ethnicity group for indicators for which race/ethnicity data is available and applicable. In some instances other disparity measures such as income or geography were used.

<sup>29</sup> Race/Ethnicity Disparities represent the score for the worst ranking race/ethnicity group for indicators for which race/ethnicity data is available.

<sup>30</sup> To be collected 2013

<sup>31</sup> Represents a combination of Asian, Hawaiian/Pacific Islander, and Native American/Alaska Native

## LET'S GET HEALTHY CALIFORNIA TASK FORCE REPORT

### Health across the Lifespan: Indicators, Baselines, and Targets

Leading Indicator			CA Baseline	2022 CA Target <sup>32</sup>	National Baseline	2020 National Target	Disparities <sup>33</sup>
Living Well: Preventing and Managing Chronic Disease							
14	Overall health status reported to be good, very good or excellent		85%	90%	83%	91%	2+ Races: 90% Am In/AK Nat: 75%
15	Proportion of adults who meet physical activity guidelines for aerobic physical activity		58%	66%	44%	48%	MultiRacial: 66% Hisp./Lat.: 50%
16	Adults who drank 2 or more sodas or other sugary drinks per day		20%	10%	Not Available	Not Available	Asian: 15% Latino: 26%
17	Adults who have consumed fruits and vegetables five or more times per day		28%	34%	24%	Not Available	\$35,000 – \$50,000: 34% < \$20,000: 24%
18	Proportion of adults who are current smokers		12%	9%	21%	12%	Asian/P.I.: 9% Af. Am.: 17%
19	Percent of adults diagnosed with hypertension who have controlled high blood pressure		Medicare 79% PPOs 50% HMOs 78%	Medicare 87% PPOs 70% HMOs 86%	46%	65% by 2017	N/A
20	Percent of adults diagnosed with high cholesterol who are managing the condition		Medicare 76% PPOs 50% HMOs 70%	Medicare 91% PPOs 70% HMOs 84%	33%	65% by 2017	N/A
21	Proportion of adults who are obese		24%	11%	34%	31%	Other <sup>34</sup> : 11% Af. Am.: 33%
22	Prevalence of diagnosed diabetes, per 100 adult		9	7	9	Not Available	White: 7 Af. Am.: 14
23	Proportion of adolescents (12-17 years old) and adults (18 years and older) who experience a Major Depressive Episode	Adolescents	8%	7%	8%	7%	N/A
		Adults	6%	5%	7%	6%	N/A
End-of-Life: Maintaining Dignity and Independence							
24	Terminal hospital stays that include intensive care unit days		22%	17%	17%	Not Available	N/A
25	Percent of California hospitals providing in-patient palliative care		53%	80%	Not Available	Not Available	N/A
26	Hospice enrollment rate		39%	54%	42%	Not Available	White: 54% Hispanic: 10%

<sup>32</sup> op.cit., p. xxii

<sup>33</sup> op.cit., p. xxii

<sup>34</sup> op.cit., p. xxii

## LET'S GET HEALTHY CALIFORNIA TASK FORCE REPORT

### Pathways to Health: Indicators, Baselines, and Targets

Leading Indicator			CA Baseline	2022 CA Target <sup>35</sup>	National Baseline	2020 National Target	Disparities <sup>36</sup>
Redesigning the Health System: Efficient, Safe, and Patient-Centered Care							
27	Percent of patients receiving care in a timely manner	Primary Care Physicians	76%	78%	Not Available	Not Available	White/English Speaking: 78% Asian/Non-English Speaking: 72%
		Specialists	77%	79%			White/English Speaking: 79% Asian/Non-English Speaking: 68%
28	Percent of patients whose doctor’s office helps coordinate their care with other providers or services	Child/Adolescent	67%	94% <sup>37</sup>	69%	Not Available	N/A
		Adult HMO	75%				
29	Preventable Hospitalizations, per 100,000 population <sup>38</sup>		1,243	Top 5 counties: 727	1,434	Top 3 states: 818	Top 5 Counties: 727 Worst 5 Counties: 1853
30	30-day All-Cause Unplanned Readmission Rate (Unadjusted)		14%	25% reduction per hospital	14%	12% by 2013	N/A
31	Incidence of measureable hospital-acquired conditions <sup>39</sup>		1 per 1,000 discharges	See footnote #40	Not comparable	Not Comparable	N/A
Creating Healthy Communities: Enabling Healthy Living							
32	Number of healthy food outlets as measured by Retail Food Environment Index		11%	21% <sup>41</sup>	10%	Not Available	Santa Cruz: 21% Sutter: 9%
33	Annual number of walk trips per capita		184	233	186	Not Available	Urban: 233 Town/Rural: 121
34	Percentage of children walk/bike/skate to school		43%	51%	Not Available	Not Available	Latino: 51% White: 33%
35	Percent of adults who report they feel safe in their neighborhoods all or most of the time		91%	96%	Not Available	Not Available	White: 96% Latino: 85%

<sup>35</sup> op.cit., p. xxii

<sup>36</sup> op.cit., p. xxii

<sup>37</sup> Staff recommended a 40 percent improvement in 10 years

<sup>38</sup> The California statewide rates are age-sex adjusted. The 2022 target represents the 2011 age-sex adjusted rate for the five best performing counties (Marin, Placer, Inyo, Santa Barbara and San Mateo) with more than 100 cases. Disparity measures are based on geography, highlighting the 2011 age-sex adjusted rate for the best performing (see above) and worst performing counties (Butte, Kings, Kern, Tulare and Yuba) with more than 100 cases.

<sup>39</sup> Agency for Healthcare Research and Quality Patient Safety Indicator (PSI) Composite measure. This composite consists of only eight hospital-acquired conditions (pressure ulcers, iatrogenic pneumothorax, central venous catheter-related blood stream, infection, accidental puncture or laceration, and any of the following after surgery: hip fracture, sepsis, wound dehiscence, pulmonary embolism or deep vein thrombosis) so the rate may be lower than other commonly used hospital acquired condition measures.

<sup>40</sup> Further composite metrics and all-cause harm metrics will be developed in the next ten years

<sup>41</sup> Target and disparities are based on RFEI data for counties with population size greater or equal to 35,000

## LET'S GET HEALTHY CALIFORNIA TASK FORCE REPORT

### Pathways to Health: Indicators, Baselines, and Targets (cont.)

Leading Indicator			CA Baseline	2022 CA Target <sup>42</sup>	National Baseline	2020 National Target	Disparities <sup>43</sup>
<b>Lowering the Cost of Care: Making Coverage Affordable and Aligning Financing to Health Outcomes</b>							
36	Uninsurance rate	Point in time	15%	5%	15%	Not Available	2+ Races: 8% Am In/AK Nat: 23%
		Some point in the past year	21%	10%	20%	Not Available	White: 14% Am In/AK Nat: 31%
		For a year or more	11%	4%	11%	Not Available	White: 6% Am In/AK Nat: 21%
37	Health care cost (Total premium + OOP) as % of median household income <sup>44</sup>	Families	22%	23%	26%	Not Available	N/A
		Individuals	13%	13%	20%		
38	Compound Annual Growth Rate (CAGR) by total health expenditures and per capita costs. For comparison, CAGR by Gross State Product is included		Total: 7% Per Capita: 6% GSP: 4%	No greater than CAGR for GSP	Total: 7% Per Capita: 6% GDP: 4%	Not Available	N/A
39	High numbers of people in population managed health plans		48%	61%	23%	Not Available	Af. Am: 61% Am In/AK Nat: 41%

### Indicators for which further data collection and/or indicator development is needed:

Leading Indicator
<b>Healthy Beginnings: Laying the Foundation for a Healthy Life</b>
School-readiness
Prevalence of diagnosed diabetes in adolescents
<b>Living Well: Preventing and Managing Chronic Disease</b>
Effectively treating depression
<b>End-of-Life: Maintaining Dignity and Independence</b>
Advanced Care Planning
<b>Redesigning the Health System: Efficient, Safe, and Patient-Centered Care</b>
Percent of patients who had difficulty finding a provider who would accept new patients (primary care, specialty care including mental health specialists)
Linguistic and cultural engagement
Sepsis-related mortality
<b>Lowering the Cost of Care: Making Coverage Affordable and Aligning Financing to Health Outcomes</b>
Transparent information on both the cost and quality of care
Most care is supported by payments that reward value

<sup>42</sup> op.cit., p. xxii

<sup>43</sup> op.cit., p. xxii

<sup>44</sup> op.cit., p. 23

**Appendix VIII: Data Sources**  
**Health across the Lifespan: Data Sources**

Leading Indicator		CA Source	CA Source Detail	National Source
<b>Healthy Beginnings: Laying the Foundation for a Healthy Life</b>				
1	Infant Mortality, Deaths per 1,000 Live Births	CDPH Birth and Death Records, Vital Statistics Query System 2010; California Birth and Death Statistical Master Files 2000-2010	County Level; Race/Ethnicity; Age of Infant	National Vital Statistics System - Linked Birth and Infant Death Data (NCHS, NVSS n.d.). Reported in the 2005 and 2007 CDC Health, United States publication
2	All doses of recommended vaccines for children 19-35 months	National Immunization Survey, 2010	Some Counties; Race/Ethnicity; Date of vaccination, Ongoing collection	National Immunization Survey, 2010
3	Respondents indicating at least 1 type of Adverse Childhood Experiences	Behavioral Risk Factor Surveillance System 2008 & 2009 combined, CDPH	State, county can be determined; Race/Ethnicity; Age; Gender; Income; Education, not currently collected	Not Available
4	Reduce Incidents of nonfatal child maltreatment (including physical, psychological, neglect, etc.) per 1,000 children	CA Department of Social Services, CWS/CMS Dynamic Report System, 2011	County Level; Race/Ethnicity, Age, Gender	National Child Abuse and Neglect Data System, 2008
5	Increase the proportion of third grade students whose reading skills are at or above the proficient level	CDE, Standardized Testing and Reporting (STAR) Results, <a href="http://star.cde.ca.gov/">http://star.cde.ca.gov/</a> June 2011 as reported in kidsdata.org	County, School District, Race/Ethnicity, Economically Disadvantaged or Advantaged, no comparable US data	No Comparable Measure
6	Emergency department visits, 0-17 years due to asthma per 10,000	State of California, California Department of Public Health, California Breathing, using OSHPD Emergency Department Data, 2010	County Level; 2010; Zip code; Payer type; Race/Ethnicity; Gender; Age	National Hospital Ambulatory Medical Care Survey, 2004
7	Percentage of “physically fit” children, who score 6 of 6 on the required California school Fitness-gram test	California Department of Education Dataquest; 2010-2011 California Fitness Report; Meeting HFZ Summary Report; Ethnicity Summary Report	Statewide, County, District Level; Gender; Grade Level; Economic Groupings, collected annually	No Comparable Measure
8	Proportion of adolescents who meet physical activity guidelines for aerobic physical activity	California Health Interview Survey 2009	Some County; Race/Ethnicity; Age; Gender, Income, Biennial survey	National Prevention Council, <i>National Prevention Strategy</i> , Washington, DC:
9	Adolescents who drank 2 or more glasses of soda or other sugary drink yesterday	California Health Interview Survey 2009	Some County; Race/Ethnicity; Age; Gender, Income, Biennial survey	Centers for Disease Control and Prevention: Youth Risk Behavior Surveillance - United States, 2009
10	Adolescents who have consumed fruits and vegetables five or more times per day	California Health Interview Survey 2009	Some County; Race/Ethnicity; Age; Gender, Income, Biennial survey	Centers for Disease Control and Prevention: Youth Risk Behavior Surveillance - United States, 2009
11	Proportion of children and adolescents who are obese	California Health Interview Survey 2009	Some County; Race/Ethnicity; Age; Gender, Income, Biennial survey; Includes children who are overweight and obese	National Health and Nutrition Examination Survey, Centers for Disease Control and Prevention, National Center for Health Statistics
12	Proportion of adolescents who smoked cigarettes in the past 30 days	2010 California Youth Tobacco Survey	County Level, Biennial survey	National Prevention Council, <i>National Prevention Strategy</i> , Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011
13	Frequency of sad or hopeless feelings, past 12 months	California Healthy Kids Survey, 2008-2010	Select schools, Grade Level, Gender, Race	No Comparable Measure



## LET'S GET HEALTHY CALIFORNIA TASK FORCE REPORT

### Health across the Lifespan: Data Sources (cont.)

Leading Indicator		CA Source	CA Source Detail	National Source
<b>Living Well: Preventing and Managing Chronic Disease</b>				
14	Overall health status reported to be good, very good, or excellent	California Health Interview Survey 2009	Some County; Race/Ethnicity; Age; Gender, Income, Biennial survey	Behavioral Risk Factor Surveillance System 2011
15	Proportion of adults who meet physical activity guidelines for aerobic physical activity	Behavioral Risk Factor Surveillance System 2011	State, county can be determined; Race/Ethnicity; Age; Gender; Income; Education, ongoing collection	National Prevention Council, National Prevention Strategy, Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011
16	Adults who drank 2 or more sodas or other sugary drinks per day	California Health Interview Survey 2009	Some County; Race/Ethnicity; Age; Gender, Income, Biennial survey	Not Available
17	Adults who have consumed fruits and vegetables five or more times per day	Behavioral Risk Factor Surveillance System 2009	State, county can be determined; Race/Ethnicity; Age; Gender; Income; Education, ongoing collection	Behavioral Risk Factor Surveillance System 2009
18	Proportion of adults who are current smokers	Behavioral Risk Factor Surveillance System 2011	State, some county can be determined; Race/Ethnicity; Age; Gender; Income; Education, ongoing collection	National Prevention Council, National Prevention Strategy, Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011
19	Percent of adults diagnosed with hypertension who have controlled high blood pressure	Integrated Healthcare Association, California Pay for Performance Program, Measurement Year 2011 P4P Manual; National Committee for Quality Assurance	Plan Specific	Centers for Disease Control and Prevention, National Health and Nutrition Examination Survey (NHANES), 2005-2008
20	Percent of adults diagnosed with high cholesterol who are managing the condition	Integrated Healthcare Association, California Pay for Performance Program, Measurement Year 2011 P4P Manual; National Committee for Quality Assurance	Plan Specific	Centers for Disease Control and Prevention, National Health and Nutrition Examination Survey (NHANES), 2005-200
21	Proportion of adults who are obese	Behavioral Risk Factor Surveillance System 2011	Some County; Race/Ethnicity; Age; Gender; Income; Education, ongoing collection	National Health and Nutrition Examination Survey, Centers for Disease Control and Prevention, National Center for Health Statistics
22	Prevalence of diagnosed diabetes, per 100 adult	Behavioral Risk Factor Surveillance System 2010	State, some county can be determined; Race/Ethnicity; Age; Gender; Income; Education, ongoing collection	Behavioral Risk Factor Surveillance System 2010
23	Proportion of adolescents (12-17 yrs. old) and adults (18 yrs. and older) who experience a major depressive episode	National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration	No county level	National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration
<b>End-of-Life: Maintaining Dignity and Independence</b>				
24	Terminal hospital stays that include intensive care unit days	The Dartmouth Atlas analysis of claims data for Medicare FFS patients in 2010	State Level, Gender, Race/Ethnicity	The Dartmouth Atlas analysis of claims data for Medicare FFS patients in 2010
25	Percent of California hospitals providing in-patient palliative care	When Compassion is the Cure: Progress and Promise in Hospital-Based Palliative Care, a statewide survey sponsored by the California HealthCare Foundation, conducted by UCSF	A repeat survey is funded by the California HealthCare Foundation	Not Available
26	Hospice enrollment rate	2010 Medicare claims files, analyzed by the California Hospice and Palliative Care Association	State Level, Race/Ethnicity, some sources going forward	2010 National Data Set (NDS), maintained and analyzed by NHCPO

## LET'S GET HEALTHY CALIFORNIA TASK FORCE REPORT

### Pathways to Health: Data Sources

Leading Indicator		CA Source	CA Source Detail	National Source
<b>Redesigning the Health System: Efficient, Safe, and Patient-Centered Care</b>				
27	Percent of patients receiving care in a timely manner	Integrated Healthcare Association, California Pay for Performance Program, Measurement Year 2011 P4P Manual; National Committee for Quality Assurance	Race/Ethnicity; Health Plan	Not Available
28	Percent of patients whose doctor's office helps coordinate their care with other providers or services	California Health Interview Survey Adolescent Survey, California Health Interview Survey Child Survey Biennial survey; Integrated Healthcare Association, California Pay for Performance Program, Measurement Year 2011 P4P Manual; National Committee for Quality Assurance	Some County; Race/Ethnicity; Age; Gender, Income; Health Plan	Health Resources and Services Administration, Maternal and Child Health Bureau; Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health, 2007
29	Preventable Hospitalizations, per 100,000 population	State of California, Office of Statewide Health Planning and Development, Healthcare Information Division, Agency for Healthcare Research and Quality (AHRQ), Prevention Quality Indicator Composite, Version 4.4, generated from the Patient Discharge Data, 2011.	County Level; Zip code; Payer type; Race/Ethnicity; Gender; Age; Acute or Chronic Condition	Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project, Nationwide Inpatient Sample, and AHRQ Quality Indicators, modified version 4.1, 2000-2008
30	30-day All-Cause Unplanned Readmission Rate (Unadjusted)	State of California, Office of Statewide Health Planning and Development, Healthcare Information Division, Patient Discharge Data, 2011.	Payer type; Race/Ethnicity; Gender; Age	Centers for Medicare and Medicaid Services, March 2012
31	Incidence of measureable hospital-acquired conditions	State of California, Office of Statewide Health Planning and Development, Healthcare Information Division, AHRQ Patient Safety Indicator (PSI) Composite generated from the Patient Discharge Data, 2011	Statewide	Agency for Healthcare Research and Quality, Inpatient Quality Indicators, version 4.4
<b>Creating Healthy Communities: Enabling Healthy Living</b>				
32	Number of healthy food outlets as measured by Retail Food Environment Index	CDC State Indicator Report on Fruits and Vegetables, 2009, indicators derived from HP 2020 objectives; and CDC Children's Food Environment State Indicator Report, 2011	Census Tract Level	CDC State Indicator Report on Fruits and Vegetables, 2009, indicators derived from HP 2020 objectives; and CDC Children's Food Environment State Indicator Report, 2011
33	Annual number of walk trips per capita	National Household Transportation Survey 2009, CA add-on sample and CA HH Travel Survey (CalTrans 2010-11); McGuckin, N., Walking and Biking in California: Analysis of the CA-NHTS, UC Davis Institute of Transportation Studies, Research Report - UCD-ITS-RR-12-13, August 2012	5 year survey	National Household Transportation Survey 2009
34	Percentage of children walk/bike to school	California Health Interview Survey 2009	Some County; Race/Ethnicity; Age; Gender, Income, Biennial survey	Not Available
35	Percent of adults who report they feel safe in their neighborhoods all or most of the time	California Health Interview Survey 2009	Some County; Race/Ethnicity; Age; Gender, Income, Biennial survey	Not Available

Pathways to Health: Data Sources (cont.)

Leading Indicator		CA Source	CA Source Detail	National Source
Lowering the Cost of Care: Making Coverage Affordable and Aligning Financing to Health Outcomes				
36	Uninsurance rate	California Health Interview Survey 2009	Some County; Race/Ethnicity; Age; Gender, Income, Biennial survey	National Health Interview Survey 2011; continuous collection
37	Health care cost (Total premium + OOP) as % of median household income, family and individual	Median income data comes from the Census Bureau's American FactFinder, based on the American Community Survey. Premium data for individual and family coverage comes from the annual Kaiser Family Foundation/California HealthCare Foundation Employer surveys. Out-of-pocket (OOP) spending data comes from the Medical Expenditure Panel Survey (MEPS) Consolidated Data File (5,803 individual California observations in 2009).	National Level; State Level and Metropolitan Areas	Median income data comes from the Census Bureau's American FactFinder, based on the American Community Survey. Premium data for individual and family coverage comes from the annual Kaiser Family Foundation/California HealthCare Foundation Employer surveys. Out-of-pocket (OOP) spending data comes from the Medical Expenditure Panel Survey (MEPS) Consolidated Data File (5,803 individual California observations in 2009).
38	Compound Annual Growth Rate (CAGR) by total health expenditures and per capita costs. For comparison, CAGR by Gross State Product is included	CMS State Health Expenditures, 2000-2009	National Level; State Level	Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census.
39	High numbers of people in population managed health plans	California Health Interview Survey 2009	Some County; Race/Ethnicity; Age; Gender, Income, Biennial survey	Kaiser Family Foundation State Health Facts. State HMO Penetration Rate, July 2011 based on HealthLeaders, Inc. Special Data Request, June 2012.

## Appendix IX: Contributing Organizations

Our special thanks are extended to the following organizations for their technical assistance:

- ❖ California Chronic Care Coalition (CCCC)
- ❖ The California Department of Education (CDE)
- ❖ The California HealthCare Foundation (CHCF)
- ❖ The Center for Health Professions, University of California, San Francisco
- ❖ Coalition for Compassionate Care of California (CCCC)
- ❖ Integrated Healthcare Association (IHA)
- ❖ The California Office of Patient Advocate (OPA)
- ❖ Pacific Business Group on Health (PBGH)
- ❖ Prevention Institute
- ❖ Public Health Institute (PHI)
- ❖ The School of Public Health and the Goldman School of Public Policy, University of California, Berkeley
- ❖ State Health Access Data Assistance Center (SHADAC) at University of Minnesota

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