

# **2008 State Health Report**

**Washington State Board of Health**

**Proposed Text**

**Interagency Discussion Draft**

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**NOTICE:** This is a discussion draft produced by Board and is subject to change. It has not been reviewed by other state health care agencies or the Office of Financial Management. Once other agencies have had an opportunity for comment, and the Board has reviewed any changes made in response to those comments, it will be transmitted to the Governor as a proposed draft. The Governor will then decide whether to approve, modify or reject the report.

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## Introduction

Since 1990, the State Board of Health has been responsible for producing a biennial report “that outlines the health priorities of the ensuing biennium.” RCW 43.20.50 specifies that the report must be produced in even-numbered years and that the Governor must approve, modify, or disapprove the report. State health reports are intended to be tools state agency administrators can use as guides for preparing agency budgets for an upcoming biennium and for developing legislation to propose to the Legislature. The *2008 State Health Report* is meant to be used during the summer and fall of 2008 to develop budget proposals for the 2009-11 biennium and legislation that agencies would like the 2009 Legislature to consider.

Over the years, these reports have varied in length, format, content, and types of input considered. The public has always been consulted. The Board is required to hold forums across the state every five years, and it held three in 2006. A summary of comments from those forums was part of the *2006 State Health Report*. The Board has typically used polls, surveys, and other tools to gather additional input. It also consults with policy makers and experts in public health and medical care. Since 2001, it has actively solicited suggestions from members of local boards of health, many of whom are elected local officials. And of course, the Board considers the best available scientific data and research findings.

The Board is also required to solicit ideas from the other agencies involved in health issues. In recent years it has gone beyond consultation, trying to be as fully collaborative as possible. When Governor Christine Gregoire took office in 2005, she immediately declared her three health policy goals—contain costs and improve quality, cover all children by 2010, and make Washington the healthiest state in the nation. She convened interagency workgroups to develop specific policy initiatives in each of these areas. In the 2006 report, state agency directors described some of the specific policy proposals that were being developed in response to each of the Governor’s initiatives.

After the 2006 report was finalized, the Governor and former State Senator Pat Thibeaudeau co-chaired the bipartisan Blue Ribbon Commission on Health Care Costs and Access. The commission conducted a robust, comprehensive and highly public policy development process, and released a final report and recommendations in January 2007.

During 2007, the Governor and the Legislature acted on the recommendations that came out of these and other policy development efforts and established an ambitious agenda for improving health care and public health in Washington. That agenda made some significant immediate changes, but it also assigned new policy development and research tasks to several state agencies. In 2009, policy makers will be able to use the results of that work to build on the reforms put in place in 2007.

This report is in three parts. The first part describes the six-point policy agenda recommended by the State Board of Health. The first five strategic directions are drawn directly from the Board’s strategic plan, while the sixth is intended to capture some very important work being undertaken by other agencies, as well as the Governor and the Legislature. They are:

1. Strengthen the public health system
2. Increase access to preventive services
3. Reduce health disparities
4. Encourage healthy behaviors
5. Promote healthy and safe environments
6. Contain costs and improve quality

The second part of this report reviews major elements of the agenda enacted in 2007. It describes key legislation, new initiatives that were launched, and some of the research commissioned that will lay the groundwork for 2009-11. The third section describes the results three long-term planning and policy development initiatives that were mandated in 2007 legislation and led to reports that were available in time for inclusion in this document. These results relate to the strategic policy directions proposed by the Board and they will need to be considered by agencies developing policy and budget recommendations for the 2009 legislative session.

It is important to understand also what this report is not. It is not meant to describe the state of health in Washington—the diseases and injuries we suffer, the causes of death, our health trends, or how Washington compares to other states. That kind of information is available in other documents, such as the Health of Washington State published by the Department of Health. Nor is this report designed to inventory all the things that agencies are currently doing—since there are too many to capture in one document and this report is required to look toward the future. Similarly, it is not meant to capture all the things agencies could or should be doing in the next few years to improve the health of Washingtonians. That information can be obtained from agency strategic plans and other documents. Instead, this report highlights strategic directions—high-level policy initiatives that deserve the attention of the Governor, the Board, and senior managers across state agencies.

## **Part I—Six Strategic Directions**

The Washington State Board of Health is selective about what it includes in its state health reports, focusing each time on a limited number of strategic directions. In recent years, these directions have tended to be similar, addressing in one way or another the capacity of the public health system, health disparities, healthy behaviors, the environment, access to appropriate health services, and the cost and quality of medical care. This year is no different, and this essay lays out the Board's six strategic directions for health policy in the state of Washington.

What is different about this year is the impressive number of policy initiatives across state government that are designed to identify effective ways to address each of these strategic directions. It is important to recognize the Governor and the state Legislature for their focus on improving medical care and public health. This began in 2005 when Governor Christine Gregoire took office and quickly articulated her health policy objectives—contain costs and improve quality, cover all children by 2010, and make Washington the healthiest state in the nation. It continued with the work of the Blue Ribbon Commission on Health Care Costs and Access and the Joint Select Committee on Public Health Finance, and it reached fruition with the passage of several major health bills in 2007. Those bills made immediate strategic investments, but they also mandated a series of research and policy development activities that should point the way toward more changes next biennium. The Board looks forward to policy and budget proposals in 2009 that will address the strategic directions described below.

### **Strengthen the public health system**

Whether by preparing against the potential of a major disease outbreak, keeping food and drinking water safe, teaching kids to eat well and avoid tobacco, or myriad other activities, public health is always working for a safer and healthier Washington. Public health is about understanding, preventing, and controlling disease and injury across our entire population. It is a public-private partnership that improves, protects, and promotes health by applying science to medical practice, personal behavior, and public policy. Hospitals, clinics, and other medical providers focus on delivering care to individuals; public health focuses on the entire community.

The people of this state have repeatedly made it clear in public forums and opinion surveys that they expect a public health system that responds. And they deserve nothing less. Yet even with an infusion of federal and state resources to enhance public health emergency preparedness, funding, and staffing for most local public health agencies in Washington have eroded over the past decade.

The state's public health system is better prepared for an emergency since 2001. Agencies have strengthened partnerships with departments of emergency management, improved disease surveillance and risk communication capabilities, and practiced emergency plans. At the same time, though, a rising rate of obesity puts more of our population at risk for a variety of chronic diseases. HIV and other sexually transmitted disease infections occur at an alarming rate. Injuries continue to be a major cause of death and long-term disability in the young and old. Too many women, especially those with challenges like chemical dependency and family violence, do not receive adequate prenatal care to ensure a healthy start for their infants. A stronger public health system could reverse these trends, and the public expects the system to do just that.

The progress that we have made on diminishing tobacco use is perhaps the best modern example of a public health success story. Fewer young people are smoking and adult users are quitting. A well-resourced, multi-pronged program, one that includes public awareness campaigns, cessation treatment, community- and school-based programs, and evaluation, is responsible for this improvement. Tobacco prevention and control is an example of what the public health system can accomplish with adequate resources.

The Joint Legislative Select Committee on Public Health Financing recommended in 2006 that another \$50 million a year in state funding go to support public health, particularly local public health jurisdictions. The Legislature ended up providing \$10 million. It also directed Secretary of Health Mary Selecky to work in consultation with a variety of partners to identify core public health services and activities that should be available statewide and to establish specific performance measures the new funding should be used to meet. Increased funding and accountability are both key ingredients in building a robust public health system. Budget and policy proposals in 2009 should look to build on the successes of the 2007-09 biennium to further strengthen the capacity of the public health system.

As the state continues to work on increasing access to health care, it should keep in mind the great advances in the health of the population that have come through disease and injury prevention activities such as immunizations, sanitation, and vehicle occupant restraints. Indeed, public health measures are responsible for about 80 percent of the 30-year increase in life expectancy in this country in the past century. Future improvements in health, longevity, and quality of life are likely to come from addressing the social determinants of health such as education and housing—and that, too, is the work of the public health system.

### **Encourage healthy behaviors**

Healthy behaviors contribute to healthy lives. Chronic diseases and injuries rank among the principle causes of injury, illness, and death (morbidity and mortality) today in Washington. Morbidity and mortality can often be prevented or postponed with good nutrition, adequate physical activity, attention to safety, avoidance of harmful substances, and safe sexual behaviors.

Individuals are responsible for their behaviors, but strong policy, a supportive environment, and good information can reinforce individual efforts and promote healthy choices. The reverse can be seen when these elements are lacking. Poor nutrition caused by reliance on fast and pre-prepared foods, as well as physical inactivity related to our dependence on automobile travel, has contributed to the staggering fact that almost one in four Washingtonians are obese. Obesity increases the risk of chronic disease and injuries. Participants at public forums repeatedly expressed concerns about poor nutrition and the need for health care providers to do a better job of identifying and addressing their patients' weight problems

Again, tobacco prevention and control provides a model for success. Smoking rates in Washington are now among the lowest in the nation. Other advances have been achieved in injury prevention by requiring the use of seat belts, child passenger restraints, and helmets. Policy approaches to advancing healthy behaviors are often controversial. Gun control is a good example, as is science-based sex education. It is important that we rely on well-formulated observational and research studies to provide a strong scientific basis for our policy choices.

Healthful behaviors begin early in life when they are encouraged by families, schools, and communities. For example, school districts that have traded fattening snacks in vending machines for healthier food choices have shown that children can and will change their eating habits. New approaches to health and physical education are encouraging youth to be more active. Support for these activities may lead to lifelong healthy nutrition and physical activity behaviors.

The Board is working with many partners to identify and promote effective strategies for reducing obesity, improving nutrition, and increasing physical activity, especially for children. Part III describes a five-year interagency strategy for promoting health by using government health programs to promote healthy behaviors. The plan also recommends ways to improve the delivery of preventive services, another strategic direction discussed below.

### **Promote healthy and safe environments**

Environmental health and protection efforts conducted by local governments, the state Department of Ecology, and other agencies do more than protect natural ecosystems, create recreational opportunities, promote tourism, and improve the quality of life. Because polluted air, water, and soil, as well as contaminated food, have an adverse impact on human health, environmental health and protection can improve the health of the people of Washington. That is why environmental agencies and public health agencies are often critical partners that have overlapping goals and programs.

Toxic air pollutants can lead to birth defects, cancer, and other forms of illness. Millions of pounds of toxic pollutants enter Washington's air each year, primarily from diesel exhaust fumes, gasoline vapors, and wood smoke. The Puget Sound Clean Air Agency has estimated that 700 cancer cases a year in Washington are attributable to airborne toxins. Small airborne particles, especially fine particulates less than 2.5 microns across, contribute to asthma and other lung diseases, sudden infant death syndrome, heart disease, and cancer. The Harvard Six Cities study followed 8,000 people for 16 years and found a 26 percent increase in death rates for people living in areas with elevated levels of particulates in the air. A follow-up study published in 2006 found that 3% fewer people died when fine particulates were reduced by just one microgram per cubic meter.

Contaminants are also found in our water and soil. Some, like mercury, lead, and certain flame retardants, persist in the environment for many years and accumulate in the food supply. Mercury contamination, for example, is associated with nervous system disorders, reproductive problems, learning difficulties, and developmental damage. Children suffer more from exposure to environmental toxins than adults. The Board has long supported the Department of Ecology's efforts, in collaboration with the Department of Health, to reduce the number of "persistent, bioaccumulative toxins" that enter our environment. It looks forward to supporting the chemical action plan for lead that is currently in the works.

Our physical environment can also influence our behaviors in ways that affect our health. If we do not have ready accessible and affordable access to trails, parks, and other recreational facilities, for example, we are less apt to be physically active—and inactivity contributes to our epidemic of obesity. Moreover, the way we construct our "built environment" impacts the rate at

which we consume fossil fuels. When we burn fossil fuels, we contribute to global warming, which could have a significant impact on human health. An interagency workgroup has suggested some possible policy changes that would address global warming by promoting a built environment that supports more walking and greater use of transportation alternatives. In addition, the Board and its partners are working to encourage better communication between urban planners, architects, and local health officials to assure that the physical environments we build support healthy lifestyles.

The Board and the Department of Health are currently working on a new set of rules to help ensure that schools are safer environments for children. Many people who attended the Board's public forums emphasized the need to ensure that children are adequately protected from environmental hazards when they attend school. If these rules are going to be successful in protecting children, schools and public health agencies must have the resources necessary to implement them.

### **Reduce health disparities**

Health disparities are measurable differences in health outcomes experienced by different populations. Unequal distribution of social, economic, and political resources and structures among populations creates inequities and disadvantages for some groups. These inequities result in poor access to societal benefits, increased exposure to risks, and innate predisposing conditions, which underlie health disparities.

People can experience health disparities because of gender, age, race or ethnicity, education, income, language, disability, geographic location, and sexual orientation. Reducing health disparities will require more than improving access to health care since disparities arise from social, economic, and political inequities. Broad health determinants, such as educational attainment, employment, income, lifestyle behaviors, discrimination, and environmental conditions, can all contribute to health disparities. These factors must be identified and addressed.

Health disparities equate to earlier death, greater disease and injury burden, decreased quality of life, loss of economic opportunity, and a sense of injustice for affected populations. Society also suffers from less productivity, higher health care costs, and social injustice. Health disparities can be recognized by such examples as higher tobacco smoking rates and poorer nutrition among less educated Washingtonians, or more use of chewing tobacco among rural men. Higher rates of vaccine-preventable diseases and HIV infection occur among certain racial groups. Birth outcomes also vary by race.

It is the role of the public health system to serve as a convener to carry out the work of reducing health disparities. Populations affected by disparities must be at the table to guide culturally sensitive approaches. Partnerships and coalitions are needed to tackle the broad determinants related to specific health issues.

The 2006 Legislature passed and the Governor signed a package of four bills designed to implement recommendations from the Joint Select Committee on Health Disparities. One new law created the Governor's Interagency Council on Health Disparities, staffed by the Board and

tasked with developing by 2012 a statewide plan for reducing health disparities. The plan may address only five conditions and social determinants of health in its first iteration. In 2007, the Council identified a short list of a dozen health conditions and social determinants of health that it will narrow down to five in 2008. The Council hopes to have the action plan completed before 2012, but it is not likely to be ready in time to influence policy and budget proposals for 2009.

The state is not waiting on that report before taking steps to reduce disparities. Examples of ongoing initiatives include the Department of Social and Health Services' cultural navigator project and a host of activities throughout the Department of Health. The Board is one of the leads in an effort by several agencies and public and private sector partners to concurrently address health disparities and the academic achievement gap.

It is important to remember that this is not a problem that will be addressed solely through medical care and traditional public health interventions. A commitment to greater social, economic, and political equity is the foundation to reducing health disparities and is in the interest of all Washingtonians.

### **Increase access to preventive services**

Polling indicates that Washingtonians' greatest health concern is whether they can access health services when they need them. Personal angst and policy debates center on the rising costs of health care and health insurance. Perhaps the greatest attention has been paid to the number of people who lack insurance. Nationally, that number grew to 47 million in 2006, an annual increase of 2.2 million over 2005, according the Census Bureau. The percentage of businesses providing insurance to their employees dropped from 64% to 60%.

Public forum participants reminded us that even those who have access to insurance worry about rising out-of-pocket costs, increasingly unaffordable premiums, and difficulty getting in to see a provider. Current trends in the way physicians are organizing their practices are expected to make it even harder for low-income people to receive care. Also, it is not enough to have the resources to access services if those services are not even available. Health labor shortages are major contributors to availability problems. Nursing positions go unfilled in hospitals. Emergency rooms close because some specialists are not available to provide certain kinds of coverage. People in rural communities must travel long distances for dental care.

As a public health agency, the Board is particularly concerned about whether people are receiving preventive services, including primary prevention and early screening, diagnosis, and treatment. From 1999 to 2003, the Board underwent a process to identify a core set of health services that should be universally available to ensure a healthy state. After reviewing the scientific evidence and gathering public input, it published a document called the *Menu of Critical Health Services*. Improving access to health services ultimately will require state and federal policy changes. In the meantime, local communities have mobilized to identify and fill gaps. Public health agencies work with community partners to ensure the availability of services, and the "menu" provides guidance about the types of services that public health and its community partners should be most concerned about. As we continue our measured steps toward improving health care access for Washingtonians, this menu also could be used to determine what everyone should receive while we struggle with rising costs and other barriers to access.

When it comes to preventive services, we know access and availability are not the only problems—utilization is also an issue. It does not help when preventive services are available and affordable but providers do not make sure their clients take advantage of them. One recent study of 1,536 children found that they received the indicated care (the care the literature suggests would be best for them) only 46.5% of the time. When they had immediate (acute) medical problems or chronic health conditions, they received the indicated care 67.6% of the time and 53.4% of the time, respectively. But when it came to preventive care, they received the indicated care only 40.7% of the time. We also know that a Medicaid program known as EPSDT—short for Early Prevention, Screening, Diagnosis and Treatment—is significantly underutilized.

One type of service recommended in the *Menu of Critical Health Services* is mental health services. The Board has been working with the Mental Health Transformation Project and numerous other partners to articulate a vision for a prevention-oriented mental health system in Washington State, one that uses a public health approach that promotes mental health, intervenes early to address emerging mental health problems, and reduces the devastating impacts of mental illness. On December 31, 2007, the Board issued a report that will provide the starting point for a discussion about how to better prevent mental illness and promote mental wellness. This will culminate in a statewide summit on May 13, 2008 that will be designed to produce policy recommendations for consideration by the Governor and the 2009 Legislature.

Health care for all, and particularly for children, is a worthwhile investment for Washington, and this has been a priority for Governor Christine Gregoire. She established a target of providing access to health insurance for all children in the state by 2010. The target for adults established by the Blue Ribbon Commission on Health Care Costs and Access is 2012. Several initiatives are now underway in this state to expand access to health insurance, increase the availability of high-quality care, and to create incentives for delivering preventive services at higher rates. These initiatives, which are discussed in parts two and three of this report, include the five-year plan for prevention and health promotion in state health programs that was mentioned above.

### **Increase quality and contain costs**

America spent 16 percent of its gross national product on health care in 2005, according to the federal government. Health care, not housing, is the biggest purchase most of us will make in our lifetime. As a nation, we spent \$2 trillion on health care in 2005, or \$6,697 a person. That is a 6.9 percent increase over the previous year's total. But are we buying the right things, are we receiving what we pay for, and are we getting top quality? According to the World Health Organization, the United States ranks first among nearly 200 member nations in per capita health care expenditures, but it ranks 24th in years of healthy life expectancy.

It is not always best to buy the cheapest product. We commonly consider quality when purchasing a car, yet rarely factor quality into medical purchasing. The Institute of Medicine report *To Err Is Human: Building a Safer Health System* found that medical mistakes cause 44,000 to 98,000 deaths each year—more than HIV/AIDS, breast cancer, or vehicle accidents. The report estimated the annual costs of preventable errors at \$17 billion to \$27 billion.

Government is the primary funder of health care in the United States, according to the Employee Benefit Research Institute and other sources. A major share of government health expenditures comes from state funds and federal funds administered by states. It is not surprising, therefore, that health care is considered the most critical cost driver for state governments. Washington is no exception; health care's share of this state's expenditures is growing and approaching 30 percent. If one includes federal funds appropriated by the state for programs such as Medicaid, the percent of all appropriations that go to provide health insurance, direct care, and public health programs approaches 50 percent.

This trend is unsustainable, and every new dollar spent on health care means less money available for other government services. Moreover, as health care costs rise, the state will have less money to expand access by covering more of the uninsured and underinsured, particularly children. Worse, it will feel pressured to cut back on current enrollment levels or reduce benefits in programs like the Basic Health Plan and Medicaid. That would mean less access to appropriate care.

As a major purchaser of health care services, Washington State is committed to obtaining value, defined as quality divided by price. Cost containment is only one piece of the health care purchasing puzzle. The state can improve value by improving efficiency in contracting and purchasing and by improving patient safety and overall quality of care. The Governor's 2008 supplemental budget made patient safety a priority. It contained almost \$8 million in new spending for initiatives aimed at ensuring providers are qualified, investigating complaints more quickly, strengthening licensing standards for counselors, establishing a database of prescriptions to reduce medication errors, improving access to patient safety reports, and training more nurses.

State government is already involved in several collaborative efforts to increase patient safety. The Washington Patient Safety Coalition, with participation from the Department of Social and Health Services, the Health Care Authority (HCA), the Department of Health (DOH), and provider and insurance organizations, is concentrating on reducing medication errors that occur during the transition from hospital to ambulatory settings. DOH and HCA are members of the Washington State Hospital Association's Safe Table Learning Collaborative, which is working to reduce infections through universal hand washing. The state is also represented on the Leapfrog Group, a national organization currently promoting 13 safe, quantifiable practices to address patient safety. Boeing and HCA are working together to get all of the state's hospitals to participate in a Leapfrog survey that can help identify their strong and weak points. Programs to improve patient safety and quality through evidence-based medicine include the Clinical Outcomes Assessment Program and the Surgical Care Outcomes Assessment Program.<sup>1</sup>

Legislation passed in 2007 required the Health Care Authority to take the lead in working with other state agencies to develop a five-year strategic plan for ensuring that the state is purchasing quality when it comes to health care. A summary of that report is included in Part III.

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<sup>1</sup> Additional patient safety language requested by DOH and HCA, with most of the information in the second paragraph coming from HCA proposed language.

## Part II—Setting the Agenda in 2007

In 2007, the Legislature passed and the Governor signed several landmark health bills. These not only instituted important changes for the 2007-09 biennium, but they also set in motion a series of studies and policy development processes that will set the stage for the 2009-11 biennium. Chief among these are Senate Bill 5093, the Children’s Health Care Act, and Senate Bill 5930, the Blue Ribbon Commission bill. Also of note are House Bill 1088, the children’s mental health bill, and House Bill 1569, which points the state in the direction of establishing a “health insurance partnership” along the lines of the Massachusetts health connector.

Before discussing strategies for the 2009-11 biennium, it is essential to understand the agenda-setting that occurred in 2007 and the many reports that will come due prior to the 2009 legislative session. This section provides an overview of the major bills and the policy development work they require. It will also review two environmental health initiatives that have policy implications for 2009—continuing efforts to reduce the harm from persistent bioaccumulative toxins and an attempt to prepare for the potential impacts global warming may have on human health. The third and final section discusses the findings and recommendations of three five-year plans that were completed prior to the January 2008 deadline for this report.

### Children’s Health

One of the three health care goals Governor Gregoire established early in her administration was that all children in Washington should have health care coverage by 2010. This goal was memorialized in statute in 2005, iterated by the Blue Ribbon Commission on Health Care Costs and Access, and reaffirmed with the passage of Second Substitute Senate Bill 5093, the 2007 Children’s Health Care Act.

**Increasing children’s access to coverage:** Perhaps the most important part of this bill is the establishment of a seamless, integrated children’s health insurance program. All children living in Washington who are under age 19 and whose families earn 250% of the federal poverty level or less are eligible. A family applying for coverage would not need to worry about which federal program they might be eligible for—medical assistance or the State Children’s Health Insurance Program. The Department of Social and Health Services would determine eligibility behind the scenes. The bill called for eligibility levels to be raised to 300% of the federal poverty level by January 1, 2009 “to the extent that funds are specifically appropriated therefore.” At that time, children whose family incomes are above the 300% threshold would be able to purchase unsubsidized coverage through the program. The bill also called for proactive efforts to get families with uninsured children to apply for coverage. The Department of Social and Health Services (DSHS) has begun targeted outreach efforts through schools and community-based organizations and has been developing a marketing and education plan.

**Incentives for providing a medical home:** DSHS, in cooperation with several partners, was required to develop quality measures that could be used to determine whether children have an effective medical home. This work is discussed in Part III. Beginning in 2009, DSHS is to increase reimbursement rates to reward health care providers who meet these quality measures.

**Improving school health:** The bill made several changes related to school health. It established a select interim legislative task force on school health reform charged with making recommendations about school personnel delivering health care and about policies, environmental changes, and programs to improve health, particularly with regard to food choices, physical activity, and fitness. Findings and recommendations are due October 1, 2008. It also established the following goals for the state by 2010:

- Schools would establish school health advisory committees
- Food served in schools would meet nutrition standards specified in the legislation
- Students in grades one through eight would have at least 150 minutes of quality physical education every week
- Health and fitness classes would be taught by certified instructors

### **Blue Ribbon Commission Bill**

The Blue Ribbon Commission bill is an omnibus health care bill requested by the Governor to implement the recommendations of the Blue Ribbon Commission on Health Care Costs and Access. It eventually grew to include 20 distinct initiatives to improve health care in this state. The final bill, Engrossed Second Substitute Senate Bill 5930, was 78 pages long. Some provisions instituted new programs and policies or made specific changes to existing ones. Examples include requiring that by January 1, 2009 all health insurance plans allow coverage of dependents up to age 25; establishing a prescription drug monitoring program; improving the delivery of care to the chronically ill; creating a “health records bank” as part of an effort to encourage greater use of electronic medical records; making scientific journals available to health care providers through the University of Washington library system;<sup>2</sup> and clarifying who bears financial responsibility for providing quality health care to jail inmates. Much of the legislation, however, set in motion various long-term planning activities, established new research and planning entities, required reports on specific topics, and established demonstration projects. In other words, the legislation laid the groundwork for sound policies and programs in the future.

**Paying for quality:** The bill charges the Health Care Authority (HCA) and DSHS with developing a five-year plan for changing the way state health plans reimburse for services. The new payment structure must encourage quality health care that is patient-driven, evidence-based and of proven value. It should promote medical homes, support primary care, help reduce disparities, and encourage better use of health information technology, and it should tie provider rate increases to measurable improvements in access. The plan, completed in September 2007, is discussed in the next section.

**Prevention and promotion:** DSHS, HCA, the Department of Health (DOH), and the Department of Labor and Industries (L&I) were charged with developing a five-year plan for incorporating health promotion and disease and accident prevention efforts into all state health programs. That report, completed August 31, 2007, is discussed in the next section.

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<sup>2</sup> Requested by Department of Corrections

**Public health performance standards:** The Legislature provided an additional \$10 million per year in state funding to support public health and most of that money will go to local health jurisdictions. The Blue Ribbon Commission bill directs the Secretary of Health to work with various public health partners to establish performance measures that will help determine whether the new funds are being spent effectively. DOH must also identify a list of activities and services that constitute core public health functions that have statewide significance. The outcome measures and list of core functions must be established by January 2008 and DOH must report annually on public health's progress in meeting the performance measures.

**Decision aids:** One way to better inform patients and to engage them in decisions about treatment options, particularly elective surgery, may be to use decision making aids that help providers communicate with patients about the benefits, harms, and uncertainties of various treatment options. HCA was charged with implementing a demonstration project and then evaluating that project.

**Quality Forum:** The bill established the Washington State Quality Forum within HCA. It will collaborate with Puget Sound Health Alliance to collect information about health care quality and promote the use of best practices and evidence-based medicine. The forum must report to the Legislature annually, with the first report due September 1, 2007.

**Unnecessary emergency room visits:** HCA and DSHS were required to prepare a report by December 1, 2007 that discussed trends in inappropriate use of emergency rooms. Next, they must partner with health care providers and community-based organizations to develop incentives to discourage overutilization and then set up a demonstration project to determine if the incentives will reduce unnecessary visits.

**Administrative costs:** The Office of the Insurance Commissioner was charged with producing a report by December 1, 2007 that examines the major factors that contribute to high administrative costs for health care and health insurance, and suggests ways to reduce such costs.

**State employee wellness:** HCA was given lead responsibility for developing a wellness program for state employees, their dependents, and retirees. The program must focus on reducing health risks and improving health status. It must establish outcome goals and report to the Legislature on those outcomes in December 2008 and December 2010. It must also establish employee wellness demonstration projects at four selected state agencies, and evaluate the performance of those projects by comparing health outcomes for employees of those agencies against those for the general populations. The results of the demonstration projects must also be reported to the Legislature in December 2008 and December 2010.

**Strategic health planning:** The Office of Financial Management (OFM) was charged with coordinating efforts to improve health care quality, promoting cost-effectiveness, and planning for the availability of health care services and facilities. To do this, it must assemble, organize, and analyze public and private health care data and convene a technical advisory committee. It must issue a strategic health resources plan by January 1, 2010 and update that plan every two years.

**Reinsurance:** OFM and the Office of the Insurance Commissioner (OIC) must jointly conduct a study that examines potential benefits of a state supported-reinsurance plan. They must examine various options and propose a design for the plan. The final report is due to the Legislature and the Governor by September 1, 2008.

**Leveraging federal funds:** DSHS is charged with working with the federal government on waivers and state plan amendments that could make better use of federal dollars in order to sustain and possibly expand coverage of the otherwise uninsured through state programs.

## **Children's Mental Health**

Second Substitute House Bill 1008 redefines legislative intent with regard to providing mental health services to children. The new language places greater emphasis on early detection, early intervention, prevention, and resiliency and recovery. It also calls for peer support, family-centered therapies, evidence-based practices, and culturally and linguistically appropriate services. The bill also requires programmatic changes and studies.

**Access to services and benefits:** DSHS is directed to re-evaluate the access to care standards that determine whether a child is eligible for state-funded mental health services. In addition to looking at the child's diagnosis (and diagnosis criteria must now be age appropriate), the standards must take into account the child's behaviors and whether those are interfering with the child's ability to function within the family, at school, or in the community. No longer must the child demonstrate imminent risk of being hospitalized or taken away from the family. DSHS must also modify the types of services offered to children in state-funded care so the benefits package reflects the new statement of legislative intent. A report with recommendations for the new access to care standards and benefits package is due to the Legislature on January 1, 2009.

**Evidence-based practice institute:** The bill established an Evidence-Based Practice Institute for children's mental health at the University of Washington Division of Public Behavioral Health and Justice Policy. The institute will provide advice to DSHS and communities about evidence-based and promising mental health practices for children and adolescents. It will also help identify performance measures, provide information and resources for families, and train providers.

**Wraparound pilot programs:** The legislation sets up a process for establishing pilot sites (four new and two expanded) that will provide wraparound services. Wraparound refers to a development of a family-driven, community-based, and culturally appropriate plan for a person with mental illness. The plan focuses on the person's strengths and sets goals. The person with mental illness, family members, representatives from entities that provide community support, and mental health professionals work as a team to develop the plan. The EBP Institute will evaluate these pilots and deliver its findings and recommendations by December 1, 2010.

**Medicaid services for confined youth:** Children on Medicaid who are confined currently lose their Medicaid eligibility because they receive care as part of their confinement. The legislation requires that DSHS work to ensure that eligibility is restored the day after confinement ends and that it explore whether eligibility can be maintained when children are placed in a juvenile detention facility temporarily.

**Prescription practices:** DSHS must also examine whether better care coordination and other practices can protect children from misuse and overuse of psychotropic medications.

## **Health Insurance Partnership**

The Blue Ribbon Commission not only affirmed the Governor's goal of covering all children by 2010, it also set a goal that all Washingtonians have access to health coverage by 2012. House Bill 1569 may make that goal more attainable. In the near term, the legislation will help low-income employees of small businesses obtain health insurance, while also helping small businesses by making it more affordable for them to offer coverage. Beginning in September 2008, low-income employees—defined as those whose income does not exceed 200% of the federal poverty level—should be able choose from among at least four health insurance plans and receive subsidies to help them cover the costs of their premiums.

The bill, however, also sets up a process for exploring whether it makes sense to expand the program to incorporate other sectors of the health insurance market. Significantly, the name of the existing Small Employer Health Insurance Program was changed to the more general Health Insurance Partnership. The partnership's governing board must report by December 1, 2008 on the risks and benefits of incorporating the individual and small group markets, and that report could have significant bearing on health policy decisions during the 2009 session. By September 1, 2009, the board must report on the risk and benefits of incorporating the high risk pool, Basic Health, the Public Employees Benefits Board, and public school employees. The 2009 report must also address the impact of requiring all residents over 18 to be covered.

Another report required by this legislation will also be due on December 1, 2008, in time to have an impact on the 2009 session. OIC is charged with commissioning a study on "health benefit mandates, rating requirements, and insurance statutes and rules to determine the impact on premiums and individuals' health if those statutes or rules were amended or repealed."

The 2008 Legislature was expected to consider refinements to this legislation.

## **Environmental Health Initiatives**

**Persistent bioaccumulative toxins:** The *2006 State Health Report* discussed the work done by the Department of Ecology (Ecology) and DOH to identify toxins that are harmful to people, linger in the environment, and accumulate in the food chain, and then to propose ways to reduce their presence. In 2007, Washington State enacted legislation to ban a particular flame retardant if effective alternatives exist. This legislation implemented one of the recommendations in the chemical action plan for a group of chemicals called polybrominated diphenyl ethers (PBDEs). This was the second chemical action plan. The first addressed mercury. The third will address lead. An advisory committee worked on the lead chemical action plan from July 2007 through January 2008. The plan may generate policy proposal for the 2009 legislative session.

**Climate change:** In 2007, Governor Gregoire made clear her intent to ensure that Washington State was prepared for the impacts of climate change. She issued Executive Order 07-02, which, among other things, directed Ecology and the Department of Community, Trade and Economic

Development to determine specific steps the state should take to anticipate the effects of global warming. The Climate Advisory team established five “preparation and adaptation working groups” (PAWGs) comprised of representatives from state and local governments, tribal, business, academic, and public and private organizations. One of these PAWGS dealt with potential impacts to human health. A preliminary draft of the five PAWGs’ recommendations was released for public discussion in December 2007. Some Health PAWG recommendations in the discussion draft can be done within existing authorities, but others, particularly those related to the built environment, suggest a need for statutory changes. The 2008 final report could prompt health-related policy proposals for the 2009 session.

## Part III—Looking ahead to 2009 and beyond

As the preceding section makes clear, health care bills passed by the Legislature and signed by the Governor in 2007 asked a lot of executive departments. Health-related agencies have been charged over the next few years with conducting several new policy development initiatives, and these initiatives will produce reports, launch demonstration projects, and in a couple cases, even establish new health planning entities within existing agencies. Most of these are directly related to one or more of the strategic directions identified by the State Board of Health in Part I.

Many of the reports and strategies required by these bills are not due to be completed until after the January 1, 2008 deadline for this report. Of those completed during 2007, many were preliminary reports or interim studies that will lay the groundwork for future policy proposals. Three reports, however, stand out because they are comprehensive strategic plans that will guide agency activities over the next five years and may raise significant budget and policy issues during the 2009 legislative session. One such report examines prevention and health promotion, a second addresses children's health care, and a third looks at improving health care quality and slowing health care inflation by using the state's purchasing power to encourage value-driven, consumer-oriented care.

Not surprisingly, there is considerable overlap between these three five-year plans. Promoting value-driven care will require addressing the quality of clinical services for children and adolescents, for instance, while ensuring children receive care through a medical home should improve the delivery of key preventive services like immunizations, and one of the best ways to reduce the health care inflation and improve health outcomes is by emphasizing health promotion and prevention. Nevertheless, this section will attempt to summarize each of the plans individually.

These plans specifically address three of the Board's six strategic directions—encourage health behaviors, increase access to preventive services, and increase quality and contain costs. They also each relate to some degree to a fourth strategic direction—reduce health disparities.

The Board looks forward to additional work that will be completed in the next few years that will advance strategic directions related to health disparities, public health infrastructure, and healthy environments. These will include a state action plan for reducing health disparities, a strategy to prepare the state for the impacts of global warming, and a list of public health performance measures. The health disparities plan is being developed by the Governor's Interagency Council on Health Disparities and is due by 2012, although the council hope to complete its plan before then. The global warming report will be completed in 2008, but a discussion draft circulated in late 2007 contained several preliminary recommendations about changing planning regulations in ways that would encourage healthier communities. Finally, recommendations from the secretary of health about public health performance measures, along with a list of core public health services and activities will have been completed by the time this report is published.

## Prevention and Health Promotion

The Blue Ribbon Commission bill directed the state's four major health care agencies—the Health Care Authority and the departments of Health, Social and Health Services, and Labor and Industries—to jointly produce a five-year strategy for integrating health promotion efforts and disease and accident prevention into state purchased health care programs.

They were specifically asked to explore ways to restructure benefit packages, reimbursement systems, and contracts with two ends in mind—to encourage healthy behaviors and to encourage the delivery of preventive services. There were also directed to encourage enrollees in state health plans to complete an assessment of their health, and then to provide appropriate follow up. The plan had to identify existing barriers and opportunities and recommend possible changes to state and federal laws. It also had to identify clear goals and ways to measure and report progress toward achieving those goals. On August 31, 2007, the agencies completed a report to the Governor and the Legislature that described their five-year strategy.

The plan goals call for maintaining an interagency workgroup created in 2007, known as the Cross-Agency Workgroup on Health Promotion and Prevention, to help agencies implement programs that reflect the mandates of the authorizing legislation, build on current strengths and programs, and create greater efficiency across state programs. Much of the report and an appendix more than 40 pages long document the tremendous number of existing state programs that promote wellness and prevention. The goals also call for selecting initiatives that are supported by evidence, are appropriate for the populations served by the agencies, have the greatest potential for success, and reflect the agencies' roles as purchasers and members of a greater health care community. Progress measures will be identified for each initiative.

The report identified 15 barriers that related to a range of issues, including Medicaid reimbursement policies, access barriers for people of color, public misconceptions, system capacity, stakeholder support, and insufficient evidence-based research in some areas.

It also identified eight priority action areas:

- Fitness and obesity, diet and nutrition, prevention of diabetes
- Smoking cessation
- Substance abuse
- Infectious diseases
- Mental health
- Oral health
- Injury, accident, and disability prevention
- Screening for cancer and chronic illness

It then examined the potential for using nine broad types of policy interventions to address the action areas. The interventions are:

- Reimbursement design and provider incentives
- Benefit design and client incentives
- Electronic medical records
- Quality measurement

- Contract standards
- Community collaboratives
- Social marketing and reminders
- Workplace services and incentives
- School health programs

Many of the action areas could benefit from multiple types of intervention. For example, infectious disease prevention could benefit from all nine types of interventions, and social marketing and reminders could contribute to improvements in all eight action areas.

The plan then goes through each of the eight action areas and identifies promising interventions. Many of these are activities already underway in Washington State, but for each action area, the plan provides examples of two to four approaches that could be started or expanded. In the area of mental health, for example, it suggests using depression screening as a contract measure when agencies purchase health care through managed care organizations. In the area of smoking cessation, one policy option would be to provide cessation benefits to state employees at no cost. Another option related to physical activity would be to give employees more flexibility in scheduling their work week so they can find time to exercise.

The plan will extend through July 2012. During the summer and early fall of 2007, the focus was on convening the workgroup, bringing together stakeholders, and gaining input. Through the summer of 2008, the group will continue to evaluate the evidence so it can identify policies and programs that are likely to be the most fruitful and will benefit most from cross-agency collaboration. The group will consider whether interventions can be expected to have success in multiracial or ethnic populations, as well as for clients at different income levels, are likely to reduce disparities, are most appropriate for well or at-risk populations, and are cost effective. It will then make strategic choices about interventions likely to have the greatest impact.

By January 2008, it expects to have identified opportunities for quick success within the eight priority areas. Beginning in September 2008, and continuing through December 2011, the workgroup will help implement three to four key strategies at any given time. It will develop and track performance measures for each strategy, provide annual updates, and request budget and policy changes as needed.

### **Children's Healthcare Improvement**

One of the goals the 2007 Children's Health Care Act was to ensure that all children get regular care from a medical home. A medical home delivers health care in an accessible and continuous, coordinated and comprehensive, family-centered, and compassionate and culturally sensitive manner. Benefits include cost savings and better health outcomes.

The Department of Social and Health Services took the lead in convening a workgroup of agency and community stakeholders to (1) develop performance measures that could indicate whether a child has a medical home, (2) identify targets for those performance measures, and (3) propose a strategy for using increased reimbursements and other incentives to assure that health care

providers and health plans use evidence-based practice to make progress toward meeting those targets.

The workgroup established an overarching goal, which was to outline a framework that would allow it to answer the essential question: Are we improving the health of Washington’s children and how do we know?” The group also established three criteria for its work:

1. Select evidence-based indicators that are linked to improving children’s health.
2. Measure and monitor primary care provider and clinic performance using outcome measures that provide valid and consistent data.
3. Reward primary care providers and clinics that demonstrate adherence to best practice and evidence-based clinical and patient experience performance measures.

The group went on to identify eight guiding principles. Working from those principles, it laid out a five-year, phased-in strategy for implementing the Children’s Healthcare Improvement System (CHIS), a framework designed to assure that health care for children is delivered in a medical home.

During 2009-2010, providers and clinics will be reimbursed at a higher rate for certain kinds of services (identified by billing codes) that are part of the current standards of care, show promise for health improvement, and are historically underutilized. Providers and clinics will be reimbursed for screenings to identify behavioral and developmental delays. The performance data collected during this first phase would be for the entire population.

During the second phase, 2011-2012, performance data related to both the kinds of clinical services provided and the results of patient satisfaction surveys will be collected from providers. That data will be pooled and analyzed at the level of the group practice, not the individual provider. Group practices will be rewarded based on demonstrated improvement and whether they meet certain improvement targets. Population-based data will also be collected and be reported to the public.

In 2013, a third phase will include the public release of information about the performance of specific group practices. The performance measures will also be re-evaluated and may change.

This phased-in approach will allow DSHS to complete its new electronic billing system, define and test performance measures, and educate providers about CHIS. It will also give providers time to make any changes they feel might be necessary before their performance becomes public.

The workgroup also identified a set of structural, process, and outcome measures that will be used to evaluate the success of CHIS. The structural measures relate to whether practices provide care after hours, whether they use the CHILD Profile Immunization Record system, and whether they expand their use of electronic medical records. The process measures relate to the delivery of preventive dental care, on-time immunizations by age two, and well-child care, as well as annual surveys of patient and parent satisfaction. Outcome measures relate to the rate of cavities, the frequency of avoidable emergency room visits, and the number of hospital visits that could have been prevented if the patient had received appropriate and timely outpatient care.

## State Purchasing to Improve Quality

The first section of the Blue Ribbon Commission bill charged the Health Care Authority (HCA) and the Department of Social and Health Services (DSHS) with producing a five-year plan for changing the way the state reimburses providers and facilities for delivery of health care. Specifically, the Legislature asked the agencies to look at changes that could:

- Reward health improvement rather than the delivery of particular services or procedures;
- Pay for care that reflects patient preferences and is of proven value;
- Require the use of evidence-based standards of care where available;
- Tie provider rate increases to measurable improvements in access to quality care;
- Encourage people enrolled in state health care plans to choose quality care systems;
- Support primary care and provide a medical home to all; and
- Create incentives, including increased payments, for providers to use e-mail and telemedicine to improve access to specialty services.<sup>3</sup>

The five-year plan completed in September 2007 emphasizes personal responsibility and the need for consumers to be actively involved in making decisions about their health. It notes that significant changes have come about in other sectors of the economy when consumers, empowered by better access to more information, have become more engaged in decision making. Prevention, health promotion, better chronic disease management, consumer choice, and more transparency about the true costs of health care and differences in the quality of care that being provided could potentially, over time, create a “value-driven” health care system.

The agencies began by envisioning the type of environment they would like to help create and in which they would like to operate. HCA foresees a future environment in which it helps provide the right kind of information to enrollees, providers, health plans, and payers so they can make sound, well-informed decisions. HCA would be focused on purchasing safe, effective, efficient, high quality care. Its members would be healthy and informed consumers. It would be able to offer affordable health plans that gave everyone access to quality, culturally sensitive care that addressed their physical, cognitive, and dental health. The authority would be a high-performing organization that was recognized as a leader and a key partner in improving health care delivery and financing.

DSHS envisions being able to provide an integrated, coordinated, high-quality system of care that ensures that people have medical homes, support primary and preventive care, and provide clients with access to a broad range of services. The health care it provided and purchased would be balanced, affordable, and accessible. Care would be evidence-based as much as possible with little or no variation in quality and access based on geographical location or who was paying the bill. DSHS clients would be healthy and knowledgeable and feel empowered as consumers. The agency would use a common set of outcome measures. Its processes would be streamlined and both consumers and providers would have access to electronic records and know how the system works and what they could expect from it.

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<sup>3</sup> Bullet reworded at request of Labor & Industries.

The five-year plan envisions an incremental and iterative process where the agencies design and implement key initiatives, evaluate their success, and make adjustments as they go along. It has two action stages. Both agencies identified core projects to focus on for the first stage in 2008 and 2009. For the second stage, the agencies will evaluate progress made in the first stage and identify strategies to build on their accomplishments.

Many of the stage one activities are ongoing programs or new ones mandated by recent legislation—but as this report makes clear, that represents a significant body of work. Indeed, more than three dozen activities are identified. They include several initiatives mentioned elsewhere in this report, such as efforts to reduce inappropriate emergency room use, promote better use of health information technology, encourage evidence-based care, and implement employee wellness programs, to name a few.

The goal for this work is to realign the state's focus on health and its approach to purchasing health care services in a way that will support and improve the health of the agencies' clients and enrollees. Providers will be rewarded for delivering evidence-based services and treatment, participating in value-based improvement activities, and promoting efficient and effective services throughout the delivery system. The system will advance transparency and provide information that creates value for the consumer.

Success during the five-year effort will be defined as progress toward a sustained value-driven health care culture, as demonstrated by:

- Increased access to affordable, evidence-based health care.
- Reimbursement policies that reward positive health outcomes and improve access to quality care.
- The delivery of care that is of proven value.
- Enrollees who utilize information and influence to improve their health and health care.
- Pre-enrollees and enrollees who select quality care programs.
- Providers who are encouraged to enter and remain in primary care.
- Meaningful action that supports the delivery of primary care and medical homes for all members.
- Payments across provider types that reflect the value of their contribution to health.
- A slowing of the upward trend in health care spending and enhanced health for each dollar spent.
- Increased ability to share medical information across care providers.
- Collection and use of data across programs to promote quality and efficiency.