WASHINGTON STATE HEALTH PLAN

VOLUME 1:
HEALTH PRINCIPLES, GOALS AND STRATEGIES

Adopted by the State Health Coordinating Council
January 21, 1987

Approved by Governor Booth Gardner
May 12, 1987

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BOOTH GARDNER
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May 15, 1987

Ward C. Miles, M.D., Chair
State Health Coordinating Council
Mail Stop OB-43F
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Dear Mr. Miles:

I am pleased to approve the State Health Plan (SHP) developed by the State Health Coordinating Council under the provisions of the State Health Planning and Resources Development Act (RCW 70.38). This document presents ambitious and worthy objectives for the improvement of health status and development of health services in the state. Executive agencies should take appropriate steps within available resources to assure that their policies are consistent with the directions set forth in this plan.

The content of the State Health Plan has been developed over many months, and there are areas where recent events require an update of the situation described in Volume 1 of the Plan:

Acquired Immune Deficiency syndrome (AIDS). The plan was developed before the scope and severity of the AIDS problem was fully recognized. I am confident that the SHCC, the Department of Social and Health Services and other responsible entities will expand their consideration of this important issue.

Conditions in correctional institutions. The overcrowding of correctional institutions referred to in the plan is mitigated by the opening of a a new state correctional facility at Clallam Bay.

Prenatal Care. Significant movement toward the plan's prenatal care goal has been made in recent months due to legislative action to appropriate additional funds for expansion of the program as I had requested. This action demonstrates the high priority placed on this goal by both the executive branch and the legislature.

Basic health care. Progress also has been made toward the plan's goal of equitable access to health care and the provision of a basic level of health services to all state residents as a result of pending legislative action on the Basic Health Care Plan (House Bill 477).

I want to thank the members of the state Health Coordinating Council and the many health care consumers and providers around the state who contributed to the development of this State Health Plan. Your continuing interest and involvement will help us to develop an efficient and effective health care system and to seek ways to improve the health status of state residents.

Sincerely,

Booth Gardner

Booth Gardner
Governor

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A. INTRODUCTION

NATURE OF THE STATE HEALTH PLAN

The State Health Planning and Resources Development Act (RCW 70.38) authorizes the development of the State Health Plan. Such a strategic plan can promote efficiency in the use of scarce public and private health care resources by clarifying aims and identifying cost-effective means of achieving those aims. A plan can also be a useful way of informing the public about governmental intents and strategies.

The State Health Plan is the product of the state health planning process. Health care consumers, service providers and government officials at the state and local level participate in this consensus-building process. The State Health Coordinating Council (SHCC) believes that citizen participation at the state and local level is essential to effective health policy development and resource allocation decision-making. For this reason they advocate the maintenance of regional health councils referenced in RCW 70.38.085.

Citizens involved in the health planning process cooperatively identify health problems, evaluate alternative solutions to those problems and develop recommedations for appropriate courses of action to be pursued. The results of these efforts are initially presented as draft State Health Plan materials. After receiving extensive public review and comment, the State Health Coordinating Council revises draft plan content as necessary and adopts it for submission to the governor. When approved by the governor, the State Health Plan is a statement of executive branch health policy.

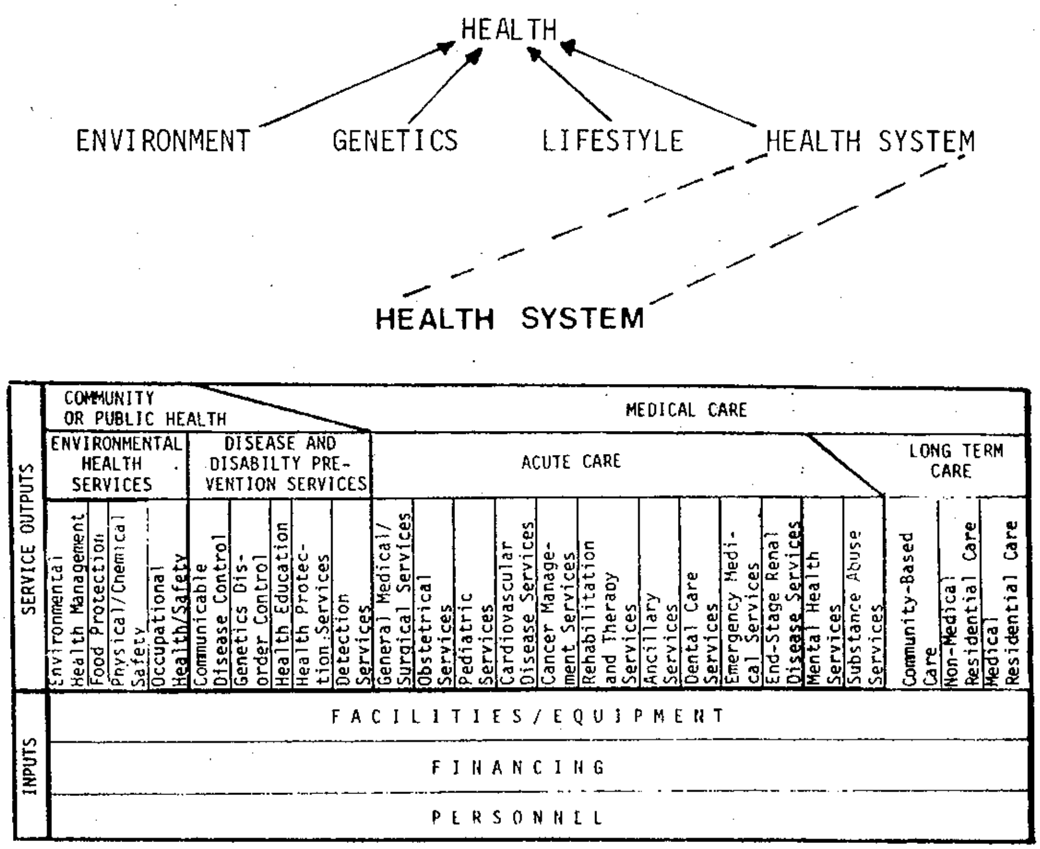
The State Health Plan has two parts. Volume I reviews the health status of state residents and presents health principles, goals, objectives and strategies. Principles and goals are desired, longer-term end-states that may take an uncertain time to attain. Objectives are activities that will help achieve goals and that should be accomplished within a specified time period. Strategies are specific actions that specific actors should carry out to contribute to the completion of objectives by the deadline presented. Initially strategies are viewed as a preliminary list of actions/actors that is suggested, rather than as a specific list of assignments that must be carried out. State agencies may change actions or actors as circumstances warrant, but there should be continuing progress towards attainment of objectives. In the future it is expected that there will be increased state program involvement in the plan development process and that the plan will specify firm deadlines for different objectives and strategies, based on an evaluation of the nature and scope of the actions involved. Then, objectives and strategies can be viewed as specific assignments for which programs are held accountable.

Volume II of the State Health Plan presents health service performance standards. These are the basis for health system monitoring processes. They also provide the basis for state capital expenditure review regulation. In Volume II health service performance standards are arranged by type of service. That volume also contains the methods for forecasting the need for nursing home, general hospital and short-stay psychiatric beds.

SCOPE OF THE PLAN

The figure below presents the scope of the State Health Plan, or universe of issues it covers. Health status is the outcome of four major factors: environment, genetics, lifestyle and "services" (the health system). Research suggests that the health system itself contributes only a minority influence on health status. However, the health system remains the focus of many deliberations because it is often easier to observe and manipulate than the other factors. To provide a common frame of reference, it is shown below as a list of health services, each having inputs (personnel, financing, facilities and equipment) and outputs related to community and individual health. Not all of these relationships can be measured, but where they can be this is a logical framework for discussing many health policy decisions.

FACTORS AFFECTING HEALTH



B. PRINCIPLES TO GUIDE STATE HEALTH POLICY AND PLANNING

The ultimate goal of health planning and the State Health Plan is healthy people. In achieving this goal the health system should move toward the broad ideals reflected in the principles below. These principles are value statements presented to guide the identification of high priority health problems and the development of solutions to those problems.

I. IMPROVEMENT OF HEALTH STATUS IS A MAJOR GOAL OF HEALTH PLANNING. ENVIRONMENTAL, LIFESTYLE AND BIOLOGICAL FACTORS ARE THE MAJOR DETERMINANTS OF HEALTH STATUS. INCREASED RESOURCES - BOTH PUBLIC AND PRIVATE - SHOULD BE DEVOTED TO EFFECTIVE, WELL-FOCUSED HEALTH PROMOTION/ILLNESS PREVENTION EFFORTS WHICH INCREASE AWARENESS OF AND REDUCE RISKS ASSOCIATED WITH ENVIRONMENTAL, LIFESTYLE AND BIOLOGICAL FACTORS.

This principle recognizes that knowledge, skills and resources are available to reduce the occurrence of many illnesses and injuries and to promote a safe and healthy environment. It encourages activities and expenditures for preventive services and for increasing people's ability to take responsibility for their own health by living healthy lifestyles, practicing appropriate self-care and making informed choices as consumers of health care and health services. It calls for more resources to be devoted to improving these determinants of health, where cost-effective means can be identified. Public expenditures should be consistent with this principle, and effective preventive/health promotive efforts should be continuously funded. Special emphasis should be placed upon preventive health directed at the school age population.

II. WASHINGTON STATE RESIDENTS SHOULD HAVE EQUITABLE ACCESS TO HEALTH CARE. EQUITABLE ACCESS MEANS A RANGE OF AVAILABILITY AND ACCESSIBILITY WHICH SATISIFIES TWO CONDITIONS: (1) EVERY INDIVIDUAL SHOULD BE GUARANTEED ACCESS TO BASIC HEALTH SERVICES. (2) THE SERVICES AND RESOURCES AVAILABLE TO POPULATIONS (IN THE AGGREGATE) SHOULD FALL WITHIN REASONABLE LIMITS OF AVAILABILITY OR RATES OF USE.

While cost containment is essential, it must be attained within a framework which assures access to needed basic care for all residents, including those who are disadvantaged by low income, limited English or other factors. This principle does not address the issue of protecting people from catastrophic financial burden if they require expensive medical services; basic access problems have been given higher priority.

For health planning purposes, where the focus must be on population aggregates, the usual standard of equity should be a community standard of care within geographic areas, subject to safeguards

against local patterns of over- or under-utilization. Other standards of equity may apply for particular purposes, for example, in planning for regionalized services for which access would require out-of-area travel, or in malpractice suits within the legal system.

III. THE HEALTH CARE SYSTEM SHOULD CONSISTENTLY DELIVER A SATISFACTORY QUALITY OF SERVICE TO ALL MEMBERS OF THE COMMUNITY. SATISFACTORY QUALITY MEANS THAT PREVENTIVE MEDICINE, DIAGNOSIS AND TREATMENT HAVE BEEN DELIVERED IN A COST-EFFECTIVE MANNER THAT MAINTAINS OR IMPROVES THE HEALTH STATUS OF RESIDENTS. THE QUALITY OF INDIVIDUAL SERVICES SHOULD BE MAINTAINED OR IMPROVED THROUGH APPROPRIATE MECHANISMS.

The measurement of quality is a blend of technical standards and consumer preference that varies with each health condition and individual. However, the system must be designed to provide effective health care in a way that best utilizes the services. A quality health care system must include both health promotion and disease prevention components that are accessible and affordable. Effective application of these two strategies can avoid the need for more expensive or less effective diagnostic and treatment strategies.

Appropriate mechanisms for assuring the quality of individual health services may include, depending on circumstances, facility or program licensing, facility or program certification required by payors, credentialing of health professionals, professional peer review, contractually required external utilization review, strategies to improve consumer information and choice, and public community review of prospective changes in services or providers through the Certificate of Need process, among other possibilities.

IV. HEALTH CARE COST CONTAINMENT IS A PRIORITY GOAL FOR THE STATE OF WASHINGTON. ALL INCENTIVES AND STRATEGIES SHOULD BE STRUCTURED TO (1) ENCOURAGE PROVIDERS AND CONSUMERS TO USE THE HEALTH SYSTEM APPROPRIATELY, AND (2) RESTRAIN INCREASES IN HEALTH CARE COSTS.

Health provider revenues reflect the dynamics of charge per unit of service and utilization of these services. There are multiple factors which combine to influence costs of delivering health care. No single solution is likely to "achieve" cost containment. A variety of both regulatory and market forces may be needed. Government should foster the development of strategies in both the private and public sector, such as prospective reimbursement, alternative delivery systems, voluntary-compliance expenditure targets, and price and quality comparison by consumers.

Cost containment efforts should be evaluated and further guided by reference to statewide health system revenue targets. The State Health Coordinating Council should develop methods and procedures (including notice and public hearing) for establishing such targets

on an annual basis. The revenues of both public and private health service provider systems, and their rates of revenue growth, should be monitored and compared to the revenue targets. The revenue targets cannot be legally binding. Therefore, the targets would not be "caps." However, targets are a valuable means to evaluate cost containment outcomes, to establish the logical relationship among the other principles in this section, and to define in concrete terms the goals for decision-making consistent with these principles.

V. AN INCREASED PORTION OF TOTAL HEALTH EXPENDITURES SHOULD BE DEVOTED TO CARING FOR PEOPLE IN THE LEAST RESTRICTIVE SETTINGS WHICH ARE EFFECTIVE AND RESULT IN LOWER TOTAL HEALTH EXPENDITURES.

This principle directs efforts to develop a balanced health care system by increasing the availability of less capital-intensive services (e.g., in clinics or offices rather than hospitals, in less intensive residential programs rather than nursing homes, at home rather than in health institutions). It should be possible for each person to be cared for in the setting that is most appropriate to meet identified individual needs, maintain maximum self-sufficiency and remain consistent with the overall goal of cost containment.

In the near term a relatively larger proportion of resources will need to be directed to establishing the non-capital intensive side of the system. This shift of resources should be carried out in ways which minimize harmful impacts on existing services, institutions and communities.

VI. LONG TERM CARE EXPENDITURES WILL NEED TO INCREASE TO ACCOMMODATE THE GROWING NUMBERS AND INCREASING AGE OF THE USER POPULATION. PLANNING MUST ENSURE THAT INCREASED LONG TERM CARE RESOURCES ARE ALLOCATED AND USED IN THE MOST APPROPRIATE AND COST EFFECTIVE MANNER.

Demographic trends will necessitate our spending proportionally more for long term care services than we do now. However, these expenditures should be carefully monitored in order that total spending stays within any revenue target for long term care. The necessary limitation of total long term care expenditures should be accomplished through efforts that control total current expenditures and support long term development of more cost effective services in this sector.

C. THE HEALTH OF STATE RESIDENTS

INTRODUCTION

Since health is the ultimate goal, measures of the health levels of the population play an important role in the state health planning process. Health status indicators and goals provide a baseline for assessing how healthy people are and for identifying high priority health problems. They can also act as outcome measures for assessing the effectiveness of health strategies and programs that are undertaken. Because of the importance of health status indicators for health program development and implementation, state health planning, the State Health Coordinating Council and Board of Health will increase efforts to develop and refine such benchmarks in the future.

POPULATION

The 1980 Census showed Washington State had a population of 4,132,156, an increase of 21 percent over the 1970 population. The population increase for the 1980s and 1990s will be slower due to the decrease in the birth rate and in-migration (Table 1). Growth among the health planning regions will be uneven. The ten-county Puget Sound Health Planning Region will experience the largest numerical and percentage increase for the coming decades. The growth rate of the elderly will be about twice that of the population below age 65. 1/

Table 1

POPULATION TRENDS IN WASHINGTON STATE AND HEALTH PLANNING REGIONS

	1980 Population	% Age 65+	1990 Population	% Age 65+	2000 Population	% Age 65+	Increase Total	1980-2000 Age 65+.
Washington State	4,132,156	10.4	4,640,459	12.1	5,249,372	12.0	27.0	46.3
Puget Sound Region	2,530,602	10.1	2,904,023	11.7	3,314,800	11.7	31.0	51.6
Southwest Region	594,372	10.8	661,247	12.4	752,903	12.2	26.7	42.5
Central Region	488,220	11.5	524,934	12.3	587,051	12.1	20.2	38.3
Eastern Region	518,962	11.6	550,255	13.5	594,618	13.6	14.6	34.6

Source: Washington Office of Financial Management, 1986 Population Trends for Washington State, August, 1986

Washington State's relatively young and racially homogenous population results in favorable health status comparisons with other states and the nation. However, by 1990 the aging component will have changed significantly and the state's proportion of elderly population will be close to the 12.2 percent forecasted for the nation.

The Puget Sound health planning region will have the greatest numerical and percentage increase in the population over age 64. However, the Eastern Washington health planning region has the largest proportion of elderly in both 1980 and 1990 (Table 1).

The population age group which uses the greatest amount of health resources (over age 74) will increase in the state by 44.9 percent.

Table 2

RACIAL COMPOSITION OF WASHINGTON STATE AND THE U.S.

	1980 Washington	1980 United States	1986 Washington
White	91.5%	83.1%	90.1%
Black	2.6%	11.7%	3.0%
Asian/Pacific Islander	2.5%	1.4%	3.5%
American Indian/Eskimo/Aleut	1.5%	.6%	1.5%
Other	2.0%	3.1%	1.9%
Spanish Origin (any race)	2.9%	6.4%	

Source: U.S. Census and OFM, 1986 Population Trends in Washington State

Washington State has a larger proportion of Whites than the nation and this is important because many health status indicators are significantly different for Whites than for minority populations. Table 2 shows the state had a smaller proportion of Blacks and larger proportion of Asians and American Indians than the nation. While the Puget Sound health planning region contained 61 percent of the state population, it had 87 percent of the Blacks, 53 percent of the Indians and 83 percent of the Asians in the state. Although not a separate racial category, persons of Spanish origin compose 3.0 percent of the state's population. The largest number of these people live in Yakima County.

The state also has a large migrant/seasonal farmworker population composed of representatives of every racial group. Twelve counties in the state are considered high migrant impact areas. The largest number peaks in the Yakima Valley in May-June, with an annual average estimated at around 37,000, including dependents. The next most impacted area is the Skagit Valley where estimates range from 10,000 to 18,000 during the peak months of July and August. The stress that this special population places on local health care delivery systems should be taken into account in resource allocation decision-making.

ENVIRONMENT

The environmental health of Washington State is changing. The outdoor air is improving. Trends in the four years of monitoring data between 1980-83 show steady reduction in carbon monoxide, ozone, suspended particulates, and lead concentrations. There were no violations of ozone or sulfur dioxide standards in 1983. 2/ The following have been identified by the State Office of Environmental Health Programs as significant environmental and safety health issues.

1. Insufficient and substandard housing for seasonal farmworkers and other low income groups. With growers abandoning the provision of farmworker housing, no public or private institution has assumed this responsibility.

2. Overcrowded correctional institutions.

3. The chronic effects of long-term exposure to low levels of toxic chemicals in our food, air and drinking water.

4. New construction methods to conserve energy have allowed less fresh air exchange indoors, resulting in the new environmental health problem of indoor air pollution from wood-burning stoves, formaldehyde, cigarette smoke, etc.

5. Problems in meeting drinking water standards are most serious in the thousands of small community water systems which generally are unable or unwilling to finance needed maintenance and operation.

6. Nuclear power plants and radioactive waste disposal constitute a potential hazard to the public health and should be appropriately monitored.

7. The use of X-rays and related diagnostic and treatment strategies constitute a potential health hazard which must continue to be appropriately monitored.

HEALTH STATUS

In 1979 the Surgeon General's report, "Healthy People," identified a variety of opportunities and strategies for avoiding health problems. In 1981, the Department of Social and Health Services issued a state counterpart: "Healthy People in Washington: Health Promotion, Protection, and Disease Prevention Plan." The goals relating to identified problems were not quantified, but the strategies for reducing them are still relevant. They should be re-examined and implemented.

Overall, the health status of Washington State residents compares favorably with other states and the nation. We have lower rates of infant death, total and age-adjusted death, and low weight birth.

Health status indicators actually measure illness instead of health, but are useful in identifying problem areas and monitoring improvements in health brought about by programs and other modifications in the environmental, genetics, life style, and health services.

This section will not focus on health status problems of individual counties or on special populations. If special populations have serious health problems which are prevalent statewide, these may be addressed in future plans or by special studies whose conclusions are reported in succeeding plans. This section will not address mental health issues or developmental disabilities. These areas are discussed in plans issued by their respective DSHS divisions.

The health status of the state's population will be described under seven broad areas: natality, overall mortality, accidents/violence, chronic disease and disability, communicable disease, dental health and lifestyle. Health risk factors and their policy implications are then given in the summary.

NATALITY

There were 68,705 births to Washington State residents in 1983. As the "baby boom" female cohort passed through its peak childbearing age (the 20s), an increased fertility rate has been observed, from 62.7 births per 1,000 females ages 15-44 in 1976 to 71.0 in 1981. The fertility rate is declining again; it was 67.2 in 1983. The Office of Financial Management forecasts about 70,000 births per year through 1990, reflecting decreasing birth and fertility rates.

With 15 maternal deaths in the state over the past four years, maternal death rates are not the sensitive indicator of health status in the state which they are in developing nations. Selected natality health indicators are defined and profiled in Table 3.

Table 3

SELECTED INDICATORS OF RESIDENT NATALITY HEALTH STATUS

	United States (Year)		1990 Goal for U.S.8/	Washington State Avg 1978-82	1983	PSHPR 1983	SHPR 1983	CHPR 1983	EHPR 1983
Fetal Death Ratio 1/	8.1	(1980)	-	7.4	6.9	7.1	4.8	8.9	6.3
Neonatal Death Rate 2/	7.2	(1983)	6.5	6.8	5.4	5.7	4.6	5.0	5.7
Infant Death Rate-Total 3/	10.9	(1983)	9.0	11.3	9.5	9.4	9.3	8.5	11.2
White	10.5	(1981)	12.0	11.3	9.4	8.9	9.5	9.5	11.6
Black	20.0	(1981)	12.0	16.3	18.4	19.9	NS	0*	NS
Asian	-		12.0	10.1	4.1	4.1	NS	0*	0*
Indian	13.2	(1980)	12.0	16.9	15.5	14.4	NS	NS	NS
Mexican/Chicanos 4/	-		12.0	8.6	2.7	NS	0*	NS	0*
% Low Birth Weight 5/	6.8	(1982)	5.0	5.21	5.25	5.18	5.22	5.27	5.35
Teen Fertility Rate 6/	52.9	(1982)	-	46.0	43.1	37.6	50.8	66.3	39.5
% Prenatal Care Begun in First Trimester 7/	76.0	(1982)	90	77.5	76.6	77.3	76.7	72.3	80.6

NS Number of events too small for statistical significance
*No deaths reported to DSHS Vital Records.
1/ Number of stillborn births per 1,000 live births
2/ Number of deaths to infants under 27 days old per 1,000 live births
3/ Number of deaths to infants under 1 year old per 1,000 live births
4/ Data collection began in 1980. See text.
5/ Percentage of live births that are under 2500 grams or 5 1/2 pounds
6/ Number births to females under 20 years old per 1,000 females age 15-19
7/ Percentage of births in which prenatal care was given during the first 3 months of pregancy.
8/ Each county in U.S. or racial/ethnic group should have rates no higher than the national goal.

SOURCE: DSHS Maternal & Child Health Program, Progress Report FY 1983 and Block Grant Application, FY 1985.
DSHS Vital Statistics, 1978-82, unpublished 1983.
National Center for Health Statistics, Monthly Vital Statistics Report, April 26, 1984, June 22, 1984, September 28, 1984.
DHEW, PHS, Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention, 1979.
DHHS, PHS, Promoting Health, Preventing Disease: Objectives for the Nation, Fall 1980
Washington OFM, Report No. 59, for teen population

The fetal, neonatal, and infant death rates are decreasing nationwide and statewide. Washington State has reached a 1990 national goal by having a neonatal death rate of under 6.5. (Table 3) However, the national goal for overall infant deaths has been reached only in the Central Washington health planning region. The race-specific goal for infant mortality has been reached for Asians. There is a possibility that reporting errors at death cause the infant mortality rate for Mexican/Chicanos to appear so low. 3/

The table shows a high infant death rate for Blacks and Indians. The situation has worsened in the past six years for Blacks but improved for Indians. In 1983, Sudden Infant Death Syndrome (SIDS) and congenital anomalies were responsible for almost half of all infant deaths in the state.

An infant's birth weight is the single most important determinant of its chances of survival and healthy growth and development. 4/ The proportion of low weight births (under 2500 grams) has been declining in Washington State, but since 1979, has hovered between 5.06 and 5.26. There is little discernible difference among the health planning regions regarding this indicator. For the five-year period 1978-82, analysis linking infant birth and death data for the state shows that 10.5 percent of low birth weight babies die during their first year; when the weight is under 1000 grams, 69.3 percent die during the first year.

Of particular concern is the fertility rate of adolescents, since this group is less likely to seek early prenatal care and more likely to have low weight babies and unintended pregnancies. For example, in 1983, 53 percent of the pregnant teens began prenatal care in the first trimester while 79 percent of pregnant women age 20+ received early care. Seven percent of births to teens were low weight as compared to 5 percent for all pregnant women. Half the births to teens were illegitimate as compared to 12 percent to women age 20+. And finally, half of all teen pregnancies were terminated by abortion as compared to 24 percent for the women age 20+. The 1983 teen fertility rate of 43.1 births per 1,000 females age 15-19 was less than in 1982 and less than the average for the previous five years. The Central Washington health planning region had the highest teen fertility rate in 1983 (Table 3).

In 1983, 10.4 percent of all births were to women under age 20. At the other end of the high risk spectrum, 6 percent of all births were to women over age 34 and this percentage was highest in The Puget Sound health planning region.

A smaller proportion of Washington women received prenatal care in the first trimester of their pregnancy in 1983 than in 1982 and the previous five-year average (Table 3). The economic recession may explain some of this behavioral change. The Eastern Washington health planning region had the highest percentage of women obtaining early prenatal care in 1982. Hispanic and Native American Indian women are least likely to receive this service.

Several public health programs are underway which seek to improve the outcome of pregnancy and women's health. The Division of Health is funding demonstration Adolescent Pregnancy Projects in Yakima, Grant, Chelan, and Grays Harbor Counties. In 1984 and through the biennium, additional funds are targeted to 25 counties to provide prenatal-obstetrical care for approximately 1,100 low income pregnant women. The Women, Infant, Children (WIC) program provided nutrition to a monthly average of 10,000 needy women and 9,200 infants in the fiscal year ending June 30, 1984. The Family Planning program provided female clinical services and male/female contraceptive services to approximately 85,000 persons of whom 75 percent had incomes at less than 150 percent of the federal poverty level. A total of 1,290 new families received genetic diagnostic and counseling services from the five regional genetic clinics. The Genetics Service Administrators believe there is a target population of 12,860 families who would benefit from the services.

MORTALITY

From the perspective of several decades, the death rate for Washington State is declining and has been under 8 per 1,000 population since 1979. In 1983 the state wide rate was 7.6 deaths per 1,000 population, the same as in 1982. The death rate was 7.4 for Puget Sound health planning region, 7.9 for Southwest Washington health planning region, 7.6 for the Central region, and 8.5 for the Eastern region. This respresents a slight increase over 1982 for the Puget Sound and Eastern regions. The 1983 death rate for the United States was 8.6.

Selected mortality indicators of health status are: age/sex adjusted mortality rates, age specific mortality rates, and leading causes of death.

Age/Sex-Adjusted Death Rates

As used here, the adjusted death rate for an individual county is that county's rate if it had the state's 1980 age/sex composition. These are useful for comparison purposes. For example, if the effects of age and sex differences among the counties are statistically eliminated, the people in HSA IV would be considered the healthiest in the state because all eleven of their counties have age/sex-adjusted mortality rates below that of the state's 1979-81 average of 7.5. The Central health planning region would have the least healthy population since only two out of its eight counties were below the state rate. Five out of ten counties in the Puget Sound region and seven out of ten counties in the Southwest region had age/sex-adjusted mortality rates below the state rate. Pacific County had the highest (8.9) and San Juan County the lowest (5.6) age/sex-adjusted death rates for 1979-81. 5/

Age-Specific Death Rates

With its younger population, one would expect Washington State to have a lower overall death rate than the nation. Except for the population over age 84, the 1983 rates within each age category were also lower for the state than for the nation. The death rate in every age category has declined in the past ten years (Table 4, "All Causes"). The groups with the largest 10-year percentage decrease in mortality rates were the ages 1-4 (41 percent) and 5-14 (38 percent).

Table 5

1983 DEATHS PER 100,000 POPULATION BY FIVE LEADING CAUSES IN TEN AGE GROUPS WITH PERCENTAGE CHANGE SINCE 1973

	1983 Rate	% Change 1973-83
STATE TOTAL		
All causes	761.5	- 15
Heart disease	272.0	- 19
Cancer	171.6	+ 5
Stroke	60.3	- 39
Accidents	37.4	- 30
Influenza/Pneumonia	23.4	- 31
All other	196.8	- 6
UNDER 1 YEAR OLD		
All causes	939.2	- 35
Early Infancy causes*	251.7	a
Sudden Infant Death (SID)	236.7	a
Congenital Anomalies	214.3	- 28
Birth injury	126.8	a
Accidents	20.1	- 28
All other	95.5	a
AGES 1 - 4		
All causes	42.0	- 41
Accidents	16.1	- 47
Cancer	5.3	- 34
Congenital Anomalies	5.3	- 40
Heart disease	2.6	+ b
Homicide	2.3	- 34
All other	10.5	- 49
AGES 5 - 14		
All causes	23.2	- 38
Accidents	10.3	- 46
Cancer	3.3	- 59
Congenital Anomalies	1.6	0
Suicide	1.1	+ b
Heart disease	.8	+ b
All other	6.0	- 25
AGES 15 - 24		
All causes	90.2	- 23
Accidents	49.9	- 28
Suicide	14.3	+ 18
Homicide	8.9	+ 306
Cancer	6.4	- 39
Heart disease	1.7	+ 10
All other	11.0	- 49
AGES 25 - 34		
All causes	108.0	- 20
Accidents	41.2	- 27
Suicide	19.5	- 10
Cancer	10.7	- 39
Homicide	8.6	- 2
Heart	6.5	- 4
All Other	21.4	- 19
AGES 35 - 44		
All causes	154.5	- 31
Cancer	38.1	- 26
Accidents	35.2	- 3
Heart disease	22.2	- 43
Suicide	18.0	- 15
Homicide	5.9	+ 18
All other	37.1	- 47
AGES 45 - 54		
All causes	433.9	- 30
Cancer	153.2	- 7
Heart	123.1	- 37
Accidents	30.4	- 36
Suicide	14.2	- 20
Stroke	13.0	- 29
All other	86.9	- 43
AGES 55 - 64		
All causes	1142.4	- 25
Cancer	415.2	- .4
Heart disease	382.7	- 33
Stroke	43.8	- 51
Cirrhosis of Liver	39.2	- 39
Accidents	29.4	- 55
All other	232.2	- 25
AGES 65 - 74		
All causes	2697.8	- 19
Heart disease	1000.4	- 27
Cancer	802.2	+ 3
Stroke	172.7	- 44
Bronchitis/Emph/Asth	59.4	- 45
Diabetes mellitus	57.3	- 25
All other	605.8	- 9
AGE 75 AND OVER		
All causes	8329	- 17
Heart	3559	- 20
Cancer	1324	+ .5
Stroke	969	- 43
Influenza/Pneumonia	427	- 22
Arteriosclerosis	226	- 39
All other	1822	- 12

* Certain diseases of early infancy such as maternal diseases affecting child, complications of pregnancy affecting child, other diseases peculiar to early infancy.

a Changes in classification since 1973 do not allow comparison with 1983.

b Although there was an increase in rate, event number too small for statistical significance.

SOURCE: 1973 DSHS Vital Statistics and unpublished data for 1973 and 1983.

The 1983 death rates in Table 4 for the age group under one year old are not comparable to 1973 rates because Sudden Infant Death Syndrome (SIDS) had not been identified in 1973 and other disease categories were coded differently. However, the overall death rate declined by 35 percent in ten years.

Much credit for the large decrease in death rates for the 1-4 and 5-14 age groups goes to the reduction in accidental death rates to about half of their 1973 level (Table 4). Continued emphasis should be placed on accident reduction.

The 15-24 age group shows an increase in suicide and homicide death rates. There were 50 homicides in this group in 1983. The homicide death rate also increased slightly for the 25-34 age group and increased by 18 percent for the 35-44 age group.

Cancer death rates increased slightly for those age 65 and over, but were offset by the large decreases in other disease categories.

ACCIDENTS AND VIOLENCE

Accidents and violence diminish the quality of life when they result in physical and mental disability and eliminate years of productive life when they result in death. Most are preventable rather than biological, a function of society, personal choices, and lifestyle. The health status indicators are mortality rates, occurrence of motor vehicle accidents, number of families investigated for child abuse, and a profile of sexual assault victims.

The combined rates of accidental and violent deaths due to suicide, homicide, and other external injuries are decreasing both in the nation and the state. Washington State has maintained a lower combined rate than the nation since 1981. (Table 5)

Deaths from accidents and violence are concentrated among adolescents and young adults, especially men. They accounted for 52 percent of all deaths in the 5-14 age group, 79 percent in the 15-24 age group, and 64 percent in the 25-34 age groups in Washington State. In 1981, the total years of life lost from premature death in Washington State was 344,485 of which a third were years lost due to accidents and violence.

Accidents are the leading cause of death from the ages 1-34. In 1983 the accidental death rate for ages 1-14 was less than half the rate in 1978. Washington has a law requiring use of child restraints in autos so one can expect an even greater decrease. The rate declined over 25 percent for the 15-34 age group and over half of this can be attributed to a decline in the motor vehicle accidental death rate.

Half of all accidental deaths in Washington State in 1983 were caused by motor vehicle accidents, 14 percent from falls, 10 percent from drowning, and the remaining 26 percent from various other causes.

The motor vehicle accidental death rate in 1983 was 18.5 deaths per 100,000 population in Washington State as compared to 18.2 in the United States. Both rates come close to achieving the national goal of 18.0 or less by 1990. Males age 15-24 had the highest motor vehicle death rate in the state (54.0). This was a 34 percent decrease from the 1978 rate of 81.9. Nationwide, the rate for adolescent males has increased. Of the four health systems agencies, the Central area residents have the highest total and motor vehicle accidental death rate.

According to State Patrol data, the number of reported motor vehicle accidents occurring in Washington State decreased from a high of over 120,000 in 1975 and 1976 to 100,000 in 1982 and was up to 106,600 in 1983. Sixty percent of the reported accidents occurred in urban areas. However, the rural accidents are more serious, probably due to the greater speed. About three times as many people were killed in rural motor vehicle accidents as in urban accidents. The number of persons injured (58,300) was almost equally distributed between urban and rural areas.

In 1983, 14 percent of all drivers involved in motor vehicle traffic accidents in Washington and 39 percent in fatal ones had been drinking. Seven percent of all drivers involved in motor vehicle traffic accidents and 31 percent in fatal ones had been drinking to the point of impaired ability. 6/ This represents a decline from the previous two years. Washington State has a tough drunk driver law.

In 1983, 21 percent of the occupants of motor vehicles involved in accidents in Washington State had been using a safety restraint. The 0-5 age group had the highest restraint usage (42.3%) and the 16-19 year olds had the lowest usage (14%). 7/

Forty-six of the 77 motorcyclists killed (60 percent) were not wearing helmets. There is no state law requiring that helmets be worn.

The death rate for suicides of Washington State residents has been higher than the national rate for many years. Washington's suicide rate was 14.5 deaths per 100,000 population in 1983 as compared to 11.9 in the United States. Using the 1980 U.S. white/non-white population mixture as standard gives Washington State a race-adjusted suicide rate of 14.2. The state's white and non-white rate in 1983 were 15.0 and 10.0, respectively as compared to the U.S. rate of 12.9 and 6.6.

The suicide death rate shows no consistent trend. (Table 5) Suicides are the second leading cause of death in the 15-34 age group. The rate is highest in the Eastern Washington health service area. Over three times as many men commit suicide as women. The 1983 rate was over 20.0 per 100,000 males age 25-64 and over 40.0 for males above age 64.

The death rate from homicide in Washington State is consistently lower than that for the United States--5.0 in 1983 as compared to 8.2 in the U.S. (Trend Table 7) There is little variance in the rate among the health service areas. Over twice as many men die from homicide as women. The rate was 12.0 for males between ages 25 and 34.

Child abuse is receiving increasing attention in the media. Washington State Child Protective Services has observed a 12.8 percent annual increase in referrals for the past five years. Of the 25,000 families investigated in 1983 to see if a risk existed for the child or children, less than 10 percent resulted in out-of-home placement or court activity.

Table 5

TRENDS IN VIOLENT DEATHS PER 100,000 POPULATION
UNITED STATES AND WASHINGTON STATE, 1970, 1975, 1980, 1981-83

	1970	1975	1980	1981	1982	1983
Accidental Deaths						
U.S.	56.4	47.6	46.7	43.9	40.8	38.5
WA	58.1	49.6	48.8	43.7	42.9	37.4
Suicide Deaths						
U.S.	11.6	12.6	11.9	12.0	11.7	11.9
WA	15.0	15.2	13.5	15.1	13.8	14.5
Homicide Deaths						
U.S.	8.3	10.2	10.7	10.3	9.6	8.2
WA	4.7	6.2	5.4	5.4	4.9	5.0
Undetermined						
U.S.	-	2.3	-	-	1.2	1.2
WA	2.4	2.8	1.7	1.2	1.5	1.3
Sum-All Violent Deaths						
U.S.	76.3	72.7	69.3	66.2	63.3	59.8
WA	80.2	73.8	69.4	65.4	63.1	58.2

Source: DSHS Vital Statistics and their unpublished 1983 Vital Statistics.
NCHS Monthly Vital Statistics Report.

According to people who work in the helping professions, one out of four girls and one out of ten boys have been sexually assaulted by age 18. Annual data (July 1982-83) from 23 rape crisis/sexual assault programs in Washington State present the following profile of 47,000 victims who use their services:

- about eight times as many females as males reported to the centers;
- half of the female victims and 80 percent of the male victims were under 16 years old;
- 77 percent of the assailants were male, one percent were female, and the sex of the remaining 22 percent unknown;
- half of the assaults were rape and 30 percent were incest/indecent liberties/indecent exposure.

CHRONIC DISEASE AND DISABILITY

The term "chronic disease" denotes a disease condition of long duration. "Disability" denotes a restricted level of functioning. "Morbidity" is the extent of illness, disability, or injury in a defined population.

With the aging of the state's population has come a sharper need to focus on problems of chronic disease, morbidity, and disability, but not necessarily a higher death rate for these diseases. Table 4 shows a decline in the death rates, for heart disease and stroke even though, when combined with cancer, these still caused two-thirds of Washington State residents' deaths in 1983, the same as in 1973. The age adjusted rates also showed a similar decline. The health status indicators are chronic disease mortality rates, cancer prevalence rates, disability rate of the working-age population, and U.S. morbidity trends.

Heart disease is the greatest killer, both in the state and the nation. The state's heart disease rates declined by 19 percent during the past ten years (Table 4). A nationwide study concluded Washington State had the greatest decline in age-adjusted coronary heart disease mortality rates for its White population of all 50 states. The data also showed great improvement for the Black population, but the small numbers make this less conclusive. 8/ The slight increase in heart disease death rates for ages 1-24 has already been noted. The U.S. heart disease death rate was 326.3 in 1983. 9/

Cancer, the second leading cause of death, is the only one of the chronic diseases shown in Table 4 with an increasing death rate. Yet it decreased over the past ten years for all but the elderly age group. Between 1973

and 1983, site-specific cancer death rates decreased or remained nearly constant for all but lung cancer (up by 24 percent). This is a reflection of lifestyle such as smoking. In Washington State cancer takes about 7,000 lives each year, a 1983 death rate of 171.6 per 100,000 population, but still below the U.S. rate of 188.6.

In Washington State, nearly 14,000 new cases of cancer occur annually. The age-adjusted incidence of new cancer cases is 325.2 per 100,000 females, 404.2 for males, and 353.3 per 100,000 total population. Most new cancers in men occur in the prostate, lung, colon or rectum, and bladder, in that order. Lung cancer is by far the biggest cancer killer of men. For women, most new cancers occur in the breasts, the colon or rectum, the corpus uteri, and the lung, in that order. 10/ Breast cancer was the biggest cancer killer of women until 1980 when it was surpassed by lung cancer.

Stroke, the name commonly given to cerebrovascular disease, is characterized by disorders of the blood vessels in or about the brain or spinal cord. The etiology of this disease is similar to that of heart disease and stroke, too, has a decreasing death rate, a 39 percent decrease in the past ten years. (Table 4) Much credit for this is given to gains made in treating high blood pressure.

The diabetes mellitus and arteriosclerosis death rates decreased by 17 percent and 31 percent between 1973 and 1983.

Regarding disability, the 1980 census showed 8.8 percent of the Washington State population ages 16-64 had a physical, mental, or other health conditions which lasted six or more months. This was less than the 11.6% shown in the 1970 census. Within this productive age group, 3.7 percent listed their disability as preventing them from working at a job in 1980, the same as in 1970.

The National Health Interview Survey of 1981 revealed about 14.4 percent of the U.S. non-institutionalized population had some degree of activity limitation as the result of one or more chronic conditions and, for 10.9 percent of them, this was a limitation in their major activity. Thirty-nine percent of persons over age 64 were limited in their major activity. For all ages and degrees of limitation, the percentage was higher in males than in females.

There are indications of an increasing morbidity in the nation as the population ages. By staying alive longer, the survivors of chronic disease have more years for their illness to advance in severity and have more time and are at higher risk to develop other chronic conditions. Additionally, two factors which cause the enumeration of the chronic disease prevalence rate to show an increase are: (1) improvement in diagnostic techniques allow chronic diseases to be diagnosed earlier, and (2) earlier behavioral changes based on such diagnoses; i.e., people making earlier accommodations in their activities in response to the disease. We expect the trends in

Washington State to be similar to those in the nation even though morbidity may not be as prevalent. The following trends for middle aged and older people were derived from National Health Interview Surveys by a researcher: 11/

1. Restricted activity for chronic conditions show especially sharp rises since 1957. The rise is mostly for non-bed days; i.e., cutting down activities, but not staying in bed.

2. The percentage of people who are limited in their major activity (job or housework) or their secondary activities (shopping, hobbies) has increased steadily since the late 1950s for middle aged people and in the 1970s, for older people.

3. Chronic diseases which often cause death have risen both in prevalence and limitations they place on activities. This is especially true for cancer, heart disease, hypertension, and diabetes.

4. Chronic diseases which are common, but seldom cause death, have also risen in prevalence and the limitations they place on activities. This is especially true for arthritis, other musculoskeletal disorders, and chronic sinusitis, the leading nonfatal diseases for middle aged and older adults.

5. Among the few diseases showing decreasing prevalence and limitations on activities are some digestive and urinary chronic conditions, varicose veins, and hemmorrhoids.

COMMUNICABLE DISEASES

If the same communicable disease mortality rates prevailed today as in Seattle at the turn of the century, 4,800 would lose their lives in Washington State in 1984 to tuberculosis, 216 to diphtheria, 1,610 to gastroenteritis, 1500 to typhoid fever, 480 to scarlet fever, and 320 to whooping cough a total of 8,600 deaths from these six causes. Yet of the six, only tuberculosis and gastroenteritis caused any deaths in Washington State in 1985 - 27 from tuberculosis and 8 for enteritis. There was a total of 236 deaths from all infective and parasitic diseases, a rate of 5.5 per 100,000 population compared to 9.1 for the U.S. No polio deaths were reported in the U.S. in 1983.

Nearly all the gains against the once great infectious disease killers have come as a result of environmental sanitation programs (treatment of drinking water and sewage, garbage disposal and food sanitation), improved housing, immunization programs, epidemiological investigation, improved nutrition, and the introduction of antibiotics. Many of the problems of the past would reoccur if effective interventions were not in place and maintained. Such maintenance is expensive, as noted by local governments in providing public drinking water and sewage treatment systems.

The health status indicators for communicable diseases are their mortality rates (above), incidence rates, and level of immunization.

The number of new cases reported each year per 100,000 population (incidence rates) for diseases now preventable by vaccine declined drastically in the past ten years, from 93 to 3, due to the introduction of mumps and measles vaccines. The incidence rate for gastroenteric diseases went from 61 to 44; however, the decrease was partly offset by an increase in the salmonellosis incidence rate which was also high in 1982. The incidence of meningitis diseases incidence increased from 3.9 in 1973 to 7.5 in 1983; the veneral diseases of gonorrhea and syphilis decreased from 350 to 235; and the tuberculosis incidence rates decreased from 10.5 to 5.6 per 100,000 population. 12/

For sexually transmitted diseases, the incidence rates for the venereal diseases of gnorrhea and syphillis decreased from 350 to 235 per 100,000 population. Since 1982 when the first case was reported in Washington State, the incidence of Acquired Immunodeficiency Syndrome (AIDS) and infection with the human T-cell lymphotropic virus type III (HTLV-III) has been increasing steadily. As of January 31, 1986, 203 AIDS cases have been reported in the state. The mortality rate for AIDS cases in Washington reported prior to 1985 is 79 percent (66 of 84), as of January 31, 1986.

From a 1984 restrospective survey of five year old children's school records, the DSHS Immunization Unit has concluded that, by the time the children were two years old, 88 percent had received three DTP doses (diphtheria, tetanus, and pertussis), but only 50 percent had received all four DTP doses at the recommended schedule. By the time they were two years old, 87 percent were immunized for polio and over 80 percent were immunized for measles, mumps and rubella. The percentage of children who had received all antigens at the recommended schedule was 52 percent for King County, 45 percent for the remainder of Western Washington, and 40 percent for Eastern Washington.

DENTAL HEALTH

Dental care is often viewed as elective, yet such care and preventive service during a child's formative years can positively influence dental health throughout a lifetime.

Fluorides are the most effective measure for preventing tooth decay in the smooth surfaces of teeth while sealants have been evaluated over 15 years and found safe in reducing decay in the chewing and other pit and fissure tooth surfaces. The Washington State Public Health Association has adopted the policy of supporting:

1. the combined use of pit and fissure sealants and fluorides in all private dental practices and public dental programs; and

2. the inclusion of pit and fissure sealants as a payable preventive service in private and public (Medicaid) dental insurance programs.

The only statewide dental health status indicator available is the percentage of children ages 5 to 11 protected by fluoride. A statewide survey revealed:

-- only four counties in the state, representing .8 percent of the children, had prophylactic concentrations of natural fluoridation in the water;

-- communities in 21 counties supplemented the water with fluoride, representing 29.8 percent of the children; and

-- approximately 32.4 percent of the children are participating in the schooled-based Dental Rinse Program promoted and supported by the DSHS Health Division 13/.

Thus, 44 percent of the children ages 5 to 11 are known to have fluoride protection and 56 percent have none other than that which they receive from topical fluoride treatments in a private dental office, use of fluoride toothpaste, etc. Eighty-two percent of the children in King County have fluoride protection because the City of Seattle supplemented its water supply with fluoride. At the other extreme, only 21.6 percent of the children in the DSHS Region 2 (Southeastern Washington) have fluoride protection.

LIFESTYLE

A majority of the health problems of Washington residents are in part related to the way we live and work--cigarette smoking, misuse of alcohol and drugs, overeating, and environmental and occupational hazards. This section focuses on a few elements of lifestyle for which data are available for Washington State.

Alcohol abuse is a factor in much of the traumatic injury already discussed, from auto deaths and spouse abuse to homicide and other crimes. In 31 percent of the 1983 investigated fatal motor vehicle accidents and 9 percent of the investigated injury accidents in Washington State, the driver had been drinking to the point of impaired ability.

Washington State's 1983 consumption of 2.16 gallons of alcohol per person (estimated from the proportion of alcohol in various beverages) was slightly higher than the U.S. consumption of 2.13 gallons per person. Washington's per capita consumption has declined by 8 percent since 1981 14/.

Smoking is the single largest preventable cause of death in America. As previously stated, lung cancer has long been the leading cancer death for men and surpassed breast cancer among Washington women in 1981 and

since. This phenomenon also has been reported for California and Kentucky. Smoking during pregnancy increases the risk of spontaneous abortion, fetal death, and infant death in otherwise normal babies. The poisons in cigarette smoke are so potent that the effects on nonsmokers can be damaging.

According to the American Lung Association, smoking accounts for an estimated 13 billion dollars in direct health care expenses every year in the U.S.; there is an additional annual cost of 25 billion in lost productivity, wages and absenteeism. Also, the Department of Agriculture's Tobacco Support Program costs the taxpayers from 39 to 51 million dollars each year.

Occupational disease and illness in Washington State were studied using the proportion of actual deaths in various occupations to expected deaths based on the overall population. The study revealed:

-- Increased mortality due to pancreatic cancer and multiple myeloma of workers at the Hanford Atomic Energy Facility. These have been shown to be associated with low level radiation.

-- Excess lung cancer deaths related to occupational arsenic exposure at a smelter.

-- Increased mortality among aluminum workers for cancer of the pancreas, leukemia, lymphoma, and emphysema.

-- Outdoor blue collar workers experienced fewer deaths from multiple-sclerosis than the general population. This suggests that exposure to sunlight or some other outdoor factor prevents multiple-sclerosis. 15/

The Washington Department of Labor and Industries (L&I) received 9.7 percent fewer claims for on-the-job illness and injury in 1982 than in 1981. This is only partly due to the 1.9 percent decline in the number of workers. The 169,917 claims accepted by L&I averaged 84.45 per 1,000 employed persons. "Craftspersons and Kindred Workers" is the occupational grouping to submit the largest number of claims. Basketball, baseball, and soccer teams were at highest risk as measured by claims per million hours of exposure. Other high risk occupations were jockeys and other employment around stables, temporary help in construction or heavy manufacturing, hot-forming tool manufacturing, and logging. Of the ten reported occupational disease fatalities in 1982, six were asbestos insulation workers. The three most common injuries in the claims were strained/sprained back, lacerated/cut finger, and abrasions to the eyes. 16/.

PRIORITY HEALTH STATUS PROBLEMS

Priority health status problems can be identified by the extent to which they evidence one or more of the following characteristics:

- cause loss of most years of life (premature death);
- have rates above the national average or other established targets;
- are of long duration and economically costly to the individual and society; and/or
- are preventable in a cost effective manner.

Priority health status problems preliminarily addressed in this edition of the State Health Plan are: 1) infant deaths of Native Americans, because their rate is higher than the national average; for Blacks, the rate is above the national goal; 2) lung cancer, because it is increasing and is largely preventable; and 3) morbidity among the elderly, because their number and proportion of the population are increasing. The infant death problem is addressed by public health policies to prevent teen pregnancy and to improve the outcome of pregnancy for low income women and by health facility/service policies aimed at promoting regionalized obstetric, neonatal and pediatric service systems. Lung cancer is addressed by public health policies on health education and chronic disease screening and by health facility/service policies relating to cancer diagnosis and treatment services. The needs of the elderly are principally treated in the long term care sections of this State Health Plan. Future editions of the SHP should expand the scope of problem-solving efforts addressing these three health status problems.

ENDNOTES

1/ Office of Financial Management (OFM), Forecasts of the State Population by Age and Sex, 1986-2010, December, 1986.

2/ Department of Ecology, Washington State Air Monitoring for 1983, June 1984, p. 38.

3/ DSHS, Vital Statistics, 1980.

4/ Center for Disease Control, MMWR, August 17, 1984.

5/ Unpublished material developed by the DSHS Epidemiology Section.

6/ Washington State Patrol, Summary of Motor Vehicle Traffic Accidents, 1983, unpublished.

7/ Washington Traffic Commission, Data Summary and Analysis of 1983 Traffic Collisions.

8/ American Heart Journal, September 1984.

9/ NCHS Monthly Vital Statistics Report, April 26, 1984.

10/ Fred Hutchinson Cancer Research Center, Cancer in Washington State, June 1984.

11/ Lois Verbrugge, "Longer Life but Worsening Health? Trends in Health and Mortality of Middle Aged and Older Persons," Health and Society, Millbank Memorial Fund Quarterly, Vol. 62, No. 3, 1984.

12/ DSHS, Epidemiology Section, Report: Communicable Disease Statistical Summary, 1920-1982, and December 1983 Communicable Disease Statistical Report.

13/ DSHS, Report: Washington State 1982 Dental Rinse Survey, November 1982.

14/ Washington State Liquor Control Board.

15/ Samuel Milham, M.D., DSHS, Occupational Mortality in Washington State, 1950-79, October 1983.

16/ Department of Labor and Industries, Washington State Work Injury and Illness Summary, 1982, June 1984.

D. HEALTH GOALS AND OBJECTIVES

HEALTH STATUS / PUBLIC HEALTH

Public Health means:

1. The level of well-being of the general population (i.e., its health status):

2. Those actions in a community necessary to preserve, protect, and promote the health of the people for which government is responsible; and

3. The governmental system developed to guarantee the preservation of the health of the people. (Senate Bill 4204, passed in 1983)

The governmental system of public health is charged with monitoring health status, collecting and analyzing data, investigating and reporting disease outbreaks, and conducting related research. Their duties also include that array of environmental health services and disease and disability prevention services presented in the Health Systems Framework of this State Health Plan. Governmental agencies responsible for providing these services include the state Departments of Social and Health Services (DSHS), Labor and Industries (L & I), Ecology, and Agriculture; local health departments; and regional air pollution control districts.

Health Promotion services are any combination of health education and related organizational, economic, or political interventions designed to facilitate behavioral and environmental changes that contribute to health or that prevent illness, injury, disease, or death.

GOAL: 1. TO ENCOURAGE AND ASSIST STATE RESIDENTS TO ACHIEVE AN OPTIMUM LEVEL OF HEALTH.

OBJECTIVE: 1.a. BY 1990 DEVELOP INCENTIVES FOR INDIVIDUALS TO MAKE HEALTH-RELATED LIFESTYLE IMPROVEMENTS AND TO REDUCE VOLUNTARY RISK-TAKING BEHAVIOR.

Personal lifestyle is an important contributing factor to health status. Examples of high risk-taking behavior are certain sports such as hang-gliding and certain habits such as smoking. State government should provide leadership in developing incentives for behavioral changes which will reduce the risk of disability and premature death and protect the financial resources of the community.

STRATEGIES:

(1) The State Board of Health (SBOH) and the health planning system should examine current financial incentives affecting individuals who engage in

voluntary high risk behaviors and develop proposals for changing those incentives. An example might be differential health insurance premiums for smokers.

(2) Private health insurers should structure health insurance premium/benefit packages to reward healthful lifestyles and encourage appropriate use of health promotion services. Care should be taken to avoid penalizing physically handicapped persons.

OBJECTIVE: 1.b. BY 1990 ASSURE THAT PUBLIC HEALTH SERVICES ARE COORDINATED AT THE STATE AND LOCAL LEVELS AND ARE BASED ON COLLECTION AND EVALUATION OF APPROPRIATE DATA, SOUND PLANNING PRACTICES, APPROPRIATE DEVELOPMENT PROCEDURES, AN EFFECTIVE REPORTING/EVALUATION SYSTEM, AND A DESIGNATED LEADERSHIP TO MANAGE THE PROCESS.

Assuring basic levels of public health services requires coordination among state and local agencies which have jurisdiction and a clear definition of their respective roles and responsibilities. Public health service needs should be determined through a systematic planning process so that limited funds will be used most effectively.

STRATEGIES:

(1) The Division of Health should expand the partial listing of basic public health services presented on the following pages of this Plan. This should be done in consultation with the SBOH, Association of Local Public Health Officials, State Health Coordinating Council (SHCC), and the DSHS Essential Public Health Services Work Group. The list should be consistent with the basic health services to be defined under this Plan.

(2) DSHS and local health departments/districts are responsible for assuring that an ongoing, effective information system is maintained in their areas of jurisdiction. The system collects vital statistics, public health program utilization characteristics, financial information and much more.

(3) Local health departments/districts should evaluate basic levels of public health services and develop and implement plans to promote or provide additional needed services.

(4) The Division of Health, in consultation with the SBOH, should identify public health program develop-

ments needed at the state or local levels to support, coordinate, and enhance the activities of local health departments/districts.

(5) DSHS and local health departments/districts should assure that accountability for program implementation is designated.

(6) DSHS and local health departments/districts are responsible for assuring that effective health education systems, programs and services are available to residents in their jurisdictions.

OBJECTIVE: 1.c. BY 1990 INCREASE THE PROPORTION OF PUBLIC AND PRIVATE HEALTH CARE EXPENDITURES FOR HEALTH PROTECTION AND PROMOTION.

STRATEGY:

(1) The State Legislature should increase funding for effective health promotion programs.

GOALS AND STRATEGIES FOR BASIC LEVELS OF HEALTH PROTECTION

The following goals and strategies represent SHCC priorities from previous State Health Plans and new priorities which resulted from the development process for this Plan. These policies are the beginning of the definition of basic health services referenced in this Plan.

In developing this list, it is recognized that the private sector will continue to have a significant role in providing most of these services. It is the state's responsibility to monitor the status of basic levels of health protection and to fill identified gaps in the provision and funding of these services.

GOAL A: TO ASSURE THAT EFFECTIVE HEALTH PROMOTION/HEALTH EDUCATION PROGRAMS AND SERVICES ARE AVAILABLE TO ALL RESIDENTS OF THE STATE.

STRATEGY:

a.1 The Department of Social and Health Services (DSHS) should establish and maintain an organized health promotion program to develop health promotion policies and guidelines consistent with the State Health Plan, maintain necessary data, coordinate health promotion activities within the state, and provide technical assistance to community organizations and businesses interested in developing health promotion programs and activities. These activities shall be sensitive to the diverse cultures in the state and language shall be no barrier.

GOAL B. TO ASSURE THAT FAMILY PLANNING SERVICES ARE AVAILABLE AND ACCESSIBLE TO ALL WHO SEEK AND NEED THEM.

b.1 The DSHS Family Planning Program should be responsible for evaluating family planning service use and for formulating and implementing plans to develop or provide additional family planning services where needed.

b.2 The DSHS Family Planning Program is responsible for insuring the provision of pregnancy prevention counseling and services.

GOAL C: TO ASSURE THAT SAFE PREGNANCY TERMINATION SERVICES AND ALTERNATIVES ARE AVAILABLE AND ACCESSIBLE TO ALL WOMEN WHO SEEK THEM.

STRATEGIES:

c.1 Local health departments/districts, family planning agencies, and private providers that receive state funds should be responsible for providing information on request regarding sources of and charges for quality pregnancy termination services; and the range of alternatives to abortion, including birthing services and adoption.

c.2 DSHS is responsible for maintaining a program of certification for facilities or agencies performing pregnancy termination services beyond the first trimester.

GOAL D. TO ASSURE THAT PRENATAL CARE IS AVAILABLE AND ACCESSIBLE TO PREGNANT WOMEN BEGINNING IN THE FIRST TRIMESTER OF PREGNANCY.

STRATEGIES:

d.1 Local health departments/districts should be responsible for evaluating prenatal service use statistics in their areas. It is a state goal that at least 95 percent of pregnant women receive prenatal care in their first trimester.

d.2 The DSHS State Maternal and Child Health Program should be responsible for developing uniform standards/guidelines for services offered by each provider of prenatal care.

d.3. Working with providers, DSHS should develop and test methods to deal with existing economic, social and cultural barriers to accessibility.

GOAL E. TO ASSURE THAT ALL PUBLIC WATER SUPPLIES HAVE ADEQUATE FLUORIDATION OR THAT ALTERNATIVE METHODS OF FLUORIDATION ARE AVAILABLE TO STATE RESIDENTS.

STRATEGIES:

e.1. Local jurisdictions should pass legislation requiring that public water supplies be fluoridated, naturally or otherwise, to state standards. In the absence of such implementation, local water districts or public health departments should provide information on the benefits of fluoridation, the level of fluoridation in the local water, and the sources of alternative means of fluoridation if the level is lower than the state standard.

e.2 The DSHS Dental Health Program should establish mechanisms, e.g., fluoride rinse, for ensuring that the benefits of fluoridation are available to communities with no public water supply or ones which are not fluoridated to the state standard.

GOAL F. TO ASSURE THAT ALL PUBLIC SCHOOL CHILDREN RECEIVE COMPREHENSIVE HEALTH EDUCATION.

STRATEGIES:

f.1 Each college or university should require basic courses of instruction in health education for students preparing to teach.

f.2 The State Legislature should appropriate necessary funds to ensure that comprehensive health education is available to all school children in the state and should specify in law minimum standards, such as those developed by the Office of the Superintendent of Public Instruction (OSPI), for these school health education programs.

f.3 The OSPI, in conjunction with professional associations of health educators and the SHCC should be responsible for making available to each school district an effective, comprehensive health education curriculum as well as learning objectives for evaluating the outcomes of individual elements of the program.

f.4 Each Educational Service District should be responsible for assuring that teacher training in health education is provided to appropriate teachers in each district.

f.5 Public school districts should be responsible for implementing effective health education programs for students which include information on the following subjects: human sexuality and family living; injury prevention; smoking, alcohol, and other substance abuse; nutrition; and oral health and techniques of plaque control.

GOAL G. TO ASSURE THAT ALL CHILDREN RECEIVE PERIODIC HEALTH ASSESSMENTS AND APPROPRIATE FOLLOW-UP CARE.

STRATEGIES:

g.1 The DSHS Divisions of Medical Assistance and Children/Family Services should assure that follow-up diagnosis and treatment services will be given to those children found to need such services when screened under the Early Periodic Screening, Diagnosis and Treatment program. It is a state goal that at least 80 percent of all children needing such follow-up service will receive it.

g.2 Private health insurers should make available child health assessments in basic health insurance coverage.

g.3 The DSHS Maternal and Child Health Program should promote the provision and funding of at least one Title V Well Child Clinic in each local health department service area.

GOAL H. TO ASSURE THAT WORKSITE-BASED HEALTH PROMOTION PROGRAMS ARE AVAILABLE TO ALL BUSINESSES IN THE STATE. WITH ENCOURAGEMENT AND REINFORCEMENT BY MANAGEMENT, SUCH PROGRAMS WOULD BE DIRECTED AT REDUCING OCCUPATIONALLY-RELATED ACCIDENTS AND ILLNESSES AND AT IMPROVING WORKERS' HEALTH THROUGH CHANGES IN WORK HABITS AND LIFESTYLE.

STRATEGIES:

h.1 DSHS and the Department of Labor and Industries should be responsible for collaborating in identifying the health status of various worker populations and for providing technical assistance, at cost, for businesses interested in developing worksite-based health promotion programs.

h.2 The State Legislature should establish financial incentives to promote the development of worksite-based health promotion activities by Washington businesses.

GOAL I. TO INITIATE MEASURES WHICH ARE KNOWN TO BE COST EFFECTIVE FOR PREVENTING AND DETECTING CHRONIC DISEASES. EXAMPLES INCLUDE SCREENING FOR CERTAIN CANCERS, DIABETES, HYPERTENSION AND GLAUCOMA AND PROVIDING CERTAIN FORMS OF HEALTH EDUCATION.

STRATEGIES:

i.1 DSHS and local health department/districts should assure that chronic disease screening and follow-up referral services are available for high-risk groups.

i.2 DSHS should consider expanding the existing surveillance system for chronic disease mortality to include incidence and prevalence of selected chronic diseases.

i.3 DSHS and local health departments/districts should assure that educational services are available and utilized for the prevention and control of chronic diseases.

GOAL J. TO ASSURE THAT RESIDENTS OF THE STATE ARE ADEQUATELY PROTECTED FROM COMMUNICABLE DISEASES.

STRATEGIES:

j.1 The DSHS Communicable Disease Section and Epidemiology Unit should maintain a comprehensive system for community surveillance of communicable diseases.

j.2 The DSHS Immunization Unit should be responsible for maintaining a statewide reporting-audit system to track all newborns to assure completion of the infant immunization schedule. It is a state goal that at least 90 percent of infants begin the immunization series at two months of age and complete it by two years of age.

j.3 The State Legislature is responsible for providing adequate resources for the purchase of vaccine material and the epidemiological investigation of unusual disease outbreaks.

j.4 Local health departments/districts should be responsible for identifying at-risk populations and for formulating and implementing plans to ensure that appropriate vaccines are available to these populations.

j.5 Local health departments/districts should provide surveillance and access to services for the broad array of sexually transmitted diseases.

j.6 The DSHS Division of Health should continue to provide statewide leadership in coordinating efforts of public health agencies, private health care providers, blood collection centers and medical laboratories to assure that effective and humane public health strategies are adopted to interrupt the transmission of the HTLV-III virus and thereby reduce the actual incidence of illness and death; to educate the public to support those strategies; and to support and facilitate continued AIDS laboratory, clinical, epidemiological and public education research.

GOAL K. TO ASSURE THAT ENVIRONMENTAL HEALTH HAZARDS ARE ADEQUATELY MONITORED, REGULATED, AND CONTROLLED TO PREVENT ADVERSE HEALTH EFFECTS AND PROTECT THE STATUS OF GOOD HEALTH WHERE IT EXISTS.

FINANCING AND COST CONTAINMENT

GOAL 2. TO CONTAIN HEALTH CARE COSTS WHILE MAINTAINING NECESSARY ACCESS TO AND QUALITY OF HEALTH SERVICES.

OBJECTIVE 2.a BY 1990 IMPROVE THE ABILITY OF HEALTH CARE CONSUMERS AND PROVIDERS TO MAKE INFORMED DECISIONS ABOUT COST-EFFECTIVE USE OF HEALTH SERVICES.

For a variety of reasons, consumers and providers of health care have not been as frugal as one would expect in industries that are more "price conscious." As the discipline of the health care market is strengthened through financing reforms, consumers and providers will need to be given useful information that helps them to make wise choices in their use of services.

STRATEGIES:

(1) The State Health Coordinating Council (SHCC) should consider publicizing charges of health care providers.

(2) Payers should make available to their clients comparative information on physician charges and utilization.

(3) The University of Washington Medical School should review its curriculum to examine current medical practice in relation to health care costs and the objectives/strategies in this Plan.

(4) Each hospital should regularly provide staff physicians with information about charges for that hospital and for services ordered by physicians.

(5) The SHCC should encourage appropriate self-care and the enhancement of consumer decision-making concerning appropriate use of the health care system.

(6) Before providing services, providers of health care services should fully disclose their fees and potential charges for hospitalization and diagnostic and treatment procedures ordered.

OBJECTIVE 2.b BY 1990 ASSURE CITIZEN PARTICIPATION IN THE DESIGN AND IMPLEMENTATION OF HEALTH CARE COST CONTAINMENT STRATEGIES.

Effective cost containment strategies require citizen participation in their development and implementation.

STRATEGIES:

(1) The health planning system should differentiate state and local planning roles in ways that assure substantial local authority in planning for the appropriate distribution of health facilities and services consistent with state resource allocation guidelines.

(2) The Department of Social and Health Services (DSHS) and the SHCC should cooperatively develop proposals to coordinate, and merge where appropriate, state health program advisory groups.

(3) Business and labor groups should take leadership in establishing coalitions aimed at controlling overall health system costs, as well as group costs.

OBJECTIVE 2.c BY 1990 ENSURE A BASIC LEVEL OF HEALTH SERVICES TO ALL STATE RESIDENTS.

A definition of the level of basic health services to be assured to all state residents is a necessary element in planning for the health system and in resource allocation decision making.

STRATEGIES:

(1) State legislature with assistance from SHCC and other citizen groups should define the basic level of health services to be available to all residents of the state and should identify the appropriate supply and distribution of these essential health services.

(2) The state Office of Financial Management (OFM) should evaluate and publicly report types and costs of health services available to people with state-purchased health care.

(3) The State Legislature should enact legislation to broaden Medical Assistance eligibility to incorporate those currently unable to pay for basic health care and should appropriate additional funds to support such expansion.

OBJECTIVE 2.d. BY 1990 DEVELOP MEASUREMENT AND MONITORING TOOLS TO BE USED TO EVALUATE CHANGES IN PRIVATE AND PUBLIC SECTOR HEALTH SPENDING AND UTILIZATION.

Health revenue targets and measures of consumers' utilization of health services provide major tools to measure progress in cost containment efforts and changes taking place in the health care system. These changes may affect the relationship between the private and public sector use of the health care system and there may be a correlation that should be monitored to identify and avoid any increasing shift toward a two-tiered system.

STRATEGIES:

(1) To monitor progress in cost containment efforts and changes taking place in the health care system, the SHCC should develop methods for establishing health care revenue targets for the public and private sectors within overall targets for total health care revenues. Separate targets for acute care, long term care, primary care and prevention/promotion should ultimately be established.

(2) The SHCC, along with OFM and state agencies, should annually evaluate the relationship of public and private sector health expenditures and utilization of the health care system.

(3) The health planning system should evaluate progress in developing short-stay residential programs, and the cost per day and per stay of such programs in comparison to short-stay hospital programs and should reassess the determination of resource needs contained in Volume II of this plan.

OBJECTIVE 2.e. BY 1990 INTRODUCE CONSUMER AND PROVIDER COST CONTAINMENT INCENTIVES AND PRUDENT BUYER CONCEPTS INTO HEALTH CARE PAYMENT/REIMBURSEMENT SYSTEMS.

Payment systems developed to help assure access to care have shielded both consumers and providers from the true costs and risks of utilization and investment. The historical cost-based reimbursement system provides incentives for uncontrolled utilization and growth, and few incentives for controlling costs.

STRATEGIES:

(1) The SHCC should identify strategies to promote individual responsibility for utilization decisions that affect costs.

(2) The Division of Medical Assistance (DMA), Department of Labor and Industries (L&I) and other state agencies paying for hospital services should develop proposals for reimbursement systems compatible with any prospective payment system adopted.

(3) DMA and other public and private third party payers in the state should test managed health care arrangements (e.g., health maintenance organizations, preferred provider organizations) based on the recommendations of the Select Committee on Managed Health Care, and implement those determined to be effective in assuring necessary access at least cost.

(4) Third party payors should require scientific evidence of demonstrated patient benefit for each new diagnostic or treatment procedure approved for reimbursement.

(5) The health planning system should encourage major private insurers to provide coverage in short-stay psychiatric residential programs within the same limitations as their policies place on benefits for hospital-based programs.

OBJECTIVE 2.f BY 1990 IMPROVE AND COORDINATE THE POLICIES AND OPERATIONS OF STATE PROGRAMS AFFECTING HEALTH FACILITY CAPITAL INVESTMENTS.

All relevant state agencies must coordinate their efforts and strengthen their decision base in order to follow a unified strategy in implementing state cost containment policy.

STRATEGIES:

(1) The WSHC, DMA, L&I, and other state agencies purchasing health services should develop common policies for reimbursement of capital expenditures.

(2) The WSHC and the health planning system should develop and use consistent mechanisms and definitions for applying financial feasibility analysis which include the community cost impact analysis.

(3) The Washington Health Care Facilities Authority should develop rules, regulations or policies to assure that its financing decisions are consistent with the health facility development requirements of this State Health Plan. Also the Authority, DSHS, and the WSHC should coordinate their efforts to assure that health care facility financing plans are consistent with this State Health Plan.

(4) The health planning system should refine statewide health service performance standards in Volume II of this plan as appropriate.

(5) The health planning system, WSHC and other state agencies providing or paying for health services should collaborate on definition, collection and analysis of health data. Steps should be taken to ensure patient confidentiality.

(6) The State Legislature should consider enacting legislation to regulate private reimbursement rates of nursing homes and to require thirty days advance notification of rate increases to private nursing home patients.

ACUTE CARE

Acute care services focus on the diagnosis and treatment of medical care problems. Acute care services generally are categorized into three types: primary, secondary and tertiary care. This section focuses on the latter two of these levels of care. Secondary care services are often in a hospital setting and include medical/surgical, pediatric, obstetric, radiology and laboratory services. Tertiary services are also generally hospital services. They consist of complex diagnostic and therapeutic services requiring highly specialized personnel and equipment. Primary care services, which are ordinarily provided on an outpatient or ambulatory basis, are treated later in this plan.

GOAL 3. TO CONTROL THE GROWTH AND IMPROVE EFFICIENCY OF THE HOSPITAL SYSTEM AND MAJOR MEDICAL EQUIPMENT.

OBJECTIVE 3.a BY 1990 ENSURE THAT CONSUMERS, PURCHASERS AND PROVIDERS HAVE EQUITABLE ACCESS TO DATA AND FORECASTS ON THE NEED, USE, COST AND OTHER CHARACTERISTICS OF HEALTH SERVICES.

Better data systems and forecasting methods are essential for improved operation of state regulatory programs and of strategies to strengthen the operation of market forces in the state.

STRATEGIES:

(1) The health planning system should consider refinements/ revisions to current hospital forecasting methods to ensure they better reflect the population's need for services. Such refinements should include: a) use rate adjustments to correct for planning area variations, b) utilization of age-specific use experience of managed health care systems, and c) establishment of state or regional target bed population ratios.

(2) The health planning system should develop and implement new health data systems expected to be cost-effective in strengthening market forces or appropriate regulatory programs.

OBJECTIVE 3.b BY 1990 PROMOTE A REGIONALIZED HOSPITAL SYSTEM WITH LINKAGES AMONG FACILITIES AND SERVICES PROVIDING DIFFERENT LEVELS OF CARE.

An efficient hospital system limits distribution of specialized services to the number which achieves appropriate utilization levels. Patient access is achieved by coordination and referrals among facilities and services, as specified in Volume II of this plan.

STRATEGIES:

(1) The health planning system, in collaboration with the WSHC and affected state health programs, should expand the effort reflected in Volume II of this plan to describe regionalized systems of acute care services in the state.

(2) The health planning system, in consultation with the WSHC, should develop a description of a regionalized system of hospital facilities. In developing this description, the State Health Coordinating Council (SHCC) should recommend facilities that WSHC should consider to be essential to ensure basic access for residents in rural areas as required by RCW 70.39.

(3) The health planning system should consider additional ways to ensure the survival of essential facilities and should recommend legislation to accomplish this.

OBJECTIVE 3.c BY 1990 ENSURE THE EFFICIENT UTILIZATION, SYSTEMATIC ADOPTION AND APPROPRIATE LOCATION OF INNOVATIVE HEALTH CARE TECHNOLOGIES IN THE STATE.

Acquisition of expensive technology and its subsequent utilization is a major factor in the escalation of health care costs. A significant part of cost containment is prevention of unnecessary duplication of technology. In addition to costs, it is also important to evaluate the safety, potential benefits and quality of a new technology. To this end, expensive technology should be subject to Certificate of Need (CON) review regardless of its location or ownership.

STRATEGIES:

(1) DSHS, WSHC and SHCC should promote the phased introduction of expensive new medical technologies.

(2) The State Legislature should revise state law to extend CON coverage to all medical technology with high capital costs irrespective of its location.

(3) Third party payers in the state should limit reimbursement for innovative technologies to medically necessary services approved by CON.

LONG TERM CARE

Long term care is social and health care rendered to people of all ages who have one or more dysfunction of intermittent, extended or permanent duration who may need one or more service for an extended duration. This edition of the plan presents a restatement and amplification of policies that have been a part of the State Health Plan since 1980. To date the State Health Plan has focused on long term care services for the elderly and younger physically disabled persons.

GOAL 4. TO DEVELOP AN EFFICIENT AND EFFECTIVE LONG TERM CARE SYSTEM THAT ENSURES COST-EFFECTIVE IMPROVEMENT OR MAINTENANCE OF FUNCTIONAL INDEPENDENCE FOR THE INDIVIDUALS SERVED.

OBJECTIVE 4.a BY 1990 SUPPORT AND ENHANCE INFORMAL LONG TERM CARE BY THE FAMILY AND FRIENDS OF DISABLED PERSONS.

A significant portion of disabled people do not use formal long term care services in large part because of traditionally non-reimbursable assistance provided by family and friends (informal care). To the extent that state government can foster such assistance, when it is appropriate, increased funds will be available to better care for individuals who do not have others capable of providing the assistance they need.

STRATEGIES:

(1) DSHS and the health planning system should develop, and the legislature should authorize and fund, cost-effective programs to promote or support informal care.

(2) The Department of Community Development (DCD) and the DSHS Long Term Care Planning Group should identify and develop proposals to eliminate unwarranted state and local barriers to voluntary shared living arrangements for disabled persons.

(3) DCD, in consultation with the State Housing Finance Commission, should investigate existing funding sources and develop proposals for the expansion of group housing with arrangements for social and health services for disabled persons.

(4) The DSHS Long Term Care Planning Group should develop legislative proposals for providing individuals with financial incentives to give informal care.

OBJECTIVE 4.b BY 1990 MAINTAIN AND IMPROVE THE ARRAY OF FORMAL LONG TERM CARE SERVICES CONSISTING OF COMMUNITY-BASED CARE (e.g. HOME HEALTH CARE, CHORE SERVICES, ADULT DAY HEALTH), NON-MEDICAL RESIDENTIAL CARE (e.g. BOARDING HOMES, ADULT FAMILY HOMES) AND MEDICAL RESIDENTIAL CARE (e.g. NURSING HOMES).

The availability of an array of long term care services assures that individuals can be placed and maintained in an appropriate environment. This array may best be structured as a continuum with separate agencies providing separate levels of care, or as organized systems in which agencies provide a range of service levels to clients.

STRATEGIES:

(1) The DSHS Long Term Care Planning Group, in consultation with other members of the health planning system, should assess the array of long term care services in the state and develop proposals for any additional service arrangements determined to be necessary to meet people's needs cost effectively.

(2) In recognition that some continuing care retirement communities (CCRCs) have the potential to provide their members with a coordinated, cost-effective array of independent living and formal long-term care services, DSHS and the SHCC should maintain policies which encourage development of those CCRCs which meet all of the following requirements:

(a) responsible financial/actuarial management;
(b) thorough disclosure of risks, benefits and conditions to consumers;
(c) participation of members in CCRC decision-making;
(d) policies which prevent or reduce state financial liability for present and future services for members.

OBJECTIVE 4.c BY 1990 ASSURE THE APPROPRIATE SUPPLY AND MIX OF INDIVIDUAL LONG TERM CARE SERVICES WITH EMPHASIS ON PROMOTING RELATIVELY GREATER GROWTH OF COMMUNITY-BASED SERVICES AND NON-MEDICAL RESIDENTIAL CARE.

This objective recognizes that there are relative shortages of community-based and non-medical residential long term care services. It also recognizes that long term care funding limits require that trade-offs among different types of long term care services be made. The extent to which such trade-offs are necessary depends on the amount of total health spending in the state and the portion of that total spending dedicated to long term care.

(1) DSHS should implement an appropriate mix of changes in current budget levels and program budget enhancements, to achieve this objective.

(2) A designated DSHS office, in collaboration with the Office of Financial Management (OFM), should develop and periodically update information on total and service specific public and private long term care expenditures in the state and areas of the state, and on the numbers and characteristics of public and private clients using long term care services.

(3) The health planning system, in cooperation with the DSHS Office of Research and Data Analysis and the DSHS Long Term Care Planning Group, should refine projections of the overall need for formal long term care services in the state, and the proportion of this total need that would be met by individual long term care services if clients were matched with cost-effective services.

OBJECTIVE 4.d BY 1990 ASSURE A BASIC LEVEL OF QUALITY FOR ALL LONG TERM CARE SERVICES PROVIDED IN THE STATE.

State government has an obligation to protect the public health and safety of users of all health services, including long term care services.

STRATEGIES:

(1) The State Legislature should enact legislation establishing mechanisms to assure the quality of in-home long term care services.

(2) The State Legislature should revise state law as necessary to require that state home health agency and hospice certification requirements reflect minimum standards to protect the public health and safety of individuals using these services.

(3) The State Legislature should enact consumer protection legislation which assures, through means including continuing oversight, that all CCRCs maintain financially and acturially sound operations; practice thorough disclosure of pertinent facts to consumers; do not engage in unfair business practices; and permit residents a voice in discussions with CCRC management. In the absence of such legislation, DSHS and the SHCC should attempt to meet these consumer protection goals through other means, and should consider them pertinent aspects of quality in reviewing facilities and services.

(4) The State Legislature should support public participation and client notification in nusing home change of ownership reviews.

(5) The DSHS Aging and Adult Services Administration and Office of Licensing and Certification should systematically review existing long term care facility/service state licensing and certification regulations for the purpose of simplifying and reducing requirements to the minimum necessary to protect the public health and safety of service users.

OJBECTIVE 4.e BY 1990 ASSURE APPROPRIATE PLACEMENT OF CLIENTS AND OPTIMAL USE OF LONG TERM CARE DOLLARS THROUGH DEVELOPMENT OF: 1) STATEWIDE LONG TERM CARE CASE MANAGEMENT APPROACHES, 2) EQUITABLE ELIGIBILITY REQUIREMENTS, ASSESSMENT/PLACEMENT CRITERIA AND SLIDING FEE SCALES ACROSS ALL LONG TERM CARE SERVICES, AND 3) REIMBURSEMENT METHODS THAT PROMOTE MATCHING CLIENTS WITH COST EFFECTIVE SERVICES AND MAXIMIZING THE USE OF AVAILABLE DOLLARS.

This policy reflects the importance of good client management in assisting vulnerable clients and their families to access the complicated long term care system, and in assuring appropriate service use. It recognizes that widely varying eligibility requirements and payment approaches for different long term care services act as a major impediment to assuring that clients get appropriate services to meet their needs. It also recognizes the importance of financial incentives in assuring the best use of limited long term care resources.

STRATEGIES:

(1) Aging and Adult Services Administration, in consultation with the DSHS Long Term Care Planning Group and other members of the health planning system, should formally evaluate current DSHS dual case management arrangements in the state, and propose any changes needed to increase the state's ability to stay within long term care expenditure targets.

(2) The DSHS Long Term Care Planning Group, in consultation with other members of the health planning system, should evaluate existing long term care reimbursement systems, and propose changes needed to permit the appropriate match of clients/ services.

(3) The DSHS Long Term Care Planning Group should develop proposals for making eligibility requirements and sliding fee scales equitable, consistent with the state government long term care expenditure target.

(4) The State Legislature and third party payors should establish pilot projects to study the effectiveness of mandatory pre-placement screening/referral in assuring appropriate service use by private nursing home clients. This pilot project should include safeguards to avoid clients backing up in hospitals.

(5) DSHS should develop and implement a process to identify, register, and collect uniformly reported cost and utilization information from all home care providers.

OBJECTIVE 4.f BY 1990 EFFICIENTLY AND EFFECTIVELY MANAGE STATE LONG TERM CARE SERVICES.

Efficient management of long term care services is necessary to minimize the dollars that must go to overhead rather than to direct services. One element of this is effective management systems. Another is opening up these systems to formal input from providers and clients.

STRATEGY:

(1) DSHS should consider merging state management systems for long term care services.

PRIMARY CARE

Primary care (ambulatory care) is that level of personal health services which meet the routine and basic needs of most of the people most of the time. It includes health maintenance, diagnosis and treatment of common illnesses, counseling and referrals, coordination and follow-up of specialty care. It also includes health promotion and disease prevention services addressed in the Health Status/Public Health section of this plan.

GOAL 5. TO ASSURE THE AVAILABILITY AND APPROPRIATE USE OF PRIMARY HEALTH CARE SERVICES IN THE STATE.

OBJECTIVE 5.a BY 1990 ENSURE ADEQUATE ACCESS TO THOSE BASIC SERVICES TO BE IDENTIFIED UNDER THIS PLAN.

Primary care practitioners serve as the entry point in the health care system. The primary care practitioner, in partnership with the client, is responsible for coordinating basic health services to assure the patient receives comprehensive and continuous care.

STRATEGIES:

(1) Primary care providers should assure necessary means of communicating with and responding to the cultural needs of clients in areas which have a significant population of racial/cultural minorities.

(2) The primary care practitioner, in partnership with the patient, should assume responsibility for monitoring the health status of the patient in order to provide early detection and preventive services.

(3) Publicly-funded agencies which provide primary care should do so on a sliding fee scale to assure that no person is refused care solely because they are unable to pay.

(4) Local provider associations should ensure the availability of a source of telephone information and referral in each county for medical and mental health problems that require prompt attention but are not life-threatening.

OBJECTIVE 5.b BY 1990 ENCOURAGE THE USE OF PRIMARY CARE OR SERVICES PROVIDED IN AMBULATORY SETTINGS AS APPROPRIATE ALTERNATIVES TO INPATIENT CARE.

It should be possible for individuals to receive care in the setting which is most appropriate considering their identified needs. Greater use of appropriate alternatives to inpatient

care reduces unnecessary use of intensive institutional care, fosters individual involvement in care-related decisions, and may enhance consumer satisfaction with care received.

STRATEGIES:

(1) Third party payors should structure health insurance benefit packages to offer the insured a higher percentage of reimbursement for procedures identified as cost-effective and maintaining quality when done in ambulatory settings.

(2) Primary care providers and their clients should discuss and arrange the least expensive combination of primary care resources and services that will appropriately meet the needs of the people served.

(3) Acute care facilities should direct consumers lacking a referring physician to the Medical Society or community clinics for follow-up and future ambulatory care.

OBJECTIVE 5.c BY 1990 PROMOTE ORGANIZED HEALTH CARE SYSTEMS THAT PROVIDE COMPREHENSIVE CARE AND THAT PERMIT AND ENCOURAGE APPROPRIATE USE OF PRIMARY CARE AS AN ALTERNATIVE TO MORE INTENSIVE FORMS OF CARE.

Health economists have long recognized that one of the fundamental reasons why health care costs have increased so rapidly is the fee-for-service system that characterizes most current health care purchasing. Some health care systems remove these cost-pushing incentives by allotting a specific sum of money to be used for care over a period of time. This requires the health care provider to manage the care required appropriately, within a clear budget. Other systems depend on vigorous utilization control, rather than assumption of financial risk by providers, as the main tool to reduce health care expenditures.

STRATEGY:

(1) Business, government, primary care professionals, individuals and the health planning system should work together to develop Health Maintenance Organizations or other managed health care programs that will assure the availability of cost-effective services in all areas of the state.

OBJECTIVE 5.d BY 1990 PROMOTE QUALITY OF CARE IN AMBULATORY SETTINGS.

Quality of care in most ambulatory settings, whether physicians' offices or an organized facility, depends on the quality of the attending physician or other practitioner. The state controls physician and practitioner quality through credentialing. Some quality control mechanisms for organized settings are self assessments accountable to Medicare or other federally funded programs such as Migrant Health, and voluntary accreditation by national organizations.

(1) The Department of Social and Health Services should consider the development of quality standards for ambulatory surgery centers and freestanding emergency centers.

HEALTH PERSONNEL

GOAL 6. TO MEET THE HEALTH CARE PERSONNEL NEEDS OF THE POPULATION.

6.a BY 1990 PERMIT ENTRY INTO A HEALTH PROFESSION BY APPLYING THE LEAST RESTRICTIVE LEVEL OF CREDENTIALING NEEDED, IF ANY, TO PROTECT THE PUBLIC INTEREST.

RCW 18.120.040 requires State Health Coordinating Council (SHCC) review and recommendations to the State Legislature on proposals to credential new categories of allied health occupations, and on proposals to substantially change the scope of practice of existing regulated occupations. Review by an independent body provides a broader decision base for the Legislature than they would otherwise hear from the professions' proponents.

STRATEGIES:

(1) The SHCC should continue its credentialing review while refining the process and criteria.

(2) The SHCC should develop and propose policies to the Legislature and Department of Licensing regarding generic credentialing issues.

OBJECTIVE 6.b BY 1990 ENSURE THE APPROPRIATE TYPE, SUPPLY, TRAINING, AND QUALITY OF HEALTH CARE PERSONNEL.

It is the proper role for the SHCC to assess the supply and future demand for various types of health care personnel, how these match with those produced by state-supported institutions, and the access of qualified low income students to training. With decreasing federal contributions to the financing of medical education, the financial burden is falling on the states.

STRATEGY:

(1) In future editions of this State Health Plan, health planning system should identify appropriate state health personnel policies and statewide health personnel resource allocation guidelines. Among the issues that should be addressed are:

° The extent of surpluses or deficits in the supply of health professionals in total and by specialty and how this should impact on the state-supported institutions' enrollment policies and funding. In

assessing future need, consideration should be given to utilization of physicians assistants, nurse practitioners, dental hygienists, other allied health professionals, and combinations of health professionals to increase productivity.

- The extent of surpluses or deficits in the supply of nurse practitioners and physicians' assistants, their future demand in the event of a physician surplus, and how this should impact on their state-supported training programs.

- The types of allied health professionals likely to be in future demand, numbers needed, and availability of resources for their training.

- The extent of surpluses or deficits in supply of nurses and how this should impact on thier state-supported training programs.

- The extent of financial assistance to low income and minority health professions students, social implications of their exclusion, and whether state government should ensure such assistance.

OBJECTIVE 6.c BY 1990 ENSURE THE APPROPRIATE DISTRIBUTION OF HEALTH CARE PERSONNEL

Some national studies indicate more physicians are now locating in previously designated health manpower shortage areas. We do not know the extent to which this is compensating in Washington State for the decreasing federal financing of primary care facilities and personnel in underserved areas.

(1) The health planning system should be responsible for identifying the appropriate supply and distribution of health personnel within their area, consistent with the policies and resource allocation guidelines specified in the State Health Plan.

(2) Based on the finding from 6.c (1) above the health planning system should recommend a system or program to encourage location of needed health manpower into identifed shortage areas.