Let's Get Healthy California Task Force Report

DRAFT

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Letter from Task Force Co-Chairs

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

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

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

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

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

Within each goal area the Task Force identified a set of priorities. To track progress within them 32 health indicators were selected that, taken together, paint a picture of the state's overall level of health. We have created a Dashboard that includes these indicators, the data behind them, and ten-year targets. We will use the Dashboard to follow whether Californians are becoming healthier, or not, over time. The Dashboard reflects priorities and indicators at this point in time and will likely change as our needs and our ability to measure them evolve. It is our hope that by tracking these indicators, we will stimulate actions to collectively make a measurable difference.

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

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

Diana S. Dooley, JD
Secretary, California Health and
Human Services Agency
Task Force Co-Chair

Donald Berwick, MD, MPP, FRCP
Former Administrator, Centers for
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I. Introduction

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

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

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

- Chronic conditions and an aging population. Although California's population is slightly younger than the rest of the nation's, the population is aging. Moreover, California, like the rest of the country, is experiencing unprecedented levels in chronic disease. The alarmingly high rates of obesity and resulting conditions, such as diabetes, may reverse the progress made over the last 100 years of increasing life expectancy. For the first time ever, children born in this generation may not live as long as their parents.

- Transformation in health care delivery. The health care delivery system is undergoing a period of rapid transformation to address a trio of problems—it is fragmented, uncoordinated, and financially unsustainable.

- Significant health disparities. California is the most populous and diverse state in the country. Significant health disparities, or differences in health outcomes, exist by race/ethnicity, income, educational attainment, geography, sexual orientation, and occupation. These disparities relate to differences in social, economic and environmental conditions as well as to conditions within the health care system itself.

- The Affordable Care Act. The passage of the federal Affordable Care Act (ACA) in 2010 offers the country, for the first time, a vehicle for providing health care insurance to a vast majority of the population; the Act prioritizes and integrates, for the first time, important prevention and public health outcomes into the health care system.

- Health care costs and the state fiscal challenges. The cost of health care continues to surpass the rate of inflation, causing increasing strain on the budgets of families, employers and government.

California has made great strides in many of these areas. For example, California has led the nation in reducing smoking, implementing managed care, and creating innovative payment mechanisms to hold down Medi-Cal costs. More recently, it has aggressively begun implementation of the health benefits exchange under the ACA. However, the state's fiscal situation, the increase in chronic

disease, and the waste and inefficiencies in the health care system demand that more robust action be taken.

The time is ripe to build on what California has already accomplished to set ambitious goals for the next ten years and develop a plan to systematically collect, prioritize and share information. With California's talent, expertise, and history of innovation, we can bring stakeholders, employers, and diverse communities together to catalyze action that will reduce the burden of disease and stem the rise in health care costs. By promoting a culture of health in our homes, our workplaces, our schools, and our communities, as well as reforming our medical care delivery system to place health, not disease, at its core, we can succeed in making California the healthiest state in the nation.

II. Background, Strategic Directions, and Goals

On May 3, 2012, Governor Jerry Brown issued Executive Order B-19-12 establishing a Let's Get Healthy California Task Force (hereinafter referred to as the Task Force) to "develop a 10-year plan for improving the health of Californians, controlling health care costs, promoting personal responsibility for individual health, and advancing health equity." The Executive Order identified a number of issues to be considered by the Task Force, including asthma, diabetes, childhood obesity, childhood vaccinations, and hypertension, as well as hospital readmissions and sepsis-related mortality. The Executive Order further directed the Task Force to issue a report by December 15, 2012, with recommendations for how the state can make progress toward becoming the healthiest state in the nation over the next decade.

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

The Secretary's charge to the Task Force was to address the following overarching question:

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

In addition, as the Executive Order stated, we were charged to help California track progress toward this goal by "establishing baselines for key health indicators...[and] establishing a framework for measuring improvements." Therefore, a second overarching question guiding the Task Force was:

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

The Triple Aim of
Health Improvement

- Better Health
- Better Care
- Lower Costs

To ground the work, the Task Force first developed a set of guiding principles (see Appendix II.) and agreed that the "Triple Aim,"—articulated by Task Force Co-Chair Dr. Don Berwick during his tenure at CMS—should serve as the foundation for developing the goals, priorities, and indicators. Several recent national and state reports were reviewed, including the National Strategy for Quality Improvement in Health Care, issued by the federal Department of Health and Human Services in March 2011, the National Prevention Strategy, issued by the National Prevention Council in June 2011, and the Framework for Tracking the Impacts of the Affordable Care Act, developed by the State Health Data Assistance Center for the California HealthCare Foundation in June 2011. In addition, a variety of scorecards, such as County Health Rankings and the Commonwealth Fund on Local Health System Performance, were examined, along with similar efforts undertaken by other states around the country.

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

Based on the extensive and wide-ranging feedback received, the Task Force recommends that California establish six goals, organized under two strategic directions.

First, to address the question of "*What will it look like if California is the healthiest state in the nation*?" the Task Force believes that we should look at health across the lifespan and aspire to be a state where Californians at all ages and stages of life can achieve optimal health. Under the strategic direction of Health Across the Lifespan, we identify three goals, each relating to a critical life stage:

Health Across the Lifespan

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

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

Pathways to Health

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

We can make California the healthiest state in the nation. But it will take working on multiple fronts simultaneously—from making very technical but important changes in the health care delivery system and protecting our public health infrastructure, to inspiring every single Californian to be take more responsibility for his/her own health. By taking this comprehensive approach, we will not only improve the health of our people, but also the fiscal health of the state by slowing the rise in health care costs.

This report is the result of six months of deep analysis, discussion, and debate among the Let's Get Healthy California Task Force members ably supported by a state staff team. The report sets forth six goals, priorities within each of the goals, and indicators to measure progress. The report also provides synopses of a variety of strategies that Task Force members, as the catalysts for change, are currently undertaking.

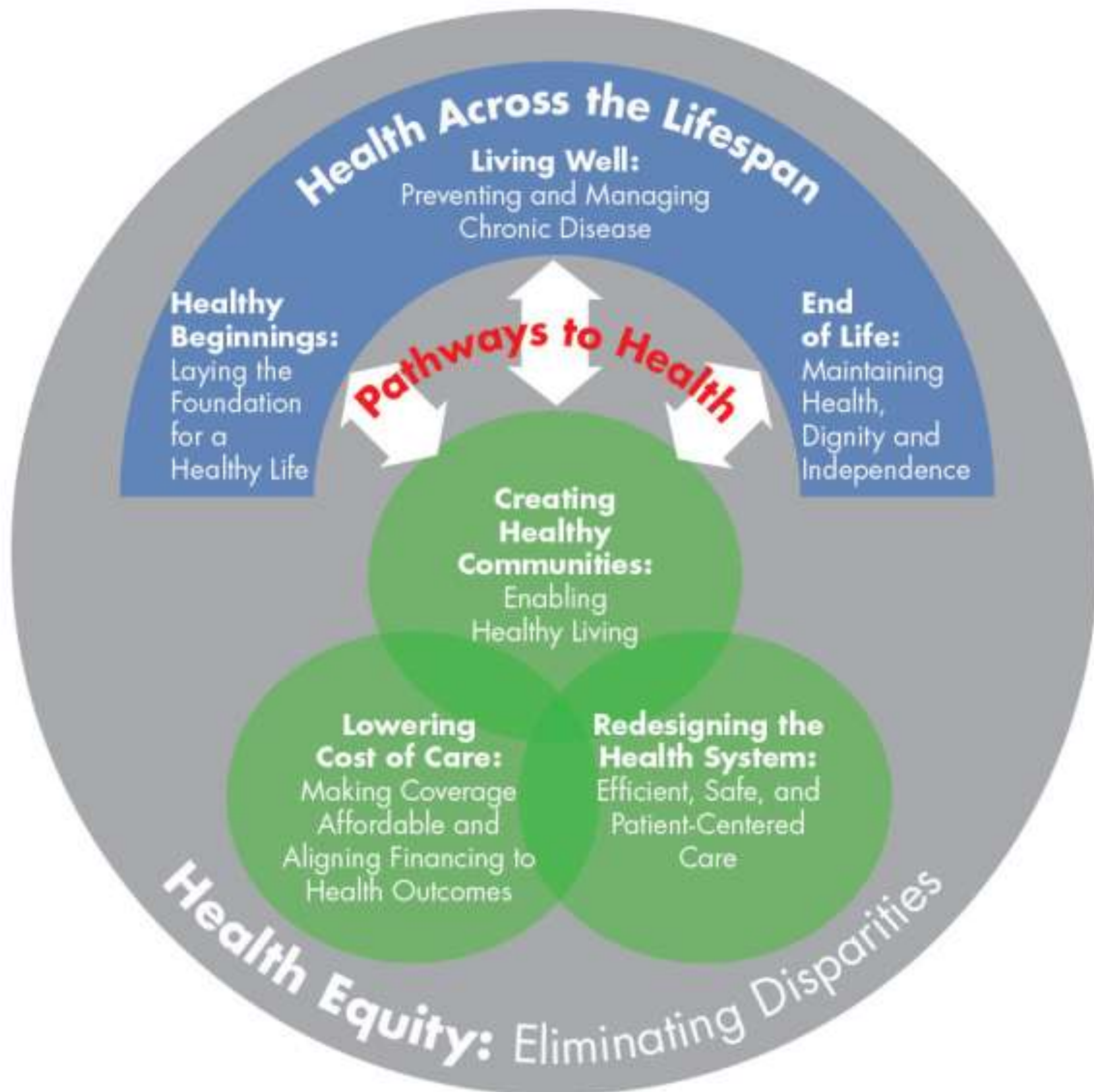
One final note: In putting together this report, we sought to reflect the voices – and the actual words – of Task Force members who shared their passion for California and gave so generously of their time and expertise. Sprinkled throughout the report are "Six-Word Stories" created by Task Force members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

III. A Framework and Goals for Measuring Health

Let's Get Healthy California Task Force Framework

The Triple Aim:

Better Health • Better Care • Lower Costs



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

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

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

- We seek to be aspirational over the long term, but also need to be practical to make progress in the short-term.
- We would like to be able to compare ourselves with the rest of the country, but don't want to be limited in what we measure to only metrics that have been adopted nationwide and don't account for California's leadership in developing additional data sources.
- We aspire to be comprehensive, but also need to limit the number of goals and targets in order to focus our efforts to make a difference.
- We desire to measure "what's most important and has heart," but also have to ground our targets in metrics for which data currently exist.
- We want to recognize the significant role played by broad determinants of health, such as poverty, but as a Task Force comprised primarily of health and health care professionals, we are focused primarily on what is within our own areas of expertise where we can have the greatest influence.

Living Well.
Dying Well.
Sharing. Caring.
—Co-Chair Diana Dooley

Healthy California: Courageous leadership stands up!
—TF Member Bruce Bodaken

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

The Task Force has identified a total of 29 priorities within the six goals described in the Framework, as well as developed a Dashboard, with measurable indicators for each of the priorities. They are organized as follows:

2 Strategic Directions → 6 Goals → 29 Priorities → 40 Indicators.

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

For each indicator, the Dashboard displays:

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

IV. Priorities and Indicators

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

Being the healthiest state in the country means that Californians throughout the lifespan—from our children to our seniors—are healthy. This strategic direction focuses on three goals related to key stages of life: Healthy Beginnings, Living Well, and End of Life.

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

Healthy beginnings: Equity, proactive, collective wellness
—TF Member America Bracho

Getting a healthy start sets the stage for health and well-being for a person's entire life. The nine priorities and thirteen indicators (one of which still needs to be developed) under this goal represent a spectrum of important dimensions of children's health and well-being. Table 1 displays an overview of the priorities and indicators, while Table 2 identifies the baseline and 2022 target for each indicator. In addition, racial/ethnic data, to the extent they are available, are included, demonstrating the significant disparities that exist between racial and ethnic populations in California.

Table 1: Priorities and Indicators for Healthy Beginnings

Priority	Indicator
↓ **Infant deaths**	1. Mortality rates
↑ **Vaccinations**	2. Doses of vaccines for children 19-35 months
↓ **Childhood trauma**	3. Adverse Childhood Experiences score 4. Nonfatal child maltreatment
↑ **Proficient reading skills**	5. Proportion of 3rd graders who read at or above proficiency level
↓ **Childhood asthma**	6. Emergency Department visit rates for asthma
↑ **Childhood fitness and healthy diets**	7. Physical fitness assessments of children 8. Adolescents who meet physical activity guidelines 9. Soda and sugary sweetened beverage consumption
↓ **Childhood obesity and diabetes**	10. Obesity rates for children and adolescents *Indicator Development Needed: Diabetes rates for adolescents*
↓ **Adolescent tobacco use**	11. Smoking rates
↑ **Mental health and well-being**	12. Frequency of feeling sad within last 12 months

Infants and Vaccinations. Although California's infant mortality rate is better than the national average, there are significant disparities, with African American babies dying at twice the rate of other groups. Achieving the 2022 target of 4.1 deaths per 1,000 live births will take concerted efforts to address the high African American infant mortality rate. With regard to vaccinations, California rates are slightly below those of the nation. The ten-year target for this indicator is 80%.

> **Everyone trying to reproduce California's results**
> —Exp. Adv. Nadine Burke-Harris

Childhood trauma. Because of the growing literature about the impact childhood trauma has on the future health and social development of children as they become adults, this topic is included as a priority. The Adverse Childhood Experience[1] (ACE) score refers to the number of traumatic events in a child's life, including verbal, physical or sexual abuse, an alcoholic parent, or mental illness. The higher the score, the greater the risk for a range of diseases and disabilities. Although the ACE score is determined in adulthood, it provides a comprehensive measure to assess whether children's overall exposure to trauma is being reduced over time. Another indicator, Nonfatal Childhood Maltreatment, provides current information on reported children maltreatment at the county level.

Reading proficiency. The Task Force wanted to include one non-health priority on school readiness because of the critical link between education and future health. Although preschool or kindergarten assessments are not available on a standardized basis, third grade reading levels are

[1] See http://acestudy.org/home for more information

used as a proxy. The good news is that between 2006 and 2011, third grade reading levels in California jumped from 36 to 44 percent, a roughly 22 percent increase.[2] The bad news is that fewer than half of our children still do not meet proficiency standards for this social determinant of health.

All kids helping each other improve.
—TF Member Joe Silva

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

Childhood asthma. Childhood asthma has become a pressing issue in recent years—nearly 1.5 million children in California have asthma, the most prevalent chronic condition for kids ages 0 to 17.[3] Asthma can result in higher school absenteeism and lead to lower levels of physical activity, among other effects of the condition. There are significant disparities in asthma prevalence. For example, African American children utilize the Emergency Department more than eight times as frequently as Asian American children for asthma.

Educated, active children moving California forward
—TF Member Joy Melnikow

Childhood fitness and healthy diets. Many unhealthy behaviors with a life-long impact on health– smoking, poor diet, and inactivity—begin in childhood and adolescence; therefore, several priorities are devoted to these issues. Surprisingly, the percent of adolescents in California who drank two or more glasses of a sugary beverage within the past day is much higher than the national rate (27.3%, 19.7 respectively). Also, California's rate of teenagers who meet physical activity guidelines is less than the national rate, and African American teenagers rate the highest. Asian Americans rank relatively high in terms of school fitnessgram scores for grades 7 and 9.

Obesity and diabetes. Because of the rise in overall weight and diabetes in children, it will be important to track these conditions. The Dashboard sets ambitious targets for childhood obesity. It is not enough to simply stem the rising rates of obese children; to become the healthiest state in the nation, California must reverse the epidemic and begin to lower the rates of obesity, given the impact of these conditions on the long-term health and well-being of the population and society. Therefore, the Task Force recommends that the 2022 target rates of obesity for children be under 10 percent and that adolescent rate be set at 11.5 percent, representing a reduction of about one-third from their baselines. Although there is no indicator to measure the prevalence of diagnosed diabetes in children/adolescents at this time, it is recommended that one be established. (See Appendix V.)

Tobacco. California has been a national leader in efforts to reduce smoking. While California performs quite well in comparison to most states with respect to tobacco use—13.8 percent of adolescents smoked cigarettes in the past 30 days compared to 19.5 percent nationally—the Task Force aims for further reductions by 2022. A target goal of 10.3 percent is proposed.

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[2] California Department of Education, Standardized Testing and Reporting (STAR) Results, http://star.cde.gov
[3] Chronic Disease in California: Facts and Figures." California HealthCare Foundation 2006. http://www.chcf.org/publications/2006/10/chronic-disease-in-california-facts-and-figures#ixzz2Aheur300

Mental health and well-being. One often under-reported issue is adolescent mental health. There are two measures that track adolescent mental health. One has found between one-quarter and one third of 7th, 9th, and 11th graders experienced feelings of sadness within the last 12 months. In the next section, a metric for adolescent depressive episodes is included.

Table 2: Dashboard for Healthy Beginnings

	Leading Indicator		CA Baseline	2022 CA Target	National Baseline	2020 National Target	Race/Ethnicity Disparities
1	Infant Mortality, Deaths per 1,000 Live Births		4.7	4.1	6.75	Not Available	White/Asian: 4.1 Af. Am.: 10.6
2	All doses of recommended vaccines for children 19-35 months		68%	80%	70%	80%	Not Available
3	Respondents indicating at least 1 type of Adverse Childhood Experiences		59.4%	45.1%	Not Available	Not Available	Other: 45.1% White: 62.1%
4	Incidents of nonfatal child maltreatment (including physical, psychological, neglect, etc.) per 1,000 children		9.4	2.8	9.4	8.5	Asian/P.I: 2.8 Af. Am.: 24.5
5	Proportion of third grade students whose reading skills are at or above the proficient level		46%	69%	Not Comparable	Not Comparable	Asian: 69% Hisp/Lat.: 33%
6	Percentage of "physically fit" children, who score 6 of 6 on the required California school Fitness-gram test	5th graders	25.2%	35.6%	Not Available	Not Available	White: 35.6% Hisp./Lat.: 18.5%
		7th graders	32.1%	45.8%	Not Available	Not Available	Asian: 45.8% Hisp/Lat, P.I: 25.3%
		9th graders	36.8%	52.2%	Not Available	Not Available	Asian: 52.2% P.I.: 27.0%
7	Proportion of children and adolescents who are obese	2-5 yrs.	12.4%	9.4%	10.7%	9.6%	White: 9.4% Hisp./Lat: 15.4%
		6-11 yrs.	12.2%	7.6%	17.4%	15.7%	2+ Races: 7.6% Hisp./Lat.: 16.1%
		12-19 yrs.	18.0%	11.5%	18.0%	16.1%	Asian: 11.5% Hisp./Lat.: 23.7%
8	Proportion of adolescents who meet physical activity guidelines for aerobic physical activity		15.2%	23.7%	18.4%	20.2%	Af. Am.: 23.7% Asian: 8.8%
9	Adolescents who drank 2 or more glasses of soda or other sugary drink yesterday		27.3%	17.4%	19.7%	Not Available	Asian: 17.4% 2+ Races: 38.4%
10	Proportion of adolescents who smoked cigarettes in the past 30 days		13.8%	10.3%	19.5%	16.0%	Asian/P.I.: 10.3% White: 14.7%
11	Emergency department visits, 0-17 years due to asthma per 10,000		72.6	28	103	Not Available	Asian/P.I.: 28 Af. Am.: 236.2
12	Frequency of sad or hopeless feelings, past 12 months	7th graders	27.9%	TBD	Not Available	Not Available	TBD
		9th graders	30.6%	TBD	Not Available	Not Available	TBD
		11th graders	32.1%	TBD	Not Available	Not Available	TBD

Goal 2. Living Well: Preventing and Managing Chronic Disease

The World Health Organization (WHO) defines health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[4] The six priorities and nine indicators (including one still to be developed) under this goal represent key aspects of living well, with a particular focus on preventing and managing chronic disease because of the rising prevalence of chronic diseases and the impact they have on the state's residents. Nearly 14 million adults (38 percent) in California live with at least one chronic condition and more than half of them have multiple chronic conditions.[5]

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

Table 3: Priorities and Indicators for Living Well

Priority	Indicator
↑ Health status	13. Self-reported health status as good or excellent
↑ Fitness	14. Adults who meet physical activity guidelines
↓ Tobacco use	15. Smoking rates
↑ Controlled high blood pressure and high cholesterol	16. Percent of adults with hypertension who have controlled high blood pressure 17. Percent of adults with high cholesterol who are managing the condition
↓ Obesity and diabetes	18. Obesity rates 19. Diabetes prevalence
↑ Mental health and well-being	20. Proportion of adults and adolescents with a major depressive episode *Indicator Development Needed: Effective treatment of depression*

Health status. In order to assess the overall health of the population, the first priority under this goal is health status. For California to be the healthiest state in the nation, California's residents should first and foremost believe that they are healthy, so the Dashboard sets a 2022 target for reported health status as very good or excellent at 90 percent, up from today's 84.7 percent.

Fitness. As much as 80 percent of heart disease, stroke and diabetes—and over 30 percent of cancers—could be prevented by increasing healthy behaviors, including physical activity levels.[6] More Californians already engage in physical activity than other states in the country, but as a state that prides itself on being active, the Dashboard sets a very ambitious goal for 2022. In ten years,

[4] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.
[5] "Chronic Disease in California: Facts and Figures." California HealthCare Foundation 2006.
[6] Table 5-10a. Ten Leading Causes Of Death, Death Rates, Age-Adjusted Death Rates And Percent Changes By Sex - Hispanic - California, 2008-2009, http://www.cdph.ca.gov/data/statistics/Documents/VSC-2009-0510A.pdf

two-thirds of adults should meet the physical activity guidelines—more than 25 percent higher than the national target of 48 percent.

Tobacco Use. As a major contributor to a range of chronic diseases, reducing smoking is a priority of living well. The Task Force believes that California should continue to be a leader in efforts to lower smoking rates. The Dashboard's 2022 target would bring the state's overall rate to 8.5 percent—a 30 percent reduction from the current rate of 12 percent. To achieve this goal, particular attention will need to be paid to smoking among African Americans, who currently smoke at a rate two times higher than Californians of Asian descent.

For lifelong health accelerate prevention now.
—Exp. Adv. Neal Halfon

Controlled high blood pressure and cholesterol. Two conditions—high blood pressure and high cholesterol—if uncontrolled, can be precursors to other more serious health issues. Effective, prevention-oriented, patient-centered clinical care can ensure that people monitor and treat their disease and, ultimately, slow its progression. Data available for these indicators come from health plan surveys and do not represent all Californians. Depending upon plan type, the range of adults diagnosed with hypertension who have controlled high blood pressure is 50-79 percent. Similarly the range for adults diagnosed with high cholesterol who are managing the condition ranges from 50-76 percent. Targets for 2022 were set to improve and significantly exceed national targets, in particular for persons enrolled in preferred provider organizations (PPOs).

Obesity and diabetes. Bringing obesity rates down is essential to improving the overall health of the population. Although California's current adult obesity rate—nearly one in four—is one of the lowest in the country, it could, nevertheless, increase by 2030 if current trends continue.[7] Obesity-related health costs in California could similarly increase by nearly 16 percent by 2030.

Collectively creating a culture of health.
— Exp. Adv. Sophia Chang

There is a strong correlation between obesity and many diseases, including diabetes. Both diabetes and obesity have very significant racial and ethnic disparities. African American adult rates are about 50 percent higher than the overall state baseline. Reaching the 2022 targets will require paying particular attention to addressing myriad issues—from the lack of access to care to the lack of access to healthy food. The Dashboard sets a particularly ambitious 2022 target for obesity. Consistent with the obesity target for children and adolescents, the Task Force believes that California should reverse the obesity epidemic in a significant way and, therefore, has set the target for adults at 10.8 percent—a reduction of more than half from the current baseline and one-third of the national target.

Mental health and well-being. As the WHO indicates, good health is not limited to physical health issues; mental health and well-being are also essential for good health. Therefore, screening and treatment for depression is an important priority for this goal. Task Force members struggled with finding good measures for effectively diagnosing *and treating* depression in adolescents and adults.

[7] "F as in Fat". Trust for America's Health. September 2012

A placeholder indicator that focuses on people that experience a major depressive episode was selected, with hopes that better measures will be developed over time.

Table 4. Dashboard for Living Well

	Leading Indicator		CA Baseline	2022 CA Target	National Baseline	2020 National Target	Race/Ethnicity Disparities
13	Overall health status reported to be good, very good or excellent		84.7%	90.4%	83.1%	91.2%	2+ Races: 90.4% Am In/AK Nat: 75.3%
14	Proportion of adults who meet physical activity guidelines for aerobic physical activity		58.2%	66.0%	43.5%	47.9%	MultiRacial: 66.0% Hisp./Lat.: 50.0%
15	Proportion of adults who are current smokers		12%	8.5%	20.6%	12%	Asian/P.I.: 8.5% Af. Am.: 17.0%
16	Percent of adults diagnosed with hypertension who have controlled high blood pressure		Medicare 79% PPOs 50% HMOs 78%	Medicare 87% PPOs 70% HMOs 86%	46%	65% by 2017	Not Available
17	Percent of adults diagnosed with high cholesterol who are managing the condition		Medicare 76% PPOs 50% HMOs 70%	Medicare 91% PPOs 70% HMOs 84%	33%	65% by 2017	Not Available
18	Proportion of adults who are obese		23.8%	10.8%	34.0%	30.6%	Other: 10.8% Af. Am.: 33.1%
19	Prevalence of diagnosed diabetes, per 100 adult		8.6	7	8.7	Not Available	White: 7 Af. Am.: 14.3
20	Proportion of adolescents (12-17 years old) and adults (18 years and older) who experience a Major Depressive Episode	Adolescents	8.2%	7.3%	8.3%	7.4%	Not Available
		Adults	6.0%	5.4%	6.8%	6.1%	Not Available

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

California's population is growing older. With hundreds of thousands of Californians celebrating their 65th birthday each year, the current state population of 3.9 million older adults (2009) is projected to double over the next 18 years. Although all of the preceding priorities under Living Well apply to the senior population, the Task Force emphasized the importance of including two additional priorities and indicators under this goal that acknowledge the importance of maintaining quality of life during advanced illness.

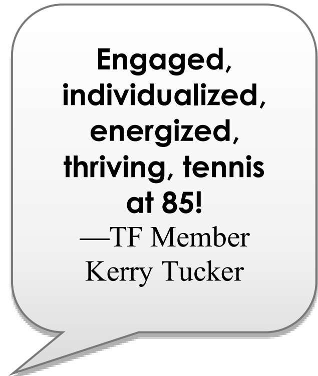

Table 5: Priorities and Indicators for End of Life

Priority	Indicator
↓ **Hospitalization during the end of life**	21. Hospital days during last six months of life
↑ **Palliative care**	*Indicator Development Needed: Rates of palliative care*

Hospitalizations during the end of life. Surveys reveal that the majority of Californians prefer to spend their last months in a non-hospital setting ideally receiving palliative care during this time.[8] Another relevant indicator that is available and included in the Dashboard tracks the number of hospital days during the last six months of life. Currently, California's baseline is 10.6, although significant racial and ethnic disparities exist—as African American seniors average 15.2 days. The 2022 target is 10.1 days, which will ensure that needed hospitalizations are not inappropriately targeted.

Palliative care. Palliative care programs assist patients with the symptoms, pain, and stress of a serious illness, and ensure that patient treatment preferences are met. Because current data show that more Californians—42 percent—die in a hospital than any other setting[9], palliative care programs play an important role in helping patients understand their choices and have access to appropriate care at the end of life, including minimizing unnecessary hospital stays. Development of an indicator(s) to gauge this is a Task Force priority as none currently exists.

Communication among caregivers, informed active patients.
—TF Member Bob Margolis

Table 6: Dashboard for End of Life

	Leading Indicator	CA Baseline	2022 CA Target	National Baseline	2020 National Target	Race/Ethnicity Disparities
21	Hospital Days during the Last Six Months of Life	10.6	10.1	10.3	Not Available	Non-black: 10.1 Black: 15.2

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

Tracking health improvements across the lifespan will enable the state to know where progress is being made and where additional effort is needed. In addition, the Task Force has identified three major goals, grounded in the Triple Aim, that represent key pathways to health. These three goals—Redesigning the Health System, Creating Healthy Communities, and Lowering the Cost of Care—are also grounded in the core disciplines of public health, health care delivery and financing. Critical to our success over the long term will be our collective ability to bridge across the three disciplines and align these drivers with the population health goals and priorities described previously.

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

[8] "Final Chapter: Californians' Attitudes and Experiences with Death and Dying" The California HealthCare Foundation, February 2012. http://www.chcf.org/publications/2012/02/final-chapter-death-dying
[9] "When Compassion is the Cure: Progress and Promise in Hospital-Based Palliative Care." The California HealthCare Foundation. February 2012. http://www.chcf.org/publications/2012/02/compassion-cure-palliative-care#ixzz296oISYer

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

Table 7: Priorities and Indicators for Redesigning the Health System

Priority	Indicator
↑ Access to primary and specialty care	*Indicator Development Needed: Percent of patients who had difficulty finding a provider*
↑ Culturally and linguistically appropriate services	*Indicator Development Needed: Linguistic and cultural engagement*
↑ Coordinated outpatient care	22. Percent of patients whose doctor's office helps coordinate their care 23. Preventable hospitalizations
↑ Hospital safety and quality of care	24. 30-day all-cause unplanned readmissions 25. Incidence of hospital acquired infections
↓ Sepsis	*Indicator Development Needed: Sepsis related mortality (to be determined)*

Transformative quality, cost & convenient access.
—TF Member Richard Levy

Access to primary and specialty care. The availability of primary and specialty care (including behavioral health) varies tremendously across the state. With the implementation of the ACA, which will provide health insurance coverage to millions more Californians, the primary care system will be stretched thin. Primary care enables Californians to obtain health care services, including preventive services, when they are needed, to detect, manage and treat illnesses as early and as effectively as possible. Monitoring access and availability standards will be essential to ensuring that the health system functions efficiently and effectively. The indicator for this priority seeks to measure how difficult it is to find a provider who will accept new patients (primary care and specialty care including mental health specialists). However, there are no data sources readily available at this time.

Culturally and linguistically appropriate services. For California's diverse populations, ensuring that providers can engage with their patients in a culturally and linguistically competent way is essential to meaningful access. Although the indicators for these priorities have not been developed

yet, they will be critical to be able to track how well patients are able to find a provider, particularly with the significant expansion of health insurance in 2014.

Continuously improving care—optimal health.
--TF Member George Halvorson

Coordinated outpatient care. Moving the system toward integrated and coordinated care is critical for patients being able to receive care in the most appropriate setting, reducing duplication, and enhancing quality. Therefore, a measure to track the percent of patients whose doctors' offices help coordinate care with other providers and services is included. Current care coordination ranges from 67.2 percent for children/adolescents to 75 percent for adults. The indicator reflects Californians enrolled in a health plan and, therefore the rates are likely higher than the overall population. A target of 78.2 percent was set based on the current best score.

55% is not good enough![10]
--Exp. Adv. Elizabeth McGlynn

A second indicator of an effective and efficient outpatient system – or lack thereof – is the rate of preventable hospitalizations. Prevention Quality Indicators (PQIs), developed by the federal Agency for Healthcare Research and Quality, are based on hospital discharge data and identify hospitalizations that are potentially preventable with timely and effective outpatient care. PQIs can be used as a "screening tool" to help flag potential health care quality and access issues and identify community needs.

Hospital safety and quality of care. Approximately 33 percent of all health care spending in 2009 in California went to hospital care. Although California's per capita spending for hospital care is less than the national average, systemic improvements are nevertheless needed. Billions of health care dollars could be saved and patient outcomes enhanced through system-wide quality improvement efforts. For example, approximately $31 billion is spent annually nationwide on hospital admissions that are potentially preventable with improved access to outpatient care[11], twenty-five billion dollars is spent on preventable hospital readmissions that result from medical errors and complications, poor discharge procedures, and integrated follow-up care[12], and between $38 and $45 billion nationwide is spent on hospital-acquired infections (the Healthcare Associated Infections Program of the California Department of Public Health estimates that such infections at California's acute care hospitals cost $3.1 billion a year.[13])

California Gold. Wealth through your health.
--TF Member Pam Kehaly

The Dashboard includes two indicators related to hospital care. They track conditions that result from lapses in patient safety or adherence to the highest quality improvement standards: a) unplanned readmissions within 30-days of hospital discharge and b) hospital-acquired conditions. While available data for the latter is limited, it is useful for the near term. The Task Force recommends that a more complete and robust composite safety measure for hospital-acquired conditions be developed within the next few years. With sustained and system-wide quality improvement efforts in hospitals, safety and quality of care for patients can be enhanced and

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[10] "Participants received 54.9 percent (95 percent confidence interval, 54.3 to 55.5) of recommended care" The Quality of Health Care Delivered to Adults in the United States, New England Journal of Medicine, 2003, http://www.nejm.org/doi/pdf/10.1056/NEJMsa022615
[11] "Bend the Curve": A Health Care Leader's Guide to High Value Health Care, NEHI, 2011.
[12] Ibid
[13] Weinberg, M. and L. Wellington Haase. California Task Force on Affordable Care: Creating a High Value Healthcare System for California. New America Foundation, May 2010.

billions of dollars saved.

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

Table 8: Dashboard for Redesigning the Health System

#	Leading Indicator		CA Baseline	2022 CA Target	National Baseline	2020 National Target	Race/ Ethnicity Disparities
22	Percent of patients whose doctor's office helps coordinate their care with other providers or services	Child/Adolescent	67.2%	94%	69%	Not Available	Not statistically stable
		Adult HMO	75%				
23	Preventable Hospitalizations, per 100,000 population		1104.0	Top 5 counties: 736.1	1,434	Top 3 states: 818	Not Available
24	30-day All-Cause Unplanned Readmission Rate (Unadjusted)		14.1%	25% reduction per hospital	14.4%	12% by 2013	Not Available
25	Incidence of measureable hospital-acquired conditions		0.76 per 1,000 discharges	TBD	Not comparable	Not comparable	Not Available

Goal 5. Creating Healthy Communities: Enabling Healthy Living

> **Creating conditions to lead healthy lives.**
> —TF Member Ed Moreno

Numerous studies have demonstrated that where we live plays a major role in our health. A variety of community conditions enhance or create barriers to health, from the level of air pollution, to the availability of parks and green space, as well as access to fresh produce. Communities that are safe and provide opportunities to be active and eat well are needed to support people in making healthy choices. There are a wide range of priorities and indicators that relate to this Goal, and the Task Force encourages public and private stakeholders to review a forthcoming report by the Health in All Policies (HiAP) that will include dozens of healthy community indicators, and consider how this Dashboard can best link with their recommendations.[14]

The HiAP project within the California Department of Public Health Office of Health Equity works with departments and agencies throughout state government, as well as the public and private sectors, to identify critical changes needed in transportation, housing, land use and agriculture, among other issues, to promote healthy living.[15] HiAP is taking a leadership role, along with many other efforts, to comprehensively promote programs and policies to advance healthy communities.

For this Dashboard, the Task Force includes one priority—healthy food outlets—which reflects the concern that many low-income communities have few options to obtain healthy food.

[14] http://www.sgc.ca.gov/hiap/docs/publications/Healthy_Community_Framework.pdf Healthy Communities Indicators, under development by the California Department of Public Health

[15] For more information, see HiAP Task Force Report to the Strategic Growth Council. December 3, 2010. http://www.sgc.ca.gov/hiap/docs/publications/HiAP_Task_Force_Report.pdf

Table 9. Priority and Indicator for Creating Healthy Communities

Priority	Indicator
↑**Healthy food outlets**	26. Retail Food Environment Index

The Retail Food Environment Index (RFEI) is a ratio describing the relative presence of healthy to total retail food outlets in a given area. The highest rate is in Marin county, where 33 percent of the food outlets are healthy. The Dashboard includes that rate as the target for the state in 2022. Although it is a stretch goal from today's baseline of 11 percent, there is significant attention being placed on this issue, and the Task Force believes that this indicator represents progress toward healthier communities throughout the state.

Table 10. Dashboard for Creating Healthy Communities

	Leading Indicator	CA Baseline	2022 CA Target	National Baseline	2020 National Target	Race/ Ethnicity Disparities
26	Number of healthy food outlets as measured by Retail Food Environment Index	11%	33%	10%	Not Available	Not Available

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

> **Optimize Wellness**
> **Provide Cost-Effectively**
> **To Everyone**
> --TF Member Steven Packer

Lowering the overall cost of care is critical for all Californians to be able to have access to affordable coverage and care as well as for the fiscal health of the state. Total spending on health care in California in 2009 exceeded $230 billion. Although California's per capita spending on health care is the 9th lowest in the country, it is still growing at a faster pace than inflation or than the growth of the economy.[16] The rise of health care costs place financial burdens on families, businesses and the state, making reining in costs an important goal. Even though California's Medi-Cal spending per enrollee is the lowest in the country, given the fiscal challenges facing the state, more needs to be done.

The six priorities and eight indicators (two of which are still to be developed) provide a snapshot of the state's progress in this goal. Table 11 displays an overview of the priorities and indicators, while Table 12 identifies the baseline and 2022 target for each indicator.

[16] California Health Care Almanac: Health Care Costs 101: California Addendum. May 2012 http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/H/PDF%20HealthCareCosts12CA.pdf

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

Priority	Indicator
↓ **People without insurance**	27. Uninsurance rate 28. Uninsured at some point in the year 29. Uninsured for a year or more
↑ **Affordable care and coverage**	30. Percent of population under 65 who spend more than ten percent of income on health care
↑ **Rate of growth in health spending in California**	31. Compound annual growth rate
↑ **People receiving care in an integrated system**	32. Percent of people in managed health plans
↓ **Transparent information on cost and quality of care**	*Indicator Development Needed: Transparent information on cost and quality*
↑ **Payment policies that reward value**	*Indicator Development Needed: Most care is supported by payments that reward value*

Everybody in: Improving our health together
--Exp. Adv. Anthony Wright

People without insurance. The ACA provides a much-needed foundation for expanding health insurance coverage and reforming the financing system to make this goal a reality. The Health Benefits Exchange is set to begin implementation in 2014, providing California with an enormous opportunity to make significant progress in getting millions of Californians covered with the most affordable health insurance coverage available to them. With more people "in the system," they will be better able to connect to a regular source of primary and preventive care, rather than rely on the use of more expensive emergency and acute care.

California Health: Both a right and a responsibility.
—TF Member Kelly Traver

Because of the disproportionately high rates of uninsurance among the state's African American, Hispanic/Latino, and Native American populations, expansion of coverage through the Exchange and Medi-Cal will be an important step toward reducing health disparities. Tracking progress regarding coverage must include breakouts of individuals who are uninsured at some point in the year–which are nearly double the number of people who are uninsured for a year or more—to develop a full picture of who is obtaining insurance and who are still without. Based on California research estimates a target 8 percent uninsurance rate overall was set for 2022.[17]

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

[17] http://www.healthpolicy.ucla.edu/pubs/files/calsim_Exchange1.pdf

Affordable care and coverage.
From 2002 to 2009, the rise in health care costs caused health insurance premiums in California to increase 117 percent—far outpacing the 23 percent inflation rate that occurred during that same period[18], not to mention the general stagnation in wages. Lack of affordable care and coverage is one of the primary reasons people are uninsured and unable to access health care when they need it. In order to track individual affordability, the Dashboard includes an indicator to assess the percent of population under 65 that spends more than 10 percent of their income on health expenses. (Data forthcoming)

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

Transparent information on cost and quality. Providing consumers with more information can aid in their decision-making and integrate more cost-consciousness into the system. At the same time, consumers need to understand what information is the most relevant, as well as basic data on cost and quality. There are no metrics yet, but the Task Force places a high priority on developing them.

Payment policies that reward value. The ACA will enhance California's ability to implement payment reforms that reward value and health outcomes, rather than volume. Alignment of health care financing with health goals is crucial to maximizing the utilization of health care dollars. Although this indicator is currently difficult to measure, like transparency, the Task Force flags it for future development.

Rewarding value via payments and market share
--TF member Arnie Milstein

Table 12. Dashboard for Lowering the Cost of Care

	Leading Indicator	CA Baseline	2022 CA Target	National Baseline	2020 National Target	Race/ Ethnicity Disparities
27	Uninsurance rate	14.5%	8.4%	15.3%	Not Available	2+ Races: 8.4% Am In/AK Nat: 23.1%
28	Uninsured at some point in the past year	21.2%	14%	19.7%	Not Available	White: 14% Am In/AK Nat: 31.4%
29	Uninsured for a year or more	11.3%	6.4%	11.2%	Not Available	White: 6.4% Am In/AK Nat: 21.2%
30	Percent of population less than 65 that spends more than 10% of income on health care expenses	TBD	TBD	TBD	TBD	Not Applicable
31	Compound Annual Growth Rate (CAGR) by total health expenditures and per capita costs. For comparison, CAGR by Gross State Product is included	Total: 7.26% Per Capita: 6.27% GSP: 3.69%	0% growth	Total: 6.81% Per Capita: 5.85% GDP: 3.81%	Not Available	Not Applicable
32	High numbers of people in population managed health plans	48.3%	61.0%	22.5%	Not Available	Af. Am: 61.0% Am In/AK Nat: 41.0%

[18] Weinberg (2010)

C. Health Equity: Eliminating Health Disparities

Given the diversity of California, the Task Force believes differences by geography, race/ethnicity and socioeconomic status, should be tracked where data are available. Such data are crucial to eliminating health disparities and contribute to priority setting.

> **Equity and social responsibility are fundamental.**
> --Exp. Adv. Ellen Wu

As previously mentioned, California's African American population has an infant mortality rate of 10.6 per 1,000, more than twice the state's average. Only looking at the state's average would mask this very critical issue. Similarly, smoking rates vary considerably by gender, race/ethnicity, income, and geography. In California, 9.3 percent of adult women are smokers, compared to 14.9 percent men. Asian Californians have the lowest rates of smoking – 8.5 percent overall, while African Americans are twice as high.

By focusing on those populations and communities with the poorest health outcomes, California can lead the way in improving the overall health of the state. That said, it will take more than the health system to fully achieve health equity. Poverty, education, and economic opportunity are major determinants of health, and efforts to address many of the goals and indicators described above, such as infant mortality, asthma or obesity, should be multi-sectoral. Although the Task Force's efforts are focused primarily on those issues where the health and health care sectors can make the greatest difference, our framework explicitly identifies the important role of community environments in achieving our goals. Moreover, the framework links the work of this Task Force to the Health in All Policies (HiAP) project within the State Office of Health Equity, since it is addressing many of the social and environmental determinants of health. Finally, as a Task Force, we each commit to continue building bridges with other sectors in order to tackle these issues in new, innovative and collaborative ways over the long term.

> **California gets healthy through engaging social determinants.**
> --Exp. Adv. Jim Mangia

> **Understanding root causes leads to results.**
> --Exp. Adv. Steve Fields

V. Catalysts for Change: Task Force Exemplary Interventions

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

> **Join together: the race for better health!**
> --Exp. Adv. Deborah Freund

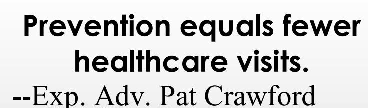
Fortunately, California is blessed with many and varied efforts that build upon the evidence base, attempting to resolve or at least make inroads into seemingly intractable health problems. This

section of the report provides examples of interventions undertaken by Task Force members. Although the many dozens of submitted interventions cannot all be included here, the examples provide a sense of the caliber of leadership, spirit of collaboration, and sense of innovation that define California. Some interventions focus broadly on community or health care system change, while others target a specific population, disease/condition, or race/ethnicity. Together, these efforts serve as a launching pad for success over the next decade.

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

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

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



Vaccinations: The **Fresno County Department of Public Health** is involved in two initiatives to improve the immunization rates. First, the *Immunization Education of Health Care Providers* program offers education to health providers on how to talk to parents who are undecided or have concerns about vaccination. To increase immunization rates, physicians should clearly communicate vaccine benefits and risks while understanding the factors that affect a parent's acceptance and perception of the benefits and risks. The program offers education opportunities to physicians and medical assistants. For example, an immunization update training was developed, promoted and coordinated in Fresno, Madera, Tulare and Kings Counties that reached over 100 medical assistants; in addition a physician education opportunity was provided to 25 local physicians. Ninety percent of attendees found the information beneficial for their practice. This intervention has only recently been implemented and, therefore, the impact in the local immunization rate for children 19-35 months has not been measured.

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

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

Childhood Fitness and Healthy Diets: Anthem Blue Cross is partnering with the Alliance for a Healthier Generation (founded by the American Heart Association and the William J. Clinton Foundation) and San Fernando Valley-based Facey Medical Group to conduct a pilot in the San Fernando Valley area to provide children who have a high body mass index with comprehensive benefits for the prevention, assessment and treatment of childhood obesity. As part of the program, eligible children have access to four visits with their primary care provider and four visits with a registered dietitian per year. Three pediatrician "champions" participate in the pilot. The involved healthcare professionals work with children and their families to establish and maintain a healthy lifestyle. Anthem reimburses these services with no cost to the patient. This program currently enrolls 40 children (members) via 3 physician champions and is scheduled for re-evaluation/re-negotiation in March 2013.

Californians set pace for national reform.
--Exp. Adv. Wells Shoemaker

Anthem Blue Cross is also supporting a second initiative through a grant to HealthCorps®, a program co-founded by renowned heart surgeon and talk show host Dr. Mehmet Oz. The grant supports eight schools in low-income communities and will target 600 students in each school who are at high risk for obesity. A full time coordinator is placed at each school to integrate peer mentors with other aspects of the school-based curriculum. The program's goal is to see changes in BMI in at least 16 percent of the student population, increase in fruit and vegetable consumption, changes in fitness activity, and changes in test scores on health related information. The project is awaiting first year results. Ultimately, the program hopes to increase its reach four-fold by engaging students' family members, school employees, and others.

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

changes in school cafeterias, increased access to clean drinking water, eating and physical activity behavior changes among youth, their peers, and families, and the acquisition of new skills and exposure to new experiences for involved youth/students.

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

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

> **Let us get healthy, California. Walk!**
> —TF Member Bill Monning

Kaiser Permanente is involved in two efforts, both focused on wellness. Kaiser Permanente's program, *Every Body Walk!* promotes walking as an easy, cost effective way for Californians to achieve real health benefits. While walking and other forms of physical activity are not innovative, *Every Body Walk!* is a creative online educational campaign aimed at getting Americans up and moving. The program is working to spread the message that walking 30 minutes a day, five days a week really can improve your overall health and prevent disease. It provides news and resources on walking, health information, walking maps, how to find walking groups, a personal pledge form to start walking, as well as a place to share stories about individual experiences with walking. The website includes downloadable apps and links to other important information and programs. The program targets 30 minutes of walking per day, 5 days per week for adults; another measure is 10,000 steps per day.

> **Get up and enjoy the coast!**
> —TF Member Anne Stausboll

The Total Health wellness program is a joint project of **Kaiser Permanente** and the **Coalition of Kaiser Permanente unions.** It addresses the Task Force goal of preventing and managing chronic disease by aiming to reduce the following: the proportion of adults who are obese; the proportion of adults who smoke; the percentage of adults with hypertension who have controlled high blood pressure; and the percentage of adults with high cholesterol who are managing their condition. The goal of Total Health is to create the healthiest workforce in the healthcare industry by improving the quality and length of employees' lives and enhancing the effectiveness and productivity of the organization. The Total Health approach seeks to create programs and a workplace environment and culture in which employees in each Kaiser hospital, medical office building, and other facility collectively take responsibility for reducing their health risks. The program additionally seeks to reduce occupational injury and illness. Total Health is innovative in three primary ways: First, instead of focusing exclusively on individual responsibility, employees' progress will be measured as a group, and they will collectively take responsibility for their success. Second, the program uses pay bonuses as incentives for employees to improve their health, rather than the financial penalties used in many other employee wellness programs. Third, the program is a labor-management partnership, and that collaboration is fundamental to its success. The Total Health goal is a 5% improvement in key biometric risk indicators over a three-year period (2013-2016). Those indicators are body mass index, smoking rates, cholesterol, blood pressure, and workplace injuries. Currently, Kaiser and the union coalition are jointly creating the health assessment tools as a prelude to launching the program system-wide.

Healthy California means invest in yourself.
—TF Member James Hay

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

- 26 percent improvement in health status due to transition from "at risk" to "healthy."
- 48 percent decrease in smoking prevalence. Smoking prevalence of 6% represents one of the lowest rates in the nation.
- 32 percent increase in regular physical activity; 48 percent decrease in sedentary behaviour
- Over the course of two years, disability costs fell 18 percent among Wellvolution participants but increased 57 percent among those not engaging in wellness.
- Non-participant medical claims are increasing at a rate 1.5 times that of wellness participants.

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

Goal 3: End-of-Life: Maintaining Health, Dignity, and Independence

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

CAPG's Case Studies in Excellence call attention to the **Sharp Community Medical Group and Sharp Rees-Stealy in San Diego**. Sharp Rees-Stealy is an integrated, multispecialty medical group located in the San Diego community. Implemented in 2011, Sharp's Concurrent Palliative Care Model in End of Life Care works to provide interdisciplinary care to patients with advanced chronic conditions, such as congestive heart failure, chronic obstructive pulmonary disease, and dementia, to benefit from a high level of care coordination. Care is team-based; hospice workers, primary care providers, specialists, nurses, social workers, pharmacists and spiritual care providers come together to deliver comprehensive care. The team works with patients and families to assess their preferences, and develop a treatment and support plan. A palliative care team interacts with patients and family through home visits, family conferences, and spiritual support and guidance. Together a treatment and support plan, complete with an advanced care plan respecting the patient's preferences, is developed. The team supports the patient through the illness progression, and when appropriate, transition into hospice. Key outcomes to date include a high level of patient and family satisfaction, improvements in quality of life as measured by the Patient Quality of Life Index, and reductions in the total cost of care through enhanced coordination/communication and reduced ED visits and hospitalization/ICU days.

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

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

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

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

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

Similar efforts for greater coordination and integration of primary care are seen in the **Progress Foundation's** approach to providing treatment for individuals with "serious mental illness." Progress Foundation, in partnership with the University of California at San Francisco School of Nursing, endeavors to bring primary care services into the 24-hour residential treatment programs settings, taking a proactive approach to ensuring those who are in the midst of an acute psychiatric episode receive necessary preventative care. Over 90% of these patients are dually diagnosed with "serious mental illness" and "serious substance abuse treatment needs;" their chronic health conditions are often overlooked and can go undetected. The work of the Progress Foundation and other institutions like it is critically important as the rates of morbidity and mortality from chronic conditions such as diabetes and obesity are rising among the seriously mentally ill population due in

part to the increased use of newer generations of psychotropic medications. Progress Foundation's internal measurements and objectives include a goal that 100% of the clients in their residential treatment settings receive a screening, assessment, and initial facility based treatment plan for addressing any existing chronic conditions. Integrating behavioral health and primary care interventions can prevent, diagnose and treat health conditions which, if are allowed to go undetected, could result in unnecessary hospitalizations for both psychiatric and physical health care conditions.

Health Caring for All! Investing in California.
--Exp. Adv. Jane Garcia

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

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

Another hospital-related effort to reduce early elective deliveries (EEDs) is underway with **Dignity Health**. In light of the growing evidence base regarding the potential harm of EEDs Dignity undertook an initiative to eliminate or substantially reduce EEDs among its network hospitals

offering maternal and child health services in 2011. Key interventions include a standardized list of accepted, evidence-based medical indications for an EED; widespread education of staff, physicians, and patients; and a "hard stop" for scheduling EEDs without a documented indication. In less than six months the rate of EEDs before 39 weeks dropped form a baseline rate of seven percent to one percent, or a system-wide rate of about 75 to 15 EEDs per month. Dignity collaborated with other health systems in the development of the EED initiative and has shared its successes and insights with other systems and CMS.

Goal 5: Creating Healthy Communities: Enabling Healthy Living

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

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

> **Prevention works! Invest in your community**
> --Exp. Adv. Mary Pittman

Like many of the initiatives described under other goals, the *Health Homes* initiative by **St. John's Well Center** is one that addresses two goals and several priorities. Because the intervention is a community intervention that directly addresses the social determinants of health, it is listed under this goal. The comprehensive approach to asthma combines medical care, coordination, case management, in home community health promotion and assessment, community organizing and legal services. When a patient is identified, diagnosed and treated for asthma symptoms at one of St. John's community health centers, a medical evidence form is filled out with the child, their family and the physician. They are then referred to a case manager, who coordinates the system of care and referrals necessary for the comprehensive intervention. Community health promoters are then dispatched to the home to assess the in-home environmental conditions and triggers (mold, cockroach infestation, rat or rodent infestation, cracking or peeling paint, leaky pipes, temperature, etc.) and to teach the family how to use low-cost, low-tech barriers and cleaning products to alleviate some of the housing conditions besieging the family. If the conditions are structural, a physician writes a letter to the landlord informing them that the dwelling is harmful to the health of the children living there. If the landlord does not respond, the family is referred to the Center's medical/legal clinic and tenant organizers to provide more pressure on the landlord to make necessary repairs. This strategy has been tremendously effective at alleviating housing conditions that lead to asthma. The progress

made includes: a 100% reduction in asthma hospitalizations; a 95% reduction in blood lead levels; a 100% reduction in emergency room use due to asthma; a 96% reduction in missed school days, a 93% reduction in missed work days for caregivers, and a 159% increase of patients with well-controlled asthma per ACT score.

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

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

Healing healthcare, affordable to all.
--TF Member Mitch Katz

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

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

VI. Next Steps/Conclusion

The Let's Get Healthy California Task Force was constituted for six-months, concluding in December 2012. It is our intent that, taken together, the Framework and Dashboard may serve as an organizing influence for stakeholders, policymakers, and the public to engage in efforts across the state to make California the healthiest state in the nation. To that end, we hope that the Dashboard can be made readily accessible, along with the initial inventory of change strategies identified in this report, to enable individuals and organizations to learn from each other and to identify opportunities for collaboration. As noted in the report, the Dashboard is intended to be reviewed and periodically updated as measurement capabilities evolve and new priorities emerge.

Cataclysm imminent. Renew. Remake. Relapse? Choose!
--TF Member Dave Regan

Number one in health is fun!
--Exp. Adv. Steve Shortell

Each Task Force member is committed to continuing to assess how his/her organization can take steps to advance the Goals and Priorities outlined in this report. While the work of the Task Force is done, we look forward to continuing the relationships forged

during the last six months and continuing to work together collaboratively– as well as to engage new partners and the public – to make progress toward achieving the ambitious goals set forth in this report.

The best place to be alive!
—Co-Chair Don Berwick

Appendices

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Appendix I: Executive Order B-19-12

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

____

EDMUND G. BROWN JR.
Governor of California

ATTEST:

____

DEBRA BOWEN
Secretary of State

Appendix II: Task Force Members and Expert Advisors

Co-Chairs

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

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

Members

Bruce Bodaken, Chairman and CEO, Blue Shield of California

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

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

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

George Halvorson, Chairman and CEO, Kaiser Permanente

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

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

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

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

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

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

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

Joy Melnikow, MD, MPH, Director, Center for Healthcare Policy and Research and professor of medicine, Department of Family and Community Medicine, University of California, Davis

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

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

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

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

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

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

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

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

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

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

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

Honorary Chair

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

Members

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

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

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

Molly Coye, MD, MPH, Chief Innovation Officer, UCLA Health System

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

Steve Fields, MPA, Executive Director, Progress Foundation

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

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

Alan Glaseroff, MD, Director, Stanford Coordinated Care

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

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

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

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

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

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

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

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

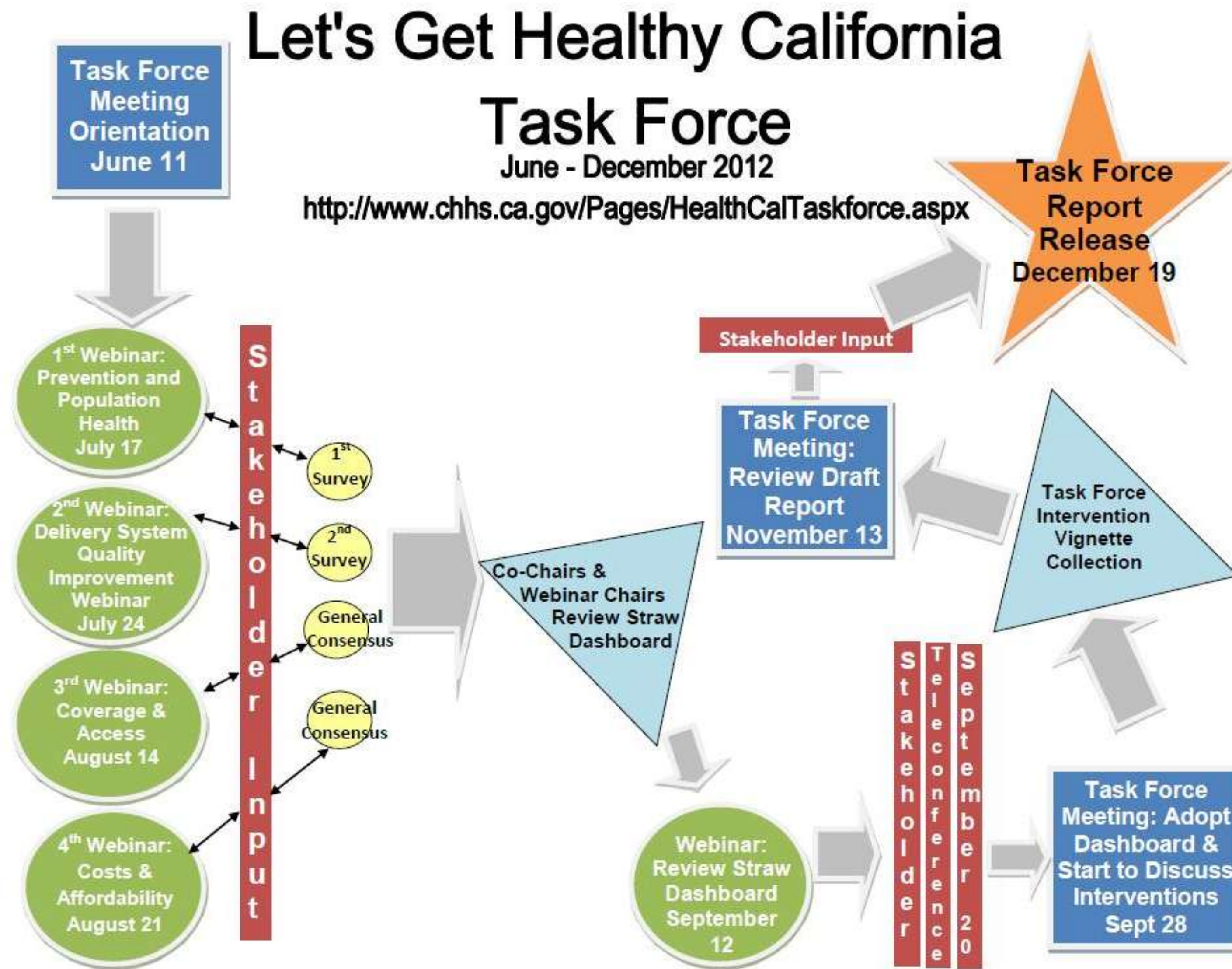
Anthony Wright, Executive Director, Health Access

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

Appendix III: Guiding Principles

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

Appendix IV: Process



Appendix V: Dashboard

To select the indicators, the availability of national data was first assessed, since national data would enable California's progress to be compared to other states. Where such data are not available, or where California data are superior, state data sources were identified. While several key indicators[19] do not have ongoing funding sources at this time, recent baseline data are available and the Task Force recommends them for inclusion in the Dashboard.

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

The underlying principle that guided the establishment of the ten-year targets is that California can only become the healthiest state in the nation if we close the race and ethnicity gaps by raising *everyone's* health to the highest outcomes that we know can be achieved. Thus, each indicator was analyzed by race and ethnicity, to the extent data are available, and the best rating was chosen for the 2022 target. For example, California's current infant mortality rate is 4.7 per 1,000 live births—two percentage points lower than the national average. Within that rate, however, there is great variation. African Americans in California have an infant mortality rate of 10.6 while Whites and Asian Americans' rates are 4.1. Therefore, the state target for 2022 is 4.1 with the aim of improving outcomes overall and closing the disparity gap.

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

The 40 total indicators represent a full range of issues that, taken together, will paint a picture of whether Californians are becoming healthier or not over time. It is not an exhaustive list by design. Rather, these select indicators will spur actions that will collectively make a measurable difference.

Included among the 40 are eight indicators have been identified for which data are not yet available, but which are integral to the Dashboard. They are included in Appendix V. The Task Force strongly encourages public, private and philanthropic partners to prioritize efforts to advance the development and collection of these data.

[19] Adverse childhood experiences and childhood mental health and well-being

Health across the Lifespan: Indicators, Baselines, and Targets

	Leading Indicator		CA Baseline	2022 CA Target[20]	National Baseline	2020 National Target	Race/Ethnicity Disparities[21]
Healthy Beginnings: Laying the Foundation for a Healthy Life							
1	Infant Mortality, Deaths per 1,000 Live Births		4.7	4.1	6.75	Not Available	White/Asian: 4.1 Af. Am.: 10.6
2	All doses of recommended vaccines for children 19-35 months		68%	80%	70%	80%	Not Available
3	Respondents indicating at least 1 type of Adverse Childhood Experiences[22]		59.4%	45.1%	Not Available	Not Available	Other[23]: 45.1% White: 62.1%
4	Reduce Incidents of nonfatal child maltreatment (including physical, psychological, neglect, etc.) per 1,000 children		9.4	2.8	9.4	8.5	Asian/P.I.: 2.8 Af. Am.: 24.5
5	Proportion of third grade students whose reading skills are at or above the proficient level		46%	69%	Not Comparable	Not Comparable	Asian: 69% Hisp/Lat.: 33%
6	Percentage of "physically fit" children, who score 6 of 6 on the required California school Fitness-gram test	5th graders	25.2%	35.6%	Not Available	Not Available	White: 35.6% Hisp./Lat.: 18.5%
		7th graders	32.1%	45.8%	Not Available	Not Available	Asian: 45.8% Hisp/Lat, P.I: 25.3%
		9th graders	36.8%	52.2%	Not Available	Not Available	Asian: 52.2% P.I.: 27.0%
7	Proportion of children and adolescents who are obese or overweight	2-5 yrs.	12.4%	9.4%	10.7%	9.6%	White: 9.4% Hisp./Lat: 15.4%
		6-11 yrs.	12.2%	7.6%	17.4%	15.7%	2+ Races: 7.6% Hisp./Lat.: 16.1%
		12-19 yrs.	18.0%	11.5%	18.0%	16.1%	Asian: 11.5% Hisp./Lat.: 23.7%
8	Proportion of adolescents who meet physical activity guidelines for aerobic physical activity		15.2%	23.7%	18.4%	20.2%	Af. Am.: 23.7% Asian: 8.8%
9	Adolescents who drank 2 or more glasses of soda or other sugary drink yesterday		27.3%	17.4%	19.7%	Not Available	Asian: 17.4% 2+ Races: 38.4%
10	Proportion of adolescents who smoked cigarettes in the past 30 days		13.8%	10.3%	19.5%	16.0%	Asian/P.I.: 10.3% White: 14.7%
11	Emergency department visits, 0-17 years due to asthma per 10,000		72.6	28	103	Not Available	Asian/P.I.: 28 Af. Am.: 236.2
12	Frequency of sad or hopeless feelings, past 12 months	7th graders	27.9%	TBD	Not Available	Not Available	TBD
		9th graders	30.6%	TBD	Not Available	Not Available	TBD
		11th graders	32.1%	TBD	Not Available	Not Available	TBD

[20] Proposed 2022 CA targets for improvement are the score for the best ranking race/ethnicity group for indicators for which race/ethnicity data is available. The following abbreviations were used: Af. Am.: African American; Am In/AK Nat.: American Indian/Alaska Native; Hisp./Lat.: Hispanic/Latino; 2+ Races: Two or more races; P.I.: Pacific Islander

[21] Race/Ethnicity Disparities represent the score for the worst ranking race/ethnicity group for indicators for which race/ethnicity data is available. See above for abbreviations.

[22] To be collected 2013

[23] Represents a combination of Asian, Hawaiian/Pacific Islander, and Native American/Alaska Native

Health across the Lifespan: Indicators, Baselines, and Targets

	Leading Indicator		CA Baseline	2022 CA Target[24]	National Baseline	2020 National Target	Race/Ethnicity Disparities[25]
Living Well: Preventing and Managing Chronic Disease							
13	Overall health status reported to be good, very good or excellent		84.7%	90.4%	83.1%	91.2%	2+ Races: 90.4% Am In/AK Nat: 75.3%
14	Proportion of adults who meet physical activity guidelines for aerobic physical activity		58.2%	66.0%	43.5%	47.9%	MultiRacial: 66.0% Hisp./Lat.: 50.0%
15	Proportion of adults who are current smokers		12%	8.5%	20.6%	12%	Asian/P.I.: 8.5% Af. Am.: 17.0%
16	Percent of adults diagnosed with hypertension who have controlled high blood pressure		Medicare 79% PPOs 50% HMOs 78%	Medicare 87% PPOs 70% HMOs 86%	46%	65% by 2017	Not Available
17	Percent of adults diagnosed with high cholesterol who are managing the condition		Medicare 76% PPOs 50% HMOs 70%	Medicare 91% PPOs 70% HMOs 84%	33%	65% by 2017	Not Available
18	Proportion of adults who are obese		23.8%	10.8%	34.0%	30.6%	Other[26]: 10.8% Af. Am.: 33.1%
19	Prevalence of diagnosed diabetes, per 100 adult		8.6	7	8.7	Not Available	White: 7 Af. Am.: 14.3
20	Proportion of adolescents (12-17 years old) and adults (18 years and older) who experience a Major Depressive Episode	Adolescents	8.2%	7.3%	8.3%	7.4%	Not Available
		Adults	6.0%	5.4%	6.8%	6.1%	Not Available
Healthy Aging: Maintaining Health, Dignity and Independence							
21	Hospital Days during the Last Six Months of Life[27]		10.6	10.1	10.3	Not Available	Non-black: 10.1 Black: 15.2

[24] op.cit., p. ix
[25] op.cit., p. ix
[26] op.cit., p. ix
[27] Denominator: 100% of Medicare enrollees age 65-99 who died during the measurement year with full Part A entitlement and no HMO enrollment during the measurement period.

Pathways to Health: Indicators, Baselines, and Targets

#	Leading Indicator		CA Baseline	2022 CA Target[28]	National Baseline	2020 National Target	Race/Ethnicity Disparities[29]
Redesigning the Health System: Efficient, Safe, and Patient-Centered Care							
22	Percent of patients whose doctor's office helps coordinate their care with other providers or services	Child/Adolescent	67.2%	94%[30]	69%	Not Available	Not statistically stable
		Adult HMO	75%				
23	Preventable Hospitalizations, per 100,000 population[31]		1,243.4	Top 5 counties: 736.1	1,434	Top 3 states: 818	Asian/P.I.: 613.1 Af. Am.: 2,352.3
24	30-day All-Cause Unplanned Readmission Rate (Unadjusted)		14.1%	25% reduction per hospital	14.4%	12% by 2013	Not Available
25	Incidence of measureable hospital-acquired conditions[32]		0.76 per 1,000 discharges	See footnote #33	Not comparable	Not Comparable	Not Available
Creating Healthy Communities: Enabling Healthy Living							
26	Number of healthy food outlets as measured by Retail Food Environment Index		11%	33%[34]	10%	Not Available	White Non Hisp: 13.5% Af. Am.: 18.3%
Lowering the Cost of Care: Making Coverage Affordable and Aligning Financing to Health Outcomes							
27	Uninsurance rate		14.5%	8.4%	15.3%	Not Available	2+ Races: 8.4% Am In/AK Nat: 23.1%
28	Uninsured at some point in the past year		21.2%	14%	19.7%	Not Available	White: 14% Am In/AK Nat: 31.4%
29	Uninsured for a year or more		11.3%	6.4%	11.2%	Not Available	White: 6.4% Am In/AK Nat: 21.2%
30	Percent of population less than 65 that spends more than 10% of income on health care expenses		TBD	TBD	TBD	TBD	Not Applicable
31	Compound Annual Growth Rate (CAGR) by total health expenditures and per capita costs. For comparison, CAGR by Gross State Product is included		Total: 7.26% Per Capita: 6.27% GSP: 3.69%	0% growth	Total: 6.81% Per Capita: 5.85% GDP: 3.81%	Not Available	Not Applicable
32	High numbers of people in population managed health plans		48.3%	61.0%	22.5%	Not Available	Af. Am: 61.0% Am In/AK Nat: 41.0%

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[28] op.cit., p. ix
[29] op.cit., p. ix
[30] Staff recommended a 40% improvement in 10 years
[31] The California statewide rates are age-sex adjusted. The 2022 target represents the 2011 age-sex adjusted rate for the five best performing counties (Marin, Placer, Inyo, Santa Barbara and San Mateo) with more than 100 cases. The race/ethnicity rates are unadjusted.
[32] Agency for Healthcare Research and Quality Patient Safety Indicator (PSI) Composite measure. This composite consists of only 8 hospital-acquired conditions (pressure ulcers, iatrogenic pneumothorax, central venous catheter-related blood stream, infection, accidental puncture or laceration, and any of the following after surgery: hip fracture, sepsis, wound dehiscence, pulmonary embolism or deep vein thrombosis) so the rate may be lower than other commonly used hospital acquired condition measures.
[33] Further composite metrics and all-cause harm metrics will be developed in the next ten years
[34] Target is based on RFEI data from higher rated census tract in Marin County, selected for highest overall RFEI county score; geographic disparity is being used instead of race/ethnicity

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

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

Appendix VI: Data Sources

Health across the Lifespan: Data Sources

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

Health across the Lifespan: Data Sources

	Leading Indicator	CA Source	CA Source Detail	National Source
	Living Well: Preventing and Managing Chronic Disease			
13	Overall health status reported to be good, very good or excellent	California Health Interview Survey 2009	Some County; Race/Ethnicity; Age; Gender, Income, Biennial survey	Behavioral Risk Factor Surveillance System 2011, ongoing collection
14	Proportion of adults who meet physical activity guidelines for aerobic physical activity	Behavioral Risk Factor Surveillance System 2011	State, county can be determined; Race/Ethnicity; Age; Gender; Income; Education, ongoing collection	National Prevention Council, National Prevention Strategy, Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011
15	Proportion of adults who are current smokers	Behavioral Risk Factor Surveillance System 2011	State, some county can be determined; Race/Ethnicity; Age; Gender; Income; Education, ongoing collection	National Prevention Council, National Prevention Strategy, Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011
16	Percent of adults diagnosed with hypertension who have controlled high blood pressure	Integrated Healthcare Association, California Pay for Performance Program, Measurement Year 2011 P4P Manual; National Committee for Quality Assurance	Plan Specific	Centers for Disease Control and Prevention, National Health and Nutrition Examination Survey (NHANES), 2005-2008
17	Percent of adults diagnosed with high cholesterol who are managing the condition	Integrated Healthcare Association, California Pay for Performance Program, Measurement Year 2011 P4P Manual; National Committee for Quality Assurance	Plan Specific	Centers for Disease Control and Prevention, National Health and Nutrition Examination Survey (NHANES), 2005-200
18	Proportion of adults who are obese	Behavioral Risk Factor Surveillance System 2011	Some County; Race/Ethnicity; Age; Gender; Income; Education, ongoing collection	National Health and Nutrition Examination Survey, Centers for Disease Control and Prevention, National Center for Health Statistics
19	Prevalence of diagnosed diabetes, per 100 adult	Behavioral Risk Factor Surveillance System 2010	State, some county can be determined; Race/Ethnicity; Age; Gender; Income; Education, ongoing collection	Behavioral Risk Factor Surveillance System 2010, ongoing collection
20	Proportion of adolescents (12-17 years old) and adults (18 years and older) who experience a major depressive episode (MDE)	National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration	No county level	National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration
	Healthy Aging: Maintaining Health, Dignity and Independence			
21	Hospital Days during the Last Six Months of Life	The Dartmouth Atlas, 2007	State Level, Gender, Race/Ethnicity	The Dartmouth Atlas, 2007

Pathways to Health: Data Sources

	Leading Indicator	CA Source	CA Source Detail	National Source
	Redesigning the Health System: Efficient, Safe, and Patient-Centered Care			
22	Percent of patients whose doctor's office helps coordinate their care with other providers or services	California Health Interview Survey Adolescent Survey, California Health Interview Survey Child Survey Biennial survey; Integrated Healthcare Association, California Pay for Performance Program, Measurement Year 2011 P4P Manual; National Committee for Quality Assurance	Some County; Race/Ethnicity; Age; Gender, Income	Health Resources and Services Administration, Maternal and Child Health Bureau; Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health, 2007
23	Preventable Hospitalizations, per 100,000 population	State of California, Office of Statewide Health Planning and Development, Healthcare Information Division, Agency for Healthcare Research and Quality (AHRQ), Prevention Quality Indicator Composite, Version 4.4, generated from the Patient Discharge Data, 2011.	County Level; Zip code; Payer type; Race/Ethnicity; Gender; Age; Acute or Chronic Condition	Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project, Nationwide Inpatient Sample, and AHRQ Quality Indicators, modified version 4.1, 2000-2008
24	30-day All-Cause Unplanned Readmission Rate (Unadjusted)	State of California, Office of Statewide Health Planning and Development, Healthcare Information Division, Patient Discharge Data, 2011.	Payer type; Race/Ethnicity; Gender; Age	Centers for Medicare and Medicaid Services, March 2012
25	Incidence of measureable hospital-acquired conditions	State of California, Office of Statewide Health Planning and Development, Healthcare Information Division, AHRQ Patient Safety Indicator (PSI) Composite generated from the Patient Discharge Data, 2011	Statewide	Agency for Healthcare Research and Quality, Inpatient Quality Indicators, version 4.4
	Creating Healthy Communities: Enabling Healthy Living			
26	Number of healthy food outlets as measured by Retail Food Environment Index	CDC State Indicator Report on Fruits and Vegetables, 2009, indicators derived from HP 2020 objectives; and CDC Children's Food Environment State Indicator Report, 2011	Census Tract Level	CDC State Indicator Report on Fruits and Vegetables, 2009, indicators derived from HP 2020 objectives; and CDC Children's Food Environment State Indicator Report, 2011
	Lowering the Cost of Care: Making Coverage Affordable and Aligning Financing to Health Outcomes			
27	Uninsurance rate	California Health Interview Survey 2009	Some County; Race/Ethnicity; Age; Gender, Income, Biennial survey	National Health Interview Survey 2011; continuous collection
28	Uninsured at some point in the past year	California Health Interview Survey 2009	Some County; Race/Ethnicity; Age; Gender, Income, Biennial survey	National Health Interview Survey 2011; continuous collection
29	Uninsured for a year or more	California Health Interview Survey 2009	Some County; Race/Ethnicity; Age; Gender, Income, Biennial survey	National Health Interview Survey 2011; continuous collection
30	Percent of population less than 65 that spends more than 10% of income on health care expenses	Medical Expenditure Panel Survey, data to be analyzed	National Level; State Level and Metropolitan Areas	Medical Expenditure Panel Survey , data to be analyzed
31	Compound Annual Growth Rate (CAGR) by total health expenditures and per capita costs. For comparison, CAGR by Gross State Product is included	CMS State Health Expenditures, 2000-2009	National Level; State Level	Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census.
32	High numbers of people in population managed health plans	California Health Interview Survey 2009	Some County; Race/Ethnicity; Age; Gender, Income, Biennial survey	Kaiser Family Foundation State Health Facts. State HMO Penetration Rate, July 2011 based on HealthLeaders, Inc. Special Data Request, June 2012.

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