

Let's Get Healthy California Task Force Final Report

December 19, 2012



Letter from Task Force Co-Chairs

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

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

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

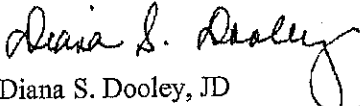
Yet faced with these challenges, this report recognizes that opportunities abound. California has a strong track record of utilizing our world-class talent and diversity to spur innovation and improve health, including being an early implementer of the federal Affordable Care Act. Building on these successes,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

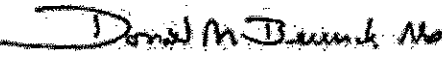
The report provides a framework for assessing Californians' health across the lifespan, with a focus on healthy beginnings, living well, and end-of-life. ~~The Task Force also identified three areas that most profoundly affect the health and health care landscape: redesigning the health care delivery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

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

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

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


Diana S. Dooley, JD
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Acknowledgements

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

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

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

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

Executive Summary

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

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

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

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

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

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

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

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

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

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

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

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

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I. Introduction

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

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

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

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

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

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

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

II. Background, Strategic Directions, and Goals

A. Background

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

Co-chaired by California Health and Human Services Secretary Diana S. Dooley and Dr. Don Berwick, Founder and former President and CEO of the Institute for Healthcare Improvement and former Administrator of the Centers for Medicare and Medicaid Services (CMS), the Task Force brought together 23 California leaders in health and health care, supported by an equally distinguished group of 109 Expert Advisors who jointly participated in all aspects of this process. Dr. Robert Ross, president and CEO of The California Endowment, served as Honorary Chair of the Expert Advisors. (See Appendix IV. for full listings of Task Force and Expert Advisors members.) For purposes of this report all Task Force and Expert Advisor members are collectively referred to as the Task Force or Task Force members.

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

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

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

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

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

The Triple Aim of Health Improvement

- Better Health
- Better Care
- Lower Costs

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

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

B. The Triple Aim

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

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

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

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

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

C. Strategic Directions and Goals

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

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

Health Across the Lifespan

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

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

Pathways to Health

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

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

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

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

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

III. A Framework for Measuring Health

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

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

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

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

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

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

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

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

Healthy California: Courageous leadership stands up!

—Bruce Bodaken
Blue Shield of California

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

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

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

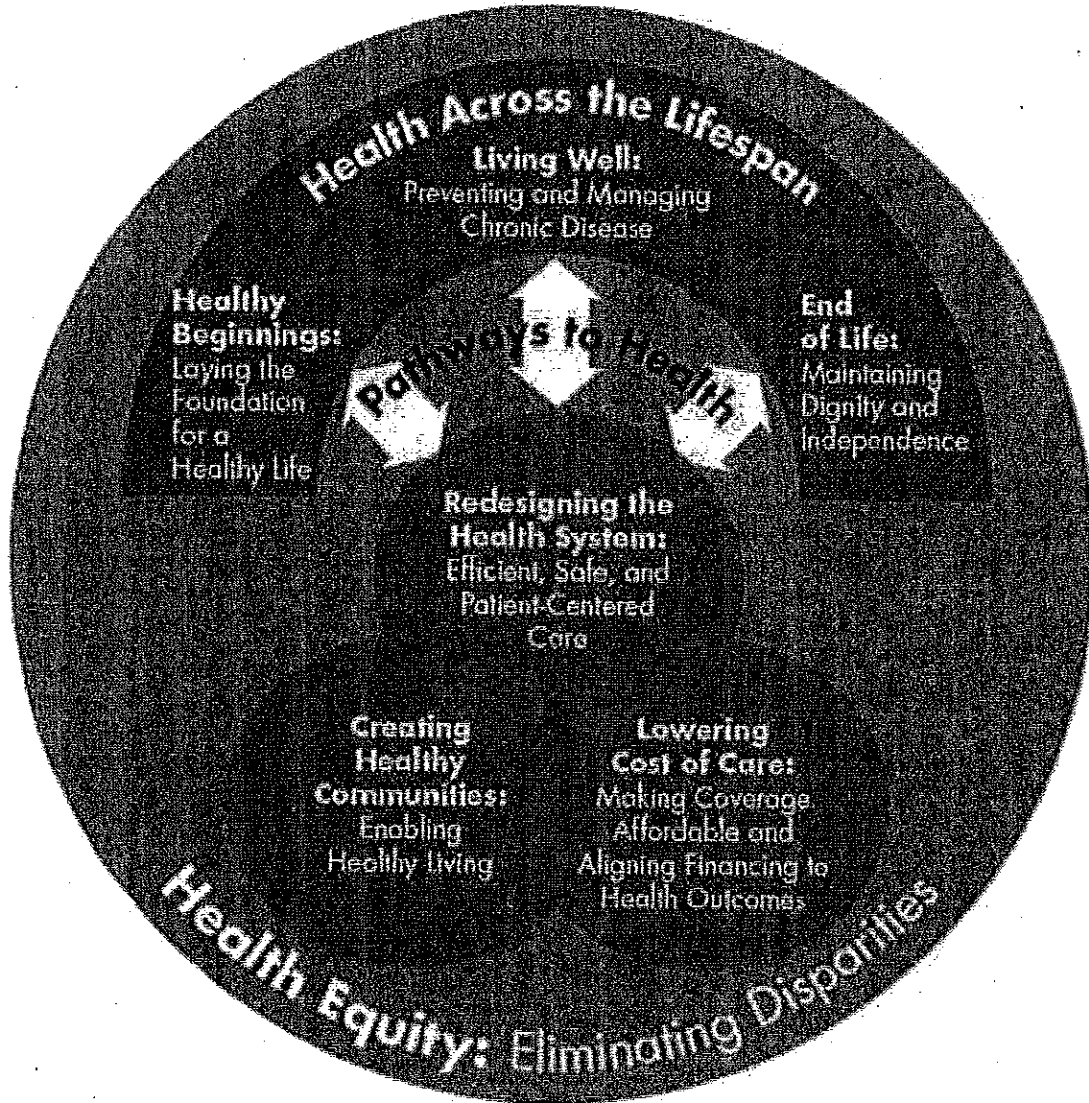
For each indicator, the Dashboard displays:

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

Let's Get Healthy California Task Force Framework

The Triple Aim:

Better Health • Better Care • Lower Costs



IV. Priorities and Indicators

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

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

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

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

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

Table 1: Priorities and Indicators for Healthy Beginnings

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

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

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

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

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

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

The first indicator relates to reading proficiency. Third grade reading levels are a strong predictor of future academic success, individual earning potential, global competitiveness, and general productivity.⁴ 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.⁵ The bad news is that fewer than half of our children still do not meet proficiency standards for this determinant of health.

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

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

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

All kids helping each other improve.

— Joe Silva, Tuolumne Co. Office of Education

One of the Dashboard's widest disparities exists in the metrics for 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.

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

Childhood Asthma. Childhood asthma has become a pressing issue in recent years—nearly 1.5 million children in California have asthma, the most prevalent chronic condition for kids ages 0 to 17.⁶ Asthma can result in higher school absenteeism and lead to lower levels of physical activity, in addition to the other effects of the condition. There are significant disparities in asthma prevalence and in the utilization of health services resulting from asthma. For example, African American children utilize the Emergency Department more than eight times as frequently as Asian American children for asthma.

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

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

Educated, active children moving California forward

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

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

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

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

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

Table 2: Dashboard for Healthy Beginnings

	Leading Indicator	CA Baseline	2022 CA Target	National Baseline	2020 National Target	Disparities	
1	Infant Mortality: Deaths per 1,000 Live Births	5	4	7	Not Available	White/Asian: 4 Af. Am.: 11	
2	All doses of recommended vaccines for children 19-35 months	68%	80%	70%	80%	Not Available	
3	Respondents indicating at least 1 type of Adverse Childhood Experience	59%	45%	Not Available	Not Available	Other: 45% White: 62%	
4	Incidents of nonfatal child maltreatment (including physical, psychological, neglect, etc.) per 1,000 children	9	3	9	8	Asian/P.I.: 3 Af. Am.: 25	
5	Proportion of third-grade students whose reading skills are at or above the proficient level	46%	69%	Not Comparable	Not Comparable	Asian: 69% Hisp/Lat.: 33%	
6	Emergency department visits, 0-17 years due to asthma per 10,000	73	28	103	Not Available	Asian/P.I.: 28 Af. Am.: 236	
7	Percentage of "physically fit" children, who score 6 of 6 on the required California school fitness program test	5 th graders	25%	36%	Not Available	Not Available	White: 36% Hisp/Lat.: 10%
		7 th graders	32%	46%	Not Available	Not Available	Asian: 46% Hisp/Lat./P.I.: 25%
		9 th graders	37%	52%	Not Available	Not Available	Asian: 52% P.I.: 24%
8	Proportion of adolescents who meet physical activity guidelines for aerobic physical activity	15%	24%	18%	20%	Af. Am.: 24% Asian: 9%	
9	Adolescents who drank 2 or more glasses of soda or other sugary drink yesterday	27%	17%	20%	Not Available	Asian: 17% 21 Races: 38%	
10	Adolescents who have consumed fruits and vegetables five or more times per day	20%	32%	Not Comparable	Not Comparable	Placer County: 32% Orange County: 15%	
11	Proportion of children and adolescents who are obese	2-5 yrs.	12%	9%	11%	10%	White: 9% Hisp/Lat.: 5%
		6-11 yrs.	12%	8%	17%	16%	21 Races: 8% Hisp/Lat.: 16%
		12-19 yrs.	18%	12%	18%	16%	Asian: 12% Hisp/Lat.: 24%
12	Proportion of adolescents who smoked cigarettes in the past 30 days	14%	10%	20%	16%	Asian/P.I.: 10% White: 15%	
13	Frequency of sad or hopeless feelings, past 12 months	7 th graders	28%	25%	Not Available	Not Available	Male: 25% Female: 31%
		9 th graders	31%	24%	Not Available	Not Available	Male: 24% Female: 36%
		11 th graders	32%	27%	Not Available	Not Available	Male: 27% Female: 37%

Goal 2. Living Well: Preventing and Managing Chronic Disease

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

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

Table 3: Priorities and Indicators for Living Well

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

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

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

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

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

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

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

**For lifelong health
accelerate prevention now.**

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

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

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

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

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

**Collectively creating a
culture of health.**

—Sophia Chang
California HealthCare Foundation

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

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

⁹ "Ten Leading Causes Of Death, Death Rates, Age-Adjusted Death Rates And Percent Changes By Sex - Hispanic - California" (2008-2009), [Accessed October 2012] <http://www.cdph.ca.gov/data/statistics/Documents/VSC-2009-0510A.pdf>.
¹⁰ *Fas in Fat* (Trust for America's Health, Washington, D.C., September 2012).

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

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

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

Table 4. Dashboard for Living Well

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

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

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

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

Table 5: Priorities and Indicators for End of Life

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

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

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

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

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

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

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

Many studies have shown that the needs of seriously ill patients and their families are best served by hospice.^{13,14,15} Patients who are enrolled in hospice receive better symptom control, are less likely to receive aggressive care in the final days of life, and their families are more likely to be satisfied with the care they received. Though hospice services are widely available, in 2010 only 39 percent of Californians¹⁶ were enrolled in hospice prior to death, a slightly lower level of utilization than the 42 percent seen nationally.¹⁷ The Task Force has set a goal of increasing hospice utilization to 54 percent by 2022. It will also be important to monitor the duration of these services to ensure that they are not under-utilized for a given patient.

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

Table 6: Dashboard for End of Life

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

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

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

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

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

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

¹⁶ 2010 Medicare claims data, analyzed by the California Hospice and Palliative Care Association

¹⁷ "NHPCO Facts and Figures: Hospice Care in America." (National Hospice and Palliative Care Organization, January 2012). [Accessed October 2012] http://www.nhpc.org/files/public/statistics_research/2011_facts_figures.pdf

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

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

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

Table 7: Priorities and Indicators for Redesigning the Health System

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

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

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

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

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

Continuously improving care—optimal health.
—George Halvorson
Kaiser Permanente

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

55 percent is not good enough!¹⁹
—Elizabeth McGlynn
Center for Effectiveness and Safety Research, Kaiser Permanente

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

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

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

Transformative quality, cost & convenient access.
—Richard Levy
Varian Medical Systems

¹⁹ The Quality of Health Care Delivered to Adults in the United States, *New England Journal of Medicine*, 2003, [Accessed October 2012] <http://www.nejm.org/doi/pdf/10.1056/NEJMs022615>

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

²¹ Ibid

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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 year²²).

California Gold. Wealth through your health.
— Pam Kehaly, Anthem Blue Cross of California

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

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

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

Table 8: Dashboard for Redesigning the Health System

Leading Indicator		CA Baseline	2022 CA Target	National Baseline	2020 National Target	Disparities	
27	Percent of patients receiving care in a timely manner	Primary Care Physicians	76%	78%	Not Available	Not Available	White/English Speaking: 78% Asian/Non-English Speaking: 72%
		Specialists	77%	79%			White/English Speaking: 79% Asian/Non-English Speaking: 68%
28	Percent of patients whose doctor's office helps coordinate their care with other providers or services	Child/Adolescent	67%	94%	69%	Not Available	N/A
		Adult/HMO	75%				
29	Preventable Hospitalizations per 100,000 population	1,243	Top 5 counties: 727	1,434	Top 3 states: 818	Top 5 Counties: 727 Worst 5 Counties: 1853	
30	30-day All-Cause Unplanned Readmission Rate (Unadjusted)	14%	25% reduction per hospital	14%	12% by 2013	N/A	
31	Incidence of measurable hospital-acquired conditions	1 per 1,000 discharges	See footnote #40, p. xxiv	Not comparable	Not comparable	N/A	

Goal 5. Creating Healthy Communities: Enabling Healthy Living

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

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

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

Creating conditions to lead healthy lives.
—Ed Moreno, Fresno Co. Department of Public Health

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

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

Table 9. Priority and Indicator for Creating Healthy Communities

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

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

Prevention works! Invest in your community
—Mary Pittman, Public Health Institute

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

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

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

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

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

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

Table 10. Dashboard for Creating Healthy Communities

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

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

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

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

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

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

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

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

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

Everybody in: Improving our health together

—Anthony Wright
Health Access

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

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

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

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

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

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

California Health: Both a right and a responsibility.

—Kelly Traver
Healthiest You Corporation

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

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

Rewarding value via payments and market share

—Arnold Milstein, Clinical
Excellence Research Center,
Stanford University

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

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

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

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

Table 12. Dashboard for Lowering the Cost of Care

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

C. Health Equity: Eliminating Health Disparities

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

Equity and social responsibility are fundamental.
—Ellen Wu, California Pan-Ethnic Health Network

California gets healthy through engaging social determinants.
—Jim Mangia, St. John's Well Child and Family Center

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

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

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

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

Understanding root causes leads to results.

— Steve Fields
Progress Foundation

V. Conclusion and Next Steps

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

Number one in health is fun!

— Steve Shortell, UC Berkeley
School of Public Health

To that end, we are committed to creating a website, to be housed at the California Health and Human Services Agency that will serve as a repository of the report, the Dashboard and the inventory of change strategies, the beginnings of which are collected here. We hope that individuals and organizations will readily avail themselves of this rich collection of data and information to learn from each other, identify opportunities for collaboration, and continue to contribute new ideas. The Secretary is also committing the Agency to serve in a convening role for work groups to develop implementation strategies and periodically bring experts and stakeholders back together to share progress, assess and highlight strategies that are having the greatest impact, and facilitate their spread. It will be critically important to regularly review priorities and indicators and, to the extent necessary, update the Dashboard as measurement capabilities evolve and new priorities emerge.

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

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

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

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

—Dave Regan, SEIU-UHW

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

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

The best place to be alive!

—Co-Chair Don Berwick

Former Administrator of the Centers for
Medicare and Medicaid Services

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Appendix I: Catalysts for Change: Task Force Exemplary Interventions

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

Join together: the race for
better health!

—Deborah Freund
Claremont Graduate University

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

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

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

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

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

Prevention equals fewer
healthcare visits.

—Pat Crawford, Atkins
Center for Weight and Health,
UC Berkeley

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

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

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

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

Californians set pace for national reform.

—Wells Shoemaker, CA
Association of Physician Groups

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

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

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

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

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

Cooperative Extension (CE) Nutrition, Family and Consumer Science Advisors and 4H

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

Goal 2: Living Well: Preventing and Managing Chronic Disease

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

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

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