

Washington State Health Report 2004



Washington State Board of Health
Governor's Subcabinet on Health



GARY LOCKE
Governor



STATE OF WASHINGTON
OFFICE OF THE GOVERNOR

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March 25, 2004

Washington State Board of Health and
Governor's Subcabinet on Health
P.O. Box 47990
Olympia, WA 98504-7990

Ladies and Gentlemen:

I am pleased to return the *2004 Washington State Health Report* to you with my approval.

Every January in an even-numbered year, the state Board of Health is required by RCW 43.20.50(1)(b) to prepare a report outlining health priorities for the ensuing biennium. It further mandates that I approve, modify, or disapprove this document.

Your report clearly articulates key challenges in making Washington safer and healthier for all residents. It suggests seven strategic directions for state health policy, all of which echo my Priorities of Government goals: to maintain and improve the public health system; ensure fair access to critical health services; improve health outcomes and increase value; explore ways to reduce health disparities; improve nutrition and physical activity; reduce tobacco use; and, safeguard healthy air and healthy water.

I appreciate your collaborative efforts to build upon the Priorities of Government process. I also commend the Washington Health Foundation for convening a broad array of community conversations to foster dialogue in these matters.

The *2004 Washington State Health Report* provides a superb foundation on which to build discussions for the next biennium. Thank you for your great work.

Sincerely,

Gary Locke
Governor





STATE OF WASHINGTON
WASHINGTON STATE BOARD OF HEALTH
1102 SE Quince Street • PO Box 47990
Olympia, Washington 98504-7990

January 29, 2004

The Honorable Gary Locke
Governor of Washington
Olympia, WA 98504

Dear Governor Locke:

We are pleased to forward the proposed *2004 Washington State Health Report* for your consideration. Since 1990, the Washington State Board of Health has been responsible for producing a biennial State Health Report “that outlines the health priorities of the ensuing biennium.” RCW 43.20.50(1)(b) stipulates that the report be produced in January of even numbered years and that it serve as an aid to you in beginning the budget process. It further stipulates that it is up to you to determine whether to approve, modify, or disapprove the report. If approved, the report is to be used by state agency administrators as a guide for preparing agency budgets and executive request legislation—in this case, for the 2005-2007 biennium.

This is the seventh State Health Report and the second produced as a collaboration between the Board and the Governor’s Subcabinet on Health. It draws on a wide variety of research and policy development efforts to suggest seven strategic directions for state health policy:

- Maintain and improve the public health system
- Ensure fair access to critical health services
- Improve health outcomes and increase value
- Explore ways to reduce health disparities
- Improve nutrition and increase physical activity
- Reduce tobacco use
- Safeguard healthy air and healthy water

These strategic directions are just that—they are not intended to be all-encompassing or restrictive. The report contains a summary of why each strategic direction is included, a “for instance” that describes one example of an initiative deserving further consideration, and a list of possible actions that illustrate the scope of the strategic direction. It does not attempt to enumerate action strategies for the 2005-07 biennium. The Board and the Subcabinet concur that decisions about specific health programs should be made by agency heads coordinating efforts through the Subcabinet.

The Board and Subcabinet recognize the significant challenges facing public health, health care, and the delivery of government services. In fact, this year’s report includes a new section describing some of the fiscal realities facing state health planners. It is our hope that identifying a specific, limited set of strategic directions can inform agency actions and help the state make Washington a safer and healthier place for all residents.

Sincerely,

Pete Cutler, Chair
Governor’s Subcabinet on Health

Linda Lake, Chair
Washington State Board of Health

The role of state government in health care

State government's health responsibilities grow from our State Constitution's commitment to provide for the public health and welfare and care for our most vulnerable populations (Article XIII, Section 1), and to regulate medicine and pharmacy (Article XX, Section 2). The Legislature has interpreted these duties to entail:

Maintaining and Improving Public Health

- Keeping records of births and deaths and monitoring illness and injury
- Acting swiftly and effectively to control the spread of communicable diseases
- Reducing preventable diseases and injuries
- Protecting the safety of our food, water, and air
- Safeguarding the health of vulnerable populations by assuring that residents have access to health services critical to their ability to lead healthy, independent, and productive lives
- Preventing injury and disability within the workforce in the state

Purchasing Health Services

- Purchasing health services for dependent children, the poor, the disabled, the elderly, injured workers, prisoners and public employees
- Ensuring that these public investments return the greatest possible value for our state's taxpayers by working constantly to contain the costs and improve the quality of these health services

Regulating Health Facilities, Health Providers, and the Health Insurance Industry

- Ensuring that health care professionals and health facilities meet minimum safety standards and encouraging them to strive for the highest level of quality
- Ensuring that health insurers remain solvent to meet their commitments to their policy holders and that the private insurance market operates fairly and equitably for our state's health insurance consumers

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State government must periodically re-examine these duties and strategically focus resources to improve the health of citizens, to respond to new health threats, to take advantage of new health discoveries, and to live within the ever-changing financial and social realities of our state and nation. For that reason, RCW 43.20.50(1)(b) makes the Washington State Board of Health responsible for producing a State Health Report "that outlines the health priorities of the ensuing biennium." The statute stipulates that the report be produced in January of even numbered years and serve as an aid to the governor and agency directors during the budget process. The 2004 report is a collaboration between the Board and representatives of the Governor's Subcabinet on Health. See the Background section, page 14, for a description of the process that led to this report.

Introduction

Going into the 2003 legislative session, the State of Washington faced one of the most serious fiscal challenges in recent history—if the state attempted to provide the same level of services that it had provided in 2001-03 without raising taxes, it would face a projected revenue shortfall for 2003-05 of roughly \$2.4 billion.

The crisis stimulated innovations in the state’s budget-writing process and led to cutbacks in state programs, including health-related programs. Rather than simply distribute cuts across all state programs when preparing the 2003-05 biennium budget, Governor Gary Locke asked his executive leadership to determine the state’s core responsibilities—those things it must do and do well to serve the citizens of Washington. They defined these responsibilities in terms of desired goals and results. Then they asked what it would cost to meet these goals and how spending could best be allocated to achieve the results desired. Ten priorities emerged from this Priorities of Government (POG) process. The Governor submitted a budget based on these priorities that proposed no new general taxes.

Other recent events have also shaped this report—in particular, a series of “Community Conversations” convened by the Washington Health Foundation (WHF). The terminologies associated with different activities can be confusing. The POG process produced ten *priorities*, each with different *goals*. The Community RoundTables produced a prioritized list of ten *values*. The priorities and values, developed by different players using different processes for different purposes, are not always consistent. This report also considers other inputs, such as the Board of Health’s priorities, legislative actions, local government feedback, and the best available science. To add value and further the discussion, it offers seven *strategic directions* that highlight commonalities and consistencies between the various disparate inputs.

One of the ten POG priorities is “improve the health of Washingtonians.” That priority encompasses three goals, the first of which is also the first of this State Health Report’s strategic directions: **Maintain and improve the state’s public health system.** This is similar to a strategic direction in the *2002 State*

Health Report, but that document focused on emergency preparedness, particularly the ability to respond to a bioterrorism event. The Board’s own work, its conversations with local boards of health, and the naturally occurring communicable disease threats facing the state suggests the focus needs to be on the stability and capacity of the entire public health system.

The other two goals under the Governor’s health priority relate to access to health care: (1) preserve health care coverage for the state’s most vulnerable and needy people; and (2) shore up the safety net to help those who will lose health insurance coverage in the coming period. These stopped short of the 2002 State Health Report strategic direction to “maintain and improve access to critical health services.”

The final 2003-05 budget largely preserved public health funding, but in light of the bleak fiscal realities it actually reduced access to critical health services for some residents. The budget, for example, reduced Basic Health Plan enrollment to 100,000 subscribers, removing 25,000 by attrition and repealing an increase to 175,000. For Medicaid, changes included scaling back the caseload by an estimated 25,000 enrollees, reducing the adult dental program, and requiring premium shares of some recipients.

As the 2004 legislative session approached, the governor again turned to the Priorities of Government. He proposed a supplemental budget increase of \$193 million. His request included supplemental appropriations to improve access to care in rural areas, increase Medicaid reimbursements for labor and delivery care, and reduce or eliminate some planned Medicaid premium shares.

Fiscal and political pressures on state budget makers are unlikely to lessen dramatically in 2005. Accordingly, this report establishes a more modest and realistic State Health Report strategic direction related to access: **Ensure fair access to critical health services.** This change is consistent with the POG results and is prompted in part by the “Community Conversations” process. Many participants in these conversations discussed barriers to access as a

fundamental problem with the current system, and fairness emerged as an important underlying value. Attendees at the October 2003 Health Leadership Summit prioritized the values elicited during these conversations. The resolution from the summit, which Governor Locke signed, put “assure fairness” at the top of the values list.

The third State Health Report strategic direction is: **Improve health outcomes and increase value.** The concept of value is a function of both the quality of care and the cost of care. For purposes of this report, value applies specifically to the purchase of health services by the state. This strategic direction relates directly to the three values that followed “assure fairness” in the summit resolution: (1) redesign the health system; (2) reallocate existing resources; and (3) improve health system performance and efficiency.

The fourth State Health Report strategic direction is: **Explore strategies to reduce disproportionate disease burdens.** This strategic direction is consistent with the value of ensuring fairness and with the Governor’s focus on addressing the health needs of the uninsured, the needy, and the most vulnerable.

The fifth value that emerged from the Washington Health Foundation’s process is to emphasize personal responsibility for healthy living and prevention. Aligned with this value are the next two State Health Report strategic directions: **Improve nutrition and increase physical activity** and **Reduce tobacco use.** For the 2002 report, these two directions had been combined into one, which read, “Encourage responsible behavior to reduce tobacco use, improve nutrition, and increase physical activity.” In this report they are split to devote more space to discuss emerging initiatives to address physical activity and nutrition. Also, while the importance of individuals taking responsibility for correcting unhealthy behaviors cannot be overstated, there are ways that current practices and policies encourage unhealthy behaviors. We know, for example, that children who have access to healthy foods in schools are more likely to eat a nutritious diet, and people who live near recreation trails are more likely to be physically active.

Finally, this report includes a new strategic direction. One of the Priorities of Government is “improving the state’s natural resources.” Under that priority are goals related to healthy air and clean water. To the extent that environmental degradation is damaging to human health, it becomes a human health issue. The final State Health Report strategic direction, accordingly, is: **Safeguard healthy air and healthy water.**

For each strategic direction, this report contains a summary of why it is included, a “for instance” that describes one example of an initiative deserving further consideration, and a list of possible actions that illustrate the scope of each of the strategic directions.

One downside of this structure is that it requires that each initiative or possible action be placed under a particular strategic direction, when in fact many policies and programs affect more than one strategic direction. Readers are encouraged to keep in mind the interrelatedness of the various strategic directions laid out in this report. For example:

- *Public health* must be part of any solution to *access* problems.
- Increasing *value* in the health care system might free up resources and improve *access*.
- Lack of insurance, the greatest barrier to *access*, lessens *value* by raising costs and contributing to poorer health outcomes.
- Poor *nutrition and physical activity* also drive costs and contribute to poorer outcomes, reducing *value*.
- *Public health* agencies convene efforts to improve *nutrition and physical activity* and lead efforts to reduce *tobacco use*.
- Barriers to *access* contribute to health *disparities*, as do greater exposure to unhealthy *air and water* and, in some communities, *tobacco use* and poor *nutrition and physical activity*.
- Targeting communities with *disparities* for certain health conditions may be an effective way to improve *value*.

Maintain and improve the public health system

Summary

As this report was being drafted, the nation was experiencing an early influenza season with an unusual number of child deaths. People packed emergency rooms and clamored for immunizations. Though it was too early then to gauge the severity of the 2003-04 flu season, anxiety was widespread. Media coverage conveyed something long known to public health experts—we are overdue for the kind of flu pandemic that will overwhelm our health system.

Public health agencies in Washington State were also dealing with several new and re-emerging diseases—a possible resurgence of sudden acute respiratory syndrome (SARS) and new cases of hantavirus. They were anticipating the arrival of West Nile virus as mosquito season approached. The need to react to public concerns about a case of bovine spongiform encephalopathy re-emphasized the importance of interagency cooperation. Some areas were also contending with a tuberculosis outbreak among homeless people and increasing numbers of new HIV infections among men who have sex with men. All while ramping up to better respond to health emergencies, including the threat of a possible attack using biological, chemical, or radiological weapons.

6 Public health is being asked to face new and re-emerging diseases, antibiotic-resistant microbes, and bioterrorism—what Senator Edward Kennedy has called the “Three Horsemen of the Modern Apocalypse”—with too few resources. A November 2003 report prepared for the Centers for Disease Control and Prevention (CDC) documents the challenges the nation must face before it can adequately respond to a major SARS outbreak. It notes, “The current shortage of epidemiologists, public health nurses, and other personnel in the U.S. will reach a crisis stage in the event of an epidemic. Budget cuts in state and local health departments have further depleted the human resources needed to deal with a public health emergency, and if these positions are not restored an otherwise containable epidemic may spread quickly.”

In 2001, the Centers for Disease Control and Prevention (CDC) asked, “Is public health’s infrastructure up

to the task, prepared for the global health threats of the 21st century?” It concluded, “Unfortunately, the answer is no.”

Many experts and organizations have called for a more “robust” public health system in response to possible bioterrorism threats. They note that public health programs and activities needed to respond to an attack—disease surveillance, laboratory testing, risk communication, vaccine distribution, public education, environmental monitoring, and more—are the very programs public health uses quietly every day to create a safer and healthier nation.

Washington State is regarded among public health professionals as having a high-performing network of state, academic, and local public health agencies. The state, however, is part of the national infrastructure and shares both its strengths and its weaknesses.

In 2000, the Department of Health asked 39 counties a series of questions based on the Draft Public Health Emergency Standards. “In general,” the Department concluded, “Washington’s local public health systems are not adequately prepared for a major biological emergency.” A tremendous amount of progress has been made since; yet, there is much more to be done. When the Trust for America’s Health issued a report on bioterrorism preparedness in December 2003, Washington met only six out of ten key indicators; however, it was among only nine states to meet six or seven, and no states met more than that.

At an April 2003 meeting, the Board held a forum on public health funding. Public health leaders and local elected officials told the Board that funding is inadequate and unreliable. The system, said one county commissioner, is crumbling. Port Orchard Mayor Leslie Weatherill, speaking of her local health district, wrote, “I find it disconcerting that we are demanding more from them and are not willing to fund the numerous requirements.”

Public opinion polls consistently show broad support for public health activities.

A 'For Instance'

Community Assessments Of Environmental Health

Public health departments rely on other agencies, organizations, and individuals to help identify and address health issues within their jurisdictions. They conduct community health assessments—broadly participatory processes designed to systematically collect health data, identify community beliefs about health issues, and involve the community in solutions.

When the Board looked at assessment practices in Washington State, it found that few community health assessments include environmental health issues (e.g., on-site sewage and safe food and water). Few environmental health programs have the capacity to do community assessments. They are largely fee-driven and typically their staffs are busy ensuring regulatory compliance and responding to urgent problems.

There are, nonetheless, clear examples of “best practices” in environmental health assessment. For example, Island County Health Department over the years has invested local capacity development funds in assessment, community development, and policy development. It received a CDC grant to use the Protocol for Assessing Community Excellence in Environmental Health to build its assessment capacity. These funds helped develop the infrastructure that allows the department and the community to collaboratively develop environmental health indicators, collect data, analyze local issues, set community priorities, and develop action plans.

Without adequate administrative funding and support for environmental health, local and state policy makers run the risk of making decisions that are based on a limited understanding of community health issues and are irrelevant to the people they serve. As the state looks to maintain and improve public health capacity, it must keep in mind that communicable disease control is just one way public health keeps Washington safe. It should promote best practices and assure capacity for planning and assessment across the system.

Other Possible Actions

- **Public Health Funding:** In November 2001, the Board adopted *Response Capacity During a Health Emergency—A Review of Selected Issues*. The report made nine recommendations and most concerned the need to increase the capacity of the public health system by providing adequate government funding. At the state level, this would mean funding that is both secure and stable. There was significant discussion of this issue during the 2003 legislative session but no long-term, statewide resolution. The state cut by 2 percent the non-dedicated funding it has provided to local health since the passage of Initiative 601. Meanwhile, many financially strapped counties substantially cut their funding for public health. Public health funding will be a critical issue during 2005-07 budget discussions.
- **Surge Capacity:** A study conducted for the CDC, “Quarantine and Isolation: Lessons Learned from SARS,” made it clear that efforts must continue to improve “surge capacity”—the ability of state and local health agencies, laboratories, and health care facilities to handle increased demand during a major disease outbreaks like pandemic flu.
- **Isolation and Quarantine:** In 2002, the Board adopted rules that provide a basic legal and enforcement framework for isolation and quarantine. Those rule changes were prompted by concerns about a possible bioterrorism attack employing smallpox. SARS, however, has renewed awareness that isolation and quarantine remain important public health tools in the modern era. The rule revision was just the first step. Work on developing community-specific plans for carrying out isolation and quarantine will continue into 2005-07.
- **Public Health Workforce:** During 2003, the Public Health Improvement Partnership conducted a survey to enumerate the public health workforce. Results are expected in April 2004. Public health is known to suffer from a shortage of trained workers in some areas (e.g., epidemiology). The results of the survey can guide training, recruitment and other workforce development efforts in 2005-07.

Ensure fair access to critical health services

Summary

Access to quality, affordable health care is a major indicator of the health of any community's residents. An Institute of Medicine (IOM) report, *Crossing the Quality Chasm, A New Health System for the 21st Century* (March 2002), states that as medical science and technology have advanced, the health care delivery system has lost ground in its efforts to provide consistent, quality care to all Americans.

In a February 2003 poll of Washington residents conducted for the Washington Health Foundation, only 42 percent rated the health care system in Washington State as excellent or good; 52 percent said it was only fair or poor. This was down from 51 percent who gave the system a good or excellent rating in August 2002. Fifty percent said the system needed major changes or fundamental overhaul, compared to 42 percent who said no new changes or only minor changes were necessary.

During a statewide series of Community Round-Tables hosted by the Washington Health Foundation, participants often mentioned the lack of consistent access as a fundamental problem with the current system. A key value that arose from those discussions was the need to ensure fairness. A gathering of hundreds of health leaders and the public in October 2003 ranked the values and placed fairness at the top. The emphasis on fairness was often linked to concerns about inequities in access.

A 1997 statewide survey by the State Board of Health asked respondents to name the most important health area on which government should work. The greatest number, 22 percent, said access to health care. When asked about the seriousness of various health issues, the greatest number, 79 percent, said state government should give access to health care a high or very high priority. During its 2001 review of the literature, the Board found extensive support for making access a top priority. Key informants frequently mentioned access as one of the biggest issues facing the state.

During 2003, the State Board of Health held discus-

sions with 15 local boards of health. At its meetings across the state, it asked to hear from local leaders about the state of public health and health care delivery in their communities. A consistent message was the need to increase access, particularly to mental health, dental health, and preventive care.

A major barrier to access is lack of affordable insurance that covers those preventive and primary interventions most likely to improve Washington's health. According to the Office of Financial Management, 9.4 percent of the state's non-elderly population lacked health insurance in 2002. There are several subpopulations for which the uninsured rate is 14 percent or higher—19- to 30-year-olds, members of households making less than twice the federal poverty level, people born in other countries, Hispanics and American Indians/Alaska Natives. (The US Census Bureau, using a different methodology, puts the nation's uninsured rate for 2002 at 15.2 percent, up from 14.6 percent in 2002, and Washington's at 14.2 percent). Uninsured adults are 30 percent less likely to have had a checkup in the last year and 40 percent more likely to have skipped a recommended treatment or test than insured adults, according to the Kaiser Commission on Medicaid and the Uninsured. They are more likely to forgo preventive care, require hospitalization for avoidable conditions, die during hospitalization, and be diagnosed with cancer during late stages of the disease. The state's recent financial challenges have led to cutbacks in public coverage and strengthened the impetus to prioritize public investments in health.

Other factors that limit access to care in this state include a variety of financial, structural, and personal barriers. In its conversations with local boards and community leaders, the State Board of Health heard testimony about residents who were having difficulties obtaining timely care even with insurance, about provider shortages, the collapse of the health care delivery system (particularly but not exclusively in rural areas), a shortage of mental health programs, and non-English speakers having difficulty obtaining access because of the lack of interpretive services.

A 'For Instance'

Ensure Access to a Core Set of Essential Services

A discussion about access begs the question: Access to what? And when talk turns to fairness, a second question arises: What is fair? Does fairness require universal access to all services, or assurances that everyone have access to a set of core services necessary to basic health? Analysts and policy makers often debate whether to shorten the line or thin the soup. An alternative is to determine a recipe that includes those ingredients necessary to provide a healthy meal—and then ensure there is no line.

Government's role, in partnership with individuals, nonprofit organizations, businesses and communities, would be to promote universal access to core services. First priority would go to public health services to prevent health problems before people require expensive "sick care," and to personal medical services known to improve the health of the community, such as anti-smoking policies, substance abuse treatment programs, prenatal care, immunizations, early childhood health screenings and other interventions with proven community benefit.

There is broad agreement on which clinical preventive services should be offered, particularly to children. The Board, for example, has developed a list of recommended "Clinical Preventive Services for Children." Assuring that children receive access to proven clinical preventive services should be a high priority for state government, with a focus on removing barriers to access. Projects should focus on improving information systems, promoting better clinical practices, working with state and private plans to encourage better service delivery, targeting delivery rates for specific interventions, and pursuing a range of incentives (including financial incentives for parents). Public benefit plans should explore ways to use the Board's evidence-based "Menu of Critical Health Services" as a starting point for restructuring financing for other medical services.

Other Possible Actions

➤ **School Health:** The Office of Superintendent of Public Instruction has developed a five-year strategic plan, *Preparing Washington Students for the 21st Century*. One goal is: "All schools, in partnership with students, families, and communities, provide safe, civil, healthy, and engaging environments." To further that goal, OSPI is developing a plan for "addressing physical, social, and emotional barriers to learning and living healthfully." School nurses, student health screenings, school-based clinics, specific health management plans, and clear standards for tending ill children attending school—all can contribute to improving access to care for children. OSPI's strategy for "learning and living healthfully" is not due until 2007, but its ongoing collaboration with the Board, the Departments of Health and the Department of Social and Health Services may suggest strategies for 2005-07.

➤ **Targeted Interventions:** One strategy for addressing access is to focus currently available resources on increasing the delivery of specific and measurable health services known to promote community health. An example would be to concentrate on increasing the percentage of Washington children who receive their fourth combined immunization for diphtheria, pertussis, and tetanus (DPT).

➤ **Healthy Aging Plan:** Washington State is aging even faster than the rest of the nation. An older population brings with it specific public health, social, and medical needs, such as mobility problems and a greater need for disease management programs, that should be addressed at the community and state level.

➤ **Public Health Improvement Partnership:** The PHIP should continue to implement standards encouraging local health jurisdictions and the Department of Health to measure access to critical health services and mobilize community efforts to close gaps. Many examples of successful strategies for improving access can be found at the local level. The state can support these efforts by promoting best practices and ensuring public health has the capacity to convene community-based efforts.

Improve health outcomes and increase value

Summary

Americans spent nearly 15 percent of the gross national product on health care in 2002, according to the federal government. Health care, not housing, is now the biggest purchase most of us will make in our lifetime. According to the World Health Organization, however, the United States ranks first among nearly 200 member nations in per capita health care expenditures but 24th in years of healthy life expectancy. We spent as a nation \$1.55 trillion a year on health care in 2002, a 9.3 percent increase over the previous year's total, but are we buying the right things, are receiving what we pay for, and are we getting top quality?

It is not always best to buy the cheapest product. We commonly consider quality when purchasing a car, yet rarely factor quality into medical purchasing. The Institute of Medicine Report *To Err Is Human: Building a Safer Health System* found that medical mistakes cause 44,000 to 98,000 deaths each year—more than HIV/AIDS, breast cancer, or vehicle accidents. These medical mistakes are largely attributable to poorly integrated services, poor information services, and other types of system errors. The report estimated the annual costs of preventable errors at \$17 billion to \$27 billion. A follow-up report, *Crossing the Quality Chasm*, called for an overhaul of health care to increase quality and safety.

Government is the primary funder of health care in the United States, according to the Employee Benefit Research Institute and other sources. A major share of government health expenditures comes from state funds and federal funds administered by states. It is not surprising, therefore, that health care is considered the most critical cost driver for state government.

As a major purchaser of health care services, Washington State is committed to obtaining value—and it defines value as quality divided by price. Cost-containment is only one piece of the health care purchasing puzzle. The state recognizes that it can improve value by improving efficiency in contracting

and purchasing *and* by improving patient safety and overall quality of care.

Three of the top four values that emerged from the Washington Health Foundation's Community Conversations speak to this nexus of cost-efficiency and quality: (1) redesign the health system; (2) reallocate existing resources; and (3) improve health system performance and efficiency. The strong relationship between these values and the lead value, assure fairness, should also be noted; redesigning the system to improve performance and efficiency could allow resources to be reallocated to pay for universal access to a set of core health services.

In 1999, the 50 states spent \$238.5 billion on personal health care, 27.1 percent of state spending. In Washington State, roughly a third of state expenditures from the general fund and other state accounts goes to health-related expenditures. If one includes federal funds appropriated by the state for programs such as Medical Assistance, the percent of all appropriations that go to provide health insurance, direct care, and public health programs is 43 percent.

Medical Assistance, the Basic Health Plan, and other state programs insure more than 20 percent of Washington residents—roughly 1.3 million of the state's 6 million people. The Public Employee Benefits Board covers approximately 300,000 state employees, retirees, and their dependents (almost 5 percent). The Medical Assistance Administration covers more than 900,000 people (16 percent). The Basic Health Plan will cover another 100,000 people in January 2004. Other state programs provide health care services directly (for example, the Department of Corrections provides health care for inmates).

Health care costs in Washington have been growing at a rate six times inflation. About one-sixth of the increase in health care spending from 2001 to 2002 is tied to prescription drug costs. Other factors include: increased utilization, rising consumer demand, medical advances that provide treatments for more conditions, and wage pressures.

A 'For Instance'

Implement Interagency Process for Technology Assessment

New medical technologies are being deployed faster than practitioners and policy makers can assess their efficacy and effectiveness. The state Agency Medical Directors Group (AMDG) went through an extensive process in 2001 to identify key areas of work where interagency coordination could result in increased value in government purchasing. Its third-highest priority was to start doing more evidence-based health technology assessments. Technology, in this instance, refers to surgeries and other procedures, medical devices, equipment, tests, and experimental or unapproved (“off-label”) uses for drugs.

During the 2003 session, the Legislature approved a bill, ESHB 1299, that charged the Health Care Authority (HCA) with developing and disseminating across state agencies a common process for evaluating health technologies. It also called for common methods for monitoring indicators related to health care quality, making decisions about what to cover, and implementing disease state management and management of consumer demand. AMDG has developed an implementation plan that calls for all work to be completed by January 2005.

ESHB 1299, however, really speaks to developing formal assessment processes that can be shared across agencies. Actually conducting technology assessments using those common processes will require ongoing work. New technologies will emerge that will require assessments, and new evidence will emerge that requires reassessment of existing technologies. HCA and AMDG are scheduled to present a progress report to the Governor’s Subcabinet on Health. One of the major issues to be discussed at that time will be the potential need for new resources in 2005-07 and beyond.

Other Possible Actions

- **Substance Abuse Services:** One recent DSHS study found that when some people received treatment for chemical dependency, they required \$252 less per month in public support than those who did not, yet Washington only has treatment slots for one in four adults who need such care. Some 1,000 patients languish on waiting lists.
- **Preferred Drug List:** HCA is developing an evidence-based list of preferred drugs based on efficacy, cost, likelihood of compliance, and outcomes. The list will need to be expanded to include additional drug classes and be reevaluated continually as new drugs and new research emerge.
- **Electronic Recordkeeping:** Electronic medical records can reduce errors by providing accurate and timely records and increasing the likelihood that records will travel with the patient. Electronic systems can notify patients who are due for preventive care. They can also contribute to administrative simplification, contain costs, reduce provider burdens, and improve service.
- **Demand Improvement:** Improve quality by encouraging consumer choices that improve outcomes and reduce costs—often by addressing the overuse, misuse, or underuse of procedures or drugs.
- **Disease State Management:** Coordinate efforts to provide systematic, cost-effective care to people with complex and sometimes progressive disorders, particularly chronic conditions.
- **Track Key Health Outcomes:** Try to reduce adverse events and medication errors by identifying specific, measurable patient-centered outcomes to track quality of care and better inform consumers.

Explore ways to reduce health disparities

Summary

The term *health disparities* describes a disproportionate burden of disease, disability, and death among a population or group. It encompasses both inequities in health status (whether a person or group is in good health) and in health care. Health care disparities include inequities in having access to care, seeking or being provided with care, and receiving quality care.

Healthy People 2010, the federal strategic health plan, identifies two major goals for improving the nation's health in the next decade—and one is to reduce health disparities (the other is to increase quality and years of healthy life). In December 2003, the Agency for Healthcare Research and Quality released the *National Healthcare Disparities Report*. It identifies disparities in health care for “priority populations”—women, children, elderly, people of color, low-income groups, and people with special health care needs. For example, people of lower socioeconomic status and African Americans are more likely to die of cancer.

In Washington State, the Board's *2001 Final Report on Health Disparities* examined the impact of disparities on communities of color. People of color (those identifying themselves as Hispanic and/or a member of a race other than white) make up more than 21 percent of Washington's population. Yet their share of disease burden is significantly higher than their proportion of the population. For instance:

- The infant mortality rate for American Indians and African Americans is more than double the rate for Caucasians.
- African Americans are more than three times as likely as Caucasians to die from HIV/AIDS, while Hispanics are more than 1.5 times more likely to die from the virus.
- The rate of tuberculosis for Asians is more than 15 times greater than it is for Caucasians.
- African Americans are more than three times as likely to die from diabetes as Caucasians; the death rate for American Indians/Alaska Natives is 2.5 times higher and for Hispanics it is 1.5 times higher.

Disparities affecting people of color were observed for 18 of 24 disease conditions reported in the 1996 *Health of Washington State*. Nationally, health disparities have been observed for asthma, many types of cancer, diabetes, heart disease HIV/AIDS, low immunization rates, infant mortality, inactivity, injuries, mental health issues, obesity, oral health, and tobacco use, and other conditions.

Many complex factors interact to produce health disparities. Those believed to contribute include poverty, housing, behavior and lifestyle, health knowledge, nutrition, environment, access to care, genetic predisposition, education, and employment. Specific findings with policy implications include:

- The Board's 2001 report demonstrated the connection between disparities in health care and the diversity of the health care workforce. It made several recommendations designed to increase the number of people of color preparing for health care careers.
- Public Health—Seattle & King County found that for people of color, racism or the perception of racism in health care settings affects the quality of care received.
- Research indicates a provider's lack of “cultural awareness” can contribute to biases, stereotyping, mistrust of the medical system, miscommunication and treatment refusal.

The federal government is focusing on eliminating inequities for specific conditions. *Healthy People 2010* calls for achieving parity in cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS, immunizations, and infant mortality across racial, ethnic, gender, and socioeconomic groups.

The recent cuts in public subsidies for medical care disproportionately affect minorities and potentially could worsen disparities.

Key informants interviewed by the Board in 2001 overwhelmingly supported its work on health disparities and said such work should continue.

A 'For Instance'

Enhance Quality of Care in Areas Where Inequities Occur

Efforts to address health disparities can target specific populations if those populations can be identified and communicated in a culturally appropriate manner. Examples include providing housing to people with no regular home, or targeting health professions recruitment at schools with a high proportion of students of color. Data on race and ethnicity is often unavailable, however, and reaching specific communities effectively can be difficult. A complementary approach is to focus quality improvement efforts on areas where inequities are found.

A case in point is diabetes care. People of African descent are far more likely to have limbs amputated as a result of diabetes complications than people of European descent. Washington's Diabetes Collaborative is an example of a public/private partnership focused on bringing about across-the-board quality improvement in the clinical management of a disease that has a disproportionate impact on communities of color. Another example is a state effort to increase the proportion of children who receive their fourth combined immunization for diphtheria, pertussis and tetanus. Children are a "priority population" and children of color have lower immunization rates. Also, the Health Care Authority is building quality improvement programs into contracts with health insurance plans, and encourages efforts in areas where disparities exist (e.g., cardiovascular disease).

Often these approaches can be combined. Reach 2010, a federally funded community coalition administered by Public Health—Seattle & King County, promotes diabetes self-care, personal and community awareness, and community support. It targets outreach efforts to individuals and communities of color.

Effective programs to improve overall access to and quality of health care can be an important component of Washington's effort to reduce health disparities. State agencies should look to involve local communities in identifying programs and seeking solutions.

Other Possible Actions

- **Workforce Development:** The Board's 2001 health disparities report described how improving diversity in the health care workforce can reduce disparities. The Institute of Medicine is due to release a report and recommendations on workforce diversity in 2004. IOM's recommendations could help shape efforts of health professions educational institutions to produce a workforce that reflects the state's growing diversity. The state must ensure that efforts to improve diversity remain at the forefront of attempts to address shortages in the health care workforce.
- **Social Determinants:** Social factors such as income, housing and education inequities may underlie many racial and ethnic disparities. A supplement to the *2002 Health of Washington State* due in 2004 will focus on race, ethnicity, income, and education. It may suggest new approaches to reducing disparities.
- **Indian Health Care:** Support implementation of *Working Together to Build a Healthy Future: The 2003 Indian Health Care Delivery Plan*, which the American Indian Health Commission and the Department of Health released in 2003.
- **Racial/Ethnic Data Collection:** Encourage the collection and analysis of racial and ethnic health data to allow for better identification of disparities and more effective design of strategies to eliminate them.
- **Interpreter Services:** Language barriers discourage people from seeking care and contribute to medical errors. The state should consider ways to increase the availability of medical interpreters.
- **Cultural Competency:** Work with provider groups, health care facilities, health professional schools, and health care and public health organizations to ensure the health care workforce has the skills needed to work with diverse populations.
- **State Policy Agenda:** Analysts at Brandeis University and Harvard are drafting "A State Policy Agenda to Eliminate Racial and Ethnic Health Disparities," which will suggest model state policies.

Improve nutrition and increase physical activity

Summary

The behaviors most damaging to our health, after tobacco consumption, are the interrelated behaviors of insufficient physical activity and poor diet and nutrition. A study of “Actual Causes of Death in the United States” in 1990, published in the Nov. 10, 1993 *Journal of the American Medical Association*, found that tobacco accounted for 400,000 out of roughly 2 million deaths that year. Diet and activity patterns accounted for another 300,000. Combined, they explained about a quarter of all deaths. No other cause accounted for more than 5 percent.

Deaths related to poor diet and too little exercise may soon surpass those related to tobacco, according to the Centers for Disease Control and Prevention. Unfortunately, this prediction is based largely on increases in the number premature deaths from poor nutrition, overweight and obesity, and lack of activity, rather than on a decrease in tobacco consumption. A federal report, *America’s Children: Key National Indicators of Well-Being 2003*, noted that, compared to 20 years ago, twice as many of the nation’s children are obese or overweight.

Surgeon General Richard H. Carmona recently put a national price tag on obesity and being overweight—\$117 billion a year in increased medical costs and lost productivity. *Healthy People 2010*, the federal government’s strategic plan for health improvement, lists “physical activity” and “overweight and obesity” as its top two health indicators.

Most state and national health trends are moving in the right direction. One of the few exceptions is obesity. Americans are getting fatter. According to data from the National Health and Nutrition Examination Survey, the prevalence of obesity in children ages six to 11 quadrupled in the last quarter century. For adolescents, the prevalence more than doubled.

The *Washington State Nutrition & Physical Activity Plan: Policy and Environmental Approaches*, lists the following indicators that Washington is facing an epidemic:

- Obesity rates have doubled over the last decade
- More than half of all state residents are obese or overweight
- Rates of chronic disease and disabling conditions associated with poor diet and lack of exercise are escalating steadily
- Medical costs related to obesity are straining the state’s ability to provide affordable access to care
- The percent of the population over 65 years of age is increasing faster in Washington than in many other states. (An older population is more likely to experience higher levels of obesity.)

In addition, 73 percent of Washington adults do not engage in moderate physical activity (at least 30 minutes daily on five or more days per week during leisure time), according to data from the 2000 Behavioral Risk Factors Surveillance System. Only 16.6 percent engage in “vigorous” physical activity.

On average, higher body weight is associated with higher death rates. In children it can lead to diabetes, heart disease, sleep apnea, depression and low self-esteem. The incidence of type 2 diabetes mellitus in children has risen tenfold in the past 20 years. In Washington, diabetes has consistently been the sixth or seventh leading cause of death during the 1990s. During that time, the percentage of all deaths resulting from it has risen slowly. Physical activity reduces the risk of type 2 diabetes, heart disease, colon cancer and high blood pressure.

Even before the current epidemic, Washingtonians were concerned about the lack of activity and the number of people obese or overweight. The respondents to the Board’s 1997 public opinion survey listed “lack of exercise and poor eating habits” second only to drug and alcohol misuse as the most serious health issue facing the state. Obesity was one of the items mentioned most often in the key informant interviews conducted by the Board in 2001. Local health assessments have also identified obesity as an important issue.

A 'For Instance'

Implement State Physical Activity and Nutrition Plan

In June 2003, the state Department of Health and its partners released the *Washington State Nutrition & Physical Activity Plan: Policy and Environmental Approaches*. Thirty-five people—from state and local agencies, academia, and advocacy organizations—engaged in a year of strategic planning to help slow the epidemic of obesity, reduce chronic disease rates, and improve the quality of life in Washington.

The plan's goals are very specific—increase the number of state residents whose lifestyles reflect the Dietary Guidelines for Americans and who get 30 minutes of moderate activity at least five days a week. It also notes the correlation between obesity in children and issues of hunger and food security.

The plan puts forth several objectives and recommends ways to achieve them. Under the physical activity goal, the objectives are:

- Increase the number of people who have access to free or low-cost recreational opportunities for physical activity
- Increase the number of physical activities available to children
- Increase the number of active community environments.

Under the nutrition goal, the objectives are:

- Access to health-promoting foods
- Reduce hunger and food insecurity
- Increase the proportion of mothers who breastfeed their infants and toddlers

Implementation will require sustained collaboration between state and local agencies, communities, and a host of organizations. DOH will provide leadership and work with partners to assess progress. Moreover, several of the specific recommendations in the report will require state government to make choices and take action—for example, by providing adequate funding for recreation sites and facilities.

Other Possible Actions

➤ **School Fitness and Nutrition:** Since 2000, Washington State has required Essential Academic Learning Requirements for health and fitness. Classroom-based assessments now being developed will provide a common basis for determining whether a student has the skills necessary to maintain an active and healthy life. An example would be understanding the relationship between dietary intake and energy expenditure through exercise. Assessments are slated for voluntary use during the 2005-06 school year. Washington law requires schools to dedicate a specific amount of class time for health and fitness, but that requirement is not always honored. It may be beneficial to schools and students to explore outcome-based measures for school health and fitness instruction, rather than measuring “seat time,” then allow local flexibility about how to achieve those outcomes. Also, the Office of Superintendent of Public Instruction recognizes it has an important role in combating the epidemic of obese, overweight, and out-of-shape children. OSPI has partnered with the Washington State Actions for Healthy Kids committee to develop a model physical activity and nutrition policy. The Board, OSPI, DOH, the University of Washington and others are working to identify and promote best practices in schools policies. They have launched a Web site (www.healthyschoolswa.org) and the Board is hosting community forums with local school boards and boards of health. Disseminating, deploying, and evaluating model policies and best practices will be important ongoing work in 2005-07.

➤ **Nontraditional Partnerships:** The causes of nutrition and physical activity problems are systemic. They require creative and collaborative solutions. Health agencies need to partner with businesses, nonprofits, and government agencies not typically associated with health promotion. An example of a public/private partnership is the School Board Challenge issued public health and education associations with funding from Stonyfield Farms. An example of nontraditional partnerships is working with the state Department of Transportation to develop transportation systems that encourage walking, bicycling and other healthy forms of transportation.

Reduce tobacco use

Summary

Tobacco is the leading cause of preventable, premature death, accounting for approximately 440,000 deaths in the United States each year—or 20 percent of the 2 million deaths that occur each year. Deaths attributable to tobacco use include 90 percent of all deaths from lung disease and lung cancer, 45 percent of all heart disease deaths in people younger than 65, a third of all cancer deaths, nearly one in five stroke deaths, and one in ten newborn deaths. In Washington State, the death toll is greater than 8,000 people a year. The cost in avoidable medical expenses is more than \$1 billion.

After “physical activity” and “overweight and obesity,” *Healthy People 2010*, the U.S. government’s strategic plan for health improvement, lists tobacco use as its top health indicator. Reducing tobacco use is the top priority of the state Department of Health.

When asked to rate the seriousness of various health issues in the Board’s 1997 public opinion survey, respondents listed “tobacco use and secondhand smoke” third (tied with “sexually transmitted diseases”). Local community health assessments have also identified tobacco use and obesity as important issues, and members of local boards of health reducing secondhand smoke as an important issue in conversations with members of the State Board of Health.

The 2002 Behavioral Risk Factor Surveillance System (BRFSS), which reports statewide prevalence of risk factors, reports that 21.5 percent of Washington’s total population currently smokes. This compares to a national prevalence rate of 23.1 percent. Tobacco use has been declining steadily, but not at a pace that would allow the nation to reach its 2010 objective of 12 percent.

Public opinion polls show increasing support in Washington (60 percent or higher on a county-by-county basis) for tighter restrictions on smoking in public places, which would reduce exposure to secondhand smoke.

A ‘For Instance’

Continue to Implement the Prevention and Control Plan

In December 1999, the Washington State Department of Health published *A Tobacco Prevention and Control Plan*, a blueprint for preventing kids from starting to smoke, helping smokers quit, reducing secondhand smoke, and reducing tobacco consumption by high-risk groups. Implementation began in 2000 with an initial investment of \$100 million from the \$4.5 billion in tobacco settlement funds the state is scheduled to receive over 25 years. The budget for 2002-2003 was \$29.3 million and included money from taxes on tobacco sales, fees paid by tobacco retailers, federal funds, and a foundation grant. The majority of the money went to local programs.

The program has contributed to an 8 percent decline in adult smokers, representing 83,000 fewer smokers. The estimated number of children who start smoking each day has declined from 65 to 55 and the percentage of the state’s youth who smoke is down significantly for all age groups. The number of sixth graders who had smoked in the last 30 days, for example, dropped by more than half between 1999 and 2002.

This long-term strategic plan should continue to guide state efforts to reduce tobacco use during 2005-2007. Future work will include: decreasing workplace and in-home exposure to secondhand smoke; reducing tobacco use by high-risk groups; increasing the number of smokers who successfully quit; counteracting the impact of tobacco ads that target young adults

In 2002-03, Washington raised current dollars to cover state spending by selling the rights to future tobacco settlement funds. It is important that tobacco settlement funds continue to be dedicated to tobacco prevention and control programs during 2005-07. It is also important that the plan be revisited occasionally as scientific information, the legal environment, and social expectations change.

Safeguard healthy water and healthy air

Summary

The Priorities of Government exercise identified several goals that relate to human health but do not appear under the health priority. The goals for “improve the state’s natural resources,” for example, include increasing the number of days with healthy air and improving the cleanliness of the state’s surface waters. Environmental protection efforts conducted by the Department of Ecology and other agencies do more than protect natural ecosystems, create recreational opportunities, and improve the quality of life. To the degree that polluted air and water (and contaminated food) have an adverse impact on human health, these efforts improve the health of the people of Washington State.

Toxic air pollutants can lead to birth defects, cancer and other forms of illness. Millions of pounds of toxic pollutants enter Washington’s air each year, primarily from diesel exhaust fumes, gasoline vapors, and wood smoke. The Puget Sound Clean Air Agency estimates 700 cancer cases a year in Washington are attributable to airborne toxins. Small airborne particles, particularly those less than 2.5 microns across, contribute to asthma, sudden infant death syndrome, heart disease, lung disease, and cancer. The Harvard Six Cities study followed 8,000 people for 17 years and found a 26 percent increase in death rates for people living in areas with elevated levels of particulates. Examples of environmental efforts that benefit health include Ecology’s program to keep diesel buses from idling outside schools and the Legislature’s decision to fund retrofits for diesel school buses.

Contaminants are also found in our water. Some, like mercury, persist in the environment for many years and accumulate in the food supply. They are associated with nervous and reproductive system problems, learning difficulties, and developmental damage.

Environmental issues, and their connection to cancer and other illnesses, were frequently mentioned during key informant interviews conducted by the Board in 2001. During 2003, they arose during the Community RoundTables across the state and in discussions between the Board and local boards of health.

A ‘For Instance’

Continue to Reduce Persistent Bioaccumulative Toxins

In December 2000, the Department of Ecology published its *Proposed Strategy to Continually Reduce Persistent Bioaccumulative Toxins (PBTs) in Washington State*. PBTs are elements and chemical compounds that are toxic to humans and animals, and include metals, pesticides, organic chemicals, and by-products of fossil fuel combustion. They linger for decades or centuries and accumulate in the food chain. Many are released into the environment through human activity. They can damage nervous and reproductive systems in humans and animals, cause developmental and learning problems in children, and interfere with the organ development in fetuses. The PBT plan lays out a long-term strategy for identifying, prioritizing and reducing PBT threats in Washington.

Ecology, working closely with the Department of Health, has established mercury reduction as the top priority under the PBT strategy, and in 2003 developed a Mercury Chemical Action Plan that seeks to eliminate human use and release of mercury in the state and minimize human exposure to the mercury that exists. It calls for metal separators in dental offices, for example, and safe disposal of products that contain mercury, such as fluorescent lamps, thermostats, and thermometers.

Many elements of the mercury plan are underway and will be completed by the 2005-07 biennium. But the Legislature chose not to fund full implementation of the plan. That means Ecology will not be able to implement many elements of the plan until 2005-07 at the earliest. Moreover, the mercury plan is just the first of several toxin-specific plans that will emerge as part of the PBT strategy.

According to the December 2000 proposed strategy, it will take about 20 years “to move our society beyond and away from our most toxic polluting activities.”

Background and methodology

The Washington State Constitution stipulates that state government will provide for public health and welfare. It requires the establishment of a State Board of Health to help lead this effort.

Since 1989, the Washington State Board of Health has submitted a state health report each biennium. RCW 43.20.50(1)(b) mandates that the report be produced in January of even numbered years so it can aid the Governor at the beginning of the budget process by suggesting health priorities for the ensuing biennium. The statute further stipulates that the Governor must approve, modify, or disapprove the report. If approved, the report is to be used by state agency administrators as a guide for preparing agency budgets and executive request legislation—in this case, for the 2005-2007 biennium.

The statute defines the minimum process required. First, the Board is required to hold public forums every five years and consider public input gathered at those forums in the preparation of the report. The Board last held public forums in 2000.

The Board augmented these forums in 2001 by interviewing 52 key informants, including agency heads, local public health leader, legislators, legislative staff, congressional staff, agency directors, gubernatorial policy staff, directors of minority affairs commissions, deans at public health and medical professional schools, policy directors of professional and industry associations, and directors of health advocacy organizations. Additionally the Board posted on its Web site a survey instrument based on the script used for the key informant interviews. Twenty-three people completed the survey.

For this year's report, the Board was able to piggy-back on an extensive series of public forums convened by the Washington Health Foundation. The foundation conducted a public opinion survey and held 44 Community RoundTable discussions (at least one in every county), involving more than 1,200 people. From these conversations it gleaned a list of common values that shape people's opinions about health care.

In October 2003, the foundation convened a Health Leadership Summit and asked some 300 attendees to

rank the top ten values that emerged from the Community RoundTables. Most summit participants then signed a resolution acknowledging those values and pledging to work for health care improvement in ways that reflect citizen principles and values.

The statute that established the State Health Report also requires the Board to consider input from the directors of state health care agencies. This report was developed in collaboration with the Governor's Subcabinet on Health, which includes most of those directors. Established in January 2001 by Executive Order 01-02, the Subcabinet is charged with developing and coordinating state health care policy and purchasing strategies, providing a forum for the exchange of information between agencies, and coordinating efforts to provide appropriate, available, cost-effective, quality health care and public health services to the citizens of the state.

The Board feels there are clear synergies and areas of complementary responsibilities between the Board and the Subcabinet. To be most effective, this report should align its strategic directions with the goals and intent of the Subcabinet.

Board staff members have also worked closely with the Washington State Health Agency Medical Directors Group (AMDG), which supports the Subcabinet's work. AMDG enhances collaboration across agencies and seeks to "identify and assess new opportunities for state agencies to increase quality, and to promote cost effectiveness, access, and affordability in the state's medical care financing and delivery system."

The Board wrote letters requesting input to the three state agencies with health-related responsibilities that are mentioned in RCW 43.20.50(1)(b) but are not represented on the Subcabinet—the departments of Ecology and Agriculture and the Office of Superintendent of Public Instruction. It received detailed and thoughtful responses from Ecology and from the Superintendent, and it has tried to incorporate that feedback into this report.

Another requirement of the statute is that the Board ask for the assistance of local health jurisdictions. In past years, the Board has solicited assistance from

local health officials. Public health leaders were among the key informants interviewed in 2001, and for this report Board staff met with the membership of the Washington State Association of Local Public Health Officials.

The Board also did something new this time around: It embarked on a series of meetings with local boards of health to improve communication, strengthen local boards, understand local concerns, and engage local policy makers in public health issues. Board members, accompanied by staff members, met with 15 local Boards in 2003 (the Board plans to continue meeting with approximately the same number each subsequent year). At each meeting the Board members discussed this report and asked local board members for their input. The comments received at those meetings are reflected in this report.

A final statutory requirement is that the Board consider the best data available from the Department of Health. The department must submit to the Board a list of high-priority study issues. The Board has always relied heavily on the department's high-quality reports, research and data, but it has always supplemented that information with other research. In 2001, Board staff reviewed more than 40 print and electronic documents, including federal and state government reports, articles from scientific and medical journals, policy analyses published by foundations and other nonprofit organizations, public opinion surveys, and local health assessments. Staff members prepared a document called the "survey of surveys" that summarized the findings. The Board asked the University of Washington's Northwest Center for Public Health Practice (NWCPHP) to review the document, and the reviewers found it to be complete.

The staff of the Board has continually updated this body of research to ensure it remains current, and they relied on this information when preparing this report. In addition, the Board requested and received information from the department about research documents published since the 2002 report and about high-priority study issues.

This year's report retains many changes implemented for the 2002 report. As noted in that document, prior

reports were lengthy (80–120 pages) and included a fairly broad list of health priorities, extensive research findings, lists of priority study projects, examples of recent successes, and comprehensive listings of action strategies for nine health-related agencies. The current format features a limited number of strategic directions. This approach is consistent with RCW 43.20.050(1)(b) since it provides agency heads with an outline of state health priorities.

The strategic directions proposed in this report are not all-inclusive, nor are they meant to be prescriptive. State agencies provide numerous health-related services that are not covered by these strategic directions, but are important and appropriate. Rather, these strategic directions suggest areas of emphasis—areas where state efforts to create new activities or preserve existing activities are most likely to be effective.

Furthermore, this report does not recommend specific action strategies for the 2005-07 biennium. The statute does not call for that level of detail and the Board and the Subcabinet concur that proposals for specific programs should be made by agency heads coordinating their efforts through the Subcabinet. For each strategic direction, this report contains a summary of why it is included, a "for instance" that describes one example of an initiative deserving further consideration, and a list of possible actions that illustrate the scope of each of the strategic directions.

About the Washington State Board of Health

The State Board of Health serves the citizens of Washington by working to understand and prevent disease across the entire population. Established in 1889 by the State Constitution, the Board provides leadership by suggesting public health policies and actions, by regulating certain activities, and by providing a public forum. The governor appoints ten members who fill three-year terms.

Board Members

Consumers

Linda Lake, M.B.A., Chair, has 25 years of experience in the field of health and social services. She has directed several community health and social service organizations, including the Pike Market Medical Clinic, and currently directs the Tuberculosis Clinic at Harborview Medical Center for Public Health—Seattle and King County.

Vacant.

Elected County Officials

The Honorable Carolyn Edmonds, a former legislator, is a Metropolitan King County Council Member and chair of the King County Board of Health.

Elected City Officials

The Honorable Dave Crump, Ph.D., a child psychologist, is a Liberty Lake City Council Member and member of the Spokane Health District Board.

Department of Health

Mary Selecky is secretary of the Washington Department of Health and former administrator of Northeast Tri-County Health District.

Health and Sanitation

Charles R. Chu, D.P.M., a practicing podiatrist, is president of the Washington State Podiatry Independent Physician Association.

Ed Gray, M.D., is health officer for the Northeast Tri-County Health District and chair of the Basic Health Plan Advisory Committee.

Carl S. Osaki, R.S., M.S.P.H., former director of environmental health for Public Health—Seattle & King County, is on the faculty at the University of Washington.

Vickie Ybarra, R.N., M.P.H., is director of planning and development for the Yakima Valley Farm Workers Clinic. Much of her work is dedicated to supporting children and families.

Local Health Officers

Thomas H. Locke, M.D., M.P.H., Vice Chair, is health officer for Clallam and Jefferson counties. He is a member of the Washington State Medical Association's Interspecialty Council and is active in several Olympic Peninsula community coalitions seeking improved access to high quality health care.

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2004 Washington State Health Report

The Washington State Board of Health and the Governor's Subcabinet on Health submitted this document to Governor Gary Locke, who approved it on March 25, 2004.

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