



The Washington State Plan for **Healthy Communities**



Healthy Communities
Washington

Partners promoting healthy
people in healthy places
www.doh.wa.gov/healthycommunities

A Special Thank You to...

...All those who gave so graciously of their time, expertise and energy to develop *The Washington State Plan for Healthy Communities*.

...All of the stakeholders working in communities across the state to create a healthier Washington.

This publication was supported by a cooperative agreement from the Centers for Disease Control and Prevention, Coordinated Chronic Disease Program grant # DP09-9010301. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

For persons with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY 711).

DOH 140-073 March 2014



STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Olympia, Washington 98504

Dear Washingtonians,

I am pleased to share *The Washington State Plan for Healthy Communities*, a statewide plan for better health.

We have made great strides in addressing the burden of infectious diseases. But in recent years, chronic diseases – such as cancer, heart disease, diabetes, arthritis and high blood pressure – have emerged as some of the greatest threats to our health and well-being. Chronic disease is often preventable and this plan calls for a focus of efforts and resources on prevention. The causes and risk factors for chronic diseases are so intertwined with who we are and how we live that a full engagement of partners is required to make community-level changes that support everyone's ability to make healthy choices where they work, learn, live, play and worship. Additionally, a strong connection between community support and clinical health care is the best foundation for a healthy, productive population.

This plan supports a comprehensive approach to life long health. As we work together to address the physical, environmental, social, and emotional factors that contribute to chronic disease, our impact will be felt throughout the everyday lives of people. We will use this plan to guide our State investments to make communities healthier.

Please join me as we continue to work together to improve the health and well-being of the people of Washington State.

Sincerely,

John Wiesman, DrPH, MPH
Secretary of Health

Executive Summary

A healthier Washington delivers healthier students to our schools, healthier workers to our employers, and healthier patients to our health care systems. The overarching goals of *The Washington State Plan for Healthy Communities* are:

- **Increase the number of Washingtonians who are healthy at every stage of life.**
- **Achieve health equity by eliminating health disparities.**


We developed this plan with generous contributions of time and thought by staff in the Office of Healthy Communities and our community partner organizations across the state. Through a better understanding of the common underlying conditions of disease we are now able to collapse what had been 14 state plans into this one plan. It is clear that the circumstances in which we are born, grow, work and age are at the root cause of health. Addressing these circumstances to affect health requires close work with partners at local, state and national levels. We hope that the strategies and objectives detailed here will provide a guide for cross-programmatic planning and policy development as well as laying groundwork for more coordination of efforts to prevent and manage chronic disease and risk factors.

Chronic disease exacts a toll in medical costs and lost productivity in our state, including \$10 billion annually from cancer, more than \$4 billion from heart disease, and more than \$8 billion from stroke. This cost burden is expected to rise as the prevalence of chronic disease and related risk factors increase, along with our aging population.

Our work to achieve the goals of this plan is organized across four domains established by the Centers for Disease Control and Prevention: Epidemiology and Surveillance; Environmental Approaches; Health Systems; and Clinical and Community Preventive Services. Additionally, during two years of meetings to develop this plan eight priority topic areas were identified along with health equity – an overarching ninth area of focus. We developed activities in these nine priority areas:

1. Healthy starts
2. Sexual and reproductive health
3. Tobacco and substance abuse prevention
4. Active and safe environments
5. Healthy eating
6. Screening, referral and follow-up
7. Social and emotional wellness
8. Quality clinical and preventive treatment services
9. Health equity

The circle diagram on **page iv** shows our goals for the plan along with the four domains and nine priority areas. Aligned with the domains and priority topics, we have identified 23 strategies and 42 objectives to achieve healthy communities. The matrix in **Appendix Three (pages 52–58)** provides a cross-walk of these strategies to important national and state plans including Healthy People 2020, The Surgeon General's National Prevention Strategy, The Washington State Agenda for Change Action Plan and Results Washington.



The Washington State Plan for Healthy Communities strategies include fighting chronic disease, helping babies make a healthy start in life, reducing the impact of adverse childhood experiences such as abuse and neglect, encouraging physical activity and otherwise helping people to make healthy choices.

These are *challenge strategies* and objectives, no single organization can accomplish them alone. However, every entity aiming to improve health should be able to see themselves in this plan:

- **Local public health agencies** can work with local planners to increase safe routes to school and increase overall walkability of your community.
- **Health systems** can incorporate disease management tools and prompts into your electronic medical record system.
- **Health care providers** can refer your patients with chronic diseases to self-care management education programs in the community.
- **Health plans** can work with businesses to provide wellness/health promotion programs for their employees.
- **School systems** can purchase and serve locally grown and healthy foods for your school lunch program.
- **Employers** can connect your employees and covered lives that smoke to cessation services and encourage everyone to use their preventive health benefits.
- **Community-based organizations** can help connect those you serve with community-based prevention and self-management resources.
- **Faith-based organizations** can participate in special events and monthly observances that encourage wellness.
- **Policy makers** can support initiatives that reinforce healthy lifestyles for your constituents.
- **Government agencies** can collaborate with community-based coalitions.
- **Anyone** can educate policymakers and planners about the importance of chronic disease prevention and management. You can encourage your children to be active and be active with them.

The plan builds on the fact that lifelong health starts at birth and continues throughout all stages of life. To ensure that all Washingtonians share in the benefits of prevention, *The Washington State Plan for Healthy Communities* includes an important focus on those who are disproportionately burdened by poor health.

Regardless of who you are, or where you work, learn, live, play or worship, you have a role in making Washington the healthiest state in the nation. When all sectors are working toward common prevention priorities, improvement in health can be amplified. All of us working together to implement the objectives included in the plan will create healthier Washingtonians at every stage of life.



Contents

2	Section One: Framework
4	Section Two: Partners in Prevention
6	Section Three: Strategic Domains
7	Domain 1: Epidemiology and Surveillance
8	Domain 2: Environmental Approaches
11	Domain 3: Health Systems
13	Domain 4: Clinical and Community Preventive Services
14	Section Four: Priority Areas
14	Healthy Starts
17	Sexual and Reproductive Health
19	Tobacco and Substance Abuse Prevention
22	Active and Safe Environments
25	Healthy Eating
27	Screening, Referral and Follow-up
29	Social and Emotional Wellness
31	Quality Clinical and Preventive Treatment Services
33	Health Equity
35	Appendix One: Burden of Chronic Disease
47	Appendix Two: Stakeholder Outreach and Input
51	Appendix Three: Justification for Evidence-based Recommendations
59	Appendix Four: Evaluation Plan
62	Appendix Five: State and National Links
63	Appendix Six: Acronym Glossary
65	Appendix Seven: Agenda for Change Action Plan



To meet the challenge of preventing and managing chronic disease, Washington's state, local and tribal public health network must engage public and private partners. By working effectively with health care providers, community-based organizations, businesses and other public agencies, we can achieve necessary environmental, program and system changes.

At the same time, public health must operate in a rapidly evolving policy environment characterized by increasingly competitive resources, new health threats, disparities in health status and access to care and implementation of health system reform.

The Agenda for Change for Washington's Public Health Network provides a strategic framework to align these elements in ways that support long, healthy and productive lives for all who live in Washington State. This framework identifies three strategic priorities for a transformed public health system:

1. Preventing communicable disease and other health threats
2. Fostering healthy communities and environments
3. Partnering with the health care system

The Washington State Plan for Healthy Communities includes strategies that directly support the second and third priorities of the Agenda for Change. These strategies include fighting chronic disease, helping babies make a healthy start in life, reducing the impact of adverse childhood experiences such as abuse and neglect, encouraging physical activity and otherwise helping people to make healthy choices.

Public health and health care systems can respond to our current health care challenges by working together and jointly placing emphasis on preventing health problems before they become expensive and hard to treat. They can also team up with a broad range of community partners to set local priorities for improving health. Public health agencies can contribute valuable information about health problems, they can help communities address the disparities in health among different groups of people and they can help promote the use of prevention practices that have been shown to get results.

With better health, children are in school more days and are better able to learn. Numerous studies have found that regular physical activity supports better learning.

With better health, adults are more productive and at work more days. Preventing disease increases productivity. Asthma, high blood pressure, smoking and obesity each reduce annual productivity by between \$200 and \$440 per person.

– Centers for Disease Control and Prevention ([cdc.gov/features/preventionstrategy](https://www.cdc.gov/features/preventionstrategy))

Fostering healthy communities to promote and protect health across the lifespan is also a top priority of the federal government's public health agency, the U.S. Centers for Disease Control and Prevention (CDC). The CDC has identified four domains for providing Americans with equitable opportunities to take charge of their health.

1. **Epidemiology and surveillance** – Collect data to monitor risk factors and chronic conditions.
2. **Environmental approaches that promote health** – Encourage access to healthy foods in communities and schools, promote physical activity and reduce tobacco use.
3. **Health system interventions** to improve the delivery of clinical and other preventive services – Screen for early stages of disease and encourage organized delivery of health services.
4. **Strategies to improve clinical and community services** – Support linkages to manage chronic diseases.

The key elements of the Agenda for Change Action Plan and the four CDC domains inform *The Washington State Plan for Healthy Communities*. Within this context we developed activities in nine priority areas:

1. Healthy starts
2. Sexual and reproductive health
3. Tobacco and substance abuse prevention
4. Active and safe environments
5. Healthy eating
6. Screening, referral and follow-up
7. Social and emotional wellness
8. Quality clinical and preventive treatment services
9. Health equity

In the following sections, we include the important role of partners, the specific strategies that Washington's public health network will pursue to prevent chronic disease and promote Healthy Communities, and our linkages to state and national evidence-based interventions.



Prevention of disease starts in our communities and at home. For example, businesses and employers can adopt practices to encourage their workforce to increase physical activity and reduce pollution (e.g., workplace flexibility, rideshare and vanpool programs, park-and-ride incentives, travel demand management initiatives and telecommuting options).

– Centers for Disease Control and Prevention (cdc.gov/features/preventionstrategy)

Partners in Prevention



For *The Washington State Plan for Healthy Communities* to be a success, it is essential for a wide range of partners to align and coordinate their efforts. Our partners come from a broad array of disciplines, institutions and sectors. They come together to help change the way communities conceptualize and solve problems to improve individual and community health and well-being.

No single entity can create healthy communities. State, tribal and local governments, businesses, health care providers, educators and community and faith-based organizations must join forces to initiate and sustain our work.

Roles that partners play

Many separate entities and actions support prevention in our communities. Opportunities for prevention increase when those working in transportation, education, housing, manufacturing and other sectors incorporate health and wellness into their decision-making.

Following are some of the ways we can work as partners to keep our communities healthy:

- **As purchasers:** We all purchase goods and services such as food, household supplies, vehicles and health insurance. Some of us finance the construction of infrastructure projects such as building, housing and roads. We can also use our purchasing power to promote health and wellness. For example, businesses can adopt policies to procure healthy foods and build healthier environments for their workers and customers.
- **As employers:** Employers can implement policies and programs that foster health, wellness and safety among their employees and their families. For example, employers can provide tailored counseling to promote tobacco cessation, combat depression, increase physical activity and enhance overall emotional well-being for all of their covered lives.
- **As policy makers:** Individuals, organizations and communities play key roles in developing, implementing and enforcing policies and regulations within their jurisdictions. For example, a county planning agency can use health criteria when making decisions on land use to provide opportunities for accessible and safe physical activity.

Partners Supporting Prevention

Examples include:

- The small business that supports evidence-based workplace wellness efforts
- The community-based organization that provides job training for the unemployed
- The parents of young children who work to give them healthy food and opportunities for physical activity

- **As health care providers:** Individuals and organizations that provide health care services can implement policies to support the delivery of high-impact clinical preventive services and enhance linkages to community prevention services and programs. For example, a health care system can adopt a decision support system that prompts clinicians to deliver age-appropriate screening to patients.
- **As communicators and educators:** We all receive information through many sources and provide information in a variety of ways. Every educational campaign, informational website, training and advertising campaign could be an opportunity to raise awareness, provide people with knowledge and create supportive environments to help people make healthy choices.

Many partnerships and coalitions provided input to help create this plan. They are examples of the shared and creative leadership necessary for success. This plan depends on these partnerships and our ability to expand upon and build new partnerships.



Strategic Domains



The overarching goals of *The Washington State Plan for Healthy Communities* are:

- Increase the number of Washingtonians who are healthy at every stage of life.
- Achieve health equity by eliminating health disparities.

These goals emphasize the lifelong impact of preventing disease while recognizing the importance of ongoing prevention and access to quality treatment for those who are already diagnosed with chronic diseases or disabilities. Achieving health equity and eliminating health disparities are complex issues and critical to achieving a healthier Washington. When we discuss disparities in this context, we refer not just to inequalities in accessing health care but also to disparities in the fundamental conditions that support health – including education, environmental conditions, economic resources and geographic location.

Our work to achieve these goals is organized across four domains established by the U.S. Centers for Disease Control and Prevention. Within these domains, we have identified 23 strategies and 42 related objectives to achieve healthy communities. We discuss each of these within this document, along with priority areas from which they are drawn (see Section Four).



Domain 1: Epidemiology and Surveillance

Gather, analyze and share data and information. Evaluate programs and population health.



Strategy 1: Develop new assessments and systems.

Short-term objectives:

- Determine the need for additional assessments and systems to track progress of healthy communities' activities with a special focus on data needed to identify health disparities as well as successful efforts to achieve health equity.
- Create a cost effective statewide mechanism to measure progress on strategies and objectives that will allow internal and external stakeholders to provide implementation updates.

Strategy 2: Use data to monitor population health, including information about disparately affected populations.

Short-term objective:

- Use common, high-value, consensus measures and existing data systems to monitor progress of healthy communities' activities, from nationally endorsed sources where possible.

Strategy 3: Evaluate interventions, programs and activities.

Short-term objective:

- Identify successful interventions as well as opportunities for improvement and share the results publicly.

Long-term objective:

- Create dedicated capacity in the Washington State Department of Health to perform health impact evaluations of interventions, proposed system and policy changes and disseminate the findings.

Strategy 4: Obtain and prioritize sustainable funding sources for surveillance and evaluation activities.

Long-term objective:

- Obtain sustainable funding sources to support statewide surveillance and evaluation activities.

For the greatest progress toward a healthier Washington, we must constantly improve our capacity to gather, analyze and use state and local data. Research – and the identification of evidence-based practices – should guide the work of health systems and delivery of health services. Improvements to program evaluation and wide dissemination of evaluation findings will raise the overall effectiveness of our public health system.



A healthier Washington delivers healthier students to our schools, healthier workers to our employers, and a healthier population to our health care systems. These types of interventions support and reinforce healthy choices and healthy behaviors and make it easier for Washingtonians to take charge of their health. They have broad reach, sustained health impact, and are good investments in public health.

Domain 2: Environmental Approaches

Commit to environmental activities that promote health and reinforce healthful behaviors in schools, work sites and communities across Washington. Focus on improvements in social and physical environments that make healthy behaviors easier and more convenient for Washingtonians.

Strategy 1: Increase access to safe and affordable physical activity where people work, learn, live, play and worship.

Short-term objective:

- Promote the establishment, improvement and use of outdoor spaces, including streets, parks, recreation areas, trails, beaches and other public spaces that are safe, tobacco free, accessible and appropriate for physical activity and play.

Long-term objectives:

- Improve physically active transportation options through community design and transportation planning.
- Increase active time and physical education in schools and early learning sites.

Strategy 2: Reduce tobacco and alcohol advertising, promotions and product placement, and enforce youth access laws for these products.

Long-term objectives:

- Reduce the proportion of adolescents and young adults in grades six through 12 who are exposed to tobacco advertising and promotion on the Internet, in the movies, magazines and newspapers, as well as at point of purchase.
- Reduce the illegal sale rate to minors through enforcement of laws prohibiting the sale of tobacco products to minors.

Strategy 3: Increase the number of places that protect employees, customers, patrons and others from second-hand smoke.

Long-term objective:

- Increase the adoption of no-smoking policies in public housing, private multi-unit housing, higher education and technical college campuses, parks, work sites and other public places.

Strategy 4: Increase access to healthy foods and beverages (including breastfeeding) where people work, learn, live, play and worship.

Short-term objectives:

- Establish stronger nutritional standards/guidelines for institutional procurement of food to guide Washington state agencies and institutions. Guidelines should address sodium.
- Increase the proportion of infants who are still being exclusively breastfed at six months.

Long-term objectives:

- Increase the number of adults, youth or families that access small retail venues offering healthy foods and beverages.
- Ensure that all people in Washington will have ready access to nutritious, high-quality and affordable foods and beverages.

Strategy 5: Establish sustainable funding for prevention.

Short-term objective:

- Seek additional funding for prevention efforts, such as through the Prevention and Public Health Fund.

Long-term objective:

- Work toward payment reform to support health providers to encourage evidence-based preventive services and screening.

Strategy 6: Develop and enhance systems and policies to support sexual and reproductive health to increase access and timeliness of preventive care, screening and treatment.

Long-term objectives:

- Establish a norm of sexual health and reproductive justice across the lifespan as crucial to the health of the public.
- Establish social, economic and health policies that improve equity in sexual health and reproductive justice.

Strategy 7: Increase social connectedness, healthy relationships, violence-free environments and community engagement across the life span.

Long-term objective:

- Decrease the presence of risk factors that contribute to violence and increase the presence of resilience factors that are protective against violence at the individual, family and community levels.

The national *Healthy People 2020* goals also commit to improving our ability to make healthy choices in our communities. Some examples that align with our Washington State objectives are:

- All multi-housing units be smoke-free by 2020
- Less than 20% of youth are exposed to tobacco advertising and promotion in newspapers and magazines by 2020
- 38% of employers are supportive of breastfeeding women by 2020
- 71% of 50–74 year old adults receive a colorectal cancer screening by 2020

Strategy 8: Cultivate state and local leadership coalitions and community engagements to develop community-informed interventions, organizational structures and supports to address health inequities.

Long-term objective:

- Increase the number of community-based organizations – including local health jurisdictions, tribal health services, non-governmental organizations and state agencies – providing population-based primary prevention services.

For nearly all infants, breastfeeding is the best source of nutrition and immunologic protection, and also provides health benefits to mothers (e.g., reduced risk of breast and ovarian cancers).

– *National Prevention Strategy 2011*

Reproductive justice work seeks to expand and protect the rights of all women and girls to make informed decisions about and exercise control over their sexual and reproductive lives.

– The Women's Foundation of California
(womensfoundca.org)

Domain 3: Health Systems

Implement strategies that improve the effective delivery and use of clinical and other preventive services to prevent disease, detect disease early, reduce or eliminate risk factors and mitigate or manage complications.



Strategy 1: Enhance and maintain health systems to increase timely access to preventive care, screening and treatment.

Long-term objectives:

- Collaborate among public health, health systems and primary care clinics to advance system changes that improve the delivery of cancer screening and other clinical preventive services.
- Increase the proportion of persons of all ages who have a specific source of ongoing health care.

Strategy 2: Promote and provide support to build capacity and availability of health care, education, resources and services.

Long-term objectives:

- Adopt proven Chronic Disease Self Management programs.
- Design primary prevention services and screenings – including those from non-medical providers – to be as convenient and affordable as possible.

Strategy 3: Establish a mechanism for reimbursement of comprehensive tobacco cessation services and substance abuse and mental and behavioral health treatment.

Long-term objectives:

- Increase comprehensive coverage of evidence-based treatment for nicotine dependency for all Washingtonians through their health plan.
- Increase mental health benefits included in Washington health plans to improve financial protection and to increase access to, and use of, mental health services.

Strategy 4: Improve the knowledge and ability of health care professionals to deliver comprehensive evidence-based services including integrated mental health and chemical dependency screening and interventions from preconception to end of life.

Long-term objectives:

- Ensure that health care practices and behavioral health providers coordinate their services for patients with chronic disease and behavioral health issues.

Health system interventions can help clinical environments deliver quality preventive services more effectively and make it easier for Washingtonians to use and benefit from those services. Quality improvement measures such as electronic medical records, clinician reminder systems and requirements for reporting on outcomes such as control of high blood pressure and screening rates encourage providers to focus on preventive services. Effective communication and outreach to consumers are also vital, as coverage alone will not ensure use of preventive care.

The national *Healthy People 2020* goals also commit to improving healthcare systems in our communities. Some examples that align with our Washington State objectives are:

- 87% of primary care facilities provide mental health treatment on site
- 95% of all people have a specific source of care by 2020
- All states have comprehensive Medicaid insurance coverage for nicotine dependency treatment by 2020

- Expand self-care and management education programs statewide including the Diabetes Prevention Program, the Chronic Disease Self-Management Program and arthritis exercise programs.

Strategy 5: Promote early identification of behavioral health issues and access to quality behavioral health services across the life span.

Long-term objectives:

- Increase the percent of primary care facilities that provide mental health treatment onsite or by paid referral.
- Increase depression screening by primary care providers.
- Increase the proportion of all Washingtonians with mental health disorders who receive treatment.
- Increase awareness among health providers about the impact of adverse childhood experiences and toxic stress on lifelong mental and physical health.

Strategy 6: Promote delivery of health care services that are culturally and linguistically appropriate and acceptable for the population being served.

Long-term objective:

- Ensure that health care providers design treatments and support programs to meet the health needs of all patients and customize care based on social and cultural needs.

Strategy 7: Increase public and health professional awareness of the importance of screening and follow-up.

Short-term objectives:

- Ensure that health providers monitor patients to receive evidence-based preventive services and screening and identify any barriers the patients are facing in obtaining these services.
- Ensure that patients receive information on opportunities for evidence-based screening and preventive services.

Long-term objective:

- Increase the proportion of Washingtonians at every life stage who receive age-appropriate, evidence-based clinical preventive services including:
Breast, cervical and colorectal cancer screening; BMI screening, weight status assessment and appropriate intervention; Screening for tobacco use and cessation assistance; Diabetes risk assessment for referral to diabetes self-management education or community diabetes prevention programs; and Chronic disease management and self-management education.

Domain 4: Clinical and Community Preventive Services

Implement strategies to improve partnerships between clinical service providers and community-based organizations so that communities support and clinics refer patients to programs that improve management of chronic conditions.



Strategy 1: Enhance capacity, infrastructure and leadership of community-based organizations that serve socially disadvantaged populations to provide the support necessary to maintain positive mental and physical well-being.

Long-term objective:

- Develop multi-disciplinary care teams with the health care home model to coordinate across clinics, hospitals, social services and community-based preventive resources.

Strategy 2: Support linkage of clinical and community prevention efforts to mobilize services, resources and self-management programs from prevention to intervention.

Short-term objective:

- Develop and disseminate at least three best practice models for better clinic-to-community linkages.

Strategy 3: Support payment reform to reduce patient out-of-pocket costs and provider reimbursement for prevention.

Short-term objective:

- Pursue policies and system changes that reduce out-of-pocket costs to the consumer of clinical preventive services, including cancer screening and treatment for tobacco use and dependence.

Long-term objective:

- Pursue policies and system changes that provide clinician reimbursement for provision of clinical preventive services, including patient education and counseling.

Strategy 4: Develop and disseminate health education that is scientifically accurate, age-appropriate, culturally and linguistically suitable for the public, health professionals, and local and state decision makers.

Long-term objective:

- Increase effective communication so that individuals, organizations, community partners and decision makers can access, understand, share and act on health information and services.

Evidence-based preventive services reduce premature death and disability and are cost-effective. Increasing the use of preventive services depends on the health care system's ability to deliver appropriate preventive services, the public's understanding of the benefits of preventive care, and individuals' willingness and ability to access services. The federal Patient Protection and Affordable Care Act expands access to clinical preventive services by helping more people obtain health care coverage and removing cost-sharing for specific preventive services.

Community programs can promote the use of services as well as assist patients in overcoming barriers such as transportation or child care issues – making it easier for people to “follow the doctor’s orders” and take charge of their health.



The Office of Healthy Communities identified eight priority topic areas to organize our state plan based on national and statewide priorities. We discuss them here, along with health equity – an overarching ninth area of focus.

Priority Area 1: Healthy Starts

A healthy start means babies are born as healthy as possible and are cared for in safe, healthy and nurturing environments.

Genetics and early experiences affect health and development across the life span. Communities can support a healthy start for children through family-centered programs that ensure access to all women's preconception needs and to age-appropriate medical, dental and behavioral health, education and care within a medical home. A healthy start also means that children receive developmental screening, education and referral at appropriate ages and that health and safety issues are addressed in both community and home environments.

Strategies and activities in all nine priority areas support Healthy Starts. The ones listed here fall outside of the other eight areas.

Strategies and Activities that Support Healthy Starts

A: Develop and disseminate health education that is scientifically accurate, age-appropriate, culturally and linguistically suitable for the public, health professionals, and local and state decision makers.

Sample activities:

- Maintain the scientific accuracy and dissemination of Department of Health women's health messages, including posting appropriate health education materials on the department website, Health Education Resource Exchange (H.E.R.E.) and partner sites.
- Coordinate with existing agencies, organizations and workgroups with subject-matter expertise as a clearinghouse for interagency and partner-developed material and content expertise.
- Conduct targeted public campaigns and disseminate educational materials on focused topics including use of folic acid to prevent birth defects, avoidance of alcohol and drugs among women of reproductive age, family planning methods, and parenting classes for prospective mothers and fathers.
- Provide training and technical assistance for providers on the importance of educating patients on infant and child health and development.
- Participate in workforce development activities, including health education, with partners and stakeholders, including staff, students, contractors and providers on topics including reproductive health issues and child development.
- Use parent and consumer organizations to review all health education materials to ensure they are culturally and linguistically appropriate.

- Use professional standards of practice and evidence-based resources to evaluate and develop educational materials.
- Translate health education materials as appropriate and needed (i.e., adhering to National Standards for Culturally and Linguistically Appropriate Services in Health Care).

B: Enhance and maintain health systems to increase timely access to preventive care, screening and treatment.

Sample activities:

- Develop and disseminate practice guidelines, standards of care, prevention and health promotion messages on women's health care, and provide training, coaching and technical assistance to provider organizations on implementation.
- Work with communities and local health jurisdictions to expand the health care work force through training, networking and outreach activities.
- Build, maintain and promote data systems to support surveillance, tracking and referrals of children undergoing periodic universal developmental screening.
- Provide technical assistance and support to health care providers, treatment centers, local health jurisdictions, home visiting programs, and other community providers to enhance their knowledge and skills to provide quality pediatric health care.
- Partner with the Washington State Health Care Authority, the Office of the Insurance Commissioner, payers and providers to support system changes to improve access, ensure adequate health benefits, and require the reimbursement of needed services such as developmental screening, nutrition, habilitative services, medical/health homes and tobacco cessation services.

C: Establish sustainable funding for prevention.

Sample activities:

- Provide data and other information regarding the benefits of paying for family-centered health education services to decision makers including employers, the Office of the Insurance Commissioner, and public and private third-party payers.



If clinic-based smoking cessation interventions were universally implemented for pregnant smokers, an additional 3.3% of pregnant smokers would quit.

If all pregnant smokers quit smoking, as many as 5%–8% of pre-term infants and 13%–19% of term low birthweight infants could be born at a normal weight.

– Centers for Disease Control and Prevention (cdc.gov/reproductivehealth/womensrh/ChronicDiseaseandReproductiveHealth.htm)

Too often individuals receive services from different state agencies and local providers with less than optimal coordination of care, supporting services, or recognition of the role of the community.

—Washington State Health Care Authority
*Washington State Health Care
Innovation Plan*

D: Promote and provide support to build capacity and availability of health care, education, resources and services.

Sample activities:

- Work with communities and local health jurisdictions to expand the health care work force within communities through training, networking and outreach activities.
- Collaborate with community organizations and providers to identify and address inadequate network capacity and other barriers that prevent people from accessing primary, specialty and preventive care.
- Promote community referral and linkages to quality pediatric services through partnerships with local health jurisdictions, parent support organizations, community health centers, etc.
- Convene and collaborate with stakeholders, including the Health Care Authority, the Office of the Insurance Commissioner, hospitals and payers to ensure consistent and appropriate policies and coverage for needed women's preconception, prenatal and reproductive health care services.
- Collaborate with the Washington State Department of Early Learning and the Washington State Health Care Authority to provide home visiting services to vulnerable families with young children.

Priority Area 2: Sexual and Reproductive Health

Sexual and reproductive health means making responsible and respectful decisions about sex, relationships and childbearing.

Strategies and Activities that Support Sexual and Reproductive Health

A: Develop and enhance systems and policies to support sexual and reproductive health to increase access and timeliness of preventive care, screening and treatment.

Sample activities:

- Increase the number of health centers that offer sexual health care in schools, community colleges and universities.
- Cultivate relationships between family planning providers and community health clinics and other primary care clinics, especially in rural communities.
- Increase awareness of preventive health services, including contraception.
- Train primary care providers on providing sexual health and family planning services in the wake of health care reform.
- Help family planning and primary care clinics adopt evidence-based sexual health education programs.
- Integrate the use of electronic health records in family planning clinics while implementing the Affordable Care Act.
- Expand telemedicine capabilities for family planning providers.
- Increase awareness of long-acting reversible contraception methods in the general population and among specialty and primary care providers.
- Create a forum for youth input regarding outreach for adolescent sexual health.
- Sustain programs that support the educational and career success of pregnant and parenting teens and young women and their children.

B: Develop and disseminate health education that is scientifically accurate, age-appropriate, culturally and linguistically suitable for the public, health professionals, and local and state decision makers.

Sample activities:

- Coordinate training for primary and specialty care providers on how to discuss reproductive life plans with patients of all ages.



It is crucial to the well-being of Washington communities to provide effective sexual health education and equitable access to safe and affordable family planning services and sexual health services. Empowering individuals, families and communities to have informed and positive discussions about sexual and reproductive health issues will improve overall health in Washington State.

Using hormonal birth control offers a number of health benefits beyond preventing pregnancy, including moderating or reducing chronic disease. It can protect against certain cancers (endometrial, ovarian and colorectal) and decrease benign breast lumps. It can also treat polycystic ovary syndrome, which in turn reduces long-term complications of obesity, diabetes and heart disease.

– Washington State Department of Health
“Contraceptives Provide Lifelong Benefits and Reduce Chronic Disease”

- Develop targeted, culturally and age-appropriate educational materials for providers and for the public about reproductive planning – how to create and the benefits of having a reproductive life plan.

C: Develop new assessments and systems.

Sample activities:

- Restore the Behavioral Risk Factor Surveillance System family planning module to measure contraceptive use and sexual risk behaviors and to add questions as needed to measure access to family planning and sexual health services.
- Require the Healthy Youth Survey demographics section to include questions on sexual orientation.
- Require the Healthy Youth Survey sexual behavior section to be included on the regular survey forms and to include questions that will more effectively measure contraceptive use, STIs and unhealthy sexual activity among young people.
- Analyze and present findings using media and methods that reach adolescents and adults in need of family planning services and providers.

Priority Area 3: Tobacco and Substance Abuse Prevention

Unhealthy use of tobacco, alcohol and other drugs across the life span can lead to addiction, disease, injury and premature death.

Strategies and Activities that Support Tobacco and Substance Abuse Prevention

A: Enhance capacity, infrastructure and leadership of community-based organizations that serve socially disadvantaged populations to provide the support necessary to maintain positive mental and physical well-being.

Sample activities:

- Reestablish cross-cultural and community networks representing specific subgroups experiencing tobacco-related disparities. Networks will assist the state tobacco program by collaborating and providing expert consultation and technical assistance on promising and proven practices.
- Provide community-specific training, technical assistance and leadership development activities to enhance the capacity of community-based organizations to develop and implement a comprehensive tobacco prevention approach.
- Increase participation and inclusion of diverse community organizations in capacity building and implementation funding opportunities to address the use of tobacco and exposure to secondhand smoke.
- Provide data and information to community-based organizations serving populations or communities experiencing tobacco-related disparities to share with policy makers.
- Develop an implementation plan that reflects evidence-based or promising strategies to define and eliminate tobacco-related disparities. The plan will address strategies and tactics articulated in *The Washington State Plan for Healthy Communities*.



Tobacco-free living means avoiding use of all types of commercial tobacco products and exposure to secondhand smoke. Communities can improve the health of their populations by reducing access to tobacco products, changing norms, identifying substance abuse early, and providing necessary services to help people conquer addictions.

There is sufficient evidence to conclude that there is a causal relationship between tobacco company advertising and promotion and the initiation and progression of tobacco use among youth.

– U.S. Dept. of Health and Human Services
Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General

The money cigarette companies spent in 2011 on U.S. marketing amounted to approximately \$23 million per day.

– Federal Trade Commission
Cigarette Report for 2011

B: Increase public and health professional awareness of the importance of screening and follow-up.

Sample activities:

- Develop a pregnancy-focused tobacco cessation and treatment module.
- Coordinate with the Washington State Department of Social and Health Services – Division of Behavioral Health and Recovery to promote alcohol and other drug screenings among health care providers.
- Update as needed pregnancy-specific tobacco cessation materials and substance abuse screening materials for providers.
- Continue to make Quitline cards and counseling services available to providers.
- Provide technical assistance to providers concerning tobacco and other substance abuse cessation during pregnancy.
- Coordinate with the Community Health Worker Training program to facilitate linkages to cessation treatment services and resources.

C: Establish a mechanism for reimbursement of comprehensive tobacco cessation services and substance abuse and mental and behavioral health treatment.

Sample activities:

- Research requirements for reimbursement of tobacco cessation, substance abuse and behavioral health treatment.
- Facilitate discussions between the Washington State Health Care Authority and the Washington Health Benefit Exchange to explore universal policies.
- Provide information to the Washington State Office of the Insurance Commissioner on the benefits to be gained by requiring adequate cessation services and nicotine replacement therapies in all health plans.
- Develop relationships with stakeholders who can monitor compliance with the Essential Health Benefits package.
- Inform employers and unions on the public health impact of providing adequate coverage.
- Inform stakeholders on tobacco-related and substance abuse disparities and the efficacy of cessation treatment and prevention programs.

D: Increase the number of places that protect employees, customers, patrons and others from secondhand smoke.

Sample activities:

- Promote the adoption and implementation of evidence-based secondhand smoke policies and provide consultation on enforcement.
- Provide consultation to employers, health care systems, multi-unit housing managers and owners, and treatment facilities to promote site-specific secondhand smoke policies.
- Promote and provide direct cessation services through the Quitline in places where secondhand smoke policies are adopted.
- Issue a call to action for all institutions of higher education to adopt and implement secondhand smoke policies.



E: Develop and disseminate health education that is scientifically accurate, age-appropriate, culturally and linguistically suitable for the public, health professionals, and local and state decision makers.

Sample activities:

- Promote the use of evidence-based prevention curriculum in K-12 grades, including youth leadership development models.
- Promote and support prevention and intervention specialists in schools to provide education and counseling.
- Develop messaging for paid and public messaging campaigns about tobacco and substance use harms and to promote Quitline.

F: Reduce tobacco and alcohol advertising, promotions and product placement and enforce youth access laws for these products.

Sample activities:

- Promote the “reduce smoking in movies” campaign to restrict tobacco use in any non-R-rated movies.
- Raise awareness of the impact of product placement, in-store advertising, and tobacco and alcohol retailer location on youth and mobilize communities to reduce or eliminate youth access to harmful substances.
- Encourage schools to enforce laws and policies on tobacco and alcohol use on K-12 campuses.
- Maintain implementation and increase compliance checks and retailer education on tobacco and alcohol laws.
- Raise awareness of the impact of fines, penalties and fees for illegal sales to minors.



Engaging in regular physical activity is an important way to improve health and lower preventable chronic diseases and obesity. Safe community environments help people of all ages and abilities engage in physical activity on a routine, daily basis. By working on policy, environmental and system changes, communities promote and ensure active and safe living to improve physical and social-emotional health and well-being.

Priority Area 4: Active and Safe Environments

Active living is getting the recommended level of physical activity daily.

Strategies and Activities that Support Active and Safe Environments

A: Increase access to safe and affordable physical activity where people work, learn, live, play and worship.

Sample activities:

- Partner with the Department of Early Learning to develop early childhood education programs that require the delivery of safe and appropriate physical activity programming.
- Work with community college systems to include physical activity training as a core part of child care certification and early childhood training programs.
- Support Safe Routes to School efforts to increase active transportation to and from school and support accommodations for children with disabilities.
- Encourage physical activity in after-school settings by: adopting state standards for the inclusion of physical activity; requiring a physical activity component in all state and federally funded programs; subsidizing transportation and program costs; and providing resources for innovative pilot projects.
- Promote work environments where active living is the norm and employees are supported in taking physical activity breaks during the work day.
- Advocate for physical activity policies at child care facilities that address the developmental needs of all children, including children with disabilities, those classified as obese, or children at high risk of inactivity.
- Provide information and technical assistance to the Washington State Department of Early Learning on Washington Administrative Codes (WACs) or Revised Codes of Washington (RCWs) regarding physical activity policies.
- Adopt community strategies that improve access to – and ensure the safety and security of – parks, recreation, fitness and sports facilities, especially in low-resource and high-crime neighborhoods.

- Improve access to public-private recreational facilities in communities with limited recreational opportunities by reducing costs of participating, increasing operating hours, co-locating schools, parks and recreational facilities, and increasing child care availability.

B: Develop and disseminate health education that is scientifically accurate, age-appropriate, culturally and linguistically suitable for the public, health professionals, and local and state decision makers.

Sample activities:

- Provide child care training and resources for early childhood professionals on physical activity and screen time reduction policies that encourage limiting children's television time to no more than one to two hours of quality programming per day.
- Provide trainings or information to worksites, early childhood education settings or after-school programs to limit screen time.

C: Cultivate state and local leadership coalitions and community engagements to develop community-informed interventions, organizational structures and supports to address health inequities.

Sample activities:

- Create standards to guide communities to develop integrated plans that incorporate land-use, transportation, community design, parks, trails and greenways, and encourage economic development planning for communities to prioritize and implement such projects.
- Develop standards for small and rural local governments that guide integrated land-use, transportation, community design and economic development decisions to support increased physical activity and improved health outcomes.
- Develop standards for health impact assessments (HIAs) for use in planning processes to increase positive health outcomes.
- Support the development of standards and identification of "best practices" for the dissemination and adoption of "safe routes" initiatives such as Safe Routes to School, Bike-to-Work, and other active transportation programs.

D: Increase public and health professional awareness of the importance of screening and follow-up.

Sample activities:

- Educate clinical providers on the best way to ensure that their patients who are at high risk for chronic disease and inactivity have easy access to physical activity services.
- Work with insurance providers to ensure reimbursement for patient education and referral.
- Train providers in educating patients about the importance of physical activity and tracking the prevalence of physical inactivity.

Priority Area 5: Healthy Eating

Healthy eating is consuming a balanced diet that meets individual nutritional needs.

Strategies and Activities that Support Healthy Eating

A: Increase access to healthy foods and beverages (including breastfeeding) where people work, learn, live, play and worship.

Sample activities:

- Include healthy eating concepts and language in municipal policies and tools such as comprehensive plans, zoning, ordinances, permits and licensing rules.
- Assure that all Washingtonians with special health care needs have access to nutritionally sound modified diets and dietary products.
- Promote affordable healthy food and beverage options in corner stores, including ensuring the ability to accept WIC/SNAP.
- Improve mechanisms for purchasing foods from farmers' markets and farms, including ensuring the ability to accept WIC/SNAP and farm-to-institution programs.
- Increase sustainable community gardens in underserved areas.
- Increase sustained management support for healthy eating practices and policies in the worksite, with leadership serving as models and implementing policies that support employees in taking breaks and accessing on-site and community-based resources for healthy eating.
- Ensure access to free, safe drinking water.
- Promote practices and policies that support breastfeeding in worksites, schools, institutions and health care settings.
- Improve healthy food options for food-insecure individuals through food programs such as summer meal programs, emergency food programs, senior meal programs and food banks.
- Increase and promote healthy food and beverage options in restaurants and increase menu labeling in restaurants, vending, snack bars and cafeterias.
- Limit unhealthy food and beverage outlets near schools and in residential areas.



A healthy diet includes a variety of vegetables, fruits, lean protein, low-fat and non-fat milk and milk products, and whole grains while limiting excess fat, sugar and salt. Healthy eating promotes growth and development, including brain development, oral health and healthy body weight, and it reduces chronic disease over the life course.

Breastfeeding is the normal and preferred practice for feeding infants a healthy diet. We encourage healthy eating by making these choices easy to understand, affordable and accessible.

B: Develop and disseminate health education that is scientifically accurate, age-appropriate, culturally and linguistically suitable for the public, health professionals, and local and state decision makers.

Sample activities:

- Provide opportunities to build skills and knowledge regarding healthy food and beverages.
- Provide opportunities to build skills and knowledge regarding breastfeeding and breastfeeding support.

Priority Area 6: Screening, Referral and Follow-up

Delivering early screening, referral and follow-up services improves population health across the life course.

Strategies and Activities that Support Screening, Referral, and Follow-up

A: Increase public and health professional awareness of the importance of screening and follow-up.

Sample activities:

- Develop and disseminate appropriate (cultural, linguistic, education level, etc.) information to all stakeholders, including community partners and targeted populations.
- Provide training and technical assistance to community partners on evidence-based and nationally recommended interventions and standards.
- Increase community demand and awareness of screenings by engaging employers and health insurance companies.
- Develop campaigns and materials that promote the value of early identification and detection of health issues for better treatment outcomes, including addressing emotional barriers.
- Promote knowledge and use of medical/health homes with a focus on preventive care and intervention services, including children with special health care needs.

B: Promote and provide support to build capacity and availability of healthcare, education, resources and services.

Sample activities:

- Build capacity for community health workers by offering educational opportunities.
- Engage employers to adopt policies to improve health, including workplace wellness programs that include screenings, health insurance benefits to support screenings, and workplace policies to support access to services.
- Increase community access to primary care and medical/health homes by increasing provider capacity, especially for underserved regions and populations.
- Increase school-based developmental and health screening, referral and follow up.



Community-based screening, referral and follow-up services address social, environmental and economic inequities by providing linkages to health and supportive services and removing barriers to access. Community-based interventions address negative health influences by targeting social, environmental and economic inequities and improving access to quality services.

- Develop best practices, guidelines and/or tool kits for community-based programs to perform screenings and help clients access services.

C: Cultivate state and local leadership coalitions and community engagements to develop community-informed interventions, organizational structures and supports to address health inequities.

Sample activities:

- Partner with and support organizations that address cultural and linguistic barriers, such as providing access to interpretation and translation and increasing cultural acceptability.
- Connect partners and consumers with culturally appropriate resources such as National Diabetes Education Program materials in multiple languages.
- Provide technical assistance to consumers on how to access and advocate for culturally and linguistically appropriate services, including medical/health homes.

D: Support payment reform to reduce patient out-of-pocket costs and provider reimbursement for prevention.

Sample activities:

- Work with state and local partners to create common goals for screening, referral and follow-up and address barriers, such as providing access to transportation, child care and other services.
- Recommend payment policies to foster collaboration and coordination among primary care, specialty care and community providers, as well as other partners involved in care.
- Improve coordinated care for families by increasing collaboration with support networks.
- Identify funding for state, local and private system coordination.
- Recommend financing mechanisms to integrate developmental, mental health, tobacco and substance use screenings into primary care across all age groups.

Priority Area 7: Social and Emotional Wellness

Social and emotional wellness is critical to health and well-being, including chronic disease prevention.

Strategies and Activities that Support Social and Emotional Wellness

A: Increase social connectedness, healthy relationships, violence-free environments and community engagement across the life span.

Sample activities:

- Engage public health leaders in promoting social and emotional wellness as a crucial part of public health work.
- Increase awareness of the connections between social and emotional wellness and physical health.
- Implement a coordinated, comprehensive early childhood system, including social, emotional and mental health.
- Provide information about nurturing parenting to service providers and community members.
- Promote a coordinated system of home visiting.
- Increase awareness of connections between social and emotional wellness and educational success, parenting, economic stability, productivity and non-criminal behavior.
- Achieve universal developmental screening, including social-emotional and mental health, for young children and behavioral health screening for parents.
- Build capacity in communities to implement healthy behavior and relationship skill-building in schools, communities and clinical settings.
- Build capacity to implement problem-solving, coping and resiliency skill-building in schools, communities and clinical settings.
- Increase community and clinic capacity to prevent violence, identify domestic violence and sexual assault, and refer to resources, including emotional support, and mental health and primary care services.
- Increase community capacity to prevent adverse childhood experiences (ACEs) and promote resiliency.
- Support safe, stable and nurturing families to prevent child abuse and neglect.



Social and emotional wellness across the life span includes being able to develop and sustain nurturing relationships, community connections and healthy expression of thoughts and feelings. From the earliest stages of life, social and emotional wellness helps build a foundation for people to realize their full potential, cope with the stresses of life, work productively, engage in activities that support health, and make meaningful contributions to society. State agencies, public health leaders, organizations and communities promote policies, systems and environments that increase social and emotional wellness for all.

B: Cultivate state and local leadership coalitions and community engagements to develop community-informed interventions, organizational structures and supports to address health inequities.

Sample activities:

- Develop and provide tools and training to primary care teams and community health workers to provide screening and follow-up services.
- Increase and support the implementation of compassionate/complex trauma systems and services.
- Increase community capacity to connect people with services to manage chronic conditions, including mental health conditions and substance abuse, and increasing coordination among services.
- Implement support programs for teen parents and teen pregnancy prevention programs.

C: Improve the knowledge and ability of health care professionals to deliver comprehensive evidence-based services including integrated mental health and chemical dependency screening and interventions from preconception to end of life.

Sample activities:

- Develop and provide tools and training to primary care staff and community health workers to integrate behavioral health screening and follow-up intervention strategies and improve access to effective behavioral health treatment for infants, children, youth, families and individuals.
- Increase and support the implementation of school-based health centers with licensed mental health and sexual health services.
- Connect primary care providers to resources for treating patients with adverse experiences.
- Promote the benefits of pursuing treatment for behavior and mental health disease.

Priority Area 8: Quality Clinical and Preventive Treatment Services

Foster measurable quality improvements across the health system for patients and families throughout the life course.



Strategies and Activities that Support Quality Clinical and Preventive Treatment Services

A: Improve the knowledge and ability of health care professionals to deliver comprehensive evidence-based services including integrated mental health and chemical dependency screening and interventions from preconception to end of life.

Sample activities:

- Facilitate quality improvement by providing training, technical assistance and resources to health care providers so they can implement evidence-based policies that meet the needs of the population across the lifespan using such approaches as family-centered and team-based care and adherence to national guidelines.

B: Support linkage of clinical and community prevention efforts to mobilize services, resources and self-management programs from prevention to intervention.

Sample activities:

- Integrate evidence-based strategies to improve training and technical assistance for health care providers across the care continuum so they can implement effective care by identifying and referring patients to appropriate services, taking responsibility for care coordination, and using appropriate transition systems and partners.

C: Support payment reform to reduce patient out-of-pocket costs and provider reimbursement for prevention.

Sample activities:

- Convene and educate key stakeholders, third-party payers and health plan purchasers to cultivate changes to benefits and payment systems.

Provider teams and health systems will have the knowledge and skills to improve clinical preventive care, screening, diagnosis and management to work to the top of their scope. Teams and systems will use this knowledge to identify guidelines, policies and evidence-based practices; to support patient and family self-management; to engage community-based resources; and to fully integrate quality improvement.

D: Promote early identification of behavioral health issues and access to quality behavioral health services across the life span.

Sample activities:

- Facilitate quality improvement by providing training, technical assistance and resources to health care providers so they can include principles for infant mental care into practice.
- Promote screening for depression, mental health and trauma concerns in children and adolescents using evidence-based guidelines.
- Promote screening and provide appropriate follow-up for depression and anxiety in adults.
- Promote the identification of patients at risk for Post-Traumatic Stress Disorder.
- Promote the incorporation of ACEs concepts into provider practice.

E: Promote delivery of health care services that are culturally and linguistically appropriate and acceptable for the population being served.

Sample activities:

- Integrate evidence-based strategies to improve technical assistance to health care providers so they can design treatment and support programs that are culturally and linguistically appropriate for their patients.

Priority Area 9: Health Equity

Health equity exists when everyone has an equal opportunity to achieve the highest level of health.

Strategies and Activities that Support Health Equity

A: Use data to monitor population health, including information about disparately affected populations.

Sample activities:

- Ensure the availability of health data on all racial, ethnic and other populations experiencing poor health outcomes.
- Use tools, such as the Connecticut Health Equity Index, to identify inequities in communities and then focus efforts.
- Complement quantitative data collection with a variety of community-appropriate qualitative methods (surveys, interviews, focus groups) to verify community-identified health priorities.
- Highlight the most striking inequities through clear, consistent and widespread messages to decision makers, affected communities, partners and the public.

B: Cultivate state and local leadership coalitions and community engagements to develop community-informed interventions, organizational structures and supports to address health inequities.

Sample activities:

- Invest resources to build strong and trusting relationships with communities.
- Hire, train and support staff to incorporate health equity into public health practice and increase the diversity of the public health workforce.
- Incorporate health equity goals in Requests for Proposals, contract language and processes.
- Develop health equity communication plans.
- Collaborate with governmental and non-governmental organizations to support and implement policies that create the social, environmental and economic conditions to realize healthy outcomes.
- Work with identified communities to choose and pilot interventions that are likely to be effective for populations with low socioeconomic status, racial and ethnic populations, and other culturally diverse populations.



We strive for fairness in the distribution of benefits and burdens, and we believe in the right of everyone to a good standard of living. But health disparities persist and are often linked to social, economic, or environmental disadvantages.

Disparities can be reduced and health equity achieved by:

- Focusing on communities at greatest risk.
- Building multi-sector partnerships that create opportunities for health equity and healthy communities.
- Increasing access to preventive services in both clinical and community settings.
- Implementing strategies that are culturally and linguistically appropriate as well as literacy- and age-appropriate.
- Evaluating strategies and interventions to ensure they are effective and progress is achieved.

Social determinants of health are life-enhancing resources such as food supply, housing, economic and social relationships, transportation, education and health care whose distribution across populations effectively determine length and quality of life.

— Centers for Disease Control and Prevention
Promoting Health Equity

- Develop and support partnerships among public, nonprofit and private entities to provide a comprehensive infrastructure to increase awareness, drive action, and ensure accountability in efforts to achieve health equity across the lifespan.
- Increase the capacity of community-based organizations to do health equity work.
- Ensure that ending health disparities is a priority on local and state public health and health care agendas.
- Balance the need to give high priority to targeted interventions for smaller at-risk populations with interventions for overall population impact.
- Work with communities to identify health indicators they want to focus on and their measures of progress in achieving health equity.

C: Evaluate interventions, programs and activities.

Sample activities:

- Invest in community-based participatory research and evaluation of community-originated intervention strategies to broaden the evidence base.
- Increase the use of current tools to measure whether strategies are having differential impacts across population groups and areas experiencing greatest health disparities.

D: Promote delivery of health care services that are culturally and linguistically appropriate and acceptable for the population being served.

Sample activities:

- Increase the capacity of community based groups to do health equity work.
- Highlight the most striking inequities, through clear, consistent and widespread messages to decision makers, affected communities, partners and the general public.

Burden of Chronic Disease

The chronic diseases that we address in this plan – including arthritis, cancer, diabetes, heart disease and hypertension – represent significant public health problems in Washington State. They cause premature death and disability, undermine quality of life and economic productivity and drive up health care spending.

Chronic disease is often preventable, and its impact is closely associated with factors such as where people live, their level of income and education and their race and ethnicity. The burden of chronic disease falls disproportionately on our most vulnerable and underserved populations.

In this section of our plan, we examine the nature of the burden of chronic disease across different racial/ethnic, income and age groups. We also explore the relationship between chronic disease trends and unhealthy behaviors.

The data show the broad impact of the burden.

We know first that chronic disease affects substantial numbers of people statewide:

- More than 1.3 million adults, or 23 percent of our adult population, has arthritis.
- About 270,000 people, or 6.8% of Washingtonians, have heart disease.
- More than 126,000 people, or 2.5% of our population, are living with the effects of stroke.
- Every year, more than 35,000 people living in Washington are diagnosed with cancer.

We also know that millions of Washingtonians have health conditions that put them at greatest risk of developing chronic disease:

- About 1.8 million have pre-diabetes.
- About 1.5 million have hypertension.
- About 2 million have high cholesterol.

Chronic disease exacts a crushing toll in medical costs and lost productivity in our state, including \$10 billion annually from cancer, more than \$4 billion from heart disease, and more than \$8 billion from stroke. This cost burden is expected to rise as the prevalence of chronic disease and related risk factors increase, along with our aging population.



Much of the suffering from cancer could be prevented by more systemic efforts to reduce tobacco use, improve diet and physical activity, reduce obesity and expand the use of established screening tests. The American Cancer Society estimates that in 2013 about 174,100 cancer deaths will be caused by tobacco use alone. In addition, approximately one-quarter to one-third of the 1,660,290 cancer cases expected to occur in 2013 can be attributed to poor nutrition, physical inactivity, overweight and obesity.

— American Cancer Society
Cancer Facts & Figures 2013



Chronic diseases and their risk factors unevenly affect communities of color, individuals with lower incomes and education and other underserved sectors of the population. For example, disparities in diabetes prevalence among communities of color are extreme and growing. Since 1993, all racial and ethnic minority groups have experienced average diabetes prevalence greater than for the population as a whole. The overall racial/ethnic disparity in diabetes is driven mainly by a rapid increase in diabetes among Hispanics, who represent a growing proportion of the Washington State's population. And while diabetes has increased for all income and education groups in Washington since 1993, it has increased more rapidly among people with lower incomes and education.

The following tables show population trends that are driving such health disparity. **Table 1** shows the distribution of Washington's population by number and percent across different racial and ethnic groups.

**Table 1: Washington State Population Growth 2000–2010
By Race and Ethnicity**

	2000	2010	Percentage population growth
TOTAL	5,894,121	6,724,540	14.1
TOTAL Non-Hispanic	5,452,612	5,968,750	9.5
NHW	4,679,830	4,888,788	4.5
NHB	189,277	231,472	22.3
NH-AI/AN	86,359	89,149	3.2
NH-API	348,821	519,073	48.8
≥2 Races	148,325	240,268	62.0
Hispanic	441,509	755,790	71.2

DATA SOURCE: Washington State Office of Financial Management, Forecasting Division

TABLE 1 NOTES
Abbreviations for racial and ethnic groups referenced in this plan
NHW: Non-Hispanic White
NHB: Non-Hispanic Black
NH-Asian: Non Hispanic Asian
NHOPI: Native Hawaiian and Other Pacific Island Populations
NH-AI/AN: Non-Hispanic American Indian and Alaska Native

Table 2 shows how Washington's population is distributed across racial/ethnic and age groups.

Table 3 shows population trends across different racial and ethnic groups by factors related to household income.

Table 2: Washington State 2012 Population Estimates By Race/Ethnicity and Age

	Years of Age						All Ages	
	0–4	5–9	10–19	20–44	45–64	65+	N	%
Total	439,657	429,877	900,361	2,303,598	1,823,370	827,677	6,724,540	
Race/Ethnicity	%	%	%	%	%	%	N	%
NHW	57.2	60.0	64.2	68.6	81.7	88.2	4,888,788	72.7
NHB	3.9	3.9	4.0	3.9	3.1	1.8	231,472	3.4
NH-Asian	6.5	6.8	6.7	8.6	6.5	5.4	479,752	7.1
NHOPI	0.8	0.8	0.8	0.7	0.4	0.2	39,321	0.6
NH-AI/AN	1.5	1.5	1.6	1.4	1.3	0.8	89,149	1.3
≥ 2 More Races	8.4	7.5	6.3	3.3	1.7	1.0	240,268	3.6
Hispanic	21.7	19.6	16.4	13.4	5.4	2.6	755,790	11.2
% of Total Population	6.5	6.4	13.4	34.3	27.1	12.3	6,724,540	100.0

DATA SOURCE: Washington State Office of Financial Management, Forecasting Division

The Hispanic population has increased over the last 10 years more than any other minority group. It represents 11.2 percent of the state total population – an increase of 71.2 percent from the census in 2000.

Washington's minority residents primarily live in metropolitan counties. King County is home to the largest percentage of Hispanic and Non-White minority populations by a wide margin. Pierce County has the second largest percentage of Black and the Two or More Races populations. Snohomish County is ranked second for the Asian/Pacific Islander population with Yakima County ranked second for the Hispanic and American Indian/Alaska Native populations.

TABLE 2 NOTES
 Abbreviations for racial and ethnic groups referenced in this plan
NHW: Non-Hispanic White
NHB: Non-Hispanic Black
NH-Asian: Non Hispanic Asian
NHOPI: Native Hawaiian and Other Pacific Island Populations
NH-AI/AN: Non-Hispanic American Indian and Alaska Native

**Table 3: Washington State Population 2000 and 2010
By Poverty Level, Educational Attainment and Language Spoken at Home**

	2000 %	2010 %	Percentage relative change	Percentage absolute change
Below Poverty Level¹				
Children				
<18 years of age	13.7	18.3	33.6	4.6
Race/Ethnicity – All Ages				
NHW	8.8	11.7	32.8	2.9
NHB	19.2	26.2	36.4	7.0
NH-Asian	12.8	12.2	-4.9	-0.6
NHOPI	15.5	16.0	3.3	0.5
NH-AI/AN	23.8	26.2	9.9	2.4
Hispanic	24.9	29.1	16.7	4.2
Uninsured Population²				
Washington State	13.7	14.2	3.6	0.5
Age				
<18 years of age		6.2		
18-64 years	Data not available	19.8		
≥65 years of age		0.7		
Race/Ethnicity – All Ages				
NHW		12.6		
NHB	Data not available	20.0		
NH-Asian		14.0		
NHOPI		15.3		
NH-AI/AN		23.0		
Hispanic		31.4		
Educational Attainment³				
<High school graduate	12.9	9.8	-24.2	-3.1
High school graduate	24.9	23.6	-5.1	-1.3
Some college ⁴	34.4	34.4	0.1	0.0
≥Bachelor degree	27.7	32.1	15.9	4.4
Language Spoken at Home⁵				
English	86.0	81.4	-5.3	-4.6
Spanish	5.8	8.1	38.6	2.3
Indo-European	3.2	3.8	18.3	0.6
Asian/Pacific Island	4.4	5.6	26.9	1.2
Other languages		1.0	XX	XX

TABLE 3 NOTES

- 1 Population for whom poverty status was determined
- 2 Total civilian, non-institutionalized population
- 3 Population 25 years and older
- 4 Some college and/or associate's degree
- 5 Population 5 years and older

DATA SOURCE: U.S. Census Bureau, 2011 American Community Survey and Washington State Office of Financial Management, Forecasting Division

Table 4 shows differences in the prevalence rates of four chronic diseases across different racial/ethnic and income groups.

**Table 4: Prevalence Rates of Self-reported Chronic Disease Outcomes
Washington 2009–2011**

Individual Factors	Four Leading Chronic Diseases Health outcome morbidity				
	Arthritis %	Arthritis limitations ¹ %	Diabetes %	Heart disease %	Stroke %
Washington State	23.0	56.6	8.2	6.8	2.5
Race/Ethnicity					
NHW [†]	23.6	54.9	7.4	4.6	2.3
NHB	23.1	46.3	14.9	7.1	3.8
NH-Asian	16.7	56.4	9.5	2.3 *	--
NHOPI	--	--	12.8	--	--
NH-AI/AN	31.6	60.4	16.7	8.8 *	7.4 *
Hispanic	19.2	60.4	12.0	5.4 *	3.2 *
Income					
<\$35,000	28.2 *	66.5 *	10.9	6.7 *	3.9 *
\$35,000–\$74,999	22.0 *	54.2	7.8	4.5 *	1.8 *
≥\$75,000 [†]	18.7	51.6	5.4	3.4	1.2
Educational Attainment					
≤High school	29.6 *	64.5 *	10.9 *	6.4 *	3.5 *
Some college ²	28.0 *	50.2	9.9 *	5.5 *	2.8 *
≥College graduate [†]	19.6	48.7	6.7	4.4	1.9

DATA SOURCE: Washington State BRFSS 2009–2011, Landline and cellphone survey data combined

TABLE 4 NOTES

- ¹ Among those diagnosed with arthritis
- ² Some college and/or associate's degree
- [†] Reference category: NHW – Non-Hispanic White, ≥\$75,000, ≥College graduate
- * p≤.05 – Statistically significant differences between subgroup and reference category
- Insufficient cases

These data reveal how profoundly three population characteristics affect health outcomes:

1. **Race/ethnicity:** With the exception of arthritis, Non-Hispanic Whites appear to have lower chronic disease prevalence rates than the Washington State average. American Indian/Alaska Native groups have substantially higher chronic disease prevalence rates than the Washington State average. With few exceptions, Non-Hispanic Asians report lower chronic disease health outcomes and associated risk factors than the average for the state and most racial/ethnic subgroups. Hispanics report substantially less access to health insurance and a personal physician than other racial/ethnic subgroups.
2. **Income:** Individuals reporting less than \$35,000 annual income have significantly higher chronic disease prevalence rates and associated risk factors than those earning \$75,000 or more. Both low-income (less than \$35,000) and middle-income (\$35,000–\$74,999) individuals report less access to health insurance and fewer have a personal physician than those in the highest income bracket (\$75,000 or more).
3. **Educational attainment:** College graduates have significantly better chronic disease health outcomes and fewer associated risk factors than individuals with a high school education or less.

Cancer is the leading cause of death in Washington State, and coronary heart disease is the second leading cause of death. Death rates also differ by race and ethnicity, as **Table 5** reveals.

**Table 5: Mortality Rates by Race and Ethnicity and Underlying Cause
Washington 2007–2009**

Race/Ethnicity	Cause-Specific Mortality Rates (Age-standardized per 100,000 population)			
	Coronary heart disease	Stroke	Diabetes	Cancer ¹
Washington State	145	36	22	167
White ²	140	37	26	176
Black ²	139	50*	58*	201*
Asian ²	82*	37	19	119*
NHOPI ²	202	53		240*
AI/AN ²	206*	58*	64*	175
Hispanic	102*	30*	35*	109*

TABLE 5 NOTES

¹ All-site cancer

² Single-race only

* p<.05 – Statistically significant differences between subgroup and reference category (Whites)

■ Insufficient cases

DATA SOURCE: Washington State Vital Statistics and Washington State Cancer Registry, 2007–2009 combined

The data show that Washington's Asian population has lower chronic disease mortality rates than all other races; in contrast Native Hawaiians and Pacific Islanders have some of the highest mortality rates due to chronic diseases. And with the exception of cancer-related mortality, the American Indian/Alaska Native population in Washington State has the highest mortality rates due to chronic diseases.

Unhealthy behaviors play a major role in promoting chronic disease.

Unhealthy behaviors – including poor diet, insufficient physical activity and tobacco consumption – contribute greatly to the burden of chronic disease. Nearly two of every three deaths annually in Washington are from smoking and obesity-related disease, including heart disease, stroke, cancer, diabetes and chronic lower respiratory disease. Age is also a factor. But while older adults share a higher burden of death from these diseases, nearly a fourth of these deaths are among people younger than 65. Additionally, arthritis continues to be the most common chronic disease and most common cause of disability.

Much of our study of chronic disease in recent years has focused on obesity trends. For example, the rise in diabetes in Washington is largely driven by a parallel increase in obesity prevalence. The age-adjusted percent of obese adults more than doubled over the past two decades – from 10% to 27% from 1990 to 2011 – and it continues to rise at a rate of nearly a percentage point a year. Today about 10% of Washington students in grades 8, 10 and 12 are obese.

More than one-third of all adults do not meet recommendations for aerobic physical activity based on the 2008 Physical Activity Guidelines for Americans, and 23% report no leisure-time physical activity at all in the preceding month.

– Centers for Disease Control and Prevention
(cdc.gov/chronicdisease/overview)

The impact of risk factors associated with chronic disease is shown in **Table 6**.

Table 6: Self-reported Risk Factors for Chronic Disease by Race, Income and Educational Attainment Washington 2009–2011

Associated Risk Factors	Morbidity risk factors			Behavioral and social risk factors				Health care		
	Individual Factors	Hypertension awareness %	High cholesterol awareness %	Obesity (BMI ≥ 30) %	Insufficient nutrition ² %	Insufficient physical activity ³ %	Smoking %	Adverse childhood experiences (ACE) %	Health insurance %	Personal physician %
Washington State		28.5	34.2	26.6	74.3	37.8	17.8	28.7	79.1	74.8
Race/Ethnicity										
NHW [†]		28.5	32.9	26.8	74.5	37.1	18.7	30.3	82.4	77.0
NHB		43.2*	35.1	39.4*	72.2	43.8*	25.4*	29.2	76.9	75.6
NH-Asian		23.8*	31.6	7.6*	68.1*	47.8*	8.3*	9.3*	84.1	76.8
NHOPI		41.0*	32.3	46.0*	72.3	43.8	21.8	37.0	75.6	69.1
NH-AI/AN		36.8*	34.0	43.8*	75.8	37.7	30.6*	49.0*	75.0*	72.9
Hispanic		24.0*	34.1	31.8*	78.7*	37.6	14.3*	24.7*	53.6*	58.1*
Income										
<\$35,000		32.2*	36.5*	31.0*	78.7*	42.0*	28.2*	36.1	60.0*	65.7*
\$35,000–\$74,999		29.4*	34.6*	28.0*	74.2*	35.2	15.5*	29.3*	86.3*	78.0*
≥\$75,000 [†]		23.8	30.4	21.1	70.3	35.0	9.2	23.7	95.1	83.9
Educational Attainment										
≤High school		35.3*	39.5*	32.7*	81.0*	39.8	27.1*	32.4*	68.6*	70.9*
Some college ¹		33.0*	37.7*	32.2*	75.6	39.4	18.7*	32.4*	82.3*	79.7*
≥College graduate [†]		26.6	34.8	20.2	68.1	38.4	6.2	20.2	92.1	83.7

DATA SOURCE: Washington State BRFSS 2009–2011, Landline and cellphone survey data combined

TABLE 6 NOTES

- ¹ Some college and/or associate's degree
- ² Eats fruits and vegetables <5 times a day
- ³ Does not meet CDC physical activity recommendation
- [†] Reference category: NHW – Non-Hispanic White, ≥\$75,000, ≥College graduate
- * p<.05 – Statistically significant differences between subgroup and reference category

Obesity is driven by patterns in physical activity and eating habits. Currently in Washington, 37.8 percent of adults report getting insufficient physical activity, and 74.3 percent report not eating at least five fruits and vegetables a day. Rates of physical activity and nutrition have not changed substantially over the past decade. The share of students who were physically active for 60 minutes at least five days a week increased during 2008–12 from 43 percent to 51 percent in Grade 10 and from 40 percent to 46 percent in Grade 12. But while more students are getting enough physical activity, at least half of these students still watch TV or use the computer for three or more hours every day. And although we have seen a downward trend in the share of students who drink two or more sodas a day, about 15 percent of students drink at least one sugar-sweetened beverage at school every day, and more students buy these drinks at school.

Tobacco consumption is also closely associated with chronic disease prevalence and with poor birth outcomes. Washington has a lower share of adults who smoke than the nation as whole; during 2009–11, about 17.8 percent of Washington adults smoked – about 880,000 people. The adult smoking rate varied by age, race, educational level and income. Among all youth in Washington about 65,000 smoke cigarettes, and about 40 kids still start smoking every day.

Table 7 shows the prevalence of three chronic conditions among 10th graders and associated behavioral risk factors.

Table 7: Self-reported Health Outcomes and Behavioral Risk Factors of 10th Graders Washington 2010 and 2012 (reported as prevalence rates)

Race/Ethnicity	Health outcome morbidity			Behavioral risk factors		
	Diabetes ¹ %	Obesity ² %	Asthma ² %	Nutrition ² %	Physical Activity ² %	Smoker ² %
Washington State	4.5	9.5	12.6	24.3	21.1	12.1
NHW [†]	3.4	8.4	13.0	22.9	21.9	12.3
NHB	9.0*	15.0*	18.3	31.4*	20.3	17.6
NH-Asian	3.1	8.6	8.0*	24.4	13.8*	4.6*
NHOPI	6.2	7.2	23.9*	24.8	29.2	20.7*
NH-AI/AN	7.4	15.7*	11.0	25.4	19.2	11.6
Hispanic	8.1	12.8*	10.9	28.4*	22.0	12.5

DATA SOURCE: Washington State Healthy Youth Surveys 2010 and 2012

TABLE 7 NOTES

¹ 2010 data

² 2012 data

* p<.0.05 – Statistically significant differences between subgroup and NHWs

NOTE: Sample sizes are small

The pregnancy state and birth outcomes can unmask increased future risk of cardiovascular disease.

- History of preeclampsia, gestational diabetes, or pregnancy-induced hypertension may be early indicators of cardiovascular disease.
 - Women who deliver early (before 37 weeks) or have a growth-restricted infant face approximately two times the risk of developing cardiovascular disease later in life compared to women who have normal weight infants at term (5.5–8.8 pounds).
- Centers for Disease Control and Prevention
“Cardiovascular Disease and Risk Factors for CVD among Women of Reproductive Age (18–44 years)”

Youth smoking rates, which are now about 12 percent for 10th graders and 16 percent for 12th graders, have dropped by half since implementation of the state's comprehensive Tobacco Prevention and Control Program in 2000. But illegal sales of tobacco to minors are on the rise, and teens are reporting that they use other types of tobacco, such as cigars or chew, along with cigarettes. Nearly as many 10th graders smoke tobacco from a hookah pipe as from a cigarette, and about 7 percent report that they smoked a cigar in the past month.

Two other types of tobacco consumption are associated with chronic disease: smoking before or during pregnancy, and exposure to second hand smoke in the workplace or at home. Data for both types show stubborn rates but improving trends in Washington State. The share of Washington women who report smoking during the three months before pregnancy dropped from 24.6 percent in 1996 to 20.2 percent in 2011. Data on exposure to secondhand smoke also indicate improvement. In 2010, 2 percent of currently employed Washingtonians said that in a typical week, they had been exposed to secondhand smoke for more than an hour at their workplace. Of those who had been exposed to smoke in their workplace for more than an hour, 58 percent were non-smokers. Four percent of adults with children in the household reported that smoking occurred in the home in the past 30 days. But this rate is down from 19 percent in 2000, a reduction of 79 percent. In 2010, 71 percent of youths reported that they do not live with anyone who smokes.

Upstream factors

Washington State's public health system is increasingly pursuing a “life course approach” to addressing chronic disease. This approach is based on research documenting the important role of early life events in determining health status as well as the ways factors such as socio-economic status, toxic environmental exposures, health behaviors, stress, physical activity and nutrition influence health throughout the lifespan.

Birthweight, for example, has been known since the late 1980s to have a direct relationship with the risk of coronary heart disease; the lower the birthweight, the greater the risk. Since then, links have also been established between low birthweight and increased risk of diabetes, hypertension and stroke in adulthood. In Washington State, the rate of low birthweight births increased steadily from 5.3 percent in 1990 to 6.5 percent in 2006 and has been steady at 6.3 percent since then. The rate is higher for children born to African American and low-income households.

Table 8 shows that health disparities start at the beginning of the life course:

Table 8: Maternal and Child Health Outcomes and Risk Factors by Racial/Ethnic and Income Group Washington 2009–2011

Individual Factors	Health Outcomes and Behavioral Risk Factors							
	Diabetes awareness %	Obesity (BMI ≥ 30) %	Hypertension awareness %	Adolescent pregnancy ¹ %	Singleton low birth weight (<2500g) %	Singleton pre-term births (<37 weeks gestational age) %	8-weeks breastfeeding %	Maternal pre-natal smoking %
Washington State	6.6	27.9	6.7	1.9	4.6	8.5	74.1	21.0
Race/Ethnicity								
NHW [†]	6.6*	35.4*	7.9*	1.7*	8.0*	11.2*	71.4	20.3
NHB	43.2*	35.1	39.4*	72.2	43.8*	25.4*	29.2	76.9
NH-Asian	11.4*	9.9*	4.4*	0.4*	5.9*	8.5*	81.8*	7.0*
NHOPI	9.6*	52.2*	7.0	2.3*	5.2*	13.8*	57.5*	23.4
NH-AI/AN	6.6*	44.3*	8.3*	4.6*	6.5*	14.9*	62.1*	49.7*
Hispanic	7.9*	32.9*	5.2*	4.6*	5.1*	10.2*	71.7	10.7*
Income Proxy								
TANF (low income)	Data not collected				6.5*	10.6*	56.0*	49.0*
Pregnancy Medical	Data not collected				5.0*	8.9*	69.1*	30.2*
Undocumented	Data not collected				4.6*	10.1*	77.8	3.4*
Non-Medicaid [†]	Data not collected				3.9	7.4	82.3	11.8

TABLE 8 NOTES

¹ 15–17 years of age

[†] Reference category: NHW – Non-Hispanic White, Non-Medicaid

* p ≤ 0.05 – Statistically significant differences between subgroup and reference category

DATA SOURCE: Washington State Vital Statistics and Pregnancy Risk Assessment Monitoring System Data 2009–11 combined

Births from unintended pregnancies in Washington were linked to lower intake of folic acid and vitamins prior to pregnancy, delayed prenatal care, smoking during pregnancy, domestic instability, stress and violence during pregnancy and less likelihood of breastfeeding.

– Washington State Department of Health
“Unintended Pregnancy 2013” section in
Health of Washington State Report

An emerging area of study within the life course approach to disease prevention is the impact of stress on the fetus and during early childhood on adult health status. The Washington State Behavioral Risk Factor Survey now tracks adverse childhood experiences (ACEs), named for a study that examined the ways that stressful or traumatic childhood experiences lead to social, emotional and cognitive impairments. These impairments, in turn, increase the risk of unhealthy behaviors, the risk of violence or re-victimization, disease, disability and premature mortality. In Washington during 2009–11, 62 percent of adults reported at least one ACE, and 19 percent reported three or more. Exposure to ACEs have been shown to be connected to greater smoking risk (2.8 times greater for those with 4 or 5 ACEs). Researchers have found modest association between ACEs and higher self-reported levels of cholesterol, hypertension, diabetes, obesity, cancer and self-reports of health status and quality of life.

Data Sources

Milken Institute, “An Unhealthy America: Economic Burden of Chronic Disease” (milkeninstitute.org)

Washington State Office of Financial Management, Forecasting Division (ofm.wa.gov/forecasting/)

U.S. Census, American Community Survey (census.gov/acs/)

Washington State Department of Health (doh.wa.gov)

- Behavioral Risk Factor Surveillance System (BRFSS)
- Vital Statistics
- Cancer Registry
- Healthy Youth Survey (HYS)
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Adverse Childhood Experiences (ACEs)

Stakeholder Outreach and Input

In order to provide a single statewide vision for chronic disease prevention, the Washington State Department of Health Office of Healthy Communities developed *The Washington State Plan for Healthy Communities*. Stakeholder input was solicited throughout the development process in two phases as outlined below.

Phase One

- **Review of 14 different program/strategic state plans** that currently exist within the Washington State Department of Health, Office of Healthy Communities:
 - Children with Special Health Care Needs Program Strategic Plan** (2011)
 - Tribal Maternal and Infant Health Strategic Plan** (2010)
 - Washington State Asthma Plan** (2011)
 - Washington State Birth to 3 Plan** (2010)
 - Washington State Collaborative Oral Health Improvement Plan** (2009–2014)
 - Washington State Comprehensive Cancer Control Plan** (2009–2013)
 - Washington State Department of Health Plan for Adolescent Health**
 - Washington State Diabetes Plan** (2005)
 - Washington State Early Learning Plan** (2010)
 - Washington State Family Planning Strategic Plan** (2010–2014)
 - Washington State Nutrition and Physical Activity Plan** (2008)
 - Washington State Public Health Action Plan for Heart Disease and Stroke Prevention and Management** (2005)
 - Washington Youth Sexual Health Plan** (2010)
 - Washington State Tobacco Prevention and Control Program Five-Year Strategic Plan** (2009)

These 14 Plans were developed through collaboration with internal and external partners of their respective programs. These partners are included in our constituent relationship database and continue to receive regular targeted communications from the Department of Health. We have over 2,300 stakeholders in the database.

- Numerous internal focus groups were held with the Washington State Department of Health Office of Healthy Communities Management Team and Program Managers to discuss the creation of one State Plan that integrates the 14 Plans within the Office.
- Preliminary draft plan developed and disseminated to 2,300 stakeholders for feedback using a survey tool with the assistance of the Health Promotion Research Center at the University of Washington.
- Internal and external content experts were identified and asked to provide feedback on the preliminary draft in written format.
- Leadership, Management and Program Teams continue to provide feedback to strengthen and align the Plan with programmatic, state and national priorities.
- Formation of internal Priority Teams.

Phase Two

- **Engaged the five Healthy Communities Regional Hubs**

The hubs are comprised of local health jurisdictions, county agencies and regional partners. The hubs collectively comprise 36 counties in Washington State, and represent a convergence of multiple chronic diseases, health risk factors and socio-economic disadvantage. Hubs provide an integral role in creation of the State Plan. The Statement of Work (SOW) for each hub requires input and review of the Plan.

- **Engaged the Prevention Alliance**

The Prevention Alliance will provide policy guidance, technical assistance and grassroots support to the Healthy Communities Regional Hubs to implement the State Plan at the local level. The Prevention Alliance is to serve as a statewide network of community-based partners and leaders dedicated to reducing the burden of chronic disease. The Prevention Alliance draws upon existing coalitions throughout the State. Membership includes commitment and representatives from the following:

The five Healthy Communities Regional Hub Coalitions

Childhood Obesity Prevention Coalition

Includes 43 organizations throughout Washington State.

Healthy Communities Partnership

Consists of 100+ organizations statewide, led by a 15-member steering committee comprised of leaders from public and private sectors.

Diabetes Network Leadership Team

A 20-member team comprised of public, private, tribal, academia, healthcare, public health, non-profit and governmental organizations. Serves as the voice for the 500-member Washington State Diabetes Network.

Washington CARES About Cancer Partnership

Includes individuals, health professionals, associations and public and private organizations throughout Washington State.

Washington Collaborative Advisory Committee

Comprised of numerous health care organizations.

Tobacco Prevention and Control Coalition

Includes regional chapters of the American Heart Association, American Lung Association, American Cancer Society Cancer Action Network, national Campaign for Tobacco-Free Kids and local advocates of tobacco prevention and control.

Public Health Seattle-King County

Represents Washington's largest city and county (by population).

Public Housing Tobacco Prevention Network

Includes Association of Washington Housing Authorities, Pacific Northwest Regional Conference of the National Association for Housing and Re-development Officials, local housing authorities, local health jurisdictions and social service providers.

Comprehensive Health Education Foundation (CHEF)

CHEF's mission is to help people and communities improve the quality of their lives through education and through elimination of health disparities. The Prevention Alliance will be housed and staffed by CHEF.

- **Engaged Community Transformation Grant (CTG) Leadership Team**

The CTG Leadership Team has been established to provide high level oversight and topical expertise for components of the Plan that address tobacco, healthy eating and active living, clinical preventive services and healthy physical, environments. The CTG Leadership Team also serves to identify shared strategies and resources, create data sharing agreements and establish shared performance objectives. Leadership Team external partners include:

American Indian Health Commission

Association of Counties

Association of Housing Authorities

Childhood Obesity Prevention Coalition

Clark County Public Health

Department of Agriculture

Department of Commerce

Department of Early Learning

Department of Health

Department of Social and Health Services

Department of Transportation

Empire Health Foundation

Grant County Health District

Grays Harbor County Public Health and Social Services

Group Health Cooperative

Health Care Authority

National Association of Housing and Redevelopment Officials

Office of the Governor

Office of the Superintendent of Public Instruction

Prevention Alliance

Snohomish Health District, representing King, Pierce and Snohomish

Spokane Regional Health District

Washington State Hospital Association

Washington Association of Community & Migrant Health Centers

Whatcom County Health Department

YMCA

- **Second round survey**

In partnership with the Health Promotion Resource Center at the University of Washington, stakeholder feedback was solicited in a web-based survey in order to refine *The Washington State Plan for Healthy Communities* prior to sharing a final version more broadly. Survey invitations were sent to over 2,300 stakeholders in the constituent relationship database. The survey included questions about stakeholders' overall attitude towards the current draft of the plan, their organization's intentions, if any, to address each of the proposed priority areas, strategies they plan to use, anticipated barriers to *The Washington State Plan for Healthy Communities* implementation and potential technical assistance needs to facilitate implementation.

- 145 surveys were completed by individuals or groups of stakeholders at one organization.
- 26% represented organizations with a statewide service area.
- Respondents represented all regions of the State.
- 96% agree or strongly agree that their organization's alignment with *The Washington State Plan for Healthy Communities* is important.
- 94% see their organization's work fitting with *The Washington State Plan for Healthy Communities*.
- Over the next three years, stakeholders are most likely to address Healthy Eating (72%) and Access to Clinical Preventive and Treatment Services (70%); they are least likely to address Sexual and Reproductive Health (35%).

- **Respondents primarily anticipate resource barriers to *The Washington State Plan for Healthy Communities* implementation:**

- Inadequate financial resources and staff capacity/time are the two most anticipated barriers to implementing the activities described in the proposed plan.
- Barriers are most anticipated for implementing strategies to improve Access to Clinical Preventive and Treatment Services.

- **Ways DOH can support *The Washington State Plan for Healthy Communities* implementation:**

- 71% of respondents indicated a desire for technical assistance to identify additional funding opportunities to help implement priority area interventions.
- Respondents also desire assistance identifying collaborating partners (55%) and identifying area-specific materials and resources (51%).

Justification for Evidence-based Recommendations

The recommendations we present in *The Washington State Plan for Healthy Communities* are consistent with available evidence-based practices. We used four major national scientific resources and three state resources to validate the evidence base for each recommendation. Below are descriptions of each of these resources and their alignment to each strategy recommendation in this report.

Healthy People 2020 (HP) provides science-based, 10-year national objectives to promote health and prevent disease. Healthy People has set and monitored national health objectives since 1979. The development process includes public input and stakeholder dialogue to ensure that Healthy People 2020 is relevant to diverse public health needs. Healthy People offers a framework to address risk factors and determinants of health for the diseases and disorders that affect our communities.

U.S. Preventive Services Task Force (USPSTF) is an independent panel of non-federal experts in prevention and evidence-based medicine and is composed of primary care providers. The task force conducts scientific evidence reviews of a broad range of clinical preventive health care services (such as screening, counseling and preventive medications) and develops recommendations for primary care clinicians and health systems.

Institute of Medicine of the National Academies (IOM) is an independent nonprofit organization that works outside the government to provide unbiased and authoritative advice to the nation's pressing questions about health and health care. Their aim is to assist those in government as well as in the private sector to make informed health decisions based on research and reliable input.

National Prevention Strategy (NPS) is a critical component of the Affordable Care Act and will move the nation from a system of sick care to one based on wellness and prevention. It is a cross-sector integrated national strategy that identifies priorities for improving the health of Americans. Goals of the strategy promote a Health in All Policies (HiAP) approach to policymaking and program development. By collaborating across multiple sectors to address health disparities and empower individuals, we can increase the number of Americans who are healthy at every stage of life.

Results WA is Governor Inslee's data-driven performance management and continuous improvement system for Washington State. Results WA aims to make state government more effective, efficient, accountable and transparent. This initiative will provide both policy leaders and the public detailed data and measurements about how well we're improving.

Agenda for Change Action Plan builds on the Reshaping Governmental Public Health work (2010) which included a review of Washington state health data, public health system assessment, forces of change and identification of health themes. The Agenda for Change was developed by a workgroup appointed by the Washington State Secretary of Health.

Title V Maternal and Child Health Services Block Grant (MCHBG) is a federal-state partnership that supports the health of women, infants, children, adolescents and their families. State programs submit a yearly application and annual report, and conduct a statewide, comprehensive needs assessment every five years. The needs assessment identifies urgent issues within a state which help focus funds on priority populations.

Supporting Evidence-based Interventions	Healthy People 2020	USPSTF	IOM	National Prevention Strategy	Supports Results WA	Agenda for Change	MCHBG
Domain 1: Epidemiology and Surveillance							
Strategy 1: Develop new assessments and systems.							
Short-term objective: Determine the need for additional assessments and systems to track progress of healthy communities' activities with a special focus on data needed to identify health disparities as well as successful efforts to achieve health equity.	SED3		x	x		none	SPM01 SPM06 NPM18
Short-term objective: Create a cost effective statewide mechanism to measure progress on strategies and objectives that will allow internal and external stakeholder to provide implementation updates.	SED3			x		none	
Strategy 2: Use data to monitor population health, including information about disparately affected populations.							
Short-term objective: Use common, high value, consensus measures and existing data systems to monitor progress of healthy communities' activities, from nationally endorsed sources where possible.	SED2		x	x		none	NPM17 SPM06
Strategy 3: Evaluate interventions, programs and activities.							
Short-term objective: Identify successful interventions as well as opportunities for improvement and share the results publicly.	SED2		x	x		none	
Long-term objective: Create dedicated capacity in the Washington State Department of Health to perform health impact evaluations of interventions and proposed system and policy changes and disseminate the findings.	SED2		x				
Strategy 4: Obtain and prioritize sustainable funding sources for surveillance and evaluation activities.							
Long-term objective: Obtain sustainable funding sources to support statewide surveillance and evaluation activities.	SED1		x			none	

Supporting Evidence-based Interventions	Healthy People 2020	USPSTF	IOM	National Prevention Strategy	Supports Results WA	Agenda for Change	MCHBG
Domain 2: Environmental Approaches							
Strategy 1: Increase access to safe and affordable physical activity where people work, learn, live, play and worship.							
Short-term objective: Promote the establishment, improvement and use of outdoor spaces, including streets, parks, recreation areas, trails, beaches and other public spaces that are safe, tobacco free, accessible and appropriate for physical activity and play.	PA-10 PA-12 PA-15		x	x	x	Obj. 2 & 3	NPM10
Long-term objective: Improve physically active transportation options through community design and transportation planning.	HDS-1		x	x	x	Obj. 2 & 3	NPM10
Long-term objective: Increase active time and physical education in schools and early learning sites.	HDS-1 ECBP-1 ECBP-2		x	x	x	Obj. 2 & 3	
Strategy 2: Reduce tobacco and alcohol advertising, promotions and product placement, and enforce youth access laws for these products.							
Long-term objective: Reduce the proportion of adolescents and young adults in grades six through 12 who are exposed to tobacco advertising and promotion on the Internet, in the movies, magazines and newspapers, as well as at point of purchase.	TU-18		x		x	Obj. 2	
Long-term objective: Reduce the illegal sale rate to minors through enforcement of laws prohibiting the sale of tobacco products to minors.	TU-19			x	x	Obj. 2	
Strategy 3: Increase the number of places that protect employees, customers, patrons and others from second-hand smoke.							
Long-term objective: Increase the adoption of no-smoking policies in public housing, private multi-unit housing, higher education and technical college campuses, parks, work sites and other public places.	TU-11		x	x	x	Obj. 3	

Supporting Evidence-based Interventions	Healthy People 2020	USPSTF	IOM	National Prevention Strategy	Supports Results WA	Agenda for Change	MCHBG
Strategy 4: Increase access to healthy foods and beverages (including breastfeeding) where people work, learn, live, play and worship.							
Short-term objective: Establish stronger nutritional standards/guidelines for institutional procurement of food to guide Washington state agencies and institutions. Guidelines should address sodium.	NWS-3 NWS-1			x	x	Obj. 1, 2 & 3	SPM04 NPM11 NPM14
Short-term objective: Increase the proportion of infants who are still being exclusively breastfed at six months.	MICH-21		x	x	x	Obj. 1, 2 & 3	SPM07 SPM05 NPM11 NPM14
Long-term objective: Increase the number of adults, youth or families that access small retail venues offering healthy foods and beverages.	NA		x	x	x	Obj. 1, 2 & 3	
Long-term objective: Ensure that all people in Washington will have ready access to nutritious, high-quality and affordable foods and beverages.	NWS-2 AH-6		x	x	x	Obj. 1, 2 & 3	SPM04 NPM11 NPM14
Strategy 5: Establish sustainable funding for prevention.							
Short-term objective: Seek additional funding for prevention efforts, such as through the Prevention and Public Health Fund.	NA		x			none	
Long-term objective: Work toward payment reform to support health providers to encourage evidence-based preventive services and screening.	NA		x	x	x	none	NPM12 NPM05 SPM03
Strategy 6: Develop and enhance systems and policies to support sexual and reproductive health to increase access and timeliness of preventive care, screening and treatment.							
Long-term objective: Establish a norm of sexual health and reproductive justice across the lifespan as crucial to the health of the public.	FP-7 FP-12 FPR-13			x		Obj. 2	NPM08 SPM01
Long-term objective: Establish social, economic and health policies that improve equity in sexual health and reproductive justice.	FP-3 FO-14 FP-15			x		Obj. 2	NPM08 SPM01 SPM06

Supporting Evidence-based Interventions	Healthy People 2020	USPSTF	IOM	National Prevention Strategy	Supports Results WA	Agenda for Change	MCHBG
Strategy 7: Increase social connectedness, healthy relationships, violence-free environments and community engagement across the life span.							
Long-term objective: Decrease the presence of risk factors that contribute to violence and increase the presence of resilience factors that are protective against violence at the individual, family and community levels.	IVP-42			x	x	Obj. 2	NPM10 SPM04 NPM16
Strategy 8: Cultivate state and local leadership coalitions and community engagements to develop community-informed interventions, organizational structures and supports to address health inequities.							
Long-term objective: Increase the number of community based organizations – including local health jurisdictions, tribal health services, non-governmental organizations and state agencies – providing population-based primary prevention services.	ECBP-10		x	x		none	SPM04 SPM05 NPM13 SPM06 SPM07
Domain 3: Health Systems							
Strategy 1: Enhance and maintain health systems to increase timely access to preventive care, screening and treatment.							
Long-term objective: Collaborate among public health, health systems and primary care clinics to advance system changes that improve the delivery of cancer screening and other clinical preventive services.	HSC-1	x	x	x	x	Obj. 1	NPM01 SPM04 SPM03
Long-term objective: Increase the proportion of persons of all ages who have a specific source of ongoing health care.	AHS-3 AHS-5 MICH-30 MICH-31		x	x	x	Obj. 1	SPM04 NPM13
Strategy 2: Promote and provide support to build capacity and availability of health care, education, resources and services.							
Long-term objective: Adopt proven Chronic Disease Self Management programs.	HSC-2		x	x		none	SPM05
Long-term objective: Design primary prevention services and screenings – including those from non-medical providers – to be as convenient and affordable as possible.	ECBP-8 ECBP-10 ECBP-11			x	x	none	SPM04 NPM12 NPM06 SPM03

Supporting Evidence-based Interventions	Healthy People 2020	USPSTF	IOM	National Prevention Strategy	Supports Results WA	Agenda for Change	MCHBG
Strategy 3: Establish a mechanism for reimbursement of comprehensive tobacco cessation services and substance abuse and mental and behavioral health treatment.							
Long-term objective: Increase comprehensive coverage of evidence-based treatment for nicotine dependency for all Washingtonians through their health plan.	TU-8		x	x	x	none	NPM15
Long-term objective: Increase mental health benefits included in Washington health plans to improve financial protection and to increase access to, and use of, mental health services.	AHS-1 MHMD-5 MHMD-9		x	x	x	none	NPM05 NPM04
Strategy 4: Improve the knowledge and ability of health care professionals to deliver comprehensive evidence-based services including integrated mental health and chemical dependency screening and interventions from preconception to end of life.							
Long-term objective: Ensure that health care practices and behavioral health providers coordinate their services for patients with chronic disease and behavioral health issues.	MICH-31			x	x	none	SPM04 NPM 06 NPM16
Long-term objective: Expand self-care and management education programs statewide including the Diabetes Prevention Program, the Chronic Disease Self-Management Program and arthritis exercise programs.	CCL-2 D-14			x	x	none	
Strategy 5: Promote early identification of behavioral health issues and access to quality behavioral health services across the life span.							
Long-term objective: Increase the percent of primary care facilities that provide mental health treatment onsite or by paid referral.	MHMD-5				x	none	NPM04 NPM16
Long-term objective: Increase depression screening by primary care providers.	MHMD-11			x	x	none	NPM04 NPM16
Long-term objective: Increase the proportion of all Washingtonians with mental health disorders who receive treatment.	MHMD-6 MHMD-9			x	x	none	SPM04 NPM06 NPM04 NPM16
Strategy 6: Promote delivery of health care services that are culturally and linguistically appropriate and acceptable for the population being served.							
Long-term objective: Ensure that health care providers design treatments and support programs to meet the health needs of all patients and customize care based on social and cultural needs.	DDI-2		x	x	x	Obj. 1	SPM07 SPM01 NPM08 SPM06

Supporting Evidence-based Interventions	Healthy People 2020	USPSTF	IOM	National Prevention Strategy	Supports Results WA	Agenda for Change	MCHBG
Strategy 7: Increase public and health professional awareness of the importance of screening and follow-up.							
Short-term objective: Ensure that health providers monitor patients to receive evidence-based preventive services and screening and identify any barriers the patients are facing in obtaining these services.	IID-17 CKD-4 D-8 D-9 D-10 D-11 D-12	x	x		x	Obj. 2	SPM04 NPM12 NPM05 SPM03
Short-term objective: Ensure that patients receive information on opportunities for evidence-based screening and preventive services.	C-18 C-19	x	x	x	x	Obj. 2	SPM04 NPM12 NPM05 SPM03
Long-term objective: Increase the proportion of Washingtonians at every life stage who receive age-appropriate, evidence-based clinical preventive services including: <ul style="list-style-type: none"> ▪ Breast, cervical and colorectal cancer screening; ▪ BMI screening, weight status assessment and appropriate intervention; ▪ Screening for tobacco use and cessation assistance; ▪ Diabetes risk assessment for referral to diabetes self-management education or community diabetes prevention programs; and ▪ Chronic disease management and self-management education. 	TU-9 C-15 C-16 C-17 AHS-7 D-14	x	x		x	Obj. 2	NPM14 NPM15
Domain 4: Clinical and Community Preventive Services							
Strategy 1: Enhance capacity, infrastructure and leadership of community-based organizations that serve socially disadvantaged populations to provide the support necessary to maintain positive mental and physical well-being.							
Long-term objective: Develop multi-disciplinary care teams with the health care home model to coordinate across clinics, hospitals, social services and community-based preventive resources.	CCL-1	x	x	x	x	Obj. 1	SPM07 SPM04 NPM05 NPM03 NPM02 NPM15
Strategy 2: Support linkage of clinical and community prevention efforts to mobilize services, resources and self-management programs from prevention to intervention.							
Short-term objective: Develop and disseminate at least three best practice models for better clinic to community linkages.	NA	x	x	x		none	NPM15

Supporting Evidence-based Interventions	Healthy People 2020	USPSTF	IOM	National Prevention Strategy	Supports Results WA	Agenda for Change	MCHBG
Strategy 3: Support payment reform to reduce patient out-of-pocket costs and provider reimbursement for prevention.							
Short-term objective: Pursue policies and system changes that reduce out-of-pocket costs to the consumer of clinical preventive services, including cancer screening and treatment for tobacco use and dependence.	TU-1 TU-10 AHS-6		x	x	x	none	SPM04 NPM13
Long-term objective: Pursue policies and system changes that provide clinician reimbursement for provision of clinical preventive services, including patient education and counseling.	NA		x	x	x	none	SPM06 SPM02 NPM09 SPM04
Strategy 4: Develop and disseminate health education that is scientifically accurate, age-appropriate, culturally and linguistically suitable for the public, health professionals, and local and state decision makers.							
Long-term objective: Increase effective communication so that individuals, organizations, community partners and decision makers can access, understand, share and act on health information and services.	DDI 1 ECBP-7 ECBP-10 HC/HIT-13			x	x	none	SPM01 SPM04 NPM05 NPM07 NPM08

The Washington State Plan for Healthy Communities

Evaluation goal

The Department of Health will work individually and collectively with key program partners to monitor increases in the promotion and adoption of healthful behaviors and practices to improve prevention and management of chronic disease and related risk factors among Washington residents at every stage of life.

Evaluation type

An implementation (process) evaluation will document whether strategies and interventions have been implemented as intended in the nine priority areas of ***The Washington State Plan for Healthy Communities***: Healthy Starts; Sexual and Reproductive Health; Tobacco and Substance Abuse Prevention; Active Living and Safe Environments; Healthy Eating; Screening, Referral and Follow-up; Social and Emotional Wellness; Quality Clinical Preventive and Treatment Services; and Health Equity.

This evaluation will determine whether activities are taking place, who is conducting the activities, who is reached through the activities, and whether sufficient inputs have been allocated or mobilized. As we implement ***The Washington State Plan for Healthy Communities***, we will systematically gather feedback from program staff and partners. This work is part of a process evaluation to understand the advantages and challenges of working collaboratively across categorical programs and partners to achieve outcomes.

An effectiveness (outcome) evaluation will also be conducted to monitor the short-, intermediate- and long-term outcomes of strategies and interventions. We have identified both outcomes and performance measures through consultation with state categorical programs and partners. We expect to make revisions over time, especially as data sources become available.

Evaluation questions

Short-term (focus: policy, environmental, programmatic and systems changes)

1. To what extent has the state improved the gathering, analysis and dissemination of data and other information to inform, prioritize, deliver and monitor programs and population health?
2. To what extent has the state improved social and physical environments in communities, work sites, schools and early care education that promote and reinforce healthful behaviors and practices?
3. To what extent has the state increased community-clinical linkages that support access and referral to quality community programs and resources to improve preconception, prenatal, reproductive, developmental, behavioral and health outcomes?
4. To what extent has the state increased effective delivery and use of quality clinical and other preventive services to improve preconception, prenatal, reproductive, developmental, behavioral and health outcomes and risk?
5. To what extent has the state improved policies, programmatic and system changes that promote health equity and incorporate culturally and linguistically appropriate and acceptable practices for populations being served?

Intermediate-term (focus: changes in health behaviors, access to health care and prevention programs, use of quality services and self-management)

1. To what extent have health behaviors and practices improved (including increased consumption of nutritious foods and beverages; breastfeeding initiation, duration and exclusivity; participation in physical activity; effective oral health activities; and decreased tobacco use and substance abuse) in key settings and populations across the life span?
2. To what extent has the use of primary prevention, self-management and family planning programs increased to improve preconception, prenatal, reproductive, developmental, behavioral and health outcomes?
3. To what extent have developmental, behavioral and health screening, referral and follow-up increased in key settings and populations across the life span?
4. To what extent has clinical support increased access to and use of effective preventive and treatment services, medication adherence and self-monitoring of chronic conditions and related risk factors?
5. To what extent has the state reduced disparity in health behaviors, access to health care, and quality of health care for individuals and communities by race, gender, nationality, age, ethnicity, religion, socioeconomic position, sexual orientation and disability status?

Long-term (focus: changes in health conditions and associated risk factors)

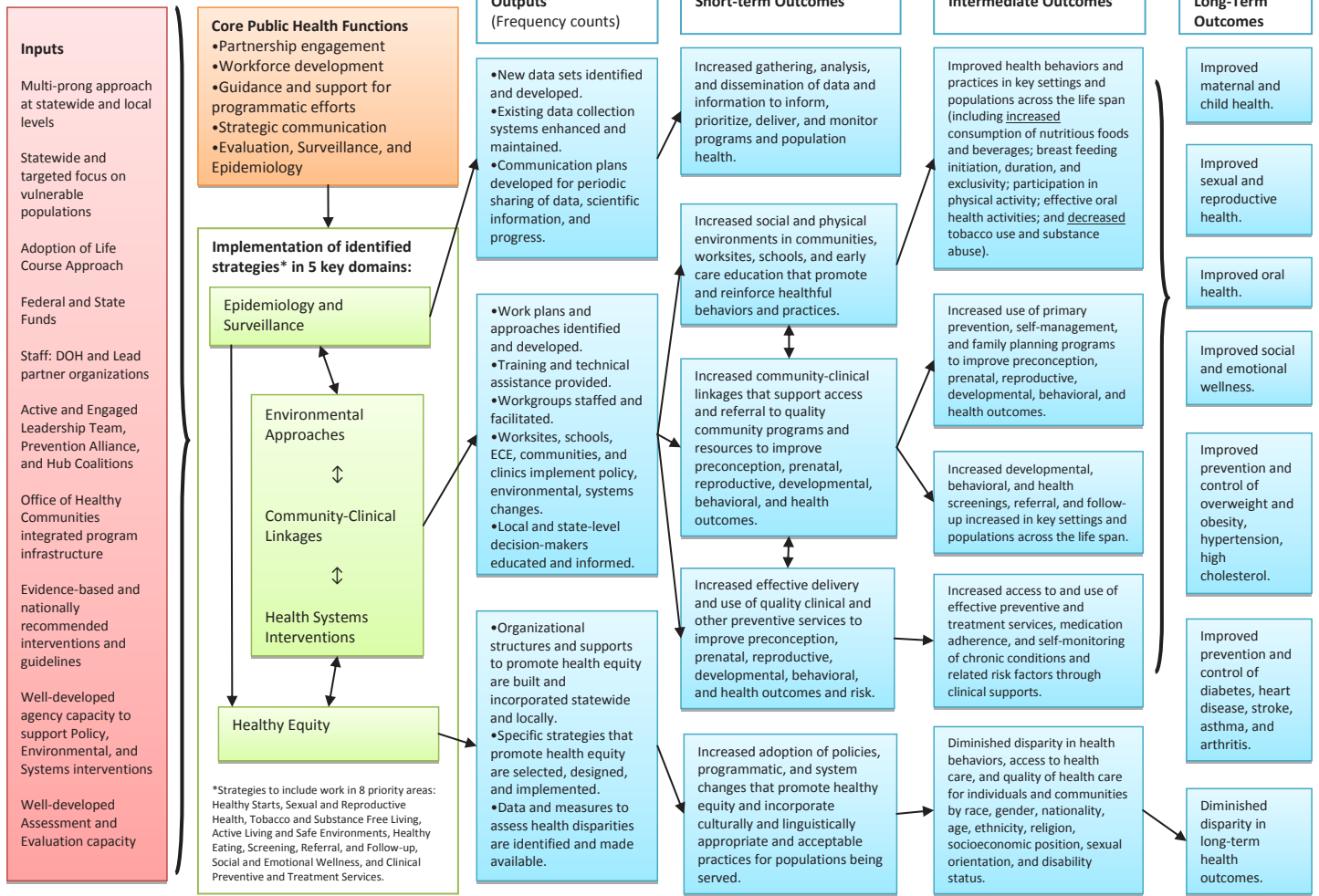
1. To what extent has progress been made toward achieving long-term outcomes at every stage of life to prevent and control chronic conditions and disease risk?
2. To what extent has the state diminished disparity in long-term outcomes for individuals and communities by race, gender, nationality, age, ethnicity, religion, socioeconomic position, sexual orientation and disability status?

The Washington State Plan for Healthy Communities implementation (process evaluation)

1. To what extent did program staff and key partners work collaboratively across programs to achieve health outcomes?
2. What collaborative work effectively contributed to achieving health outcomes?
3. How did programs and key partners address any challenges encountered in working collaboratively across programs?
4. What lessons were learned regarding the advantages and challenges in working collaboratively across programs to achieve health outcomes?

Evaluation Logic Model

Washington State Plan for Healthy Communities



External factors, environmental influences, moderators: National and state priorities and initiatives—Agenda for Change, The National Prevention Strategy, Rethinking Maternal and Child Health, National Strategy for Quality Improvement in Health Care, health care reform related to Affordable Care Act and Triple Aim, Healthy People 2020, Million Hearts, *Lets Move!* to address childhood obesity.

State and National Links

Healthy People 2020

<http://healthypeople.gov/2020/>

U.S. Preventive Services Task Force

www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/uspstf/index.html

Institute of Medicine of the National Academies

www.iom.edu/

National Prevention Strategy

www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf

Title V Maternal and Child Health Services Block Grant / U.S. Department of Health and Human Services

<http://mchb.hrsa.gov/programs/titlevgrants/>

Results Washington

www.results.wa.gov

Washington State Department of Health

www.doh.wa.gov/

- **Agenda for Change – Action Plan Summary (2012)**
www.doh.wa.gov/Portals/1/Documents/1200/A4C-APsummary.pdf
- **Health of Washington State**
www.doh.wa.gov/DataandStatisticalReports/HealthofWashingtonStateReport.aspx
- **Cancer Registry**
<https://fortress.wa.gov/doh/wscr/WSCR/StaticPage.mvc>
- **Vital Statistics**
www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData.aspx
- **Behavioral Risk Factor Surveillance System**
www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/BehavioralRiskFactorSurveillanceSystemBRFSS.aspx
- **Healthy Youth Survey**
www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/HealthyYouthSurvey.aspx
- **Pregnancy Risk Assessment Monitoring System**
www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/PregnancyRiskAssessmentMonitoringSystem.aspx

Acronym Glossary

- ACE** – Adverse Childhood Experience
- ACA** – Affordable Care Act
- AHRQ** – Agency for Healthcare Research and Quality
- BMI** – Body Mass Index
- BRFSS** – Behavioral Risk Factor Surveillance System
- CDC** – Centers for Disease Control and Prevention
- DEL** – Department of Early Learning
- DOH** – Department of Health
- HCA** – Health Care Authority
- H.E.R.E.** – Health Education Resource Exchange
- HP2020** – Healthy People 2020
- HRSA** – Health Resources and Services Administration
- HYS** – Healthy Youth Survey
- IOM** – Institute of Medicine
- OHC** – Office of Healthy Communities
- MCHBG** – Maternal and Child Health Services Block Grant
- SNAP** – Supplemental Nutrition Assistance Program
- STI** – Sexually Transmitted Infections
- USPSTF** – U.S. Preventive Services Task Force

Agenda for Change Action Plan

FOR WASHINGTON'S PUBLIC HEALTH NETWORK

SUMMARY

2012



TABLE OF CONTENTS

**A Message from the Public
Health Improvement
Partnership**

**The Agenda for Change
Action Plan**

**Foundational Public
Health Services**

Strategic Priorities

Partners are Essential

**Next Steps: Implementing
the Agenda for Change**

Collaboration THE FUTURE OF PUBLIC HEALTH



A growing and changing population, new and resurgent diseases, and a severe funding crisis all make for a challenging future for Washington’s public health network. While public health agencies on the state and local levels have seen major cutbacks, our communities are faced with significant health problems that impact people today and will likely affect the health of our state for generations.

Obesity, diabetes, and tobacco use are just a few examples of the health issues that are taking a huge toll on the people of Washington. About 95 percent of health spending goes toward treatment and health care, yet we know that how and where we live have the biggest influence on our health. That’s why the work of public health agencies is so important. Preventing unhealthy behaviors and replacing them with healthy habits can drive down chronic disease rates and improve quality of life. Making it easier in local communities to access medical care, get fresh fruits and vegetables, and live an active lifestyle can help people live longer and save on health care costs.

The combined efforts of local, state, and federal health agencies have made major strides, but there’s much more to do. The partners in Washington’s governmental public health network realize we can’t do it all. To protect and improve the public’s health into the future, we must build a plan that sustains our past successes, confronts our emerging challenges, and uses the resources we have as efficiently and effectively as possible.

Washington’s Public Health Improvement Partnership is working to plan for, guide, and strengthen our future public health network. The partnership includes local and state public health leaders, local boards of health and tribal nations, the state Board of Health, the American Indian Health Commission, and the federal Department of Health and Human Services. Together, this comprehensive group has produced an “Agenda for Change Action Plan.” The plan provides the guidance needed to ensure that we continue to protect and improve the health of people in Washington state in spite of the many challenges.

The following is a summary of the vision, strategies, and steps to move toward a valued and effective 21st Century public health network that will help everyone in our state have a better chance for a long and healthy life.

Thank you for taking an interest in the Agenda for Change and the important work of making Washington a safer and healthier place to live, work, and play.

Mary C. Selecky

Washington State Secretary of Health (1998–2013)

Regina Delahunt

Director of Whatcom County Health Department

Co-Chairs, Public Health Improvement Partnership

The Agenda for Change

AN ACTION PLAN



Washington state’s public health network has long been recognized as a national leader. The state Department of Health collaborates with a network of local public health agencies and tribes to protect every resident. Today, Washington continues that tradition of leadership by providing this Agenda for Change. This is a strategic framework that responds to a rapidly changing environment, such as new preventable disease challenges, health care reform, and diminishing resources, and helps everyone in our state have a better chance for a long, healthy and economically productive life. A successful public health network keeps Washingtonians safer and healthier, reduces health care costs, and improves the productivity of our workforce so we can continue to be competitive now and into the future.

Planning for the Future

The landscape for health is changing across the nation. Thanks to successes in public health and federal, state, local, and tribal funding commitments, communicable diseases such as tuberculosis and influenza are no longer the leading causes of death. People now become ill and die early from preventable chronic diseases like diabetes and heart disease that result from tobacco use, poor nutrition and lack of physical activity. Public health approaches will help solve this new challenge if we align our resources and competencies to match.

Implementation of the Affordable Care Act brings new opportunities for expanding insurance coverage and access to care for some of our most vulnerable populations. It provides states the ability to define essential health benefits. Ultimately, it allows the health care system to reform its business practices while ensuring better collaboration with partners — as a means to slowing the increase in health care costs, improving the experience of care and improving the health of populations.

We are also living in a time when resources are scarce and competitive. Public health agencies at the state and local levels have seen major cutbacks over the past several years, compromising our ability to protect and improve the health of our communities.

continued on next page •••••



The Agenda for Change

AN ACTION PLAN

continued from page 2

With the Agenda for Change, our state can be **at the forefront of responding** to this changing landscape by transforming our public health network through three approaches:



- 1 Foundational Public Health Services Ensure** every resident in Washington can access a foundational set of public health services, no matter where he or she lives. The Agenda for Change introduces a new concept: residents can access a foundational set of capabilities and programs supported by adequate and predictable funding. These foundational services are necessary but not sufficient. Just like the foundations of buildings support the larger structure, the public health foundational programs support other standalone federal or fee supported programs, like WIC, emergency preparedness and response, food safety inspections, and diabetes prevention.
- 2 Strategic Priorities Prioritize** our work so the public health network is working together to confront emerging challenges. The Agenda for Change helps us focus on the most important elements of preventing communicable disease and other health threats, fostering healthy communities and environments, and partnering with the health care system.
- 3 Transform Business Processes Reform** how we do business. Just as the health care system is changing through health care reform to better meet current challenges, the public health network must also undergo reform. This includes taking steps to ensure our workforce has the necessary skills and competencies to address new challenges, adopting the best of both private and public sector management into our operations, and developing a long-term strategy for predictable and appropriate levels of financing.

Committing to Health Equity and Eliminating Health Disparities

All Washingtonians should have the opportunity to live long, healthy lives regardless of geography; education; income level; race; ethnicity; sexual orientation; or physical, mental, or emotional abilities. While data shows improvements overall, there are groups of people suffering from health problems above and beyond the population as a whole; as well as getting care and services that are lower quality, if they are receiving them at all. It is difficult to comprehend and painful to acknowledge that not everyone has an equal opportunity for a long, healthy, enjoyable life. Achieving health equity is a public health priority as local public health agencies, tribes, and the state work to identify health disparities and implement strategies to eliminate them.

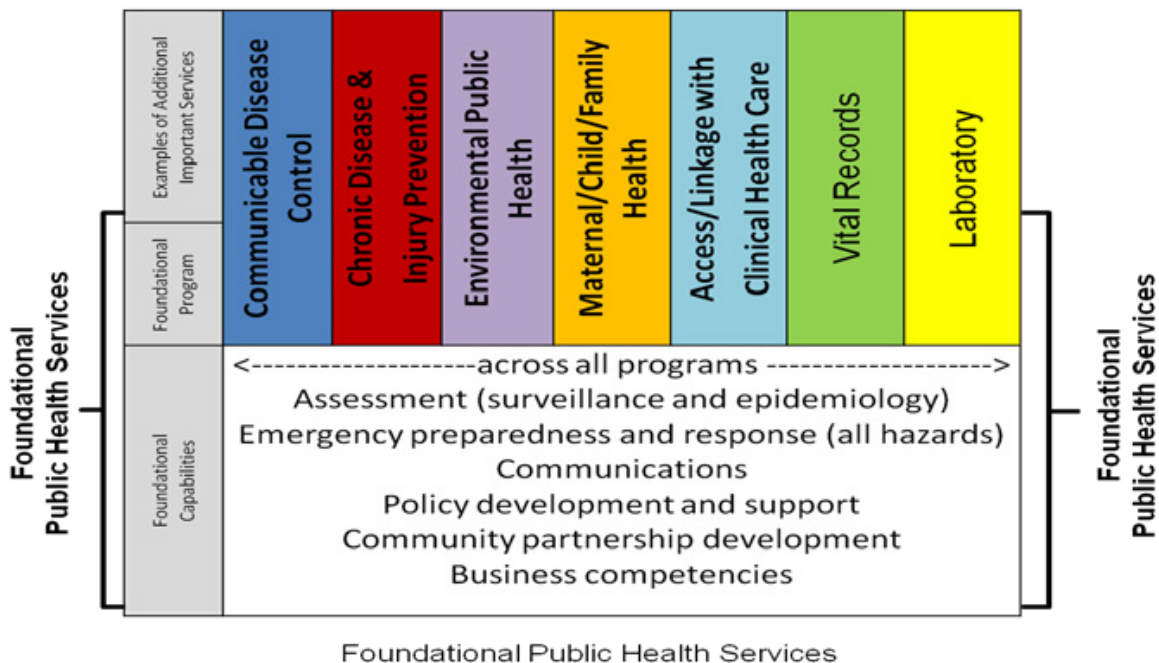
Foundational Public Health Services

Public Health Services for Every Community

Similar to other public safety (fire and law enforcement), public utilities (power, water) and infrastructure services (roads, sewer), a minimum level of public health capabilities and programs must be in place everywhere to protect and improve the overall health of the state. No matter where they live, residents of our state should be able to rely on the governmental public health network to deliver foundational services that protect all Washingtonians.

Health insurance plans describe their minimum benefits package – defining the services available to everyone who has that plan. Similarly, the Foundational Public Health Services defines the public health services that no community should be without, regardless of how the services are provided. It includes:

- » **Foundational Capabilities** like community health assessments, communications, policy development, community partnerships, emergency preparedness, and modern business practices.
- » **Foundational Programs** like communicable disease control; chronic disease and injury prevention; environmental public health; maternal, child and family health; linking with clinical health care; vital records; and laboratory services.



continued on next page





The Foundational Public Health Services **define what must be present** everywhere for the public health system to function anywhere.

- ▶ **GOAL** Develop sustainable public health financing statewide so that all residents have access to a foundational set of services that protect and improve their health.
- **Objective** Develop a scalable cost model for Foundational Public Health Services that can be adjusted for different population sizes and geographic locations.
- **Rationale** A foundational level of capabilities and programs are needed everywhere to protect and improve the overall health of the state. No matter where they live, all residents of our state should be able to rely on the governmental public health network to detect and remedy hazards to the health of the public, deliver a foundational set of services that protect their health, and meet specific standards.
- **Strategies**
 - » **Develop** a list of foundational capabilities and programs that should be available in every community. The list will not indicate who or how the services should be delivered.
 - » **Using** a representative sample of counties, identify the cost of delivering the foundational services statewide.
 - » **Develop** a funding model that accounts for these costs.

While the Foundational Public Health Services defines the basic services to protect and improve health that people rely on government to provide, it does not define a vision for the future of public health in Washington. That vision is articulated in the strategic priorities to follow.

Strategic Priorities



Priorities for the Future

The following strategic priorities build on the strengths of the decentralized public health network in Washington by supporting local solutions to local issues. Having statewide priorities enhances our ability to work together with essential partners, resulting in the most impact for the investment and effort. This plan will move the public health network toward increased consistency in business practices and will fulfill public expectations for consistent services from government across the state. It will improve efficiency and make the best use of our available resources. The three priorities are:

- 1 Preventing Communicable Disease and Other Health Threats
- 2 Fostering Healthy Communities and Environments
- 3 Public Health Partnering with the Health Care System

PRIORITY 1

Preventing Communicable Disease and Other Health Threats

Preventing people from getting sick from communicable disease is **foundational to the work** of public health agencies. We do this by assuring safe drinking water and food, providing immunizations, monitoring disease, and investigating outbreaks.



Preventing communicable disease is as important at home as it is in the developing world. The recent whooping cough epidemic in Washington shows that **we must be vigilant** in our efforts, embrace improvements in how we do our work and modernize our systems to ensure effectiveness. We must be able to respond effectively to new disease threats like we did successfully with H1N1 flu, SARS, and Mad Cow disease. **Our efforts are vitally important** to the health of the whole population of Washington state.

➔ **GOAL** Implement the most effective and important elements of prevention, early detection, and swift responses to protect people from communicable diseases and other health threats.

— **Objective 1** Increase immunization rates for all age groups.

Strategies

- » **Improve** our understanding of immunization coverage in Washington state by enhancing the completeness and quality of data entered in the Washington Immunization Information System (adults and children).
- » **Identify** and implement evidence-based practices to improve immunization coverage rates. Emphasize immunizations that provide the greatest impact to the health of people in Washington.

— **Objective 2** Standardize and prioritize communicable disease tracking, monitoring and response.

Strategies

- » **Prioritize** the activities that are most critical to protect the public's health
- » **Establish** evidence-based statewide recommendations for identifying and controlling communicable diseases.

— **Objective 3** Develop, maintain and integrate a data collection system for communicable disease tracking, monitoring, and response.

Strategies

- » **Modernize** our data systems for disease tracking, monitoring, and response.
- » **Increase** capacity to receive electronic laboratory reporting of communicable diseases through a health information exchange.
- » **Implement** an updated secure communication alerting system to send urgent messages from public health agencies to community partners.

PRIORITY 2

Fostering Healthy Communities and Environments

Governmental public health agencies work to protect and improve people's health **throughout the course of their life**, from healthy childhoods to living well as older adults. As we learn more about how childhood illness and trauma can affect someone for a lifetime, new evidence shows a strong connection between a woman's health *before* becoming pregnant and the health of her child.



While some factors that impact health are out of a person's control, behaviors are not. **People make choices every day** that impact their health, like what to eat, how active to be, and whether or not to use tobacco. These choices are largely influenced by where you live, work, play, and go to school.

Not everyone has an equal opportunity to make healthy choices. **Success means making changes** to our communities and environments so that everyone can choose to live a healthy life.

- ➔ **GOAL** Prevent illness and injury, and promote health equity through sustainable, population-based changes in communities.
- **Objective 1** Implement policy, environmental, and system changes that give all babies a planned, healthy start in life.
- **Strategies**
 - » **Connect** uninsured and underinsured women to preconception, prenatal, and postnatal care services.
 - » **Collaborate** with health care providers to support women carrying babies to full-term.
 - » **Improve** access to safe and healthy food for low-income women and families.
 - » **Help** women quit using tobacco before and during pregnancy.
 - » **Support** breastfeeding mothers in child care settings, hospitals, and worksites.
- **Objective 2** Implement policy, environmental, and system changes that prevent or reduce the impact of Adverse Childhood Experiences, such as abuse and neglect on children and families.
- **Strategies**
 - » **Link** low-income families to programs that provide social and parenting support (examples include: home visiting and nurse-family partnerships).
 - » **Screen** young children for developmental and social-emotional issues, and connect them with appropriate community services.
 - » **Give** children safe and healthy meals (including snacks and beverages) in schools, child care settings, and after-school programs.
 - » **Provide** opportunities for physical activity before, during, and after school and in child care settings.
 - » **Prevent** youth from using tobacco products.
- **Objective 3** Implement policy, environmental and system changes that help adults make healthy choices for themselves and their families.
- **Strategies**
 - » **Promote** affordable, healthy food and beverage options at worksites, colleges, hospitals, and other venues.
 - » **Offer** free or low-cost physical activity opportunities in communities and worksites.
 - » **Include** healthy design concepts when planning communities.
 - » **Provide** smoke-free multi-unit housing.
 - » **Link** people to quality tobacco cessation services (like the Tobacco Quitline).
 - » **Protect** employees, customers, patrons, and others from secondhand smoke.

PRIORITY 3

Public Health Partnering with the Health Care System

A recent report from The Institute of Medicine argues that much can be gained by bringing primary care and public health together to improve individual, community, and population health. **Washington must act on new opportunities** presented through health care reform to bridge the divide between the two disciplines with a shared goal of improved health.



Health care today in **Washington faces many challenges**: the disease burden has shifted to chronic diseases, health care costs are rising and are unsustainable, and health care reform will increase the number of people with insurance, further challenging the health care delivery system.

Public health and health care providers can **respond to these challenges** by finding innovative ways to work together, jointly placing emphasis on preventing health problems *before* they become hard to treat and expensive. They can also team up with a broad range of community partners to set local priorities for improving health.

Public health agencies can contribute valuable information about health problems, they can help communities address the disparities in health among different groups of people, and they can help promote the use of prevention practices that have been shown to get results.

» **GOAL** Improve access to quality, affordable, and integrated health care that incorporates routine clinical preventive services and is available in rural and urban communities alike, by effectively and strategically partnering with the health care system.

— **Objective 1** Provide more information about the community's health care system and the health of local communities.

Strategies

» **Improve** knowledge about the health status of the community.

» **Improve** information about the capacity of the health care delivery system within the community.

» **Increase** information about how people use the health care system in the community.

— **Objective 2** Engage community leaders with a shared interest in improving health to identify and address community health problems. Mobilize resources and strategies to improve the health of the community, especially among populations affected by health disparity.

Strategies

» **Convene** interested parties to develop community health needs assessments. This includes connecting hospitals, consumers, behavioral health, primary care, specialty care, and dental care services.

» **Convene** interested parties to share information about the health of the community so that problems can be identified and potential solutions achieved.

— **Objective 3** Promote and adopt the use of evidence-based clinical preventive services and patient-centered health homes as a way to assure that needed care is well-coordinated.

Strategies

» **Improve** provider use of evidence-based clinical preventive services like screening tests, counseling, immunizations, and medications used to prevent disease.

» **Increase** the availability and use of patient-centered health homes so that patients receive the benefits of access to care, preventive services, and continuity of care.



Partners are Essential

Keeping our communities healthy is not the job of one agency alone; many organizations influence the health and wellness of the people they serve. Public health agencies throughout the state are continually working with partners. An important role of the public health network is to convene community groups to help define and address local health problems. This is especially vital with populations experiencing disparities.

We can also help our partners understand the relationship of health to their agency’s mission. Examples of partners and possible actions they might take include:

- | | |
|---|--|
| <ul style="list-style-type: none"> <p>Child care and early learning centers</p> <p>» Example: Adopt healthy food and beverage procurement guidelines</p> <p>Community employers and businesses</p> <p>» Example: Provide physical activity opportunities for employees</p> <p>Community organizations</p> <p>» Example: Participate in forums to learn about the health status of the community and identify policies to improve health</p> <p>Health care system (payers, providers, hospitals)</p> <p>» Example: Work with local health agencies and the Washington State Department of Health to improve completeness of Washington Immunization System data</p> | <ul style="list-style-type: none"> <p>Housing authorities, non-profit housing organizations, property management organizations, and landlords</p> <p>» Example: Educate residents on the health risks of secondhand smoke and the benefits of quitting tobacco</p> <p>Schools, colleges, and universities</p> <p>» Example: Work with local health agencies to promote immunization and improve coverage</p> <p>State and local government agencies</p> <p>» Example: include healthy community design elements in comprehensive plans</p> <p>Tribes and The American Indian Health Commission</p> <p>» Example: Increase capacity to use policies, systems, and environmental changes when addressing health issues</p> |
|---|--|

Next Steps

IMPLEMENTING THE AGENDA FOR CHANGE



With Foundational Public Health Services and strategic priorities now defined in the Agenda for Change, we're ready to implement. To make these strategies a reality, we will focus on workforce development, modify business practices for maximum impact, and identify long-term, sustainable financing for programs and services.

The future work of public health agencies must include retraining their workforce so they have the skills and competencies to meet today's challenges. Recruitment, selection, and retention strategies must be implemented to address skills gaps in health equity, policy change, social media, and communications.

The Agenda for Change also calls on Washington's public health network to **transform its business practices** and reprioritize its work by:

Working with policymakers to set and prioritize specific health outcomes, and establish ways to measure them.

Streamlining performance and accountability measures on public health actions that lead to the achievement of the prioritized health outcomes.

Committing fully to quality improvement by striving to meet state and national public health standards.

Organizing a more cost-effective public health network to achieve prioritized health outcomes.

Applying the best of private and public sector management techniques to the operation of each of our programs.

Critically evaluating and reprioritizing our limited resources, and better defining roles and responsibilities among the overlapping government authorities and jurisdictions.

Modernizing and sustaining capabilities to collect, analyze, and share information, that policy makers, health agencies, and the public can use to make Washington a healthier place to live.

Implementation of the Affordable Care Act brings new opportunities for expanding insurance coverage and access to care for some of our most vulnerable populations. It also provides states the ability to define essential health benefits, and ultimately, it allows the health care system to reform its business practices while ensuring better collaboration with partners. Our challenge and opportunity in public health is to do no less.

Health is important to all of us, yet we have limited government resources so we must use them wisely. Like police and fire services, people expect government to consistently and reliably provide public health services for all. The Agenda for Change Action Plan describes our vision for the future of public health in Washington state and how we will achieve it. We look forward to working with policy makers and partners as we implement the vision and strategies in this document.

REFERENCES



Adverse Childhood Events. <http://www.cdc.gov/ace/about.htm>

For the Public's Health: Investing in a Healthier Future (April 2012). Institute of Medicine. www.iom.edu/phfunding

National Prevention Strategy: America's Plan for Better Health and Wellness. (June 2011). By the National Prevention Health Promotion and Public Health Council. <http://www.healthcare.gov/prevention/nphpphc/index.html>

Primary Care & Public Health (March 2012). Institute of Medicine. <http://www.iom.edu/Reports/2012/Primary-Care-and-Public-Health.aspx>

Photos provided by the Washington State Department of Health, the Rudd Center for Food Policy and Obesity, and Bigstock.

.....▶ For more information visit: www.doh.wa.gov/hip

PUBLIC HEALTH
ALWAYS WORKING FOR A SAFER AND
HEALTHIER WASHINGTON

