Recommendations to the Blue Ribbon Commission (BRC)
Measures for Goals Adopted by the BRC on July 27, 2006
Prepared by the BRC Staff Work Group

Recommendations for BRC Goal Measures

1. Adopt the measures in Attachment 1.
2. As specific proposals are adopted by the Commission, adjust the Attachment 1 measures to more precisely reflect the proposed interventions.
3. Include in the Commission's 5-year plan a recommendation to bring informed experts together to periodically review the measures to keep pace with emerging work.

Findings and Assumptions

1. Creating a set of measures separate from those being used, or developed, by state and national efforts is redundant and wasteful.

   We are not assuming that one set of measures meets all needs; different organizations focus on measuring progress in different areas. However, we do assume that where goals are similar and where others have invested significant time and expertise in developing measures it is most efficient to adopt or build on their work.

   Examples of relevant state efforts are: The *Washington Health Foundation* has developed its "2006 Report Card on Washington's Health"; the *Puget Sound Health Alliance* is developing comparison measures of quality, cost and patient experience with care (for release in 2007); the *Public Health Improvement Partnership* has its "Report Card on Health in Washington 2005" (updated biennially); the *Department of Health* periodically produces "The Health of Washington State: A Statewide Assessment of Health Disparities by Race, Ethnic Group, Poverty and Education" (update due in 2007).

   Examples of relevant national efforts are: The *United Health Foundation* produces its annual "America's Health Rankings" (2005 is its 16th edition); the *Commonwealth Fund* recently released (September 2006) its "National Scorecard on U.S. Health System Performance" which contains a set of measures for a high performance health system.[1]

2. The measures are broad-based and monitor the progress of Washington State as a whole; that is, they are not solely about measuring the progress of state government agencies.

   State government agencies use GMAP to measure their performance; this is separate from, although not unrelated to, measuring the progress of the state as a whole.

3. In addition to broad-based measures, measures specific to evaluating the impact of any given proposal adopted by the BRC should be considered.

   Monitoring general progress is different than measuring the impact of a specific intervention. For example, broad-based monitoring uses data from a variety of *lagged* time periods, none of which capture changes in "real time" (i.e., they are generally 2 to 3 years old). Therefore, specific interventions should be required to have evaluation components that assess the return on investment from that intervention (where return on investment is defined in non-monetary as well as monetary terms).

[1] The Scorecard is a new product of The Commonwealth Fund's "High Performance Health System" program. The Scorecard assesses how well the health care system is performing relative to other nations and to what is achievable, i.e., it sets benchmarks for improvement across goals of health outcomes, quality, access, efficiency, and equity.

4. A specific group or entity will have to be funded and accountable for producing an annual state-of-the-state regarding selected measures; and for periodic review and refinement of relevant measures.

   For example, an existing state agency, academic entity, or non-profit organization could be tasked with this responsibility.

5. The draft recommendations are those of the BRC staff work group, representing input from executive, legislative, and other-elected-official staff. No input beyond this small group has been sought. We assumed the BRC would discuss the draft recommendations and make a decision on how to move forward regarding public input and vetting.

Primary Measurement Sets Examined

1. Agency for Healthcare Research and Quality, *2005 National Healthcare Quality Report*, December 2005.
2. Agency for Healthcare Research and Quality, 2005 *National Healthcare Quality Report, Washington State Snapshot.*
3. Agency for Healthcare Research and Quality, *2005 National Healthcare Disparities Report.*
4. Ambulatory Care Quality Alliance, *Clinical Measures for Physician Performance, Recommended Starter Set*, revised April 2006.
5. Department of Health, *The Health of Washington State, A Statewide Assessment of Health Disparities by Race, Ethnic Group, Poverty and Education*, September 2004 Supplement to *2002 Health of Washington.*
6. Department of Health and Human Services, *Healthy People 2010 Leading Health Indicators.*
7. HealthPartners Research Foundation and Partnership for Prevention, *Methods for Prioritizing Clinical Preventive Services; and Priorities for America's Health: Capitalizing on Life Saving, Cost Effective Preventive Services*, May 2006.
8. Public Health Improvement Partnership, *Report Card on Health in Washington 2005*, October 2005.
9. Puget Sound Health Alliance, www.pugetsoundhealthalliance.org.
10. RAND Research Highlights 2004, *The First National Report Card on Quality of Health Care in America; and Quality Assessment Tools System,* 2004.
11. The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best, Results from a National Scorecard on U.S. Health System Performance; National Scorecard on U.S. Health System Performance, Technical Report and Chartpack Technical Appendix*, September 2006.
12. The Dartmouth Atlas of Health Care Project, www.dartmouthatlas.org., on-going.
13. United Health Foundation, *America's Health Rankings 2005 Edition.*
14. Washington Health Foundation, *2006 Report Card on Washington's Health*, October 2006.

Attachment 1: Goal Measures, Draft Recommendations to the Blue Ribbon Commission (BRC)

Attachment 2: Goal Measures, Components of Measurement Sets Discussed in Attachment 1, Organized by Relationship to Blue Ribbon Commission Goals

Attachment 2a: Goal Measures, Summary Description of Components from the United Health Foundation's *America's Health Ranking 2005 Edition.*

Attachment 2b: Goal Measures, Summary Description of Components from the Washington Health Foundation's *2006 Report Card on Washington's Health.*

Attachment 2c: Goal Measures, Summary Description of Components from the Commonwealth Fund's *National Scorecard on U.S. Health System Performance*, 2006.

Attachment 3: Goal Measures, Criteria Used by the Staff Work Group in Developing Measure Recommendations for the BRC Goals

Attachment 1: Goal Measures,
Recommendations to the Blue Ribbon Commission (BRC)

BRC Goals to be Achieved by 2012 (adopted 7-27-06)	Assumptions / Recommended Measures
In Improving Access:	
1. All Washingtonians will have access to health coverage that provides effective care by 2012, with all children having such coverage by 2010.	Assumptions: ▪ Focus on access to coverage; defer the "effective care" piece to Goal 4, related to evidenced-based care.[1] ▪ Complement coverage measures ('a' & 'b' below) with an "adequacy of access to care" measure ('c' below) and an "adequacy of financial protection" measure ('d' below). Measures: a. Uninsured rates & counts by various sub-groups (age, race-ethnicity, gender, income, region), over time. (Washington State Population Survey[2]) b. Insured rates & counts by source of coverage (employer, public, individual market, uninsured), over time. (Washington State Population Survey[3]) c. Percent of households in which people report being unable to obtain health care or experience difficulty or delay in obtaining health care – measures unmet healthcare need. (Behavioral Risk Factor Surveillance System[4]) d. The cost of uncompensated care for services provided to the uninsured. (Office of the Insurance Commissioner[5])
In Improving Health:	
2. Washington will be one of the top ten healthiest states in the nation.	Assumptions: ▪ Measures for Goals 2, 3, and 4 should overlap as much as possible. ▪ The ideal is to have an overall "state rank" *from one source* that allows benchmarking to self and comparison to other states / nations over time. However, two good "ranking" sources for Washington currently exist; they have substantial overlap but also important differences. Use both to triangulate on Washington's status. Measures[6]: a. Overall state rank from *America's Health Rankings*, annual edition, United Health Foundation (UHF). (nationally produced) b. Overall state rank from *Report Card on Washington's Health*, annual edition, Washington Health Foundation (WHF). (locally produced)

3. Population health indicators will be consistent across race, gender and income levels throughout the state.	Assumptions: ▪ Measures for Goals 2, 3, and 4 should overlap as much as possible. ▪ Whatever measures are adopted in Goal 4 should be compiled by race-ethnicity, gender, income, and region *where possible.* Measures: a. Same as Goal 4 recommendation; reported *where possible* by race-ethnicity, gender, income, and region.
4. Increased use of evidence-based care brings better health outcomes and satisfaction to consumers.	Assumptions: ▪ Measures for Goals 2, 3, and 4 should overlap as much as possible. ▪ Focus on measures for the separate parts of this goal (i.e., degree to which evidence-based care is increasing; degree to which health outcomes are improving; degree to which consumer satisfaction is increasing); broad system measures demonstrating the causal link between evidence-based care and the other two pieces are elusive. Measures: a. Report on the individual items that make up the overall state rankings from the United Health Foundation's (UHF) *America's Health Rankings* and the Washington Health Foundation's (WHF) *Report Card on Washington's Health.* See Attachments 2, 2a, and 2b for additional detail on the individual items that make up the UHF and WHF measurement sets.[7] [8]
In Improving Affordability:	

5. The rate of increase in total health care spending will be no more than the growth in personal income.	Assumptions:
	▪ The goal is itself a comparison of two measures:
	  ▪ Rate of increase in health care spending (Centers for Medicare and Medicaid Services, National Health Expenditure Accounts).
	  ▪ Rate of increase in personal income (US Department of Commerce, Bureau of Economic Analysis).
	▪ The degree to which the goal is fully achievable is debatable but at a minimum we can measure the degree to which the gap between the two trend lines is shrinking.
	
	Measures:
	a. Track the 2 components of the goal, over time.
	b. Use a ratio of the two components (increase in spending divided by increase in personal income) to easily see if they are converging (e.g., a ratio of 2.5 would indicate that spending continues to increase at 2.5 times the rate of income; a ratio of 1.0 would indicate convergence)

[1] Deferring "effective care" to Goal 4 is based on the *Crossing the Quality Chasm* definition of effective as "effectiveness refers to care that is based on the use of systematically acquired evidence to determine whether an intervention …

produces better outcomes than alternatives, including the alternative of doing nothing." (Institute of Medicine, 2001, pages 46-47)

[2] The Washington State Population Survey (WSPS) is conducted biennially in even numbered years; the most recent version is from Spring 2006. It measures point-in-time health insurance coverage (i.e., does a person have coverage at the time s/he is surveyed). A variety of factors (for example, sample size, elimination of recall bias, and adjustments to ensure accurate counts of public program enrollees) make it the most reliable and valid source of data for point-in-time estimates of Washington's uninsured.

The drawback of the WSPS is that it does not allow comparisons to other states. There are several national surveys that are available for this purpose; the most widely used is the Census Bureau's Current Population Survey (CPS). The work group addressed the state-comparison issue by recommending to the BRC that the United Health Foundation and Washington Health Foundation measurement sets be collected (see Goals 2 – 4); each includes the CPS measure of the uninsured, allowing for comparison to other states.

Notwithstanding the interest in comparing ourselves to other states, the measurement team recommends that the WSPS be used for rates and counts and as the basis for policy discussions about Washington's uninsured population. The CPS provides a barometer of where we are relative to other states but cannot provide the same level of precision as the WSPS in its state estimates. (Theoretically, the CPS measures the number of people uninsured for an entire year but most analysts agree that it really provides a point-in-time estimate. Thus, it is likely measuring the same concept as the WSPS however it does so with less precision.)

[3] See Note 2.

[4] The Behavioral Risk Factor Surveillance System (BRFSS) is an annual survey sponsored by the Centers for Disease Control and Prevention. It provides national and state-level estimates on a variety of health risks. The measure recommended to the BRC is defined as follows: If a person answers "yes" to any of the following four questions, s/he is counted as having an unmet health need: (1) In the last 12 months, were you or any adult in your household unable to obtain any type of health care you or they thought was needed? (2) In the last 12 months, did you or any adult in your household experience difficulty or delay in obtaining any type of health care you or they thought was needed? (3) In the last 12 months, were any children living in your home unable to obtain any type of health care you thought they needed? (4) In the last 12 months, did any children living in your home experience difficulty or delay in obtaining any type of health care you thought they needed? This same measure is also being used by the Priorities of Government (POG) health group.

[5] *The Uninsured and the Cost of Uncompensated Care in Washington State: A Data Report by Region and County.* Office of the Insurance Commissioner (OIC). August, 2006. This measure recognizes the financial component of coverage, that is, it helps protect people from financial disaster – those who provide services get paid and those who suffer catastrophic occurrences aren't bankrupted. The work group acknowledges that a better measure of this concept is needed; however, the work of the OIC is the best statewide measure currently available and provides a good starting point.

[6] The latest (16th annual) edition of *America's Health Rankings* is 2005. The latest (first) edition of *Report Card on Washington's Health* is 2006. Both use the latest data available for their respective measures (although those data are often 2-3 years old).

[7] The 2005 edition of *America's Health Rankings* includes 18 individual components that are weighted and combined to create an overall rank for the state. The 2006 edition of *Report Card on Washington's Health* weights and combines 17 measures to create its overall state rank. (Some of the individual measures are themselves combinations of other measures.)

[8] Draft Recommendation #3 is "Include in the Commission's 5-year plan a recommendation to bring informed experts together to periodically review the measures to keep pace with emerging work". Based on information to-date, the workgroup recommends that at least two emerging measurement sets be examined in any future review: (1) any measures adopted by the Puget Sound Health Alliance (coming in 2007) and (2) the recently released set of measures from the *National Scorecard on U.S. Health System Performance*, The Commonwealth Fund (see Attachments 2 and 2c for more detail).

Attachment 2: Goal Measures,
Components of Measurement Sets Discussed in Attachment 1,
Organized by Relationship to Blue Ribbon Commission Goals
(See Attachments 2a, 2b, and 2c for more detailed definitions of each measure.)

	Components of Recommended Measurement Sets Discussed in Attachment 1 [1]		**Example of *One* Emerging Measurement Set for Future Review**[2]
BRC Goal	United Health Foundation (nationally produced)	Washington Health Foundation (locally produced)	Commonwealth Fund's National Scorecard on US Health System Performance
In Improving Access			
1. All Washingtonians will have access to health coverage that provides effective care by 2012, with all children having such coverage by 2010.	▪ **Lack of health insurance**	▪ **Lack of health insurance**	▪ Adults insured all year, not underinsured ▪ Adults with accessible primary care provider ▪ Children with a medical home ▪ Adults with no access problems due to costs ▪ Families spending <10% of income or <5% of income, if low-income, on out-of-pocket medical costs & premiums ▪ Adults living where premiums for employer-sponsored health coverage are <15% of median household income ▪ Adults with no medical bill problems or medical debt
In Improving Health			
2. Washington will be one of the top ten healthiest states in the nation.	▪ **Prevalence of smoking (adults)** ▪ **Infectious disease** ▪ **Per capita public health spending** ▪ **High school graduation** ▪ Prevalence of obesity ▪ Motor vehicle deaths ▪ Occupational fatalities ▪ Children in poverty ▪ Violent crime	▪ **Prevalence of smoking (adults)** ▪ **Infectious disease** ▪ **Per capita public health spending** ▪ **High school graduation** ▪ Prevalence of drinking (adults) ▪ Prevalence of exercise (adults) ▪ Prevalence of healthy eating (adults) ▪ Shoulder belt use (adults) ▪ Income, unemployment, child poverty, and overall poverty (composite)	
3. Population health indicators will be consistent across race, gender and income levels throughout the state.	↑ Where possible, compile Goal 2 and Goal 4 measures by race-ethnicity, gender, income & region ↓	↑ Where possible, compile Goal 2 and Goal 4 measures by race-ethnicity, gender, income & region ↓	

4. Increased use of evidence-based care brings better health outcomes and satisfaction to consumers.	▪ **Premature deaths** ▪ **Limited activity days (adults)** ▪ Total mortality ▪ Cardiovascular deaths ▪ Cancer deaths ▪ Infant mortality ▪ Adequacy of prenatal care ▪ Immunization coverage (children)	▪ **Premature deaths** ▪ **Limited activity days (adults)** ▪ Total mortality (includes cardiovascular deaths, cancer deaths, infant mortality, accidental deaths) ▪ Average state ranks for receipt of prenatal care, children's immunizations, mammography, cholesterol screening and colorectal cancer screening (combined) ▪ Average rank across 14 key health care measures ▪ Adult routine check-ups ▪ Adult mentally unhealthy days	▪ Mortality amenable to health care ▪ Infant mortality ▪ Hospital-standardized mortality ratios ▪ Healthy life expectancy at age 60 ▪ Limited activity days (adults) ▪ Missed school days (children) ▪ Adult preventive care ▪ Child immunization & preventive care ▪ Received treatment for needed mental health care ▪ Chronic disease under control ▪ Adults with chronic conditions given self-management plan ▪ Recommended care for AMI, CHF, & pneumonia received in hospital ▪ Care coordination at hospital discharge ▪ Nursing home residents with pressure sores ▪ Went to emergency room for condition that could have been treated by regular doctor ▪ Hospital admissions & readmissions for nursing home residents ▪ Hospital admissions for home health recipients ▪ Medicare hospital 30-day readmission rates ▪ Hospital admissions for ambulatory care sensitive conditions ▪ Reported medical, medication, or lab test error ▪ Unsafe drug use ▪ Ability to see doctor on same/next day when needed ▪ Very/somewhat easy to get care after hours without going to emergency room ▪ Doctor-patient communication [is satisfactory] ▪ Patient-centered hospital care provided ▪ Physicians using electronic medical records ▪ Potential overuse or waste

In Improving Affordability			
5. The rate of increase in total health care spending will be no more than the growth in personal income.			▪ Percent of national health expenditures spent on health administration & insurance ▪ Medicare annual costs of care and mortality for AMI, hip fracture, and colon cancer ▪ Medicare annual costs of care for chronic diseases: diabetes, CHF, COPD

[1] Measures in bold are defined the same by the United Health Foundation (UHF) and the Washington Health Foundation (WHF).

[2] The Commonwealth Fund measures are provided as *one example* of an emerging source of measures that could be reviewed to fill gaps in the UHF and / or WHF measures relevant to the BRC goals (e.g., in the area of affordability). The Commonwealth measures are designed to compare the U.S. system to other nations' systems; not all of the measures would be available at a state level. Whether we've linked the right Commonwealth measures to each BRC goal can be debated; the purpose here is to demonstrate to the BRC that emerging measurement sets could be used in the future to refine the BRC measures. The workgroup also recommends that any measures adopted by the Puget Sound Health Alliance be included in future reviews and refinements of BRC goal measures.

Attachment 2a: Goal Measures,
Summary Description of Components from the United Health Foundation's
America's Health Rankings 2005 Edition

Personal Behaviors

1. Prevalence of Smoking	Percentage of population over age 18 that smokes on a regular basis. This is an indication of known, addictive, health-adverse behaviors within the population.
2. Motor Vehicle Deaths	Number of deaths per 100,000,000 miles driven in a state. It is a proxy indicator for excessive drug and alcohol use within a population.
3. Prevalence of Obesity	Percentage of the population estimated to be obese, with a body mass index (BMI) of 30.0 or higher. Obesity is known to contribute to a variety of diseases, including heart disease, diabetes and general poor health.
4. High School Graduation	Percentage of incoming ninth graders who graduate in four years from a high school with a regular degree. It is an indication of the consumer's ability to learn about, create and maintain a healthy lifestyle and to understand and access health care when required.

Community Environment

5. Violent Crime	The number of murders, rapes, robberies and aggravated assaults per 100,000 population. It reflects an aspect of overall lifestyle within a state and its associated health risks.
6. Lack of Health Insurance	Percentage of the population that does not have health insurance privately, through their employer or the government. This is another indicator of the ability to access care as needed, especially preventive care.
7. Infectious Disease	Number of AIDS, tuberculosis and hepatitis cases reported to the Centers for Disease Control and Prevention per 100,000 population. This is an indication of the toll that infectious disease is placing on the population.
8. Children in Poverty	The percentage of persons under age 18 who live in households that are at or below the poverty threshold. Poverty is an indication of the lack of access by this vulnerable population to health care.
9. Occupational Fatalities	Number of fatalities from occupational injuries per 100,000 workers. This measure reflects job safety as a part of public health.

Health Policies

10. Per Capita Public Health Spending	The dollars spent on direct public health care services, community-based services and population health activities as defined by NASBO. This indicates the actual financial commitment a state has made to public health.
11. Immunization Coverage	Percentage of children ages 19 to 35 months who have received four or more doses of DTP, three or more doses of poliovirus vaccine, one or more doses of any measles-containing vaccine, three or more doses of HiB, and three or more doses of HepB vaccine.
12. Adequacy of Prenatal Care	Percentage of pregnant women receiving adequate prenatal care, as defined by Kotelchuck's Adequacy of Prenatal Care Utilization (APNCU) Index. This measures how well women are receiving the care they require for a healthy pregnancy and development of the fetus.

Outcomes

13. Limited Activity Days	Number of days in the previous 30 days when a person indicates their activities are limited due to physical or mental difficulties. This is a general indication of the population's ability to function on a day-to-day basis.
14. Cardiovascular Deaths	Number of deaths due to all cardiovascular diseases, including heart disease and strokes, per 100,000 population. This is an indication of the toll that these types of diseases place on the population.
15. Cancer Deaths	Number of deaths due to all causes of cancer per 100,000 population. This is an indication of the toll cancer is placing on the population.
16. Total Mortality	Number of deaths per 100,000 population. This is an overall indicator of health of a population as it measures death from all causes.
17. Infant Mortality	Number of infant deaths (before age 1) per 1,000 live births. This is an indication of the prenatal care, access and birth process for both child and mother.
18. Premature Death	Number of years of potential life lost prior to age 75 per 100,000 population. This is an indication of the number of useful years of life that are not available to a population due to early death.

Attachment 2b: Goal Measures,
Summary Description of Components from the Washington Health Foundation's
2006 Report Card on Washington's Health

Promoting Community Health

1. Composite measure of median household income, unemployment, child poverty and poverty rates. (Sightline Institute (formerly Northwest Environmental Watch; Cascade Scorecard 2005, 2004 data from US Census Bureau, U.S. Bureau of Labor Statistics)

2. Percentage of persons who graduate in four years from a high school with a regular degree. (UHF; America's Health Rankings 2005 Edition, 2001-2002 data, National Center for Education Statistics)

Investing in Prevention

3. Percent of the population that does not have health insurance privately, through their employer or through the government. (UHF; America's Health Rankings 2005 Edition, 2004 data, Current Population Survey, March 2005, US Census Bureau)

4. Dollars per person spent in 2003 on public health, in three categories defined by the National Association of State Budget Officers. (UHF; America's Health Rankings 2005 Edition, 2003 data, National Association of State Budget Officers)
    - Population health expenditures: including infectious disease control, immunizations and related infrastructure, food and water safety
    - Direct public health care services: including WIC, administration of immunizations, Ryan White Act Funds, and local health clinics
    - Community-based services health expenditures: including non-Medicaid spending for community mental health and substance abuse treatment

Increasing Value in Health Services

5. Percent of adults who answered "in the past year" to the question: About how long has it been since you last visited a doctor for a routine checkup? (BRFSS, CDCP; 2000 data)

Medical Care Quality

6. Average rank across 14 key health care measures for hospitals, nursing homes and home health care. (AHRQ; 2005 Quality Report)
    - Diabetes flue shots (% of non-institutionalized high-risk diabetic adults, 18-64, having an influenza immunization in the past year, 2001 and 2003)
    - Dialysis and good urea reduction (% of hemodialysis patients with urea reduction ratio 65 percent or higher, 2000 and 2003)
    - Beta blocker prescribed at discharge for heart attach (% of Medicare AMI patients with beta blocker prescribed at discharge, 2002 and 2003)
    - ACE inhibitor for heart attach with dysfunction (% of Medicare AMI patients with left ventricular systolic dysfunction prescribed ACE inhibitor at discharge, 2002 and 2003)
    - Suicide deaths (Suicide deaths per 100,000 population, 1999 and 2002)
    - Pneumonia vaccinations, age 65 plus (% of adults, 65 and over, ever receiving a pneumococcal vaccination, 2001 and 2003)
    - Nursing home residents, physically retrained (% of residents who were physically restrained, 2002 and 2004)
    - Nursing home residents, low-risk pressure sore cases (% of low-risk residents having pressure sores, 2003 and 2004)
    - Home health care, improved mobility (% of improvement in ambulation / locomotion for home health episodes, 2002 and 2004)
    - Always get appointment for care, Medicare, fee for service (% of adults, 18 and over, who reported availability of immediate care for illness / injury, Medicare fee for service, 2003)

- High satisfaction overall with providers, Medicare, fee for service (% of adults, 18 and over, whose health providers listened carefully, explained clearly, respected patient input, and spent enough time, Medicare fee for service, 2003)
- Percent of Medicare AMI patients prescribed aspirin at discharge (2002 and 2003)
- Percent of Medicare heart failure patients with left ventricular systolic dysfunction prescribed ACE inhibitor at discharge 2002 and 2003)
- Percent of Medicare pneumonia patients receiving first dose of antibiotic within four hours of hospital arrival (2002 and 2003)

Protecting Against Injury and Disease

7. Average state ranks for receipt of prenatal care, children's immunization, mammography, cholesterol screening and colorectal cancer screening combined. (AHRQ; 2005 Quality Report)
    - % of pregnant women receiving adequate prenatal care, as defined by Kotelchuck's Adequacy of Prenatal Care Utilization Index, APNCU
    - % of children, 19 to 35 months, receiving 4 or more doses of DTP, 3 or more doses of poliovirus vaccine, 1 or more doses of any measles containing vaccine, 3 or more doses of HiB, and 4 or more doses of HepB vaccine
    - Women over 40 having a mammogram within the past 2 years
    - % of adults having had blood cholesterol checked within the last 5 years
    - % of adults over 50 ever receiving flexible sigmoidoscopy or colonoscopy

8. Percent of adults observed using shoulder belts. (NHTSA; National Occupant Protection Use Survey, 2004 data)

Avoiding Addictions

9. Percent of the population over age 18 that smokes on a regular basis. (UHF; America's Health Rankings 2005 Edition, 2004 data, BRFSS, CDCP)

10. Percent of adults who report having five or more drinks on one occasion during the past 30 days. (BRFSS, CDCP, 2004 data)

Engaging in Healthy Habits

11. Percent of adults who report 30+ minutes of moderate physical activity five or more days per week OR vigorous physical activity 20+ minutes three or more days per week (BRFSS, CDCP, 2003 data)

12. Percent of adults who report consuming five or more servings of fruits and vegetables per day. (BRFSS, CDCP, 2003 data)

Outcomes

13. Number of years of life lost per 100,000 population. (UHF; America's Health Rankings 2005 Edition, 2002 data, CDCP)

14. Combined mortality rates includes: infant mortality, accidental deaths, cancer deaths and cardiovascular deaths per 100,000 population. (UHF; America's Health Rankings 2005 Edition, 2002 data, CDCP)

15. Number of days in the previous 30 days when an adult's activities are limited due to physical or mental difficulties, self-reported (UHF; America's Health Rankings 2005 Edition, 2004 data, BRFSS, CDCP)

16. Percentage of adults with 14 or more of the previous 30 days that were mentally unhealthy days, self reported. (BRFSS, CDCP, 2004 data)

17. Number of AIDS, tuberculosis and hepatitis cases reported to the Centers for Disease Control and Prevention per 100,000 population. (UHF; America's Health Rankings 2005 Edition, 2002-2004 data, CDCP)

Attachment 2c: Goal Measures,
Summary Description of Components from the Commonwealth Fund's
National Scorecard on U.S. Health System Performance

National Scorecard on U.S. Health System Performance TABLE 1

Indicator	U.S. National Rate	Benchmark	Benchmark Rate	Score: Ratio of U.S. to Benchmark
1. Mortality amenable to health care, Deaths per 100,000 population	115	Top 3 of 19 countries	80	70
2. Infant mortality, Deaths per 1,000 live births	7.0	Top 3 of 23 countries	2.7	39
3. Healthy life expectancy at age 60, Years	16.6	Top 3 of 23 countries	19.1	87
4. Adults under 65 limited in any activities because of physical, mental, or emotional problems, %	14.9	Top 10% states	11.5	77
5. Children missed 11 or more school days due to illness or injury, %	5.2	Top 10% states	3.8	73
6. Adults received recommended screening and preventive care, %	49	Target	80	61
7. Children received recommended immunizations and preventive care*	Various	Various	Various	85
8. Needed mental health care and received treatment*	Various	Various	Various	66
9. Chronic disease under control*	Various	Various	Various	61
10. Hospitalized patients received recommended care for AMI, CHF, and pneumonia (composite), %	84	Top hospitals	100	84
11. Adults under 65 with accessible primary care provider, %	66	65+ yrs, High income	84	79
12. Children with a medical home, %	46	Top 10% states	60	77
13. Care coordination at hospital discharge*	Various	Various	Various	70
14. Nursing homes: hospital admissions and readmissions among residents*	Various	Various	Various	64
15. Home health: hospital admissions, %	28	Top 25% agencies	17	62
16. Patients reported medical, medication, or lab test error, %	34	Best of 6 countries	22	65
17. Unsafe drug use*	Various	Various	Various	60
18. Nursing home residents with pressure sores*	Various	Various	Various	67
19. Hospital-standardized mortality ratios, Actual to expected deaths	101	Top 10% hospitals	85	84

Indicator	U.S. National Rate	Benchmark	Benchmark Rate	*Score:* Ratio of U.S. to Benchmark
20. Ability to see doctor on same/next day when sick or needed medical attention, %	47	Best of 6 countries	81	58
21. Very/somewhat easy to get care after hours without going to the emergency room, %	38	Best of 6 countries	72	53
22. Doctor–patient communication: always listened, explained, showed respect, spent enough time, %	54	90th percentile Medicare plans	74	74
23. Adults with chronic conditions given self-management plan, %	58	Best of 6 countries	65	89
24. Patient-centered hospital care*	Various	Various	Various	87
25. Adults under 65 insured all year, not underinsured, %	65	Target	100	65
26. Adults with no access problem due to costs, %	60	Best of 5 countries	91	66
27. Families spending <10% of income or <5% of income, if low-income, on out-of-pocket medical costs and premiums, %	83	Target	100	83
28. Population under 65 living in states where premiums for employer-sponsored health coverage are <15% of under-65 median household income, %	58	Target	100	58
29. Adults under 65 with no medical bill problems or medical debt, %	66	Target	100	66
30. Potential overuse or waste*	Various	Various	Various	48
31. Went to emergency room for condition that could have been treated by regular doctor, %	26	Best of 6 countries	6	23
32. Hospital admissions for ambulatory care sensitive conditions*	Various	Various	Various	57
33. Medicare hospital 30-day readmission rates, %	18	10th percentile regions	14	75
34. Medicare annual costs of care and mortality for AMI, hip fracture, and colon cancer (Annual Medicare outlays; deaths per 100 beneficiaries)	$26,829; 30	10th percentile regions	$23,314; 27	88
35. Medicare annual costs of care for chronic diseases: diabetes, CHF, COPD*	Various	Various	Various	68
36. Percent of national health expenditures spent on health administration and insurance, %	7.3	Top 3 of 11 countries	2.0	28
37. Physicians using electronic medical records, %	17	Top 3 of 19 countries	80	21
OVERALL SCORE				**66**

* Various denotes indicators that comprise two or more related measures. Scores average the individual ratios for each component. For detailed information on the national and benchmark rates for individual components, please refer to C. Schoen et al., "U.S. Health System Performance: A National Scorecard," *Health Affairs* Web Exclusive, Sept. 20, 2006. See also the box on page 31.
AMI = acute myocardial infarction; CHF = congestive heart failure; COPD = chronic obstructive pulmonary disease

Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006

Attachment 3: Goal Measures,
Criteria Used by the Staff Work Group
in Developing Measure Recommendations for the BRC Goals[1]

The measure …

1. Must be from a reliable source.
   Purpose: Steers *toward* data already used and accepted by the public, and by others who are measuring progress toward similar goals.

2. Must be available and consistent over time.
   Purpose: Steers *away from* emerging data that have not stood the test of time and from administrative data that are vulnerable to changes in collection and processing policies.

3. Should be available and consistent for all states.
   Purpose: Steers *toward* data that allow inter-state comparisons where appropriate.

4. Should reflect a salient outcome or measure of well-being.
   Purpose: Steers *toward* outcome measures that reflect the ultimate aim of improved well-being.

5. Must be easily understandable to the public.
   Purpose: Steers *away from* complex measures that cannot be effectively communicated to an educated lay public.

6. Must have a relatively unambiguous interpretation.
   Purpose: Steers *toward* measures where there is widespread agreement that a change, up or down, is a bad or good thing.

7. Should be a high probability that the measure will continue to be produced in the near future.
   Purpose: Steers *away from* "one-time" data, no matter how good they may be.

8. Should be broadly focused on Washington State as a whole, with relevance to one or more of state government's roles.
   Purpose: Steers *away from* measures solely related to state agency activities.

9. Must adequately capture impacts resulting from the BRC 5-year plan.
   Purpose: Steers *toward* measures that will exist beyond the 5-year planning horizon of the BRC and can inform future planning.

The criteria have equivalent weight and are not in any priority order. They are intended as guideposts, not hard and fast rules. *For a measure to be selected, all criteria do not have to be met.*

[1] The first seven criteria are adopted from *2006 Kids Count Data Book*, The Annie E. Casey Foundation.