

# California Wellness Plan

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## DRAFT Synopsis for Review

7/8/2013

Guidance for Review

Thank you for taking the time to review this Draft Synopsis of the California Wellness Plan. We appreciate those who provided input previously on Plan Goals and Strategies. This draft allows for the continuance of input from stakeholders into Draft Plan objectives. These objectives align with the Let's Get Health California Task Force priorities and California Department of Public Health (CDPH) currently funded chronic disease prevention efforts.

As you review this Synopsis, please consider the following questions.

- Do these Plan objectives align with your work? If so, which ones? Would you like to be identified in the Plan as a lead or key partner?
- Does your organization have key objectives that are not included in this Plan that you would like to include to highlight your work and leadership under current Plan priorities? If so, please be sure to provide specific, measureable, achievable, realistic and time-bound objectives that follow our format along with the data source for measurement in the online survey.

Save the date: Once finalized the California Wellness Plan will serve as the basis for a January 2014 Statewide Conference in Sacramento; we look forward to your participation to ensure that our implementation of the Plan is conducted with full involvement of all stakeholders.

**We will provide access to an online survey for feedback in mid-July.**

## Introduction

Approximately 14 million Californians are living with chronic diseases and more than half of this group has two or more chronic diseases. Most chronic diseases cannot be addressed effectively through education or preventive health care alone. Without addressing the social and economic conditions, as well as the physical environment, community attitudes and/or social norms that influence community health, behavior change is difficult to sustain, even when the public is aware of the health risks.

Cardiovascular disease, cancer, diabetes, asthma, chronic obstructive pulmonary disease, mental health conditions, substance use disorders, oral health conditions, arthritis, Alzheimer's disease, and injury are the leading causes of death, disability, and diminished quality of life in California. Up to 80 percent of heart disease, stroke, and type 2 diabetes and over 30 percent of cancers could be prevented by eliminating risk factors such as tobacco use, obesity, unhealthy diet, physical inactivity, and harmful alcohol use. Many of these risk factors can be attributed to community environments and neighborhood design. Where Californians live, work, learn, and play has a significant impact on their health and impacts life expectancy.

### Snapshot of California Priorities

- Cardiovascular disease is the leading cause of death in California.
- Diabetes is the leading cause of blindness, amputation and kidney failure and is a major contributor to heart attacks and strokes.
- The number of persons with diabetes has increased 32 percent over the past decade in California.
- 3.9 million people or one in seven adults in California have diabetes and almost 11.4 million California adults have pre-diabetes.
- Without intervention, about one in four people with pre-diabetes will develop type 2 diabetes within three to five years.
- Diabetes alone costs California over \$24 billion each year. (CDPH, The Burden of Chronic Disease and Injury, California 2013).

### Health Equity

Despite significant advances in reducing overall incidence and mortality, chronic disease is the major contributor to health inequities in our communities. Achieving health equity is an imperative for California. Health equity is defined as “an environment in which all community members have equal access to the resources needed to achieve their full health potential.” (New York State Chronic Disease and Injury Prevention Plan) Attaining it requires explicit attention to address the avoidable and unjust social, economic, policy, environmental, or infrastructure conditions that prevent communities from equally reaching health. These “social determinants of health” cannot be controlled by individuals alone, and require systematic efforts at the community and policy level to improve health for all.

In 2002, (latest figure available) chronic diseases cost California \$70 billion, or eighty percent of California's health care expenditures. According to State Controller John Chiang, "The economic costs to California of adults who are obese, overweight and physically inactive is equivalent to more than a third of the state's total budget" ("California's Cost of Obesity Climbs to \$41 Billion." [http://www.publichealthadvocacy.org/\\_PDFs/Costofobesity\\_PressRelease\\_070909.pdf](http://www.publichealthadvocacy.org/_PDFs/Costofobesity_PressRelease_070909.pdf)). Without effective prevention and management strategies, these costs will continue to increase.

### The Burden of Chronic Disease

*The Burden of Chronic Disease and Injury: California, 2013* report illustrates chronic disease-related health disparities in California.

- Native Americans and Pacific Islanders have heart disease rates two times higher than heart disease rates of other race/ethnic groups.
- One out of seven Hawaiians/Pacific Islanders, one out of eight Native Americans and Hispanic/Latinos, and -one out of nine African Americans have diabetes, compared to one out of eighteen Whites.
- African Americans have the lowest life expectancy (73 years) among race/ethnic groups.
- Californians living in the Riverside-San Bernardino metropolitan area have the lowest life expectancy (78 years) of the five most populous metropolitan areas.
- Californians - who live in neighborhoods where educational achievement is low, unemployment is high, and where poverty is widespread - die at a younger age and are often race/ethnic minorities.
- Adolescents and teens who live in neighborhoods with widespread poverty are more likely to be victims of violence, are at increased risk for tobacco, alcohol and substance use, and are at greater risk for obesity.
- Neighborhoods where poverty is widespread are less likely to have access to recreational facilities and full -service grocery stores and are more likely to have high concentrations of liquor/convenience stores and fast food restaurants.

The burden of chronic disease and injury is no longer sustainable for California. We need to collectively decrease death and disability from chronic disease, eliminate health disparities and lower health care costs through innovative, evidence-based and practice-based interventions. We must enhance and leverage statewide infrastructure to improve health (primary care and public health), strengthen deeper understanding of public health, achieve targeted improvements in health outcomes, expand and strengthen collaborations and partnerships, and achieve health equity. This may include working together to strengthen statewide public health workforce, enhance state and local public health services, and develop communication strategies for unified messaging. Alignment of priority activities to maximize impact from funding from multiple sources (federal, state, foundation, NGO, CBO) is required.

### **Background**

In September 2011, the California Department of Public Health (CDPH) was awarded a grant from the Centers for Disease Control and Prevention (CDC) to establish an infrastructure to support and facilitate coordination of chronic disease prevention and health promotion efforts and collaboration within and across programs and sectors. Within California, the Health and Human Services Agency,

and other statewide partner organizations are engaged in ongoing efforts to address specific risk factors and chronic diseases and/or their precursors. This Plan aims to increase the impact of these collaborative efforts by identifying common goals, strategies, and objectives to achieve synergy.

In May 2012, Governor Jerry Brown established the Let's Get Healthy California Task Force through Executive Order B-19-12. The Let's Get Healthy California Task Force was formed, in part, to identify ways to alleviate the impact of preventable chronic diseases in California by establishing a collaborative of 23 California health and health care leaders and 19 Expert Advisors. The Task Force was charged to develop a ten-year plan for "improving the health of Californians, controlling health care costs, promoting responsibility for individual health, and advancing health equity."

### **Overarching Plan Goal**

The overarching Plan goal is wellbeing and equity in health status for all.

### **CDPH Contribution and Leadership Role**

The publication provides a roadmap to prevent and control chronic disease and achieve health equity. CDPH's aim is to provide leadership for governmental and non-governmental statewide partners to support the launch and implementation of the Plan. The objectives of the Plan are to reduce the number of Californians living with chronic disease, prevent new cases of chronic disease, and eliminate chronic disease disparities.

A variety of information sources informed the development of the draft California Wellness Plan, including the National Prevention Strategy; the National Strategy for Quality Improvement in Health Care; the Health in All Policies Taskforce Recommendations; the Prevention Institute Spectrum of Prevention; the Robert Wood Johnson Foundation, A New Way to Talk About Social Determinants of Health; the Let's Get Healthy California Task Force Recommendations; and state plans of state-administered programs addressing specific chronic diseases and/or risk factors.

In addition, the draft document represents feedback received from both CDPH program staff and external stakeholders, and is grouped by goals, priorities, strategies, and short-term, intermediate, and long-term objectives.

### **Development of the State Plan**

The development of the Plan involved a variety of stakeholders and partners across disciplines whose vision is to reduce chronic disease in California. A variety of information sources were used to inform its development, including state and national efforts such as the *Let's Get Healthy California Task Force* and *the National Prevention Strategy*. While Plan Goals, Priorities and Objectives are numbered, this is currently for organizational purposes only.

### **Intended Audience**

The Plan is intended for use by state and local stakeholders, including community groups and organizations, committed to working collaboratively at the local level to prevent chronic disease and promote health and wellness.

**SUMMARY OF PLAN GOALS, STRATEGIES AND PRIORITIES**

**OVERARCHING GOAL: WELLBEING AND EQUITY IN HEALTH STATUS FOR ALL**

<b>GOAL 1: EMPOWER COMMUNITIES TO CREATE HEALTHY, SUSTAINABLE, PHYSICAL AND SOCIAL ENVIRONMENTS</b>	
<i>Healthy Environments: Healthy Choices</i>	
<b>Strategies</b>	
Strategic focus on communities at greatest risk	
Facilitate social connectedness and community engagement across the lifespan	
Support evidence-based environmental change strategies to create and maintain healthy communities	
Integrate health criteria into decision making across multiple sectors	
Increase access to essentials for healthy living	
Increase access to healthy foods and beverages across multiple sectors	
Increase access to physical activity by promoting the adoption and implementation of physical education and/or physical activity across multiple sectors	
Provide individuals, communities, professionals, and institutions with tools and information to make healthy choices	
<b>Let's Get Healthy California Task Force Priorities</b>	
1.1	Increase health status
1.2	Decrease adult and adolescent tobacco use
1.3	Increase adult and child fitness and healthy diets
1.4	Increase healthy food outlets
1.5	Increase walking and biking
1.6	Increase safe communities
1.7	Decrease childhood trauma
1.8	Increase early learning
<b>GOAL 2: OPTIMIZE HEALTH SYSTEMS AND CLINICAL-COMMUNITY COLLABORATION</b>	
<i>Quality Care at Lower Cost</i>	
<b>Strategies</b>	
Equitable and affordable access to high quality health care	
Increase access to quality services and early identification of medical, behavioral, mental and dental needs	
Enhance coordination and integration of medical, behavioral, mental and dental health strategies across the continuum of care	
Reduce barriers and support implementation of community-based preventive services and enhance clinical linkages	
Provide individuals and families with tools and information to make healthy choices	
Promote awareness of high blood pressure and pre-diabetes	
<b>Let's Get Healthy California Task Force Priorities</b>	
2.1	Increase controlled high blood pressure and high cholesterol
2.2	Decrease childhood asthma
2.3	Decrease adult and childhood obesity and diabetes
2.4	Increase mental health and wellbeing
2.5	Decrease infant deaths
2.6	Increase advance care planning
2.7	Increase palliative care and hospice care
2.8	Decrease hospitalization during the end of life

2.9	Increase access to primary and specialty care
2.10	Increase vaccinations
2.11	Increase culturally and linguistically appropriate services
2.12	Increase coordinated outpatient care Increase people receiving care in an integrated system
2.13	Increase hospital safety and quality of care
2.14	Decrease people without insurance
<b>GOAL 3: MAKE HEALTH DATA AND INFORMATION ACCESSIBLE AND USEABLE</b> <i>Shared Knowledge is Power</i>	
<b>Strategies</b>	
Better identify and address inequities	
Increase access to and expand use of health information technology and integrated data systems	
Expand electronic access and usability of data and information	
Promote standardization and cross-system electronic information exchange of data via electronic reporting	
Increase implementation of quality improvement processes across the continuum of care and collaboratively between health providers and stakeholders.	
Consistent health messaging across the patient's health care experience.	
<b>Let's Get Healthy California Task Force Priorities</b>	
3.1	Increase transparent information on cost and quality of care
<b>GOAL 4: INVEST IN WELLNESS</b> <i>Sustainability and Capacity</i>	
<b>Strategies</b>	
Create social norm change that supports healthy environments and lifestyles for all	
Develop a long-term chronic disease prevention and health promotion sustainability plan	
Assure adequate funding for statewide chronic disease prevention infrastructure	
Maintain a skilled, cross-trained and diverse prevention workforce	
Mobilize partners to develop resources to sustain public health efforts	
Use payment and reimbursement mechanisms to encourage delivery of clinical and community preventive services	
<b>Let's Get Healthy California Task Force Priorities</b>	
4.1	Increase affordable care and coverage
4.2	Decrease rate of growth in healthcare spending
4.3	Increase payment policies that reward value

DETAILED PLAN OBJECTIVES BY GOAL AND PRIORITIES

**GOAL 1: EMPOWER COMMUNITIES TO CREATE HEALTHY, SUSTAINABLE, PHYSICAL AND SOCIAL ENVIRONMENTS**

**GOAL 1 OBJECTIVES**

**Sectors (color-coded):**

Early Childhood Education

Schools/Local Education Agency

Health Facilities

Worksites

Community

<b>1.1</b>	<b>INCREASE HEALTH STATUS</b>
<b>Short-term Objectives</b>	
1.1.1S	By 2020, adopt health equity as a key consideration in 5 state guidance documents.
<b>Intermediate Objectives</b>	
1.1.1I	By 2020, increase the percentage of people who agree with the statement "people in my neighborhood are willing to help each other" from x to y.
1.1.2I	By 2020, increase the percentage of people who agree with the statement "people in this neighborhood can be trusted" from x to y.
1.1.3I	By 2020, increase the percentage of people who agree with the statement "you can count on adults in this neighborhood to watch out that children are safe and don't get in trouble" from x to y.
1.1.4I	By 2020, increase the percentage of people who have done volunteer work or community service from 58.8% to y.
1.1.5I	By 2020, increase the percentage of people who have gotten together informally with others to deal with community problems from x to y.
1.1.6I	By 2020, increase the percentage of people who have served as a volunteer on any local board, council, or organization that deals with community problems from x to y.
1.1.7I	By 2020, increase percentage of adults age >=18 years who are registered voters from x to y.
1.1.8I	By 2020, decrease the percentage of households in overcrowded ( $\geq 1.01$ persons/room) and severely overcrowded ( $\geq 1.50$ persons per room) conditions from x to y.
1.1.9I	By 2020, increase the percentage of adults who report they receive the social and emotional support they need from x to y.
1.1.10I	By 2020, increase the score of Academic Performance Index (API) from 753 for grades 9-11 to 800.
1.1.11I	By 2020, increase the percentage of the population who have high school or greater educational attainment from x to y. (Stratified by race/ethnicity)
1.1.12I	By 2020, decrease the annual unemployment rate from x to y.
1.1.13I	By 2020, increase the housing to jobs ratio from x to y in communities with a ratio less than 1 (percent of the adult working population who could find a job that matches their general occupational qualifications within a specified travel radius of their residence). (Developmental)
1.1.14I	By 2020, increase Neighborhood Completeness Index ( $< \frac{1}{2}$ mile radius for 8 out of 11 common public services and 9 of 12 common retail services) from x to y. (Developmental)

1.1.15I	By 2020, decrease the degree of residential segregation (ratio of percent of non-white race/ethnic groups in a specific geographic area to city or county average) from x to y.
<b>Long-term Objectives</b>	
1.1.1L	By 2022, increase the percentage of people who report their overall health status to be good, very good, or excellent from 85% to 90%.
1.1.2L	By 2023, decrease percentage of adults (from racial/ethnic minority groups) in fair or poor health from 16.5% to y% for African Americans, 21.4% to y% for Hispanics and 24.6% to y% for American Indian/Alaska Natives.
1.1.3L	By 2030, increase the percentage of adults who live to age 65 from 84% to 91% (stratified by race/ethnicity).
1.1.4L	By 2030, increase the percentage of adults who live to age 85 from 37% to 58% (stratified by race/ethnicity).
1.1.5L	By 2030, increase the percentage of 24-64 year old adults in good or better health from x to y (stratified by race/ethnicity).
1.1.6L	By 2030, increase the percentage of 65-84 year old adults in good or better health from x to y (stratified by race/ethnicity).
1.1.7L	By 2020, decrease the percentage of household income spent on rent or mortgage from x to y (using benchmarks of >30% = burdened and >50% = severely burdened).
1.1.8L	By 2020, decrease the percentage of household income spent on travel from x to y. (Developmental)
1.1.9L	By 2020, decrease the overall and child (0 to 18 years of age) poverty rate from x to y.
1.1.10L	By 2020, decrease the percentage of the population living in concentrated poverty (census tracts in which >40% of households are living below poverty line) from x to y.
1.1.11L	By 2020, increase neighborhood stability [5-year change in number of households by income and race/ethnicity (neighborhood change or gentrification)] from x to y.
1.1.12L	By 2020, decrease Income Inequality: Gini coefficient (describing the amount of total annual community income generated by the number of households) from x to y.
1.1.13L	By 2020, increase the percentage of resilient high school students from x to y.
1.1.14L	By 2020, increase place-based equity score (composite of multiple core indicators calculated for census tracts) from x to y.
1.1.153L	By 2020, increase race/ethnicity equity score (composite of multiple core indicators, including median income) from x to y.
1.1.16L	By 2020, increase the resilience index (composed of places with climate action and hazard mitigation plans and other Healthy Community Indicators such as unemployment, lacking health insurance, educational attainment, income inequality, and registered voters) from x to y.
<b>1.2</b>	<b>DECREASE ADULT AND ADOLESCENT TOBACCO USE</b>
<b>Short-term Objectives</b>	
1.2.1S	By 2014, increase enforcement of existing tobacco laws from x to y.
1.2.2S	By 2014, expand the availability and utilization of cessation aids and services from x to y.
1.2.3S	By 2014, increase adoption and enforcement of laws that regulate the sale, distribution, and marketing of tobacco products to minors from x to y.
1.2.4S	By 2014, eliminate untaxed or low-taxed sources of tobacco from x to y.
1.2.5S	By 2014, increase the number of tobacco-free schools from x to y.
<b>Intermediate Objectives</b>	
1.2.1I	By 2016, decrease the percent of indoor workers who report exposure to secondhand smoke in the workplace from 7.5% to 5%.
1.2.2I	By 2016, increase workers' secondhand smoke exposure protections provided through Labor Code 6404.5 by eliminating the following exemptions: owner-operated bars, employee break

	rooms, retail tobacco shops, workplaces with five or fewer employees, and long term care facilities.
1.2.3I	By 2017, increase successful quit attempts from x to y.
1.2.4I	By 2016, increase the proportion of the population protected by local tobacco retail license policies from 10% to 15%.
1.2.5I	By 2017, increase public support for “cigarette butts are toxic to the environment” from 83.0% to 90%.
1.2.6I	By x, x local jurisdictions in California will adopt a new, or strengthen an existing tobacco retail licensing (TRL) policy that includes sufficient fee revenue to enforce the policy.
1.2.7I	By x, increase the tobacco excise tax by at least \$1.00 per pack of cigarettes with an equivalent tax on other tobacco products and specifically designate at least \$0.20 of the increase for tobacco control, indexed incrementally to inflation.
1.2.8I	By 2016, increase the “average” social norm index score about secondhand smoke and tobacco industry influences by 5 percent in low socioeconomic status (SES) populations in California from x to y.
<b>Long-term Objectives</b>	
1.2.1L	By 2022, decrease the percentage of adolescents who smoked cigarettes in the past 30 days from 14% to 10%.
1.2.2L	By 2022, decrease the percentage of adults who are current smokers from 12% to 9%.
1.2.3L	By 2020, decrease the percentage of youth aged 3 to 11 years exposed to secondhand smoke from x to y.
1.2.4L	By 2014, decrease the proportion of Californians reporting exposure to secondhand smoke from 44.8% to 40%.
1.2.5L	By 2020, decrease the incidence of Chronic Obstructive Pulmonary Disease from x to y.
1.2.6L	By 2020, decrease the incidence of lung cancer from x to y.
<b>1.3</b>	<b>INCREASE ADULT AND CHILD FITNESS AND HEALTHY DIETS</b>
<b>Short-term Objectives</b>	
1.3.1S	By 2018, increase the number of early childhood education organizations that adopt strategies to increase physical activity from x to y.
1.3.2S	By 2018, increase the number of children that attend early childhood education organizations that adopt strategies to increase physical activity from x to y.
1.3.3S	By 2018, increase the number of early childhood education organizations that develop and implement standards to increase physical activity from x to y.
1.3.4S	By 2018, increase the number of children who attend early childhood education organizations that adopt and implement guidelines to increase physical activity from x to y.
1.3.5S	By 2018, increase the number of local education agencies that received professional development and technical assistance on strategies to create a healthy school nutrition environment from x to y.
1.3.6S	By 2018, increase the number of local education agencies where staff received professional development and technical assistance on strategies to create a healthy school nutrition environment from x to y.
1.3.7S	By 2018, increase the percent of schools that provide information to students and families on the nutrition, caloric and sodium content of foods available from 29.8% to y.
1.3.8S	By 2018, increase the percent of schools that allow students to have access to drinking water from 85.2% to y.
1.3.9S	By 2018, increase percent of local education agencies that have adopted and implemented policies that establish standards (including sodium) for all competitive foods available during the school day from x to y.

1.3.10S	By 2018, increase the percent of local education agencies that have adopted and implemented policies that prohibit all forms of advertising and promotion (e.g. contests and coupons) of less nutritious foods and beverages on school property from 71.5% to y.
1.3.11S	By 2018, increase percent of schools that prohibit all forms of advertising and promotion for candy, fast food restaurants, or soft drinks from x to y.
1.3.12S	By 2018, increase the percent of schools that place fruits and vegetables near the cafeteria cashier, where they are easy to access from x to y.
1.3.13S	By 2018, increase the percent of schools that offer fruits or non-fried vegetables when foods and beverages are offered at school celebrations from 14.2% to y.
1.3.14S	By 2018, increase the number of local education agencies where staff received professional development & technical assistance on the development, implementation, or evaluation of recess and multi-component physical education policies from x to y.
1.3.15S	By 2018, increase the number of students in local education agencies where staff received professional development & technical assistance on the development, implementation, or evaluation of recess and multi-component physical education policies from x to y.
1.3.16S	By 2018, increase the number of state-level multi-component physical education policies for schools developed and adopted by the state from x to y.
1.3.17S	By 2018, increase the number of local education agencies receiving professional development and technical assistance to establish, implement, and evaluate Comprehensive School Physical Activity Programs from x to y.
1.3.18S	By 2018, increase the number of students in local education agencies where staff received professional development and technical assistance on establishing, implementing, and evaluating Comprehensive School Physical Activity Programs from x to y.
1.3.19S	By 2018, increase the percent of schools that provide or require daily physical education from x to y.
1.3.20S	By 2018, increase the percent of schools within local education agencies that have established, implemented, and/or evaluated Comprehensive School Physical Activity Programs.
1.3.21S	By 2018, increase the number of health facilities designated as Baby-Friendly from x to y.
1.3.22S	By 2018, increase the number of employers that provide space and time for nursing mothers to express breast milk from x to y.
1.3.23S	By 2018, increase the number of breastfeeding friendly worksites by x% in California from x to y.
1.3.24S	By 2018, increase the number of adults in worksites with guidelines/nutrition standards from x to y.
1.3.25S	By 2018, increase worksites that adopt strategies to increase physical activity from x to y.
1.3.26S	By 2018, increase the number of employees in worksites that adopt strategies to increase physical activity from x to y.
1.3.27S	By 2018, increase the number of corner stores that sell healthier food options in underserved areas from x to y.
1.3.28S	By 2018, increase the number of community sites that provide professional and peer support for breastfeeding from x to y.
<b>Intermediate Objectives</b>	
1.3.1I	By 2018, increase the percent of children in early childhood education organizations who engage in levels of age-appropriate physical activity as recommended by Caring For Our Children from x to y.
1.3.2I	By 2018, Increase the percentage by 5% from x to y of K-12 students who ate vegetables 3 or more times per day.
1.3.3I	By 2018, decrease the percent of schools that do not sell less healthy foods and beverages (soda pop or fruit drinks, sports drinks, baked goods, salty snacks, candy) from x to y.
1.3.4I	By 2018, increase percent of schools that price nutritious foods and beverages at a lower cost

	while increasing the price of less nutritious foods and beverages from 29.8% to y.
1.3.5I	By 2018, increase the percent of schools that allow students to purchase fruits and vegetables from vending machines or at the school store, canteen, snack bar, or as a la carte items from 14.2% to y.
1.3.6I	By 2018, increase the percent of K-12 students participating in 60 minutes of daily physical activity from 19.75% to y.
1.3.7I	By 2018, increase the percent of K-12 students who attend physical education classes on one or more days in an average week when they were in school from x to y.
1.3.8I	By 2018, increase the percentage by x% from x to y of adults who increase consumption of nutritious foods and beverages
1.3.9I	By 2022, decrease the percentage of adolescents who drank 2 or more glasses of soda or other sugary drink yesterday from 27% to 17%.
1.3.10I	By 2022, increase the percentage of adolescents who have consumed fruits and vegetables five or more times per day from 20% to 32%.
1.3.11I	By 2022, increase the percentage of adults who have consumed fruits and vegetables five or more times per day from 28% to 34%.
1.3.12I	By 2018, increase the proportion of infants breastfed at 6 months from x to y.
<b>Long-term Objectives</b>	
1.3.1L	By 2018, reduce average sodium intake from 3.5 g/day to 2.8 g/day.
1.3.2L	By 2018, reduce average trans-fat consumption from 1% to .5% of calories per day.
1.3.3L	By 2022, increase the percentage of "physically fit" children, who score 6 of 6 on the required Fitnessgram test from: 25% to 36% for 5th graders, 32% to 46% for 7th graders, and 37% to 52% for 9th graders.
1.3.4L	By 2022, increase the percentage of adolescents who meet physical activity guidelines for aerobic physical activity from 15% to 24%.
1.3.5L	By 2022, increase the percentage of adults who meet physical activity guidelines for aerobic physical activity from 58% to 66%.
<b>1.4</b>	<b>INCREASE HEALTHY FOOD OUTLETS</b>
<b>Short-term Objectives</b>	
1.4.1S	By 2015, increase the percentage of farmers' markets that accept electronic benefits transfers (EBTs) for payment by 50 percent, from the current baseline of 6.6% to 10%.
<b>Intermediate Objectives</b>	
1.4.1I	By x, increase the proportion of food service entities (purchasers, suppliers, and/or vendors) that purchase, secure, or sell nutritious foods and beverages including low-sodium foods from x to y.
1.4.2I	By x, increase the number of food service contracts that offer nutritious foods and beverages including lower sodium foods from x to y.
1.4.3I	By x, increase the adoption of procurement policies and practices that limit non nutritious foods and beverages including high sodium in government-purchased food in worksites and schools from x to y.
1.4.4I	By 2022, increase the number of healthy food outlets as measured by Retail Food Environment Index from 11% to 21%.
1.4.5I	By 2020, decrease the average weekly cost of a market basket for food items relative to income from x to y.
1.4.6I	By 2020, increase the percentage of households within ½ mile of a full-service grocery store, fresh produce market, or store with fresh produce from x to y. (Developmental)
<b>Long-term Objectives</b>	

	No objectives have been identified at this time.
<b>1.5</b>	<b>INCREASE WALKING AND BIKING</b>
<b>Short-term Objectives</b>	
	No objectives have been identified at this time.
<b>Intermediate Objectives</b>	
1.5.1I	By 2018, increase the number of local schools/districts where staff received professional development and technical assistance on the development, implementation or evaluation of Walk, Bike and Roll activities, with Roll activities geared toward children with disabilities x to y.
1.5.2I	By 2018, increase the number of youth who have access to places for physical activity, with a focus on walking, from x to y.
1.5.3I	By 2018, increase the number of local policies that include language that supports environmental changes to enhance places for physical activity, emphasizing walking from x to y.
1.5.4I	By 2022, increase the annual number of walk trips per capita from 184 to 233.
1.5.5I	By 2022, increase the percentage of children who walk/bike/skate to school from 43% to 51%.
1.5.6I	By 2020, increase the percentage of commuters who use active transportation (walk, bicycle, and/or public transit) to travel to work from x to y.
1.5.7I	By 2020, increase the percentage of the population aged 16 years or older by time walking and biking to work ( ≥10 minutes/day) from x to y.
1.5.8I	By 2020, increase the percentage of residents who do not drive a personal car to work from x to y.
1.5.9I	By 2020, increase the percentage of the population located <1/2 mile of a regional bus/rail/ferry and <1/4 mile local bus/light rail from x to y.
1.5.10I	By 2020, increase the percentage of residents within 1/2 mile of park, beach, open space, or coastline from x to y. (Developmental)
1.5.11I	By 2020, increase the acres of tree canopy coverage in urban areas by from x to y. (Developmental)
1.5.12I	By 2020, increase acres of parkland per 1,000 residents from x to y. (Developmental)
<b>Long-term Objectives</b>	
	No objectives have been identified at this time.
<b>1.6</b>	<b>INCREASE SAFE COMMUNITIES</b>
<b>Short-term Objectives</b>	
1.6.1S	By x, increase awareness (training and technical assistance/professional development) of health risks from locating “sensitive” land uses near high volume roadways and associated traffic pollution from x to y.
<b>Intermediate Objectives</b>	
1.6.1I	By x, minimize exposure to contaminated outdoor air and promote safe and healthy outdoor school environments from x to y.
1.6.2I	By x, reduce worker and public exposure to asthma triggers related to agricultural practices, forestry practices, and other outdoor workplaces from x to y.
1.6.3I	By 2014, reduce the exposure of California workers to inhaled vapors, gases, dusts, and fumes associated with the development of COPD from x to y.
1.6.4I	By x, reduce air pollution from sources such as "goods movement" industries, stationary industries, and transportation from x to y.

1.6.5I	By x, increase port and rail yard pollution reduction measures from x to y.
1.6.6I	By 2020, decrease the percentage of high school seniors who reported binge drinking during the past two weeks from x to y.
1.6.7I	By 2020, decrease the percentage of adults aged 18 years and older who reported that they engaged in binge drinking during the past month from x to y.
1.6.8I	By 2020, decrease the density of on-site and off-site alcohol outlets from x to y.
1.6.9I	By 2020, decrease the percentage of youth aged 12 to 17 years who have used illicit drugs in the past 30 days from x to y.
1.6.10I	By 2020, decrease the number of days per year geographic area exceeds ambient air standards for criteria pollutants (ozone and PM2.5) from x to y.
1.6.11I	By 2020, decrease annual per capita Greenhouse Gas emissions from x to y.
1.6.12I	By 2020, decrease the percentage of households/population near busy roadways from x to y.
1.6.13I	By 2020, decrease the amount of toxic pollutants released into the environment from x to y.
1.6.14I	By 2020, decrease the pounds of toxic chemicals generated by reporting facility per capital/geographic area from x to y.
1.6.15I	By 2020, decrease reported pesticide use from x to y.
1.6.16I	By 2020, increase the percentage of the population served by water systems meeting regulations of the Safe Drinking Water Act from 98% to 99%.
1.6.17I	By 2020, increase the percentage of the population served by community water systems with optimally fluoridated water from x to y.
1.6.18I	By 2020, increase the percentage of cities and counties with adopted climate action plans and FEMA-approved local hazard mitigation plans from x to y.
<b>Long-term Objectives</b>	
1.6.1L	By 2020, decrease the rate of fatalities due to alcohol impaired driving from x to y.
1.6.2L	By 2020, increase the percentage of adults who report they feel safe in their neighborhoods all or most of the time from 91% to 96%.
1.6.3L	By 2020, decrease the rate of homicides from x to y.
1.6.4L	By 2020, decrease the rate of fall-related deaths among adults age 65 and older from x to y.
1.6.5L	By 2020, decrease the rate of unintentional injury deaths from x to y.
1.6.6L	By 2020, decrease the rate of fatal and nonfatal occupational injuries from x to y across industries
1.6.7L	By 2020, decrease the rate of all injuries (including fatal injuries) from collisions from x to y (stratified by mode of transport).
1.6.8L	By 2020, decrease the rate of collisions per vehicle mile from x to y (stratified by mode of transport).
1.6.9L	By 2020, decrease pedestrian injury rates from x per 100,000 population to y per 100,000.
1.6.10L	By 2020, decrease the percentage of persons aged 12 or older who reported nonmedical use of any psychotherapeutic drug in the past year from x to y.
1.6.11L	By 2020, decrease the reported crime rate from x to y (stratified by type).
1.6.12L	By 2020, decrease the percentage of adults (18-65 years) who report physical or sexual violence by an intimate partner from x to y.
<b>1.7</b>	<b>DECREASE CHILDHOOD TRAUMA</b>
<b>Short-term Objectives</b>	
	No objectives have been identified at this time.
<b>Intermediate Objectives</b>	
	No objectives have been identified at this time.
<b>Long-term Objectives</b>	

1.7.1L	By 2022, decrease the percentage of respondents indicating at least 1 type of Adverse Childhood Experience from 59% to 45%.
1.7.2L	By 2022, reduce the (substantiated) incidence rate of child maltreatment (including physical, psychological, neglect) per 1,000 children from 9 to 3.
1.7.3L	By 2020, decrease the rate of child maltreatment deaths from x /100,000 to y/100,000.
1.7.4L	By 2020, decrease the percentage of children exposed to violence within the past year, either directly or indirectly (as a witness to a violent act; a threat against their home or school) from x to y.
<b>1.8</b>	<b>INCREASE EARLY LEARNING</b>
<b>Short-term Objectives</b>	
	No objectives have been identified at this time.
<b>Intermediate Objectives</b>	
1.8.1I	By 2020, increase the number of subsidized center based program slots for licensed daycare for children aged 0-5 years from 60/1000 to y/1000 for families meeting the income threshold of 70% of state median income.
1.8.2I	By 2018, increase the percentage of children enrolled in preschool from x to y (stratified by race and ethnicity, income and eligibility for preschool subsidy).
<b>Long-term Objectives</b>	
1.8.1L	By 2022, increase the percentage of third grade students whose reading skills are at or above the proficient level from 46% to 69%.
1.8.2L	By 2020, increase the percentage of children who are kindergarten ready from x to y. (not available statewide) (Developmental)

**GOAL 2: OPTIMIZE HEALTH SYSTEMS AND CLINICAL-COMMUNITY COLLABORATION**  
**GOAL 2 OBJECTIVES**

Sectors (color-coded):

Early Childhood Education

Schools/Local Education Agency

Health Facilities

Worksites

Community

<b>2.1</b>	<b>INCREASE CONTROLLED HIGH BLOOD PRESSURE AND HIGH CHOLESTEROL</b>
<b>Short-term Objectives</b>	
2.1.1S	By 2018, increase the proportion of health care systems with policies or systems to encourage patient self-management of high blood pressure from x to y.
2.1.2S	By 2018, increase the proportion of patients that are in health care systems that have policies or systems to encourage patient self-management of high blood pressure from x to y.
2.1.3S	By x, increase provider awareness and knowledge of national guidelines that promote the highest quality for the management and treatment of high blood pressure from x to y.
2.1.4S	By x, increase provider awareness and knowledge of national guidelines that promote the highest quality for the management and treatment of high cholesterol from x to y.
2.1.5S	By 2018, increase the percentage of adults aware they have high blood pressure from 26% to 36%.
<b>Intermediate Objectives</b>	
2.1.1I	By 2018, increase the percentage of patients with high blood pressure that have a self-management plan from x to y.
2.1.2I	By 2020, increase the number of adults who have been screened for high blood pressure within the previous 2 years from x to 95%.
2.1.3I	By 2020, increase the number of adults who have been screened for high cholesterol in the previous 5 years from x to 80%.
2.1.4I	By x, increase the number of health care payers that cover and reimburse for comprehensive management of high cholesterol, including self-management education, home visits by nurses, community health workers, and or promotoras from x to y.
2.1.5I	By x, increase the number of health care payers that cover and reimburse for comprehensive management of high blood pressure, including self-management education, home visits by nurses, community health workers, and or promotoras from x to y.
<b>Long-term Objectives</b>	
2.1.1L	By 2018, increase the percentage of adults diagnosed with hypertension who have controlled high blood pressure from: 79% to 87% for Medicare patients, 50% to 70% for PPO patients, and 78% to 86% for HMO patients.
2.1.2L	By 2018, increase the percentage of adults diagnosed with high cholesterol who are managing the condition from: 76% to 91% for Medicare patients, 50% to 70% for PPO patients, and 78% to 86% for HMO patients.
2.1.3L	By 2020, decrease rate of hospitalization with acute stroke as principal diagnosis from 5.7/1000 to 5.1/1000.
2.1.4L	By 2020, decrease rate of hospitalization with acute myocardial infarction as primary diagnosis from 15.8/1000 to 14.2/1000.

2.1.5L	By 2020, decrease the rate of hospitalizations for adults 65 and over with heart failure as the principle diagnosis from 10.2/1000 to 9.2/1000.
2.1.6L	By 2020, decrease stroke mortality rate from 36.9/100,000 to 29.5/100,000.
2.1.7L	By 2020, decrease heart disease mortality rate from 120.5/100,000 to 96.4/100,000.
2.1.8L	By 2020, decrease heart failure mortality rate from 12.5/100,000 to 10/100,000.
2.1.9L	By 2020, decrease the prevalence of high blood pressure from x to 16%.
2.1.10L	By 2020, decrease the prevalence of high cholesterol from x to 17%.
<b>2.2</b>	<b>DECREASE CHILDHOOD ASTHMA</b>
<b>Short-term Objectives</b>	
2.2.1S	By x, increase provider awareness and knowledge of national guidelines that promote the highest quality asthma care (e.g. NAEPP guidelines and HEDIS measures) from x to y.
<b>Intermediate Objectives</b>	
2.2.1I	By x, increase the number of healthcare payers that cover and reimburse for comprehensive asthma management, including self-management education, the use of certified asthma educators, and home visits by nurses, community health workers, and/or promotoras from x to y.
<b>Long-term Objectives</b>	
2.2.1L	By 2020, decrease the percentage of children aged 5 to 17 years with asthma who missed school days in the past 12 months from x to y.
2.2.2L	By 2020, reduce the asthma hospitalizations from x to y.
2.2.3L	By 2020, reduce the asthma emergency department visit rate from x to y.
<b>2.3</b>	<b>DECREASE ADULT AND CHILDHOOD OBESITY AND DIABETES</b>
<b>Short-term Objectives</b>	
2.3.1S	By x, increase provider awareness and knowledge of national guidelines that promote the highest quality diabetes care from x to y.
2.3.2S	By 2018, increase prevalence of people with self-reported prediabetes from 8% to 12%.
<b>Intermediate Objectives</b>	
2.3.1I	By 2018, increase proportion of adults with diabetes in adherence to medication regimens from x to y.
2.3.2I	By 2018, decrease the proportion of people with diabetes who have Hemoglobin A1C >9 from x to y.
<b>Long-term Objectives</b>	
2.3.1L	By 2022, decrease the percentage of children and adolescents who are obese from: 12% to 9% for 2-5 year olds, 12% to 8% for 6-11 year olds, and 18% to 12% for 12-19 year olds.
2.3.2L	By 2022, decrease the percentage of adults who are obese from 24% to 11%.
2.3.3L	By 2022, decrease the prevalence of diagnosed diabetes, per 100 adults, from 9 to 7.
2.3.4L	By 2018, decrease the age-adjusted hospital discharge rate for diabetes as any-listed diagnosis per 1,000 persons with diabetes from x to y.
<b>2.4</b>	<b>INCREASE MENTAL HEALTH AND WELLBEING</b>
<b>Short-term Objectives</b>	
	No objectives have been identified at this time.
<b>Intermediate Objectives</b>	
2.4.1I	By 2020, increase the percentage of primary care physician office visits that screen adults and youth for depression from x to y.
<b>Long-term Objectives</b>	
2.4.1L	By 2022, decrease the frequency of sad or hopeless feelings in the past 12 months from: 28% to 25%

	for 7th graders, 31% to 24% for 9th graders, and 32% to 27% for 11th graders.
2.4.2L	By 2022, decrease the percentage of adolescents (12-17 yrs. old) and adults (18 yrs. and older) who experience a major depressive episode from 8% to 7% and 6% to 5%, respectively.
2.4.3L	By 2020, reduce the rate of suicide death from x to y among youths aged 15-19.
<b>2.5</b>	<b>DECREASE INFANT DEATHS</b>
<b>Short-term Objectives</b>	
2.5.1S	By 2014, increase the number of families enrolled in CDPH Home Visiting Program from 0 to 2200 and increase number of home visits from 0 to 25,000.
<b>Intermediate Objectives</b>	
2.5.1I	By 2020, increase percentage of pregnant females who received early and adequate prenatal care ( $\geq 80\%$ on Kotelchuck Index) from x to y.
2.5.2I	By 2020, reduce the non-medically indicated singleton elective deliveries before 39 weeks gestational age from x to less than 3%.
<b>Long-term Objectives</b>	
2.5.1L	By 2022, decrease infant mortality rate, deaths per 1,000 live births, from 5 to 4.
2.5.2L	By 2020, decrease the percentage of children born with low birth weight (<2500 gms) and very low birth weight (<1500 gms) from x to y.
2.5.3L	By 2020, decrease the rate of birth (per 1000) from x to y for teenagers aged 15-17.
2.5.4L	By 2020, decrease maternal mortality rate, deaths per 1,000 live births, from x to y.
<b>2.6</b>	<b>INCREASE ADVANCE CARE PLANNING</b>
<b>Short-term Objectives</b>	
	No objectives have been identified at this time.
<b>Intermediate Objectives</b>	
	No objectives have been identified at this time.
<b>Long-term Objectives</b>	
	No objectives have been identified at this time.
<b>2.7</b>	<b>INCREASE PALLIATIVE CARE AND HOSPICE CARE</b>
<b>Short-term Objectives</b>	
	No objectives have been identified at this time.
<b>Intermediate Objectives</b>	
	No objectives have been identified at this time.
<b>Long-term Objectives</b>	
2.7.1L	By 2022, increase the hospice enrollment rate from 39% to 54%.
<b>2.8</b>	<b>DECREASE HOSPITALIZATION DURING THE END OF LIFE</b>
<b>Short-term Objectives</b>	
	No objectives have been identified at this time.
<b>Intermediate Objectives</b>	
	No objectives have been identified at this time.
<b>Long-term Objectives</b>	
	No objectives have been identified at this time.

<b>2.9</b>	<b>INCREASE ACCESS TO PRIMARY AND SPECIALTY CARE</b>
<b>Short-term Objectives</b>	
2.9.1S	By 2015, increase the proportion of men 40 years and older who have talked with their healthcare providers about prostate cancer screening from x to y.
2.9.2S	By x, increase provider awareness and knowledge of national guidelines that promote the highest quality of care from x to y.
2.9.3S	By 2016, increase the proportion of children, adolescents, and adults who used the oral health care system in the past year from x and y, respectively.
2.9.4S	By 2016, increase the proportion of low-income children and adolescents who received any preventive dental service during the past year from x to y.
<b>Intermediate Objectives</b>	
2.9.1I	By x, increase the number of school-based health clinics from x to y.
2.9.2I	By x, increase the number of school health professionals by 25% from x to y.
2.9.3I	By 2020, increase the proportion of women aged 50-74 who receive a breast cancer screening from 73.7% of women to 81.1%
2.9.4I	By 2015, increase the proportion of early-stage diagnoses of breast cancer among all women by 29 percent, from a baseline proportion of 69% to 89%.
2.9.5I	By 2020, increase the proportion of women aged 21-65 who receive a cervical cancer screening from 84.5% of women to 93%.
2.9.6I	By 2015, increase colorectal cancer screening rates among people 50 years and older using one of the screening options recommended by the most current United States Preventive Services Task Force screening guidelines (2008) by 15 percent, from the current baseline of 68.1% to 78.3%.
2.9.7I	By 2015, decrease the proportion of late-stage diagnoses of colorectal cancer among all Californians by 15 percent, from the current proportion of 47.1% to 40%.
2.9.8I	By 2015, decrease the proportion of late-stage diagnoses of colorectal cancer among African Americans and Asian and Pacific Islanders by 20 percent, from the current proportions in African Americans of 51.5% to 41.2%, and in Asian and Pacific Islanders of 51.8% to 41.4%.
2.9.9I	By 2022, increase the proportion of Medi-Cal recipients who have been screened for breast cancer from x to y, cervical cancer from x to y, and colorectal cancer from x to y.
2.5.10I	By x, increase the proportion of women ages 15-44 with a usual source of care or medical home from x to y.
2.9.11I	By 2022, increase the percentage of patients receiving care in a timely manner from: 76% to 78% for primary care physicians and 77% to 79% for specialists.
2.9.12I	By 2020, decrease the percentage of individuals who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines from x to y.
2.9.13I	By 2020, increase the percentage of sexually active persons aged 15 to 44 years who received reproductive health services from x to y.
<b>Long-term Objectives</b>	
2.9.1L	By 2015, reduce the mortality rate of female breast cancer by ten percent, from the current baseline rate of 21.4/100,000 to 19.3/100,000.
2.9.2L	By 2015, decrease the mortality rate of colorectal cancer by 17.5 percent, from the current baseline rate of 14.5/100,000 to 12.0/100,000.
2.9.3L	By 2015, decrease the mortality rate of prostate cancer among all Californians by ten percent, from the current baseline rate of 21.7/100,000 to 19.5/100,000.
2.9.4L	By 2015, decrease the mortality rate of prostate cancer among African-American (non-Hispanic black) men by ten percent, from the current baseline rate of 51.6/100,000 to 46.4/100,000.

<b>2.10</b>	<b>INCREASE VACCINATIONS</b>
<b>Short-term Objectives</b>	
	No objectives have been identified at this time.
<b>Intermediate Objectives</b>	
2.10.1I	By 2015, increase the percentage of girls 13-17 years old that have completed the HPV vaccine three-shot series by 60 percent, from the current baseline of 21.8% to 35%.
<b>Long-term Objectives</b>	
2.10.1L	By 2015, decrease the incidence rate of cervical cancer by 15 percent, from the current baseline rate of 8.2/100,000 to 7.0/100,000.
<b>2.11</b>	<b>INCREASE CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES</b>
<b>Short-term Objectives</b>	
	No objectives have been identified at this time.
<b>Intermediate Objectives</b>	
2.11.1I	By x, incorporate equity and cultural competency standards into chronic disease prevention programs, processes, and publications.
<b>Long-term Objectives</b>	
	No objectives have been identified at this time.
<b>2.12</b>	<b>INCREASE PEOPLE RECEIVING CARE IN AN INTEGRATED SYSTEM INCREASE COORDINATED OUTPATIENT CARE</b>
<b>Short-term Objectives</b>	
2.12.1S	By 2018, increase the proportion of health care systems with policies or practices to refer persons with prediabetes or at high risk for type 2 diabetes to a CDC-recognized lifestyle intervention program from x to y.
2.12.2S	By 2018, increase the proportion of participants in CDC-recognized lifestyle intervention programs who were referred by a health care provider from x to y.
2.12.3S	By 2018 increase the proportion of health systems that engage Community Health Workers to link patients to community resources that promote self-management from x to y.
2.12.4S	By 2018, increase the number of Chronic Disease Self-Management Program (CDSMP) workshops offered annually from x to y.
2.12.5S	By 2018, increase the proportion of counties with CDSMP workshops from 67% to y.
2.12.6S	By 2018, increase the number of Diabetes Self-Management Education (DSME) programs from 159 to 176.
2.12.7S	By 2018, increase the proportion of counties with DSME programs from 66% to 76%.
2.12.8S	By 2018, increase the number of Medicaid recipients with diabetes who have DSME as a covered Medicaid benefit from 0% to 10%.
2.12.9S	By 2018, increase the proportion of people with diabetes in targeted settings who have at least one encounter at an accredited DSME program annually.
2.12.10S	By 2018, increase the proportion of health care systems with policies or systems to encourage a multi-disciplinary team approach to blood pressure and Hgb A1c control from x to y.
2.12.11S	By 2018, increase the proportion of patients that are in health care systems that have policies or systems to encourage a multi-disciplinary team approach to blood pressure and Hgb A1c control from x to y, respectively.
2.12.12S	By 2018, increase the number of Medicaid recipients or state/local public employees with prediabetes or at high risk for type 2 diabetes who have access to evidence-based lifestyle intervention programs as a covered benefit from 0 to 1000.

2.12.13S	By x, provide technical assistance to Local Health Departments in counties of greatest need to increase the number of evidence-based community physical activity programs from x to y.
2.12.14S	By x, provide technical assistance to Local Health Departments, Community-Based Organizations, and e-health systems in the number of counties with the greatest need to increase the number of evidence-based community chronic disease self-management programs from x to y.
<b>Intermediate Objectives</b>	
2.12.1I	By x, increase the number of patients in a patient-centered medical home or dental home from x to y.
2.12.2I	By x, increase the number of health care systems and health care payers who reimburse for team-based care such as Medication Therapy Management (MTM) from x to y.
2.12.3I	By 2018, increase the proportion of people with diabetes in targeted settings who have at least one encounter at a DSME program during the funding year.
2.12.4I	By 2018, increase the number of CDSMP participants who self-report having diabetes and complete at least 4 out of 6 workshop sessions, as a proportion of the total number of people with diabetes in the state from x to y.
2.12.5I	By x, increase the number of cancer patients who have received an aftercare plan after completing treatment by ten percent, from the current baseline of 71.9% to 79.1%.
2.12.6I	By 2018, increase percent of participants in CDC-recognized Lifestyle Intervention Programs achieving 5-7% weight loss from x to y.
2.12.7I	By March 2014, increase calls to the California Smokers' Helpline referred from health care providers to 15,000 from a baseline of 14,221.
2.12.8I	By x, increase referrals of Medi-Cal members by 25,000 from x to y to the California Smokers' Helpline through the Medi-Cal Incentives to Quit Smoking Project.
2.12.9I	By 2022, increase the percentage of people in population managed health plans from 48% to 61%.
<b>Long-term Objectives</b>	
2.12.1L	By 2022, increase the percentage of patients whose doctor's office helps coordinate their care with other providers or services from: 67% to 94% for children/adolescents and 75% to 94% for adult health maintenance organization patients.
2.12.2L	By 2020, increase the percentage of persons who report their health care provider always listens carefully from x to y.
2.12.3L	By 2020, increase the percentage of persons who report their health care provider always explained things so they could understand them from x to y.
<b>2.13</b>	<b>INCREASE HOSPITAL SAFETY AND QUALITY OF CARE</b>
<b>Short-term Objectives</b>	
2.13.1S	By 2014, publish the adverse events in hospitals underreporting study.
2.13.2S	By June 2014, promulgate regulations clarifying the definitions and reporting requirements for adverse events in hospitals.
<b>Intermediate Objectives</b>	
2.13.1I	By 2015, increase from x percent to 50 percent of adults who undergo emergency medical services transport and receive diagnostic evaluation for acute myocardial infarction that will receive treatment within the recommended therapeutic time-windows, currently 90 minutes for acute myocardial infarction.
2.13.2I	By 2015, increase from x percent to 60 percent of adults who undergo emergency medical services transport and receive diagnostic evaluation for stroke that will receive treatment within the recommended therapeutic time-windows, currently 180 minutes for ischemic stroke.
2.13.3I	By x, adopt x number of policies and systems changes to improve quality of emergency response services for heart attack and stroke events.
2.13.4I	By x, adopt x number of policies and systems changes to improve hospital-based quality of acute care.
2.13.5I	By x, decrease nonfatal accidental poisoning due to medication errors rate for adults 65 and over from

	x per 100,000 to y per 100,000.
2.13.6I	By x, decrease fatal accidental poisoning due to medication errors rate for adults 65 and over from x per 100,000 to y per 100,000.
2.13.7I	By January 1, 2015, make adverse events by individual hospital publically available online.
<b>Long-term Objectives</b>	
2.13.1L	By 2022, decrease preventable hospitalizations, per 100,000 population, from 1243 to 727 in the top 5 counties.
2.13.2L	By 2022, decrease the 30-day All-Cause Unplanned Readmission Rate (Unadjusted) from 14% to 25% reduction per hospital.
2.13.3L	By 2022, reduce the incidence of measurable hospital-acquired conditions from 1 per 1,000 discharges to x (further composite metrics will be developed so target to be determined).
2.13.4L	By December 2017, adverse events in hospitals will decrease statewide from x in the year 2015 to y.
<b>2.14</b>	<b>DECREASE PEOPLE WITHOUT INSURANCE</b>
<b>Short-term Objectives</b>	
2.14.1S	By x, increase public outreach to the uninsured to enroll them in appropriate health care plan from x to y.
<b>Intermediate Objectives</b>	
2.14.1I	By 2018, enroll 80% of all Medi-Cal-eligible uninsured into Medi-Cal.
2.14.2I	By 2018, enroll 70% of all eligible uninsured.
2.14.3I	By x, maintain chronic disease screening and management programs that provide healthcare to undocumented persons in California from x to y.
<b>Long-term Objectives</b>	
2.14.1L	By 2022, decrease the uninsured rate from: 15% to 5% for "point in time", 21% to 10% for "some point in the past year", and 11% to 4% for "for a year or more".

**GOAL 3: MAKE HEALTH DATA AND INFORMATION ACCESSIBLE AND USEABLE**

**GOAL 3 OBJECTIVES**

Sectors (color-coded):

Early Childhood Education

Schools/Local Education Agency

Health Facilities

Worksites

Community

<b>3.1</b>	<b>INCREASE TRANSPARENT INFORMATION ON COST AND QUALITY OF CARE</b>
<b>Short-term Objectives</b>	
3.1.1S	By 2018, increase the proportion of health care systems reporting on the percentage of adults with adequately controlled blood pressure (National Quality Forum Measure 18) from x to y.
3.1.2S	By 2018, increase the proportion of patients that are in health systems that have electronic medical record systems appropriate for treating people with high blood pressure and patients with diabetes from x to y.
3.1.3S	By 2018, increase the proportion of health care systems reporting on the percentage of adults with diabetes who have Hgb A1c >9.0%) (National Quality Forum Measure 59) from x to y.
3.1.4S	By 2018, increase the proportion of health care systems with certified electronic health records from x to y.
<b>Intermediate Objectives</b>	
3.1.1I	By x, increase proportion of providers that adopt electronic provider reminder/recall and provider assessment and feedback systems from x to y.
3.1.2I	By 2015, increase electronic data reporting to the California Cancer Registry from x number of providers and hospitals to y.
3.1.3I	By x, increase the number of hospitals in California who participate in the stroke registry from x to y and publish report on website on quality of care.
3.1.4I	By x, increase the number of health systems that contribute electronic health data to population based health registries (i.e. immunizations, cancer, etc.).
3.1.5I	By x, x providers with electronic health records report all blood pressure and diabetes quality care indicators.
3.1.6I	By x, federal electronic medical record system reimbursement is allowable for Denti-Cal providers.
3.1.7I	By 2018, develop an oral health surveillance system for California.
3.1.8I	By 2020, increase the percentage of medical practices that use electronic health records from x to y.
3.1.9I	By 2015, publish x number of user-friendly cancer information and data reports that meet the needs of the general public, public health-based organizations, research-based institutions, and other stakeholders.
3.1.10I	By x, develop unified data warehouse with central repository host with aggregated data from different sectors to support health information exchange and population health surveillance.
3.1.11.I	By x, CDPH will adopt 1 policy to add type of insurance to every data set collected in the department.
3.1.12I	By x, implement 1 state all-payer state claims database.
<b>Long-term Objectives</b>	

3.1.1L	By 2020, the 10 largest health plans in California will achieve the National 90th percentile in performance of HEDIS control measures for hypertension, heart disease and diabetes.
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**GOAL 4: INVEST IN WELLNESS**  
**GOAL 4 OBJECTIVES**

Sectors (color-coded):

Early Childhood Education

Schools/Local Education Agency

Health Facilities

Worksites

Community

<b>4.1</b>	<b>INCREASE AFFORDABLE CARE AND COVERAGE</b>
<b>Short-term Objectives</b>	
	No objectives have been identified at this time.
<b>Intermediate Objectives</b>	
4.1.1I	By x, begin or increase coverage of the National Diabetes Prevention Program by public and private health plans from x to y.
<b>Long-term Objectives</b>	
4.1.1L	By 2022, decrease health care cost (Total premium + out of pocket <OOP>) as % of median household income from: 22% to 23% for families and 13% to 13% for individuals.
<b>4.2</b>	<b>DECREASE RATE OF GROWTH IN HEALTHCARE SPENDING</b>
<b>Short-term Objectives</b>	
	No objectives have been identified at this time.
<b>Intermediate Objectives</b>	
	No objectives have been identified at this time.
<b>Long-term Objectives</b>	
4.2.1L	By 2022, decrease the Compound Annual Growth Rate (CAGR) by total health expenditures and per capita costs from total - 7%, per capita - 6%, and Gross State Product (GSP) - 4%: to no greater than CAGR for GSP.
<b>4.3</b>	<b>INCREASE PAYMENT POLICIES THAT REWARD VALUE</b>
<b>Short-term Objectives</b>	
4.3.1S	By 2015, reestablish funding and mandate California Healthy Kids Survey to continue to objectively measure the health and risk behaviors of children and adolescents in California on a population level.
4.3.2S	By x, increase the number of Local Health Departments participating in non-profit hospital community benefit health assessments and improvement plans from x to y.
<b>Intermediate Objectives</b>	
4.3.1I	By x, increase the number of health care systems that pay and reimburse medication management therapy from x to y.
4.3.2I	By x, increase the proportion of Accountable Care Organizations that use models in which all members of care team assume fiscal risk and obtain fiscal benefit from patient outcomes (not just providers) from x to y.
4.3.3I	By x, health care systems use public health reports to guide reimbursements that pay for value not volume.
4.3.4I	By x, 1 Prevention Fund for California will be funded through health care cost savings attributable

	to public health interventions.
<b>Long-term Objectives</b>	
	No objectives have been identified at this time.

**Summary**

This Plan aims to provide stakeholders – chronic disease prevention and health promotion programs within the California Department of Public Health, other state agencies, local health departments, and other health and non-health partners – with an opportunity to coordinate and collaborate for the prevention of chronic disease and the promotion of wellness. This statewide plan identifies ambitious, long-term goals and is intended to be dynamic, changing over time as we monitor population-level health outcomes. This Plan delineates a roadmap for collaboration and health program integration to improve individual and population health outcomes, increase healthy communities, and bend the medical care cost curve using evidence-based prevention strategies and interventions for maximum impact that reaches the largest number of Californians.

**Contact Information**

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