King County

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

KING COUNTY

Signature Report

May 8, 2007

Motion 12507

Proposed No. 2007-0252.2 **Sponsors** Gossett, Patterson, Ferguson, Phillips and Constantine

A MOTION relating to children's health; adopting policies and a measurement and evaluation plan for a Children's Health Initiative and accepting a report on the health of children in King County, in accordance with the requirements of the 2007 Budget Ordinance, Ordinance 15662, Section 83, Proviso P4.

WHEREAS, King County's mission for the health of the public is to identify and promote the conditions under which all people can live within healthy communities and can achieve optimum health, as adopted in Motion 12475, and

WHEREAS, King County's goal is to protect and improve the health and well-being of all people in King County, as defined by per person healthy years lived, and

WHEREAS, whenever possible, King County will employ strategies, policies and interventions to reduce health disparities across all segments of the population, and

WHEREAS, it is the intent of the county to improve the health of children, and

WHEREAS, significant disparities in children's health by race, ethnicity, region, and income persist in King County and in some cases are growing, and

WHEREAS, research shows that effective policy for ensuring healthy children, resulting in healthy, productive adults, rests on removing barriers that prevent children from achieving consistent access to comprehensive health care, and

WHEREAS, the main barriers children face in receiving consistent access to comprehensive health care are lack of insurance, failure to enroll in an insurance plan and failure to access a consistent source of high quality health care services, and

WHEREAS, Washington State, through enactment of Senate Bill 5093, has expanded health care insurance coverage to thousands more children and simplified the enrollment process, and

WHEREAS, the State intends to provide affordable insurance coverage options for all children by 2010, and

WHEREAS, fifteen thousand children in King County are uninsured, and

WHEREAS, under the expanded State eligibility requirements, approximately nine thousand of the uninsured children in King County will be entitled to State-funded health insurance programs in July 2007, with an additional one thousand children becoming eligible in 2009, and

WHEREAS, in 2006, the King County executive demonstrated leadership in addressing children's health by convening the King County Children's Health Access Task Force, comprised of child health experts and advocates, to recommend an approach for assuring children in King County are able to obtain the health care coverage and services they need to achieve optimal health, and

WHEREAS, the task force's recommendations included an outreach strategy to enroll children in insurance coverage and link them to a regular source of medical and dental care, and

WHEREAS, the task force's recommendations reflect evidence-based best practices that demonstrate a proven ability to provide children with health and dental insurance coverage and access to a usual doctor and a regular dentist, resulting in children receiving the health care services they need when they need them, leading to an increase in healthy years lived, and

WHEREAS, the executive, upon recommendation from the task force, developed a proposal addressing children's health for transmittal to the council, and

WHEREAS, this motion is the result of a true partnership between a work group made up of council staff, executive office staff and public health staff, and

WHEREAS, the executive's proposal and the task force's recommendations are reflected in this motion, which establishes policies for the County's Children's Health Initiative ("CHI"), and

WHEREAS, the CHI is designed to surmount the barriers children face in receiving consistent access to health care services by: assertively locating and enrolling children in public health insurance programs for which they are eligible; disseminating messages about the value of early prevention and insurance in many languages; using trusted messengers from the community to deliver these messages; linking families and children to a regular source of medical and dental care; and encouraging quality integrated service delivery within clinics by utilizing case managers, and

WHEREAS, the CHI is a foundational and cost-effective strategy for the county to embark on for improving the health of children because of its holistic approach to the child and because it directly connects children to existing public health insurance programs funded by the state and federal government, and

WHEREAS, through the CHI, King County has the opportunity to leverage funding from public and private entities in order to continue to provide leadership by piloting strategies that will build evidence for statewide efforts in areas including, but not limited to, best practices in outreach and linkage, oral health quality improvement and integration, mental health integration pilot programs, and on-line enrollment application, and

WHEREAS the measurement and evaluation plans that are part of the CHI will allow the county to assess progress toward meeting the vision, mission and goals of the CHI and build an evidence base for future State public health interventions, and

WHEREAS, the CHI is consistent with the adopted Policy Framework for the Health of the Public, and

WHEREAS, the CHI is a reasonable and financially sustainable strategy, and

WHEREAS, this motion and the attached report on the health of children in King County fulfill requirements of the 2007 Budget Ordinance, Ordinance 15652, Section 83, Proviso P4, as amended;

NOW, THEREFORE, BE IT MOVED by the Council of King County:

A. Vision and Mission. The county hereby adopts the following vision and mission statements for the Children's Health Initiative ("CHI"): King County's vision is for every child in King County to achieve optimal health and grow into a healthy adult.

Recognizing that regular access to health care is necessary to achieving optimal health, the mission of the county's Children's Health Initiative is to create conditions under which children have consistent access to comprehensive, preventive-focused primary health care, prioritizing those activities which will have the most significant impact on health or reduction in health disparities. Activities shall be based on need and consistent with the adopted Policy Framework for the Health of the Public.

B. Program Components. To achieve the vision and mission, the county hereby adopts the following components for the CHI:

1. Advocacy for insurance coverage for children. The county will actively advocate at the state and federal level to ensure that children and their families have options for affordable health care coverage;

2. Outreach to children. The county shall fund and conduct outreach to enroll children in the state and federal insurance programs for which they are eligible. The county's outreach efforts shall also include ensuring that children receive appropriate preventive-focused primary care once they are enrolled in insurance, through both education and care coordination;

3. Health innovation pilot projects. The county will partner with private sector donors on creating pilot projects that will strengthen linkages in the health care system and reduce barriers children face in accessing comprehensive health care.

C. Goals. The county hereby adopts the following goals for the CHI:

1. Advocacy goals:

a. Ensure that the state fulfills its adopted goal to extend health care insurance coverage to all children by 2010; and

b. Ensure that the state fulfills its goals to connect children to a medical home and assure that high-quality, cost-effective care is provided;

2. Outreach goals. The county will:

a. Improve insurance access by increasing the number of insured children by identifying and enrolling eligible children in public insurance programs.

b. Improve health knowledge by training parents and staff at community agencies to identify children's health problems and encourage families to seek preventive care;

c. Improve access to health care by connecting children to regular sources of medical and dental care; and

d. Improve health status by ensuring that children receive appropriate evidence-based preventive health care services; and

3. Health innovation pilot projects goals:

a. Ensure that children receive appropriately integrated services for the mouth, the mind and the body by strengthening linkages in the health care system;

b. Reduce barriers children face in accessing health care services by developing systems that assure children receive timely coordinated preventive care; and

c. Leverage current opportunities to build evidence for future state-funded efforts by demonstrating innovative approaches and measuring effectiveness with carefully designed and implemented evaluations.

D. Resources. The county shall dedicate the following resources to achieve the goals of the CHI:

1. Advocacy resources. The county will continue to maintain the appropriate resources to develop, advocate for and respond to state policies affecting the health of children;

2. Outreach resources. The county intends to dedicate the following resources to the outreach component of the CHI:

a. One million dollars annually from the county general fund in 2007, 2008 and 2009. The executive shall reserve these funds in the county's general fund financial plan until such a time as they are appropriated. Thereafter, the county shall evaluate whether there is continued need for county funds to support the outreach goals of the CHI;

b. Four outreach teams comprised of contracted community health workers, health educators, application workers and contracted care coordinators. The outreach teams shall be located in those geographic areas that contain the highest number of uninsured and low-income children, currently identified as:

(1) East King County;

(2) Seattle, White Center and North King County;

(3) South King County – Des Moines to Renton; and

(4) South King County – Federal Way, Kent and Auburn;

c. The county will continue to maintain the existing resources to support management and evaluation of the outreach component; and

d. Should the county receive additional funding from the state to conduct outreach, the county may choose to apply those funds to current outreach efforts, thereby

reducing the county contribution of one million dollars annually, or may choose to use state funds to augment the county's outreach effort; and

3. Health innovation pilot projects resources. With the exception of staff support that is primarily dedicated to managing the other components of the CHI or other existing county functions, the health innovation pilot projects component shall be funded solely with funds donated to the county and not with county general fund resources.

E. Governance and Management. The county hereby adopts the following governance and management structure for the CHI:

1. Any changes or additions to policies for the CHI shall be established and adopted by the Metropolitan King County Council.

2. An outreach implementation committee comprised of experts in King County representing participating community-based organizations and their communities shall provide oversight to the implementation of the outreach component of the CHI. The committee shall adopt a charter that shall describe committee roles and responsibilities; membership; reporting structure; meeting frequency; deliverables; and the manner in which recommended changes or additions to policies resulting from the committee's oversight of the implementation of the CHI shall be proposed to the council; and

3. A health innovation implementation committee comprised of private sector donors, child health experts, health care system and public health representatives shall design and provide oversight to the implementation of pilot projects to support the mission, vision and goals of the CHI and that adhere to the policies in subsection G. of this motion. The committee shall adopt a charter that shall describe committee roles and responsibilities; membership; reporting structure; meeting frequency; deliverables; and

the manner in which recommended changes or additions to policies resulting from the committee's oversight of the implementation of the CHI shall be proposed to the council.

F. Measurement and Evaluation.

1. The county hereby adopts the measurement and evaluation plan, Attachment A to this motion, for the outreach component of the CHI.

2. The executive shall develop a measurement and evaluation plan(s) for the health innovation component and related pilot projects of the CHI. In accordance with subsections D and G of this motion, development of these plans shall be supported by funds donated to the county.

3. The executive shall develop semiannual and annual measurement and evaluation reports based on the measurement and evaluation plans referenced in this section to report to the implementation committees and the council on progress in meeting the CHI vision, mission, and goals. The executive shall transmit these reports to the implementation committees semiannually and to the council annually by August 15 of each year. The reports shall include key performance measures, targets, baseline data and benchmarks. The annual report to the council shall also include: (1) the implementation committee charters; (2) updated measurement and evaluation plans for the outreach component of the CHI, to include objective and performance measure targets for years two and three of the program; (3) measurement and evaluation plans for the health innovation pilot projects component, to be updated annually; (4) a summary of related activities being undertaken or funded by the state; and (5) recommendations on changes to the CHI based on the measurement and evaluation data or changes in state activities. Twelve copies of the annual report to the council shall be filed with the clerk of the

council, for distribution to all councilmembers and to the lead staffs for the board of health and the law, justice and human services committee or their successors.

G. The county hereby adopts the following policies governing the health innovation pilot projects component of the CHI:

1. As county contributions are necessarily limited to the levels set forth in this motion, the county encourages public and private sector organizations to donate funds to supplement the county's contribution to this initiative. In accordance with K.C.C. chapter 2.80, the council shall accept such donations by motion and, recognizing the particular importance of such donations, shall appropriate the funds by ordinance before their expenditure;

2. Health innovation pilot projects shall be designed such that donated funds are assured to complete each project;

3. Health innovation pilot projects shall be designed to coordinate and support state and county efforts to increase children's access to preventive medical and dental care;

4. Health innovation pilot projects shall include defined goals, objectives and measurement and evaluation plans in order to develop an evidence base for future interventions by the state;

5. Health innovation pilot projects shall be consistent with the adopted Policy Framework for the Health of the Public; and

6. In requesting appropriation of funds donated to the county for health innovation pilot projects, the executive shall transmit to the council information that demonstrates the projects adhere to the policies adopted by this motion.

H. The council hereby finds that the CHI as defined in this motion is consistent with the adopted Policy Framework for the Health of the Public. The council recognizes that children's health is affected by many factors not directly related to health care. The council supports the development of strategies through the public health operational master plan process that will further our communities' ability to protect, promote, and provide for children's health.

I. The report, A Report on the Health of Children in King County, Attachment B to this motion, is hereby accepted as information supporting the policies contained herein.

Motion 12507 was introduced on 4/16/2007 and passed by the Metropolitan King County Council on 5/7/2007, by the following vote:

Yes: 9 - Mr. Gossett, Ms. Patterson, Ms. Lambert, Mr. von Reichbauer, Mr. Dunn, Mr. Ferguson, Mr. Phillips, Ms. Hague and Mr. Constantine
No: 0
Excused: 0

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

Larry Gossett, Chair

ATTEST:

Anne Noris, Clerk of the Council

Attachments A. The Measurement and Evaluation Plan for the Outreach Component of the Children's Health Initiative dated May 7, 2007., B. A Report on the Health of Children in King County, dated May 7, 2007.

ATTACHMENT A
12507

Attachment A
2007-0252

King County

THE MEASUREMENT AND EVALUATION PLAN FOR THE OUTREACH COMPONENT OF THE CHILDREN'S HEALTH INITIATIVE

MAY 7, 2007

Prepared by:
The Seattle-King County Department of Public Health
Susan Johnson
Lisa Podell
Kirsten Wysen

Revised by:
David Randall
Metropolitan King County Council

King County

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Introduction

Through an adopted 2007 budget proviso, the Metropolitan King County Council asked Public Health-Seattle and King County to provide two reports (Actual proviso language can be found in Appendix One):

1. A report that contains information to help develop a plan to improve children's health. A Report on the Health of Children in King County addresses the first reporting requirement of this proviso; and

2. Evaluation criteria to measure and track the outcomes of an initiative to improve children's health. This report, titled The Measurement and Evaluation Plan for the Outreach Component of the Children's Health Initiative, addresses the second reporting requirement of this proviso.

What is the Children's Health Initiative?

The Children's Health Initiative (CHI) is an innovative program to provide healthcare access to a medical and dental home so children receive the services they need when they need them to lead healthier lives. A "medical and dental home" are terms that refer to a usual doctor and a regular dentist.

Following are the vision, mission, outreach program component and goals for the CHI as adopted by Council:

Vision

King County's vision is for every child in King County to achieve optimal health and grow into a healthy adult.

Mission

Recognizing that regular access to health care is necessary to achieving optimal health, the mission of the county's Children's Health Initiative is to create conditions under which children have consistent access to comprehensive, preventive-focused primary health care, prioritizing those activities which will have the most significant impact on health or reduction in health disparities. Activities shall be based on need and consistent with the adopted Policy Framework for the Health of the Public.

Outreach Component for the CHI:

The CHI is comprised of three components: (1) advocacy for affordable healthcare insurance options for children; (2) county-funded outreach to enroll eligible children in insurance programs and connect them to medical homes; and (3) privately-funded, innovative projects to integrate the health care system and reduce the barriers children face in accessing care.

This report describes how the outreach component of the CHI will be measured and evaluated. An additional measurement and evaluation plan will be developed for the privately-funded CHI component.

Specifically, the outreach component of the CHI is described as follows:

The county shall fund and conduct outreach to enroll children in the state and federal insurance programs for which they are eligible. The county's outreach efforts shall also include ensuring that children receive appropriate preventive-focused primary care once they are enrolled in insurance, through both education and care coordination.

How will the Children's Health Initiative Be Measured and Evaluated?

Outreach Overarching Goals

The county will:

- Improve insurance access by increasing the number of insured children by identifying and enrolling eligible children in public insurance programs;
- Improve health knowledge by training parents and staff at community agencies to identify children's health problems and encourage families to seek preventive care;
- Improve access to health care by connecting children to regular sources of medical and dental care; and
- Improve health status by ensuring that children in care are receiving appropriate evidence-based preventive services.

Outreach Specific Goals

These specific goals align with the overarching goals described above.

1. Increase the number of insured children.
2. Increase in the number of parents (especially among cultures in which preventive care is not accessed) who understand the value of preventive care for their children and know how to access it.
3. Increase in the number of children in King County will have a medical home (regular source of medical care).
4. Increase in the number of children in King County will have a dental home (regular source of oral health care).

5. Increase in the early prevention, identification and treatment of health issues including caries, developmental delays mental illness and chronic diseases.

6. Improvement in health status using evidence based preventive services

Outreach Objectives

Program objectives for the outreach component of the CHI are presented below, by program component goals. Targets for each program objective are presented for the first year of program operations. In addition, targets for the program objective to enroll children in public health coverage are presented for the second and third years of program operations. Targets for all other program objectives will be presented in annual updates to this measurement and evaluation plan.

CHI Goal: Improve insurance access.

CHI Objective 1: Enroll children in public health coverage.

- In year 1, enroll 1,000 children in public health coverage.
- In year 2, enroll 3,000 children in public health coverage.
- In year 3, enroll 2,500 children in public health coverage.

Four teams of community health workers, health educators and application workers, as well as care coordinators at clinics, in each of the four geographically targeted areas:

1. East King County
2. Seattle, White Center and North King County
3. South King County—Des Moines to Renton
4. South King County—Federal Way, Kent and Auburn

CHI Goal: Improve health knowledge.

CHI Objective 1: Increase number of community services staff who are trained to have information and tools to perform ongoing physical, oral, developmental and mental health surveillance of the children in their programs and encourage families to seek preventive care through medical and dental homes.

- In year 1, increase by 1,000 the number of Community Services Agency staff trained.

CHI Objective 2: Provide parents of low-income children, especially in isolated immigrant groups, with culturally appropriate health education and guidance regarding recommended preventive care, health insurance, and linkage to medical and dental homes.

- In year 1, provide 1,500 parents of low-income children especially in isolated immigrant groups with culturally appropriate health education and guidance

regarding recommended preventive care, health insurance, and linkage to medical and dental homes.

CHI Objective 3: Decrease persistent cultural barriers for families in isolated immigrant groups regarding insurance, access, or health system navigation issues.

- In year 1, decrease persistent cultural barriers for 100 families in isolated immigrant groups regarding insurance, access, or health system navigation issues.

CHI Goal: Improve access to health care.

CHI Objective 1: Establish medical homes for children.

- Establish medical homes for 1,500 children in year 1.

CHI Objective 2: Establish dental homes for children.

- Establish dental homes for 1,000 children in year 1.

CHI Goal: Improve health status.

CHI Objective 1: increase the percentage of 3-6 year old children who are up-to-date on early periodic screening, diagnosis, and treatment (EPSDT) visits.

- In year 1, increase the percentage of 3-6 year old children who are up-to-date on EPSDT visits by 20%.

CHI Objective 2: increase the number of children with an oral health visit by age 1.

- In year 1, increase the number of children with an oral health visit by age 1 by 20%.

CHI Objective 3: increase the number of fluoride applications for children.

- In year 1, increase the number of fluoride applications for children by 15%.

CHI Objective 4: increase the number of children with immunizations up to date.

- In year 1, increase the number of children with immunizations up to date by 15%.

CHI Objective 5: Increase the number of children 0 to 5 who receive a structured developmental assessment.

- In year 1, increase the number of children 0 to 5 who receive a structured developmental assessment by 20%.

Management and Organization

The CHI Phase One activities will be carried out by Public Health-Seattle & King County staff. These staff include Susan Johnson, Executive Director, King County Health Action Plan; Kirsten Wysen, Policy Analyst; Lisa Podell, Program Manager; Kathy Carson, Director, Parent and Child Health; Pat Kennedy, Community Health Services; application workers and health educators.

Approximately half of the county-funded CHI 2007 activities will be implemented through contracts with experienced community organizations. These contracted functions include care coordinators, community health workers and translation services. Remaining functions will be carried out by the department staff mentioned above including application assistance, health education, and administration and oversight activities.

Governance and Oversight

The outreach and access improvement activities of the CHI are guided by an expert committee, the Outreach Implementation Committee composed of countywide experts with extensive knowledge on outreach strategies for children's health programs. This Committee will monitor how well the outreach component of the CHI is meeting its goals and objectives.

In addition, the CHI will measure performance and report to the oversight committee on a semi annual basis and on an annual basis to the King County Council.

Performance Measures

On a semi-annual and annual basis progress in meeting outreach goals and objectives will be reported based on the key performance measures presented in Table One.

Data Sources

Data sources consist of the performance data provided by application workers and health educators, contracted care coordinators and contracted community health workers. Benchmark data sources include program achievements from the Kids Get Care program, Healthy People 2010, National Committee for Quality Assessment (NCQA), Healthcare Employer Data Information System (HEDIS), Washington State Medicaid program data and Behavioral Risk Factor Surveillance System (BRFSS) findings.

TABLE 1: GOALS & OBJECTIVES FOR THE OUTREACH COMPONENT OF THE CHI

GOAL (WHAT IS EXPECTED TO HAPPEN)		OBJECTIVES (MEASURABLE OUTCOMES)	KEY MEASURES
Overarching Goal	**Specific Goals**		
Improve insurance access	Increase the number of insured children	Enroll 1,000 children in public insurance programs (Medicaid, SCHIP, BHP and Children's Health Program)	Number of accepted applications for Medicaid, SCHIP, CHP and BHP for children under 19
Improve health knowledge	Parents (especially among cultures in which preventive care is not accessed), will understand the value of preventive care for their children and know how to access it	Increase by 1,000 the number of Community Agency staff who are "wise watchers"; possessing the knowledge and tools to perform ongoing physical, oral, developmental and mental health surveillance of the children in their programs and encouraging families to seek preventive care and Health Care Homes	• Number of staff trained • Number of parents or caregivers trained
		Scan 5,000 children for development and oral health issues in community agencies by trained staff.	
		Provide 1,500 parents of low-income children especially in isolated immigrant groups with culturally appropriate health education and guidance regarding recommended preventive care, health insurance, and linkage to medical and dental homes	
		Decrease persistent cultural barriers for 100 families in isolated immigrant groups re insurance, access, or health system navigation issues	
Improve access to health care	More children in King County will have a medical home (regular source of medical care)	Establish medical homes for 1,500 children	Number of children completing ≥ 1 medical visit
	More children in King County will have a dental home (regular source of oral health care)	Establish dental homes for 1,000 children	Number of children completing ≥ 1 oral health visit
Improve health status	Early prevention, identification and treatment of health issues including caries, developmental delays mental illness and chronic diseases	Increase the percentage of 3-6 year old children who are up-to-date on EPSDT visits by 20% *	HEDIS measures for 3-6 year olds*
	Improve health status using evidence based preventive services	Increase the number of children with a oral health visit by age 1 by 20% *	Number of children receiving oral health check by dentist or doctor by 18 months*
		Increase the number of fluoride applications for children by 15% *	Number of fluoride varnishes and/or % of children with EPSDT receiving fluoride varnish *
		Increase the number of children with immunizations up to date by 15 % *	HEDIS measures for 19-35 months*
		Increase the number of children 0 to 5 who receive a structured developmental assessment by 20 %*	% of 0-6 yr olds with EPSDT receiving validated screening*

* Contracted clinics will choose 2 of these 5 areas for improvement; objective will be included if chosen by clinics.

Appendix 1: P4 Budget Proviso on Children's Health

From the budget proviso, page 61 of the 2007 adopted King County budget:

It is the intent of the council to evaluate and develop an implementation plan for how the county can best improve the health of children, given limited resources.

This work shall be conducted through the Public Health Operational Master Plan ("PHOMP") steering committee, which shall develop options for a plan for submittal to the council.

In order to support this work, by May 31, 2007, the department of public health in consultation with the PHOMP steering committee shall submit a report to the council on the health of children in King County. The report shall:
(1) Identify the most significant health problems and conditions affecting children currently as well as those problems and conditions that will impact their future health;
(2) Identify the major factors, including social, economic, dietary, demographic and environmental determinants, that contribute to these health problems; and
(3) Identify evidence-based best practices and innovations that can appropriately be undertaken by the department of public health and that have the greatest likelihood of having a measurable and significant impact on alleviating the contributing factors that lead to health problems for children.

If lack of access to health care is determined to be one of the major factors leading to health problems for children, the report shall also identify:
(1) The barriers that prevent children from achieving consistent access to health care, including preventive, primary, specialty, emergency and hospital care;
(2) The infrastructure and practices needed in the health care and insurance systems to ensure that children have consistent access to preventive care and a medical home; and
(3) The options regarding the role the department of public health can play in overcoming barriers to consistent access to health care and in creating, coordinating and fostering these health care and insurance system reforms, including through working with other governments and private sector organizations.

The report required to be submitted by this proviso must be filed in the form of 12 copies with the clerk of the council, who will retain the original and will forward copies to each councilmember and to the lead staff for the board of health and the law, justice and human services committee, or their successors.

In addition, of this appropriation, $250,000 shall only be expended or encumbered for costs related to an access and outreach pilot project to enroll eligible children in state and federal health insurance programs. By January 15, 2007, the executive shall transmit to the council for review and approval by motion evaluation criteria to measure and track the outcomes of this project, including the impact of the project on children's health and the success of the project in connecting children to consistent access to preventive care and a medical home. By thirty days after the end of each quarter, the executive shall

transmit to the council a status report that measures the project against the adopted evaluation criteria.

The report required to be submitted by this proviso must be filed in the form of 12 copies with the clerk of the council, who will retain the original and will forward copies to each councilmember and to the lead staff for the board of health and the law, justice and human services committee, or their successors.

ATTACHMENT B
12507

Attachment B
2007-0252

King County

A REPORT ON THE HEALTH OF CHILDREN IN KING COUNTY

May 7, 2007

Prepared by:
The Seattle-King County Department of Public Health
Susan Johnson
Lisa Podell
Kirsten Wysen

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Introduction

Through proviso, the King County Council has asked Public Health-Seattle & King County to provide a report that contains information to help develop a plan to improve children's health. Actual proviso language can be found in Appendix 1. This report is intended to include:

Part I: The broad picture of children's health
- Children's health problems
- Factors leading to those problems
- Options for what the department can do

Part II: Children's health care
- Barriers in access to care
- Infrastructure needed to create medical homes (regular physician)
- Options for what the department can do to get children into medical homes

King County Children's Health Indicators

While overall King County infant mortality rates have met Healthy People 2010 goals, significant disparities persist in King County by race/ethnicity, poverty and region and seem to be getting larger.[1]

More work is needed to improve immunization rates, dental care and asthma treatment. King County's childhood vaccination rate is above the Washington State average rate of 75%, but below the Healthy People 2010 goal of 90%. In King County, half of all children in King County do not receive regular oral health care. One out of six third graders has untreated decay.[2] About 4% of King County children have asthma, and asthma is almost twice as common among Asian American and African American children, over 8% in King County have asthma.[3]

In addition, improving the food and physical activity environments of both children and adults will make it easier for everyone to lead healthier lives. Additional information about children's health and the causes of health can be found in Appendix 2.

What is the Children's Health Initiative?

The Children's Health Initiative (CHI) is an innovative program to provide health and dental insurance coverage and access to a medical and dental home so children receive the services they need when they need them to lead healthier lives. A "medical and dental home"are terms that refer to a usual doctor and a regular dentist.

The CHI began in April 2006, when Executive Sims convened a Children's Health Access Task Force of child health experts to advise King County on the creation of an innovative county-based children's health program. The Task Force recommended the creation of a program that would dovetail with the State's efforts and build on the innovative work of the King County Health Action Plan, such as the Kids Get Care program.

With initial authorization of $250,000, Public Health-Seattle & King County began work in January 2007 on a multi-team program where Public Health application workers and community health educators work hand-in-hand with community agency staff and care coordinators (Phase

1). The outreach and linkage team members deliver important health messages about the importance of prevention in culturally targeted ways and help enroll children in health coverage. They assist with finding a regular doctor and dentist and assure that comprehensive preventive care is delivered. One such team is in place in South King County and with authorization for an additional $750,000, three additional teams can carry out intensive, culturally tailored outreach and linkage activities throughout the county to assure that children are connected to the health care services they need (see attached report for more information on multi-team program).

Next Steps for the Children's Health Initiative

In June 2006, the Children's Health Access Task Force recommended the creation of a King County-based gap insurance product for the remaining 2% of low-income children who are not eligible for current programs. If the state's timetable and anticipated funding levels are both met, the practicality for providing this gap insurance product is diminished with the passage of the new state children's health care act on March 13, 2007. With private funding, the CHI will continue to explore other innovative pilot approaches to improve children's health in King County that will dovetail with the State's timeline, including but not limited to such things as best practices in outreach and linkage, oral health quality improvement and integration, mental health integration pilot programs, on line enrollment application, and financial sponsorship. The public contribution to this partnership has been defined as $1 million in county support for outreach and linkage activities for three years.

How the CHI Meets the Goals of the Public Health Operational Master Plan Policy Framework

The Children's Health Initiative outreach and access improvement activities meet the goals of the Public Health Operational Master Plan (PHOMP) Policy framework in the following ways:

1. Based on Science and Evidence
(Excerpt from Vicki Wilson's, Washington State Office of Financial Management, September 2006 briefing paper, "Why Cover Children?")

> Based on the health services research literature to-date, the most effective policy for ensuring healthy children (resulting in healthy, productive adults) rests on four inter-related components:
> - Providing insurance coverage to all children, but especially low-income and other vulnerable groups (e.g., children with special health care needs, racial & ethnic minority children);
> - Ensuring that the coverage includes a medical home (in the form of a person, not just a site);
> - Creating incentives for each medical home to provide integrated medical, dental, developmental & behavioral screening at regular intervals through adolescence; and
> - Maximizing the ability of entire families to obtain coverage.

2. Focused on Prevention
Preventive approaches are especially important for children, who can expect many years of healthy life if they have the foundation of a healthy youth. The CHI is based on the premise that many children's physical, mental, developmental and oral health problems can be prevented if identified and treated early on. The outreach and access improvement activities focus on

education to parents and social service agency staff about the importance of immunizations and comprehensive preventive care for children. The care coordinators working in safety net medical practices work to assure that when children are treated, coordinated and integrated preventive services are delivered.

3. Centered on the Community

The CHI is designed to be both shaped and implemented by community agencies. The shaping occurred initially through the community-based Task Force that developed recommendations for King County on how to improve children's health in the spring and summer of 2006. The Task Force was chaired by Dr. Ben Danielson, Medical Director, Odessa Brown Children's Clinic and Dr. Maxine Hayes, State Health Officer, Department of Health. See the August 2006 Task Force Report in Appendix 4 for a list of the Task Force members.

Driven by Social Justice

The outreach and access improvement activities of the CHI target the populations that have the highest level of poverty and uninsurance. Geographic information system analysis suggests focusing much of the work of the outreach teams in South King County. Isolated immigrant groups—pockets of immigrants and/or refugees who have significant language, cultural and literacy barriers—will be a particular focus for receiving assistance in securing coverage and care. Examples of such groups in King County include Latino, Somali and other East Africans, Russian/Ukrainians and Vietnamese populations, especially those who are new to the U.S. Outreach staff and community agencies speak multiple languages representing the population. Hiring community health workers from the existing social networks allows messages about prevention and health promotion to reach vulnerable families in areas with the highest need.

The Three "P's"

The PHOMP defines King County's public health functions to include health protection, health promotion and the provision of preventive and curative quality health care services. The CHI addresses the last two "P's:" promotion and provision. The CHI helps fulfill the department's responsibility to carry out health promotion activities through a collaborative and educational approach. In addition, the CHI helps assure that access to quality health care is improved for low-income children. Under the CHI, improvements in the provision of care occur in two ways: linkage to medical and dental homes performed by outreach staff and expanded capacity and service delivery improvements through partnerships with health care providers. A more detailed analysis of the CHI's congruence with the PHOMP Policy Framework can be found in Appendix 5.

Unique Financial Leveraging Opportunities with the CHI

Local investment in outreach activities brings state and federal dollars into King County through the newly covered children. The rationale to support additional local outreach is even more compelling in 2007 with the passage of Senate Bill 5093, addressing access to health care services for children, which expands coverage to all children in families earning less than 250% FPL starting in July 2007 and to families earning less than 300% FPL starting January 2009. Of the estimated 16,000 uninsured children in King County, 11,000 to 13,000 in families earning less than 250% FPL are now eligible and just need to be enrolled through the approaches described in the next section. See Appendix 6 for additional information about state and federal children's health programs and a summary of SB 5093.

The CHI is a true public-private partnership. The county's $1 million investment has drawn equal size contributions from Group Health Cooperative and the Washington Dental Service, and sizable contributions from Community Health Plan and the Kellogg Foundation. Additional fund raising from private donors is on-going.

Barriers that prevent children from achieving consistent access to health care and how the Children's Health Initiative addresses them

The following quotes are from a *Health Affairs* article, "Access and Quality in Child Health Services: Voltage Drops," by Paul J. Chung and Mark A. Schuster, Vol. 23 No. 5, 77-87, September/October 2004). After the article describes an access barrier for children, a corresponding description of how the CHI access and outreach activities will address the problem is supplied.

> Childhood is a unique period of rapid growth and development characterized by dependency, vulnerability, and, for a disproportionate number of children, poverty. The U.S. health care system, best suited to acute care for adults, struggles to accommodate vulnerable populations (such as the elderly or mentally ill), preventive care and care for chronic conditions. Children require a protective, preventive system—early detection and interventions that help families anticipate upcoming needs, monitors problems as they arise, and coordinates services. Developing such a system is a critical health policy frontier.
>
> It is essential to understand where the current system succeeds and fails for children. John Eisenberg and Elaine Power adopted the term "voltage drops." Just as an electrical system loses voltage when current passes through resistance, the health care system loses people as they confront barriers in seven areas: access to insurance coverage, enrollment in available insurance plans, access to covered services/providers, choice of plans/providers, consistent access to primary care, access to referral services, and delivery of high-quality care. For children, evidence is scant regarding one drop, the impact of plan/provider choice. The other six drops, however, clearly have policy implications that are the focus of this paper. How large are these drops for children, and how might they be reduced?
>
> **Voltage Drop 1: Access to Insurance Coverage**
> Lack of insurance is a major barrier to receipt of services. Uninsured children are half as likely as privately insured children to have well-child visits, office visits, or hospitalizations. By contrast, uninsured children are more likely to visit emergency departments. Lack of insurance may cause parents to shift care to emergency rooms or wait until emergency care becomes unavoidable.

Children's Health Initiative Energy Source 1: The outreach and linkage activities of the CHI will connect eligible uninsured children to a medical home, a dental home and health coverage. New state children's health eligibility improvements make health coverage available to all children in the state whose families are earning up to 250% of the federal poverty level (about $50,000 for a family of four).

CHI Goal: Improve insurance access
CHI Objective: Enroll 1,000 children in public health coverage in year 1.

Four teams of community health workers, health educators and application workers, as well as care coordinators at clinics, in each of the four geographically targeted areas:

1. East King County
2. Seattle, White Center and North King County
3. South King County—Des Moines to Renton
4. South King County—Federal Way, Kent and Auburn

Voltage Drop 2: Enrollment in Available Insurance Plans
Even when they have access to insurance, many parents do not enroll their children in a plan. In 2001, 20 percent of children within typical income limits for Medicaid/SCHIP were uninsured all year; 64 percent of uninsured children met income eligibility criteria for Medicaid/SCHIP but were not enrolled. Complex applications and enrollment and re-enrollment procedures and fear of being reported to Immigration National Service are just some of many reasons why uninsured children eligible for these programs are not enrolled.

Children's Health Initiative Energy Source 2: As above, the outreach and linkage activities of the CHI will connect eligible uninsured children to health coverage and help parents complete sometimes lengthy application forms. Starting in January 2009, the state will extend coverage to families earning up to 300% of the federal poverty level. Increased enrollment of children into coverage for which they are eligible as described above brings additional state and federal dollars into King County.

Voltage Drop 3: Access to Covered Services and Providers
Enrollment in an insurance plan does not guarantee access to services. First, many insured children may be "underinsured" (lacking coverage for specific services, such as prescription drugs or dental care) or unaware of the need for preventive services.

Children's Health Initiative Energy Source 3: Health educators will work with the outreach staff to increase parents' and community services agency staff' awareness of the importance of preventive care. Supporting parents when they have a concern about their child's development leads to earlier identification of children's health problems when they are more amenable to treatment.

CHI Goal: Improve health knowledge
CHI Objectives:

- In year 1, increase by 1,000 the number of Community Services Agency staff who are trained to have information and tools to perform ongoing physical, oral, developmental and mental health surveillance of the children in their programs and encourage families to seek preventive care through medical and dental homes, and
- Provide 1,500 parents of low-income children especially in isolated immigrant groups with culturally appropriate health education and guidance regarding recommended preventive care, health insurance, and linkage to medical and dental homes
- Decrease persistent cultural barriers for 100 families in isolated immigrant groups regarding insurance, access, or health system navigation issues

Voltage Drop 4: Access to a Consistent Source of Primary Care
Once services can be accessed, actual health care delivery becomes possible. Well-child care is the cornerstone of child health services. Its goals are to prevent illness and promote health through immunizations, routine surveillance (such as developmental

screening), and anticipatory guidance (such as car-seat counseling). Children who meet well-child-visit recommendations are half as likely as other children to visit an ED or be hospitalized and 30 percent more likely to be immunized. Continuity of care (visits with the same provider) may improve these benefits.

Children's Health Initiative Energy Source 4: In addition to making sure that children are enrolled in health coverage, the outreach and linkage staff of the CHI will connect eligible uninsured children to a medical home and a dental home. These terms refer to a usual doctor and a regular dentist. Having a usual source of primary care makes it more likely children will receive needed preventive services, and will use the most cost effective setting for the care they need, rather than obtaining expensive and fragmented care at emergency rooms.

CHI Goal: Improve access to health care
CHI Objectives:

- Establish medical homes for 1,500 children in year 1
- Establish dental homes for 1,000 children in year 1

Voltage Drop 5: Access to Referral Services
Although access to consistent primary care is essential for children, it is often not enough. Most children need referral to other services at some point, and primary care clinicians often have no systematic ties with providers of these services (such as dental clinics, social services, or subspecialists), which makes referral, feedback, and coordination challenging.

Access to referral services might be greatly improved, especially for children with special health care needs, through widespread implementation of medical home programs.

Children's Health Initiative Energy Source 5: As above, in addition to making sure that children are enrolled in health coverage, the outreach and linkage staff of the CHI will connect eligible uninsured children to a medical home and a dental home. Having a usual source of care makes it more likely children will receive needed preventive services, and will use the most cost effective setting for the care they need, rather than obtaining expensive and disconnected care at emergency rooms. Access to some medical subspecialists remains challenging for children in low-income families and is not addressed directly by the CHI.

Voltage Drop 6: Delivery of High-Quality Health Care Services
Access to services is beneficial only if the quality of those services is high. Clinical practices, however, vary widely among regions, institutions, and individuals, and evidence links practice variations with variations in quality.

Children's Health Initiative Energy Source 6: The CHI funds care coordinators in safety net health care providers, often community health centers or public health centers. These care coordinators are charged with using quality improvement techniques to expand the medical practice's delivery of comprehensive well child care. Within well child visits, systems are put in place to assure that developmental screening, oral health screening, social and emotional health screening and on-time immunizations are provided.

CHI Goal: Improve health status
CHI Objectives:

- In year 1, increase the percentage of 3-6 year old children who are up-to-date on EPSDT visits by 20%

- Increase the number of children with a oral health visit by age 1 by 20%
- Increase the number of fluoride applications for children by 15%
- Increase the number of children with immunizations up to date by 15 %
- Increase the number of children 0 to 5 who receive a structured developmental assessment by 20%

Conclusion: the Right Cause, the Right Reasons, the Right Scale

The conclusion of this report comes from the August 16, 2006 transmittal letter from the Co-Chairs of the Children's Health Access Task Force, Dr. Maxine Hayes, State Health Officer, Washington State Department of Health, and Dr. Benjamin Danielson, Medical Director, Odessa Brown Children's Clinic:

> Bringing health care coverage and access to needed services to low-income King County children is the *Right Cause,* for the *Right Reasons;* it is on the *Right Scale* and solutions are needed *Right Now.* We need to start making smarter investments in health care services. It would be difficult to find anyone who would say that today's status quo healthcare is adequate or acceptable. Our current system often leads to the highest possible costs by failing to promote prevention or lower cost early interventions. The health burden of uninsured and under-insured children in King County is a burden that all of us bear in more ways than might be appreciated.
>
> Bringing health care coverage and access to needed services to low-income King County children in this program is an opportunity to turn the page in King County. We have good reference models and lessons learned from some similar piloting efforts in counties in other states. Local expertise has been brought together in an energetic task force with a comprehensive knowledge of the healthcare system.
>
> The scope of this program is appropriate because in King County we are addressing the health needs of a manageable number of children. This provides for a logistically efficient model to pilot health coverage solutions. This size program is more easily feathered into the existing healthcare system without disrupting other forms of coverage or services. Manageable scope also allows for accurate measurement and tracking of its effectiveness. This is especially important as it informs larger statewide strategies in accord with Governor Gregoire's 2010 goal to cover all children in Washington.
>
> Once again, we were honored to serve as co-chairs of the King County Children's Health Access Task Force, and we and the rest of the Task Force are ready to work with you to assure that we do the best we can for our children's health. We close this letter with the quote you used in the "State of the County" address on May 22, 2006 when you spoke of your commitment to children's health:
>
> > Many things we need can wait. The child cannot. Now is the time his bones are being formed, his blood is being made, his mind is being developed. To him we cannot say tomorrow, his name is today.
> >
> > *-Gabriela Mistral, Chilean poet, 1889-1957*

Appendix 1: P4 Budget Proviso on Children's Health

From the budget proviso, page 61 of the 2007 adopted King County budget:

It is the intent of the council to evaluate and develop an implementation plan for how the county can best improve the health of children, given limited resources.

This work shall be conducted through the Public Health Operational Master Plan ("PHOMP") steering committee, which shall develop options for a plan for submittal to the council.

In order to support this work, by May 31, 2007, the department of public health in consultation with the PHOMP steering committee shall submit a report to the council on the health of children in King County. The report shall:
(1) Identify the most significant health problems and conditions affecting children currently as well as those problems and conditions that will impact their future health;
(2) Identify the major factors, including social, economic, dietary, demographic and environmental determinants, that contribute to these health problems; and
(3) Identify evidence-based best practices and innovations that can appropriately be undertaken by the department of public health and that have the greatest likelihood of having a measurable and significant impact on alleviating the contributing factors that lead to health problems for children.

If lack of access to health care is determined to be one of the major factors leading to health problems for children, the report shall also identify:
(1) The barriers that prevent children from achieving consistent access to health care, including preventive, primary, specialty, emergency and hospital care;
(2) The infrastructure and practices needed in the health care and insurance systems to ensure that children have consistent access to preventive care and a medical home; and
(3) The options regarding the role the department of public health can play in overcoming barriers to consistent access to health care and in creating, coordinating and fostering these health care and insurance system reforms, including through working with other governments and private sector organizations.

The report required to be submitted by this proviso must be filed in the form of 12 copies with the clerk of the council, who will retain the original and will forward copies to each councilmember and to the lead staff for the board of health and the law, justice and human services committee, or their successors.

In addition, of this appropriation, $250,000 shall only be expended or encumbered for costs related to an access and outreach pilot project to enroll eligible children in state and federal health insurance programs. By January 15, 2007, the executive shall transmit to the council for review and approval by motion evaluation criteria to measure and track the outcomes of this project, including the impact of the project on children's health and the success of the project in connecting children to consistent access to preventive care and a medical home. By thirty days after the end of each quarter, the executive shall

transmit to the council a status report that measures the project against the adopted evaluation criteria.

The report required to be submitted by this proviso must be filed in the form of 12 copies with the clerk of the council, who will retain the original and will forward copies to each councilmember and to the lead staff for the board of health and

Appendix 2: King County Children's Health Indicators and Causal Factors

Infant mortality

- In King County in 2004, the rate was 4.4 per 1,000 live births. This meets the Healthy People 2010 goal of 4.5 deaths per 1,000 live births.
- Significant disparities persist in King County by race/ethnicity, poverty and region remain and may be getting larger.[4]
- King County ranks ahead of 11 demographically similar U.S. counties in this measure and behind three others. See detail in Table 1, Children's Health Comparison Data from the Public Health-Seattle & King County Core Indicators website.
- Other measures of infant health include low-birth weight and pre-term delivery. Information about these measures in King County can be found in the *2006 Health of King County*.[5]

Table 1: Infant Mortality, Comparison Areas and Healthy People 2010 Objective

Source: US National Center for Health Statistics, US Office of Disease Prevention and Health Promotion and WA State Department of Health

Place	Latest Available Year	Rate	Lower CI	Upper CI
Healthy People 2010 Objective		4.5		
Similar Counties	2001	6.4	5.8	7.1
Washingon State	2003	5.6	5.1	6.1
Wayne County, MI	2001	9.6	8.5	10.7
Cook County, IL	2001	8.5	7.9	9.2
San Bernardino County, CA	2001	7.4	6.4	8.4
Broward County, FL	2001	6.5	5.5	7.7
Maricopa County, AZ	2001	6.5	5.8	7.2
Kings County (Bklyn), NY	2001	6.1	5.4	6.9
Dallas County, TX	2001	6.0	5.3	6.8
Miami-Dade County, FL	2001	5.7	4.9	6.6
San Diego County, CA	2001	5.5	4.8	6.2
Los Angeles County, CA	2001	5.3	5.0	5.7
Harris County, TX	2001	5.1	4.6	5.7
King County, WA	**2003**	5.1	**4.2**	**6.1**
Queens County, NY	2001	4.9	4.2	5.7
Orange County, CA	2001	4.6	4.0	5.2
Santa Clara County, CA	2001	4.0	3.3	4.8

CI is 95% Confidence Interval
Rate = Number of infant deaths per 1000 live births.

Source: Public Health-Seattle & King County Core Health Indicators available at www.metrokc.gov/health/reports/CoreIndicators/IndicatorIndexPublic.xls. Accessed 3/27/07.

Immunizations

- The King County child immunization rate for 19-35 months of age (national benchmark) is 77% up-to-date in 2005, just below national average of 80%.[6]
- King County's childhood vaccination rate is above the Washington State average rate of 75%, but below the Healthy People 2010 goal of 90%. See Table 2 for more detail.

Table 2, Immunization Coverage King County, Comparison Areas, and Healthy People 2010 Objective

Rates of Child Immunization is the percent of children 19-35 months of age who have completed 4:3:1:3:3 vaccine series.

Source: U.S.Department of Health and Human Services (DHHS). National Center for Health Statistics. The 2003 National Immunization Survey,Hyattsville,MD:Centers for Disease Control and Prevention, 2004

Current prevalence:

Place	Latest Available Year	Rate	Lower CI	Upper CI
Healthy People 2010 Objective	N/A	90.0	N/A	N/A
U.S.	2003	79.4	78.5	80.3
Washingon State	2003	75.3	70.7	79.9
Rest of WA State	2003	74.7	68.8	80.6
King County, WA	2003	77.1	71.1	83.1

Source: Public Health-Seattle & King County Core Health Indicators available at www.metrokc.gov/health/reports/CoreIndicators/IndicatorIndexPublic.xls. Accessed 3/27/07.

Oral health

- In 2000, the Surgeon General's report on oral health documented disparities in oral health and access to dental care among vulnerable populations.[7] 80% of tooth decay is experienced by 25% of children.[8]
- Dental-related illnesses cause U.S. children to miss more than 51 million hours of school per year.[9]
- The Surgeon General's report emphasizes that oral health is integral to general health and is especially amenable to preventive strategies since safe and effective disease prevention measures are well established.[10]
- Results from a Washington State oral health survey demonstrate unmet dental needs particularly among children from low-income and minority families.[11]
- In King County, data show the following:
    - Half of all children in King County do not receive regular oral health care.
    - Children of color and those in low income families are at least twice as likely, and in Seattle are three times as likely, to have untreated decay. Children who do not speak English are about twice as likely to have untreated decay. [12]
    - One out of six third graders has untreated decay.[13]
    - Only 30 percent of Medicaid children under six and 40% of those under 19 in King County in 2005 saw a dentist.

Asthma

- Asthma is a common chronic health problem among children. In 2004, 4.3% or about 17,000 children age 0-17 in King County had asthma.[14]
- Asthma is almost twice as common among Asian American and African American children, over 8% in King County have asthma.[15]
- With high quality primary care, most children can completely avoid hospital stays for asthma. However, the asthma hospitalization rate in King County in 2002 was 200 per 100,000 children age 0-17, or 787 hospitalizations.[16]
- Whereas the hospitalization rate was 144 among children in families with incomes above poverty, it was almost three times higher (430) among the lowest income children in King County.[17]
- Within King County, the childhood asthma hospitalization rate varies more than sixfold by neighborhood, ranging from 75 hospital admissions per 100,000 children in Lower Valley and Upper Snohomish Health Planning Areas to a rate of 584 hospitalizations per 100,000 children in Beacon Hill and south east Seattle. See Table 4 below and Figure 1 on page 5 of Appendix 2.

Table 3: Childhood Asthma Hospitalization

Health Planning Areas, King County

5-year Average, 1998-2002

Sources: CHARS Data: Washington State Department of Health, Center for Health Statistics.

Health Planning Area	Rate	Lower CI	Upper CI	Average Annual Count
Beacon & SE Seattle	582.8	531.0	638.4	93
Downtown & Central	520.7	461.3	585.8	55
W. Seattle/Delridge	382.7	340.6	428.5	60
Tukwila/SeaTac	325.4	268.1	391.5	22
White Center/Boulevard P	305.6	266.6	348.7	44
N. Seattle/Shoreline	277.4	249.6	307.4	73
Renton	273.9	244.4	306.0	62
Ballard-Fremont-Greenlake	255.6	217.7	298.2	32
Capitol Hill/Eastlake	221.7	163.0	295.0	9
Burien/Des Moines	220.4	184.4	261.5	26
Queen Anne/Magnolia	212.2	164.6	269.4	13
NE Seattle	204.6	169.3	245.2	23
Bellevue	194.0	170.9	219.4	51
Kent	173.5	155.5	193.0	68
Redmond/Union Hill	159.7	135.4	187.1	31
Bothell/Woodinville	154.0	131.4	179.4	33
Auburn	139.4	115.7	166.5	24
Kirkland	135.5	110.8	164.2	21
Cascade & Covington	135.5	112.0	162.5	23
Federal Way	132.4	115.4	151.2	43
Issaquah/Sammamish	129.5	106.8	155.5	23
Mercer Isle/Point Cities	107.8	75.1	149.9	7

Vashon Island	102.4	53.0	178.2	2
Lower Valley & Upper Sno	99.0	74.7	128.8	11
Southeast King County	72.4	48.5	103.9	6

CI is 95% Confidence Interval
Rate = Hospitalizations per 100,000.

Source: Public Health-Seattle & King County Core Health Indicators available at www.metrokc.gov/health/reports/CoreIndicators/IndicatorIndexPublic.xls. Accessed 3/27/07.

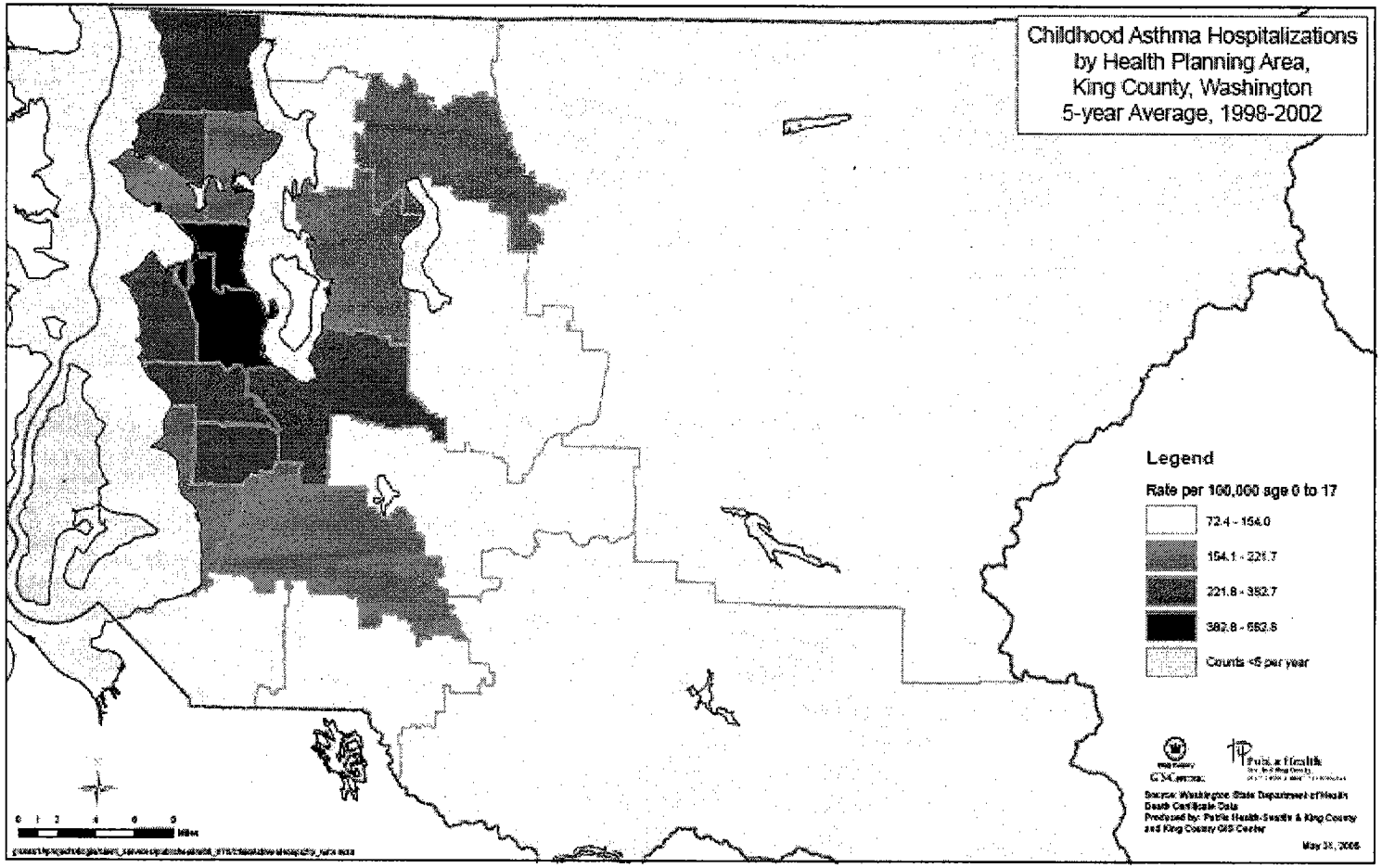
Obesity and related health conditions, including diabetes

- In Washington, almost one in four high school children are overweight or obese.
- While 21% of white 10th graders are overweight or obese, 27% of black, 29% of Hispanic and 32% of American Indian children are.[18]
- The percentage of children in the US who are obese grew from 5% in 1971 to 16% in 2002.[19]
- With low levels of physical activity, poor nutrition and obesity come related health problems, including heart disease, bone and joint disorders, depression and diabetes.
- Obesity-related health conditions once thought applicable only to adults are now being seen in children and with increasing frequency. Examples include high blood pressure, early symptoms of hardening of the arteries, type 2 diabetes, nonalcoholic fatty liver disease, polycystic ovary disorder, and disordered breathing during sleep.[20]
- Type 2 diabetes is virtually only observed among obese children, and "metabolic syndrome," a kind of pre-diabetes constellation of health risks, occurs among 4% of all children and among 30% of overweight children.[21]
- Several researchers have concluded obesity trends could result in the current generation of children suffering greater illness or experiencing a shorter lifespan than that of their parents—the first such reversal in lifespan in modern history.[22]

Adolescent health

- In King County:
  - Frequent mental distress is reported on surveys most frequently among teens and young adults (13%), and becomes less prevalent as people get older.
  - Almost one in five (18%) 10th grade students who participated in the Healthy Youth Survey reported seriously considering suicide, and 14% made a plan for committing suicide in the previous 12 months.[23]

Figure 1. Childhood Asthma Hospitalization Rates by Health Planning Area, King County, 1998-2002



Source: Public Health-Seattle & King County Core Health Indicators available at www.metrokc.gov/health/reports/CoreIndicators/IndicatorIndexPublic.xls. Accessed 3/29/07.

Major factors, including social, economic, dietary, demographic and environmental determinants, that contribute to these health problems:

Social and Economic Determinants

The following quotes are from Barbara Starfield's article in *Health Affairs*, Volume 21 Number 5, 165-170, "U.S. Child Health: What's Amiss, and What Should Be Done about It?"

- Explanations (about poor children's health indicators) related to heterogeneity of the population are not convincing.[24]
- Explanations related to risky behavior also are not persuasive; there is less smoking and less alcohol use in the United States than in most of the other comparison countries.
- One possible explanation concerns the higher degree of relatively low income in the United States than in the other countries. Indeed, the United States is the most income inequitable country among the industrialized nations.
    - Evidence on the relationship between income inequality and health is strong in the United States; most studies show that states and localities that are more income-inequitable have poorer health as measured by a variety of indicators
- The second possibility is that poorer health may be related to a lack of generosity in health policy. The United States is the only industrialized country to lack universal health insurance.[25]
- The United States differs from many industrialized countries in the absence of universal access to health services and through its policies that are do little to promote primary care.[26]

The Role of Health Coverage

From Vicki Wilson's, Washington State Office of Financial Management, September 2006 briefing paper, "Why Cover Children?"

- Increasingly, working families need help paying for health insurance for their children. Children without health insurance live sicker and die sooner than children with health insurance.[27]
- It costs less to provide health insurance coverage to children than to any other group.
- Every dollar spent vaccinating children against measles, mumps, and rubella saves $16 in medical costs to treat those illnesses.
- Health coverage improves children's academic performance. Reading scores and school attendance of uninsured children improve dramatically after they become insured.[28]

Dietary and Demographic Determinants

- Most industrialized countries are experiencing increasing trends in overweight and obesity among children attributed to poor diet and decreasing physical activity.[29]
- Countries with similar demographic profiles to specific US child populations have better health outcomes than the US.[30]

Environmental Influences

- Poor indoor environmental quality, usually related to substandard or poorly ventilated buildings, is linked to asthma and allergies. For example, 23% of low-income homes have visible mold, as do 16% of all homes in the county.[31]
- The food environment influences children's health. This includes the food provided in many settings: school, community, childcare, and the home.
- The built environment, i.e. the buildings, roads and structures in the environment, influence health through housing quality and affordability, ease of walking and bicycling, opportunities for recreation/physical activity, and school and childcare environmental quality.
- Media and advertising influence knowledge and behaviors related to health. A recent Kaiser Family Foundation study found that the average 6 to 10 year old child in the US views 21 television advertisements about food per day.
- Finally, neighborhood environments, such as the levels of violence, accessibility of drugs and tobacco and alcohol also influence children's health.
- Given the relationship between social disadvantage and health, health disparities are likely to grow. Moreover, challenges such as the increased vulnerability of the young to environmental hazards and to social disadvantages are increasingly recognized but not met.[32]

Appendix 3: Best Practices for the Department of Public Health

From P4 Budget Proviso on Children's Health: Identify evidence-based best practices and innovations that can appropriately be undertaken by the department of public health and that have the greatest likelihood of having a measurable and significant impact on alleviating the contributing factors that lead to health problems for children

- **Strategies/interventions to connect those in need to social services**
  - Public health nurses provide assessment, education, referral and follow-up to families of children with special needs (Best Practice).
  - Contracts from the Child Protective System (CPS) support public health nurses to work with families whose children are not at immediate risk of harm either as an alternative to involvement with a CPS worker (ARS) or as a supplement to CPS worker involvement. Strategies vary depending on family needs, but always include safety and developmental assessment and linkage to needed resources (Best Practice).
  - *Infant Case Management.* Nurses, nutritionists and social workers provide referral to needed services and follow-up to assure services are received for families of Medicaid-covered infants who are at risk for poor outcomes (Best Practice).

- **Interventions to improve health status of the most vulnerable populations**
  - *Home visits for critical outcomes* (Best Practice). Public Health Nurses visit within 48 hours all women who are discharged from University Hospital Medical Center within 48 hours of a vaginal delivery or 72 hours of a C-section delivery. Nurses, nutritionists and social workers provide referral to needed services and follow-up to assure services are received for families of Medicaid-covered infants who are at risk for poor outcomes. Nurses, nutritionists and social workers provide assessment, education, skills-building and support to pregnant and post-delivery women covered by Medicaid. Supports include basic health messages, case management, referral and counseling. Services are provided in home visits and office visits.
  - *Domestic Violence training* (Best Practice). A contract with King County Women's Program and various grant funds have supported this effort to train those involved in Domestic Violence and CPS service systems to understand each other and work together to promote the well-being of the children. Additionally efforts are currently underway to implement Domestic Violence screening in all Public Health clinics.
  - *Best Beginnings* (Best Practice). Public health nurses provide an evidence-based model of home visiting services to low income teens who are enrolled during their first pregnancy and followed until their child's 2nd birthday. Goals include improving mother's life course as well as improved birth outcomes and promoting optimum child development and early learning.
  - *Infant Mortality Prevention Outreach* (Innovation). A network of outreach workers employed by PHSKC or contract agencies work in low income minority communities to identify women of childbearing age and families with young children, engage them to identify service needs, and link them to health care, housing and other services, and support harm-reducing behavioral change

- **Interventions at school and childcare centers.** School and child care settings influence children's health through the quality of early childhood education and support, the quality of education and, eventually, through high school completion/college matriculation. The tie between early learning optimal opportunities for children and health is known. So too is the relationship between nurturing and supportive childcare environments and a child's health and learning trajectory. A central early intervention to reach this population is in the Department's assistance and training offered to childcare sites on early development, nutrition, chronic disease management, the value of preventive services and immunizations.

  - *Child Care Health Program at Public Health – Seattle & King County* (Best Practice). Child Care Health staff includes public health nurses who can provide consultation on health and safety issues. A child psychologist provides expertise and workable solutions for child behavior issues. Nutritionists and health educators complete the team, providing child care providers with consultation, nutrition advice and expertise, as well as training opportunities and a variety of health and safety education materials.

    People who work with children on a daily basis are often the first to identify a health or safety concern. Child care providers may not always know exactly what the problem is; but they usually know when there is a problem. Child Care Health's goal is to identify children who need more intervention (based on child care provider observations), find the right services for them, and provide the child care provider with assistance to keep the child in their care. Child Care Health works with child care programs to provide a safe and healthy environment for the children in their care. It supports policies and system restructuring that can increase access to quality early learning opportunities is an area long championed by the Department in its history of work with the early learning community, SOAR, and the development of the State Department of Early Learning. It also supports school district health champions who can promote and develop healthy school policies and link schools to community and health sectors as with asthma and overweight continues to be a developing area for fruitful work.

- **Interventions to Improve Environmental Health Factors**
  - *The Tacoma Smelter Plume project* (Innovation) is an effort by PHSKC, state agencies and local communities to determine the extent of soil contamination in King County. Specifically, soils are being sampled for arsenic and lead that likely came from the smokestacks of the Asarco copper smelter in Ruston, near Tacoma.

    In King County, Public Health - Seattle & King County is contacted by law enforcement officials regarding illegal drug labs. Public Health has the following responsibilities in responding:
    - Posting warnings
    - Informing the public of hazards
    - Assessing the extent of the contamination at the lab sites once the bulk of lab-related materials are removed
    - Overseeing decontamination and determining when a structure can safely be reoccupied

- Assuring that clean up contractors properly handle and dispose of wastes generated during the cleanup process.

Other department programs that seek to improve the built environment's influence on health include (Best Practices and Innovations):

- Advocacy for increased affordable housing
- Participation in planning efforts and bodies, Health Impact Assessments
- Safe routes to school
- Advocating for filling missing bike and pedestrian links
- Promoting code revision for healthy homes, CHWs and inspectors for home visits, certification program for healthy homes, required inspections of rental properties on regular basis, etc.
- An example is the Seattle Asthma program, which provides free-in-home visits to Seattle residents who have a child with asthma. An Environmental Health Specialist surveys the home environment to identify things you can do to reduce the presence of asthma triggers.

- **Interventions to Prevent and Manage Chronic Diseases and promote optimal growth and development**
  - *Evidence-based classes and support groups* (Best Practice) (e.g. for Asthma, Diabetes) also are a part of key community work, as are efforts to improve the quality and connections of the linkage of community and schools to medical practitioners in clinics to improve the management and support of individuals in the behavior changes necessary to sustain long lasting effects. Much of this work is done via the Children's Health Improvement Collaborative (Obesity, ADHD Asthma), the Diabetes Collaborative and other similar regional and statewide efforts.

A specific example of department work in this area is the REACH Coalition, which includes Public Health-Seattle & King County, works cooperatively toward the goal of eliminating diabetes-related health disparities among African American, Asian American/Pacific Islander American, and Hispanic/Latino communities in King County.

  - *Community Health Workers* (Best Practice & Innovation). Community Health Workers (CHW's) are trusted members from the community and knowledgeable about the community. These are widely used within the Department especially in the several years' long work of three major grants: REACH, STEPS and Kids Get Care. In addition to this work by CHW's in the primary areas of diabetes, asthma and developmental, mental and oral health; community health educators also work to educate community-based organizations about the overall value of prevention and early detection and management of chronic diseases.
  - *Women Infants Children (WIC)* (Best Practice). The department influences and improves the food environment for children through many venues: school, community, childcare, after-school programs, home, WIC and others. WIC is a preventive health and nutrition program that provides short term assistance to young families to promote optimal growth and development. Nutritionists and nutrition

assistants provide nutritional assessment, education, and supplemental food vouchers to low income women, infants and young through age 5.

- *STEPS to a HEALTHIER Community work* (Innovation). This program has implemented community-based efforts that:
  - Support community health workers who make home visits to encourage asthma and diabetes self-management and provide community outreach and education.
  - Train child care providers in asthma management and breast-feeding promotion.
  - Work in collaboration with clergy and health ministry members to provide cardiovascular health and outreach and education in churches which includes information assessments and screenings, referral to education/self-management classes and support groups, provision of action plans for participants.
  - Promote environmental and programmatic interventions to encourage physical activity (e.g., running for adolescent girls, walking groups, biking to school, mentors, personal trainers) and good nutrition (e.g., food preparation demonstrations, healthy snacks).
  - *Oral Health Program* provides clinical and community based oral health services to improve the oral health of King County residents and reduce the level of dental disease in accordance with the U.S. Healthy People 2010 Goals and the Washington State Public Health Improvement Plan.
  - *Injury Prevention* The Smart Kids! Safe Kids! Injury Prevention Program was developed by the Seattle Fire Department and King County Emergency Medical Services to target the main injury categories relevant to three to five year old children.

- *King County Physical Activity Coalition (KCPAC)* (Innovation) began in December of 2000 to respond to high rates of sedentary living in King County. The primary objective of the Coalition is to raise the activity levels of those residents in King County who are currently sedentary or total inactive in order to decrease their risk for chronic disease. The public health department works directly and with its partners to understand and improve the influence of the built environment on children's health. These influences are take place through housing quality and affordability, friendliness to non-motorized mobility, opportunities for recreation/physical activity, school and childcare environmental quality

  KCPAC is staffed by the Chronic Disease Prevention and Healthy Aging Unit located in the Prevention Division of Public Health. Physical Activity was identified as a priority area for the Unit because it affects many different chronic diseases including diabetes, hypertension, heart disease, and cancer.

- **Other programs**
  - *Media and advertising influences* (Innovation). Department staff has participated in developing guidelines on advertising to children and have provided technical assistance and education on media literacy around healthy eating.
  - *Neighborhood violence, accessibility of drugs and tobacco and alcohol* (Innovation). The department has a successful track record in working to prevent injuries among King

County residents, including initiatives targeting: car seats, pedestrian safety, bike helmets, gun storage and control, etc.

- *Health care quality* (Innovation). Department staff has worked to improve health care quality through efforts related to registry support and integration, promotion of data sharing, support of improvement strategies (collaboratives, technical assistance on rapid cycle change, etc.) and skills-based provider training. One example is the Children's Health Improvement Collaborative the purpose of which is to use quality improvement (QI) methodology and the Breakthrough Series Collaborative (BTS) model to improve the delivery of care for low-income children suffering from three specific chronic illnesses: asthma, attention deficit/hyperactivity disorder (AD/HD), and overweight.
- *Health care access* (Best Practices). Public Health-Seattle & King County has application workers who assist families in applying for health coverage programs. The department's access promotion work also includes community health workers, promotion of cultural competence, advocacy for short-term expansion of health care coverage and advocacy for single payer reform for intermediate term.
- *Lack of system integration* (Innovation). The department works to address the health care system's current lack of system integration by supporting coalitions, partnerships, councils and other mechanisms for systems integration and coordination. Now in its tenth year, the King County Health Action Plan is a seasoned coalition convened by PH-SKC in partnership with over thirty additional organizations. The mission of the Action Plan is to implement innovative collaborative policy development and pilot projects that focus on system change and improvement of worsening health trends affecting vulnerable populations within Seattle and King County. Kids Get Care and the Children's Health Improvement Collaborative are two of the Action Plan's largest programs.

  Another example is the King County Asthma Forum (KCAF). The KCAF is a coalition of schools, public health and housing agencies, academic institutions, hospital systems, health plans, community clinics and other health providers, and community organizations created in 1998 through a joint effort of the American Lung Association of Washington and Public Health - Seattle & King County. The Forum has opened communication channels among members, worked on assessing school asthma-related policies and developing model policies, and participated in activities of the Washington State Asthma Initiative. The Forum broadened membership to include additional community-based organizations, established a defined structure and governance process, and secured funding to expand the scope of work.
- *Monitoring and evaluation* (Best Practice).Last, the department has important monitoring and evaluation responsibilities to track and report on child health indicators and determinants and to evaluate policies and programs.

  The Public Health Core Indicators Project is a set of indicators measuring the health of King County residents. It was developed to provide a broad array of comprehensive, population-based data to community-based organizations, community clinics, public agencies, policymakers and the general public in an accessible format. Core Indicators were conceived as a follow-up to the 2002 Institute of Medicine report, The Future of the Public's Health in the 21st Century, which emphasizes relying on data about the entire

community to look at multiple determinants of health. Our indicators are organized into the following subject areas: health determinants, access to care, risk factors and health outcomes. Within each subject area, indicators are arranged by topic. Each topic has one or more indicators. The Core Indicators project presents available data for these health determinants. For each indicator, linked tables, maps and charts present the most recent data, trend over time, demographic comparisons, neighborhood-level data, comparisons to other metropolitan counties and the related Healthy People 2010 objective. The complete range of this data is not available for every measure.

Appendix 4: Children's Health Access Task Force Report, August 2006

The entire report including appendices can be found at:
www.metrokc.gov/exec/chatf

Healthy Children:
Health Care Coverage and Access for King County's Low-Income Kids

Children's Health Access Task Force
Final Report

August 2006

King County

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES

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Additional information can be found on the web, at: www.metrokc.gov/exec/chatf

ATTACHMENT B
12507

Washington State Department of Health

ODESSA BROWN CHILDREN'S CLINIC

August 2006

King County Executive Ron Sims
701 Fifth Ave. Suite 3210
Seattle, WA 98104

Dear Executive Sims,

It has been an honor to co-chair the King County Children's Health Access Task Force from April to June 2006. Thank you for this opportunity to serve, and for your incredible vision and energy. We are especially proud that King County is taking a pro-active stance on this issue of providing better healthcare and dental care to children from low-income families.

With this letter we are transmitting the recommendations of the Task Force, which advises you to expand access and outreach activities for health care coverage immediately, and to create a Children's Health Initiative that will offer health coverage to children in low-income families in King County who are not eligible for state or federal programs. For Phase 1, in the remainder of 2006, we recommend targeting outreach to families who are currently uninsured yet eligible for state and federal health insurance programs. In Phase 2 in early 2007, we recommend launching a new health and dental coverage program for children in low-income and working poor families with incomes up to 300 percent of the federal poverty level. By 2010, we will reach a Phase 3 where the state achieves its pledge to cover all children in Washington State.

Bringing health care coverage and access to needed services to low-income King County children is the *Right Cause,* for the *Right Reasons;* it is on the *Right Scale* and solutions are needed *Right Now* We need to start making smarter investments in health care services. It would be difficult to find anyone who would say that today's status quo healthcare is adequate or acceptable. Our current system often leads to the highest possible costs by failing to promote prevention or lower cost early interventions. The health burden of uninsured and under-insured children in King County is a burden that all of us bear in more ways than might be appreciated.

Bringing health care coverage and access to needed services to low-income King County children in this program is an opportunity to turn the page in King County. We have good reference models and lessons learned from some similar piloting efforts in counties in other states. Local expertise has been brought together in an energetic task force with a comprehensive knowledge of the healthcare system.

The scope of this program is appropriate because in King County we are addressing the health needs of a manageable number of children. This provides for a logistically efficient model to pilot health coverage solutions. This size program is more easily feathered into the existing healthcare system

without disrupting other forms of coverage or services. Manageable scope also allows for accurate measurement and tracking of its effectiveness. This is especially important as it informs larger statewide strategies in accord with Governor Gregoire's 2010 goal to cover all children in Washington.

Once again, we were honored to serve as co-chairs of the King County Children's Health Access Task Force, and we and the rest of the Task Force are ready to work with you to assure that we do the best we can for our children's health. We close this letter with the quote you used in the "State of the County" address on May 22, 2006 when you spoke of your commitment to children's health:

> Many things we need can wait. The child cannot. Now is the time his bones are being formed, his blood is being made, his mind is being developed. To him we cannot say tomorrow, his name is today.
>
> *-Gabriela Mistral, Chilean poet, 1889-1957*

With appreciation,

Maxine Hayes, M.D., MPH
State Health Officer
Washington State Department of Health

Benjamin Danielson, M.D.
Medical Director
Odessa Brown Children's Clinic

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EXECUTIVE SUMMARY

An estimated 16,000 children living in King County (4%) have no health insurance, according to 2004 survey data. About half of these 16,000 uninsured children are eligible for existing publicly-funded insurance programs. After Public Health-Seattle & King County (PHSKC) conducted an internal study on uninsured low-income children in King County, County Executive Ron Sims concluded that the County has a unique opportunity. In partnership with the State of Washington, which has declared its intention to cover all children in the state by 2010, the County has begun work to design an innovative program to provide health and dental insurance coverage and access to a medical home – a regular source of healthcare that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective – for most of the 16,000 children uninsured in King County.

To make a difference in children's health, it is essential to have both health care coverage and a health care delivery system that is ready to provide early preventive services and link children to needed care. Recognizing this dynamic, in April 2006, King County Executive Sims convened a Children's Health Access Task Force (CHATF) of child health experts to advise King County on the creation of an innovative county-based children's health program. Dr. Maxine Hayes, the Washington State Health Officer, and Dr. Ben Danielson, the Medical Director at Odessa Brown Children's Clinic, co-chaired the Task Force, with support from Milliman consultants and actuaries who carried out actuarial and programmatic analyses of various program designs. The Task Force met three times between April and June 2006 and recommended the creation of a program that will dovetail with the State's 2010 goal and build on the innovative work of the King County Health Action Plan, such as the Kids Get Care program.

Task Force Recommendations

The Task Force recommends a phased approach to improving the health of low-income children, starting with an outreach and access phase in 2006, followed in 2007 by a health insurance program to fill in the "gap" left by current public coverage programs and culminating in 2010 with full statewide coverage.

Phase 1: Outreach and Access Improvement: The Task Force recommends investing funds to identify and sign up the estimated 8,000 low-income children eligible for existing publicly funded insurance programs by implementing a targeted access and outreach program, and connecting families to comprehensive preventive services including oral and mental health and a medical home.

Phase 2: "Gap" Insurance Program for Children: The Task Force recommends creating a basic gap medical and dental insurance program that would be offered to an estimated 5,000 children in families under 300 percent of the federal poverty level or children who are not eligible for existing public or private programs. These programs will be similar to existing publicly-funded health programs in terms of benefits, eligibility and cost, and have minimal cost sharing.

Phase 3: Consolidation with State Programs in 2010: Governor Gregoire has set a goal for the State of Washington that all children in the state will be covered by health insurance by 2010. By 2010, the King County program should either be consolidated into the state's coverage programs or the state should provide the financial resources to King County to continue this program as a component of the state's overall strategy.

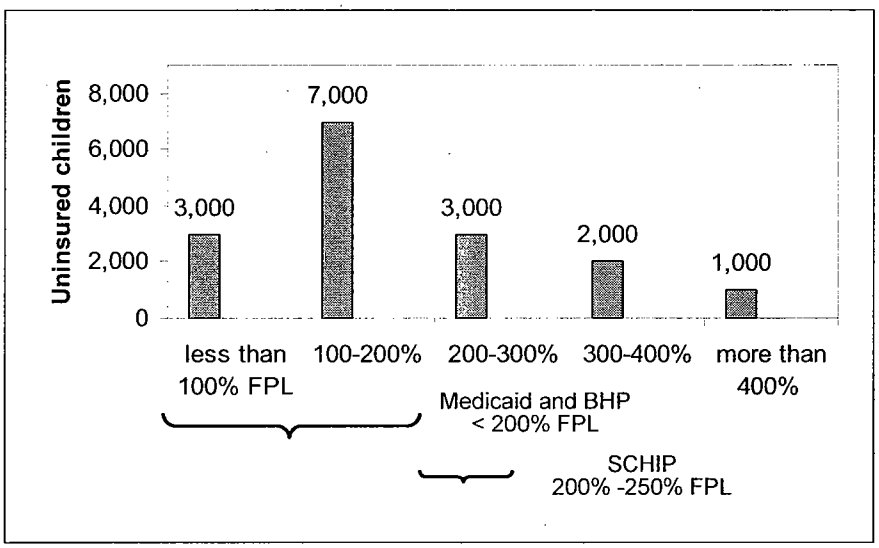
In addition, the Task Force recommends King County aggressively seek partners and funding opportunities, conduct a comprehensive evaluation of the initiative, coordinate efforts with the State of Washington's child health expansion efforts, and employ strategies that reward quality and efficiency that align with the goals of prevention and overall improved health status.

As next steps, the Task Force proposes that Task Force staff continue to finalize the programmatic and financial information necessary to move the proposed program through King County's decision process with the King County Council and to explore funding partnerships with foundations and private organizations. Concurrently, the Task Force recommends that two committees be established to steer the implementation process—an Outreach Committee, and an Operations and Policy Committee – to guide outreach strategies and provide general oversight and guidance, respectively, As the committees develop an implementation strategy, the Task Force strongly recommends they adopt innovative program design features and reimbursement strategies that promote the use of incentives to improve health status and align with the work of the Puget Sound Health Alliance.

BACKGROUND

An estimated 16,000 children in King County (4%) have no health insurance, according to 2004 survey data.[1] About half of these 16,000 uninsured children are eligible for existing programs: Medicaid, Washington State Children's Health Insurance Program (SCHIP) or Basic Health Plan (BHP) coverage. Medicaid covers about 460,000 children statewide below 200 percent of the federal poverty level (FPL). SCHIP covers about 11,000 children statewide from 200 percent to 250 percent of the FPL, and excludes immigrant children. Basic Health covers about 15,000 children living in Washington up to 200 percent of the FPL, with limited benefits, e.g. no dental or physical therapy, and substantial cost sharing.

Chart 1. Uninsured children by family income level in King County, 2004



Consequences of being uninsured and access to care barriers

Data show that uninsured children have less access to health care, are less likely to have a regular source of primary care or medical home and use medical and dental care less often compared to children who have insurance.[2] Data also show that access to early preventive health care services can profoundly improve the trajectory of a child's health and well-being and readiness for school. Undiagnosed and untreated conditions that are amenable to control, cure, or prevention can affect children's functioning and opportunities over the course of their lives.[3] Even with presence of

health insurance such as Medicaid coverage, access to proper health and dental services may be difficult.[4] For example, only 31 percent of King County children under age six with Medicaid received any dental services in 2004.[5] Access improvement programs, such as the Access to Baby and Child Dentistry (ABCD), have worked with physicians, dentists and public health departments to increase the percentage of children receiving early preventive dental care. For more examples and citations, please see the feasibility study conducted by Public Health-Seattle & King County (PHSKC) in Appendix A.

Costs of the uninsured

The real costs of uninsured children far exceed the costs of providing coverage because children without health insurance eventually receive care from emergency rooms or other safety net providers, where the cost of care is often greater than it would have been if these children had received preventive care or early treatment for a health problem. Children's Hospital & Medical Center in Seattle provided $7.5 million or 2.1 percent of revenue in charity care in 2005. The Public Health-Seattle & King County clinics provided about 3,000 primary care visits to 1,900 uninsured children in 2005 at a cost of approximately $550,000. The community health centers in King County bear a higher financial burden; they provided care to an additional 7,000 to 9,000 uninsured children in 2005.[6]

Improving Access and Coverage for Children

Insured children have better access to a medical home or regular source of care, and through medical homes have better access to appropriate and timely prevention, detection and care. The California Health Status Assessment Project found that children who were enrolled in health insurance improved their school performance ("paying attention in class" and "keeping up with the school activities") by 68 percent. Improved access and coverage also brings savings. In San Mateo County, California, the Child Health Initiative program was associated with a 58 percent decline in uninsured hospital stays for children in nearby hospitals.

CHILDREN'S HEALTH ACCESS TASK FORCE & ITS CHARGE

To make a difference in children's health, it is essential to have both health care coverage and a health care delivery system that is ready to provide early preventive services and link children to needed care. This is a key lesson learned as states such as Vermont and California have embarked on initiatives to improve the health of children. King County has a unique opportunity to create a program to extend coverage and access to low-income children currently without health insurance in partnership with the State of Washington, which has declared an intention to cover all children in the state by 2010.

To explore the potential of such a program, King County Executive Sims called upon PHSKC to conduct a feasibility study to analyze the costs, potential savings, potential revenue sources, benefit package modeling, delivery system linkages and enhanced prevention services necessary to pilot an expansion of health coverage and access to all low-income children living in King County with incomes up to 300 percent of the FPL. That work was completed in the spring of 2006 (see Appendix A for Feasibility Study).

In April 2006, following review of the feasibility study findings, King County Executive Sims convened a Children's Health Access Task Force (CHATF) of child health experts to advise King County on the creation of an innovative county-based children's health program. (See Appendix B for invitation letter from Executive Sims). Dr. Maxine Hayes, the Washington State Health Officer, and Dr. Ben Danielson, the Medical Director at Odessa Brown Children's Clinic co-chaired the Task Force. The Task Force's work was supported by Milliman Consultants and Actuaries who carried out actuarial analyses of various program designs and by staff from the Office of King County Executive and the King County Health Action Plan (PHSKC), an existing coalition of public and private health care delivery system representatives, several of whom served on the Task Force.

The Task Force was asked to consider the feasibility study and to respond to the Executive's goals for a King County children's health program that would:

- Create an innovative program that can fill the existing gap in coverage for low-income children

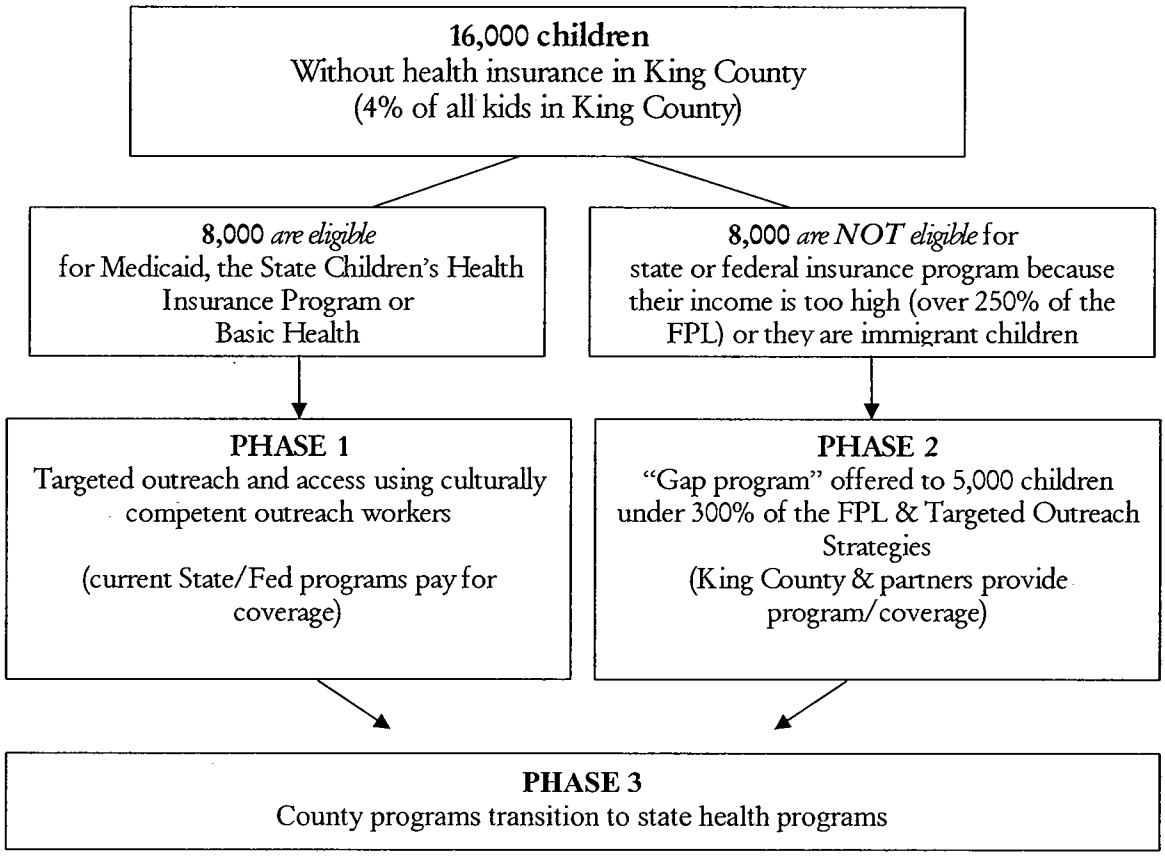
- Design and implement a model program that will expand coverage and improve access on a cost effective basis

The Task Force has now completed its work and what follows are their recommendations.

RECOMMENDATIONS

The Task Force recommends that King County implement a phased in approach to improving the health of low-income children, starting with an outreach and access phase in 2006 and following in 2007 with a health insurance program to fill in the "gap" left by current public coverage programs (see Figure 1 below). A third phase will ensue as the County program transitions into the state children's coverage expansions.

Figure 1. King County's Child Health Coverage



Phase 1: Outreach and Access Improvement Elements

The Task Force recommends investing funds to identify low-income children eligible for existing publicly funded insurance programs by implementing a targeted access and outreach program, beginning in Fall 2006. Strategies include funding new outreach staff and community health workers who are trusted communicators to help sign up the estimated 8,000 children for the coverage they qualify for, and to connect them to comprehensive preventive services including oral and mental health and a medical home. This investment is projected to connect the majority of children eligible for Medicaid and SCHIP to a medical home and health insurance.

Also included in Phase 1 are the start up costs of the gap insurance program, including hiring a program manager, writing a request for proposals for health plans to cover children in 2007, funding for a rigorous evaluation, and establishing operational expertise for processing applications from families.

Phase 2: "Gap" Insurance Program for Children

Beginning in 2007, the Task Force recommends creating a gap insurance program that would be offered to 5,000 children in families under 300 percent of the FPL or children who are not eligible for existing public or private programs. Children in families over 300 percent of the FPL are not eligible for this gap insurance program. Final enrollment targets will be determined by the level of funding available to the new program.

The Task Force recommends that the new King County gap coverage program offer similar health and dental benefits as Washington State's Healthy Options (Medicaid) benefits for children in families with incomes up to 300 percent of the FPL ($49,800 for a family of three, $60,000 for a family of four). Cost sharing is imposed for families with incomes between 200 and 300 percent of the FPL but not for families with incomes below 200 percent of the FPL, except for a modest copayment for brand name prescription drugs. As program staff talk to families about the new program, it is expected that they will find an equal or larger number of families eligible for current coverage programs.

Details about the access improvement elements, eligibility, benefits, and cost sharing levels recommended by the Task Force follow in tabular format, starting on page 9. The estimated actuarial costs of the medical and dental program models are as follows:

Proposed Medical and Dental Benefit Plans for King County Gap Insurance Program	Per Member Per Month Net Claim Cost
Medical benefit plan for children 200 – 300 percent of FPL	$76.38
Medical benefit plan for children below 200 percent of FPL	$84.28
Dental benefit plan for children under 300 percent of FPL	$28.03

For Milliman's detailed actuarial analysis see Appendix C.

Related to Phase 1 and Phase 2, the Task Force recommends a number of general programmatic components be employed:

- **Seek partners and funding opportunities.** King County should partner with the State of Washington and should aggressively solicit financial support from local and national private organizations and foundations. The recommended three-phase approach will not succeed without the involvement and support of local stakeholders. When implemented, these three phases will provide immeasurable benefits to uninsured and underinsured children as well as the entire King County community.

- **Coordinate and collaborate with the Governor's Office and State.** King County should work closely with the Governor's Office and the State of Washington to ensure that the county's program will segue effectively into the upcoming state initiative. Child health will only make significant improvements if local, state and national efforts and strategies are coordinated and complement, not conflict, with each other.

- **Conduct a comprehensive evaluation of Phases 1 and 2.** King County's Children's Health Initiative should dedicate sufficient resources and funds to conduct a comprehensive evaluation of the different programmatic components. Being able to demonstrate improvement based on performance assessment will be a necessity for the phased approach to maximize its operational

effectiveness and stay within budget. Equally important, performance and outcome results will inform the State's effort as it develops its strategy to cover all kids in 2010. For example, potential performance measures of success for Phase 1 would include the number of accepted applications for Medicaid, SCHIP and other publicly funded insurance, the number of new children with a regular source of medical and dental care, and the number of trained community agency staff e.g. child care workers. For Phase 2, promising measures include the number of new children with coverage, the number of new children with a regular source of medical and dental care, the number of children up-to-date with well child visits, the number of children up-to-date with immunizations, reductions in emergency room visits, reductions in unnecessary hospitalizations, reduced access barriers, and others.

- **Employ strategies that reward quality and efficiency that align with the goals of prevention.** King County's Children's Health Initiative, through its Policy Committee, should pursue connections with the Puget Sound Health Alliance to reward providers who provide preventive care and quality health care services to children that lead to improved health status.[1] The Puget Sound Health Alliance is a regional nonprofit founded and led by the King County Executive and in which King County is a major participant, to improve the quality of health care in the Puget Sound region.

Phase 3: Consolidation with State Programs in 2010

In Phase 3, the King County children's coverage programs will segue into the state program expansions. By 2010, the King County program should either be consolidated into the state's coverage programs or the state should provide the financial resources to King County to continue this program as a component of the state's overall strategy.

[1] The Alliance in December 2005 adopted the Institute of Medicine (IOM) starter set of measures. There are at least three dozen pediatric or child-related measures in the IOM starter set for pre-natal care, childbirth, neonatal care, childhood wellness and immunizations, childhood access to care, adolescent immunizations, pediatric asthma care, pediatric upper respiratory infection (URI) treatment, pediatric pharyngitis care, and parents' satisfaction with their children's health care.

Outreach and Access Improvement Elements

Purpose	Proposed Design	Goal
Phase 1: In the Community (Beginning Fall 2006): Outreach and Access Improvement Elements		
Promote advantages of prevention and assist families to enroll in coverage and access needed care	**Outreach Teams** Create four teams consisting of an application worker, community health worker and health educator Teams in each of four geographically targeted areas: • East King County • Seattle, White Center and North King County • South King County—Des Moines to Renton • South King County—Federal Way, Kent and Auburn	Increase coverage rates and early access to health care for low income populations in targeted areas as measured by increases in enrollees and children with medical and dental homes. Increase the focus on the advantages of prevention, especially among cultures in which preventive care is not accessed, to increase the rates of immunizations, well-child checks, developmental screening, early oral health exams, fluoride varnishes, and sealants. Find children eligible but not enrolled for current programs in '06, and for the new county gap program in '07 and assist with enrollment, linkage to a health care home, and navigating the health care system Provide culturally effective, tailored health messages in enrollees' first language when necessary (including translated materials). Additional target populations include at-risk children such as homeless youth and those in detention centers Teach families and community staff who work with children about the benefits of preventive care

Phase 2: In the Clinic (Beginning 2007): Care Coordination and Behavioral Health		
Link families to needed wrap around services and promote integrated preventive care	**Care Coordination** Hire one Patient Care Coordinator per 2,000 children at one or multiple health care provider sites. Staff four sites in 2007 and, pending evaluation of the cost effectiveness of this model, seven sites in 2008. Patient Care Coordinators provide a single point of contact for community agency staff and families. They assist with securing needed preventive care, chronic care, wrap around services, referrals, and follow-up care.	Care Coordinators can assist clinics to increase well child visits by 41%, oral health screens by 104% and developmental screenings 72-fold.

Eligibility and Benefits

	Proposed Design	Rationale
Phase 2 (January 2007): "Gap" Insurance Program for Children		
Age	Up to 19	Same as Medicaid and SCHIP
Residency	King County residents	Same as California county programs
Income	• Children in families between 200%-300% of FPL Family of 2: $26,400 – $39,600 Family of 3: $33,200 - $49,800 Family of 4: $40,000 - $60,000 • Children not eligible for existing insurance programs due to immigration status (0-300% of FPL)	All but one of the California county programs extend to 300%, Santa Clara County goes to 400%; the goal of the gap program is to provide insurance to lower-income middle-class families, not to subsidize those families who are able to afford employer-based coverage.
Other	Uninsured children ineligible for other health care coverage	
Waiting period protection (the period of time during which must be uninsured before enrolling)	3 months	Los Angeles (CA) has 3 month waiting period. After 2 years there is very little evidence "crowd out," i.e. when enrollees drop private health insurance and the public program is thought of as "crowding out" private coverage (one out of 2,000 persons who applied previously had employer-based private coverage). San Mateo (CA) has 6 months. There is little evidence of crowd out from private insurance. New Jersey over the last 5 years has lowered their crowd out provision from 12 to 6 to 3 months because there has very little evidence of crowd out.
Pre-existing condition waiting	None for general population, but 9 months for transplants, lipid storage diseases, malignancy, hemophilia and	This provision is imposed so that the new gap program does not create an incentive for families living outside King County with severely ill children to move. The Task Force

	Proposed Design	Rationale
period	congenital malformations	acknowledges that this provision is not consistent with the goal of expanding access and coverage to children, but feels the need to have this rule in place to keep premiums affordable and to retain the intention of expanding coverage to King County families. This provision will enable children to get routine care and treatment for common conditions like asthma, therefore making it attractive for children to join without putting the program in financial strain.
Medical	Same as Medicaid	
Dental	Same as fee-for-service Medical Assistance Administration (MAA); added Access to Baby and Child Dentistry cost additions	The ABCD Program, now in 25 WA counties, has been shown to be effective in increasing the number of young children receiving early preventive services On average, ABCD-trained dentists receive an additional 10-30% reimbursement for preventive services
Vision	Same as fee-for-service Medicaid	
Mental health	24 outpatient visits 30 inpatient days Comparable to Medicaid	Under Medicaid, enrollees receive up to 12 outpatient visits through their managed care plan and if they need further services these are obtained through the Regional Support Networks, (RSN), without standard visit or day limits. The RSNs have severely limited capacity to serve new patients, especially those with mild to moderate mental health conditions who do not qualify as severely emotionally disturbed. The Task Force felt that a 24 visit and 30 inpatient day benefit was comparable and probably slightly less comprehensive than Medicaid mental health coverage, but that it was affordable and would meet the needs of most families. The Task Force supports an innovative delivery side strategy placing behavioral health specialists in the clinic in order to increase

	Proposed Design	Rationale
		access for children needing mild to moderate mental health care—a need that is not adequately met by the RSNs.
Substance abuse services	Same as Medicaid or up to a specific dollar limit	

Proposed Cost Sharing Features

	Below 200% FPL	Between 200% - 300% FPL	Rationale
Monthly Premiums	No	$15 per child per month, $45 max per family A hardship fund for premium assistance also will be created.	*Below 200% of FPL* • Medicaid does not have premiums. • The families of these eligible children do not have the means to pay premiums. *Between 200%-300% of FPL* • WA SCHIP program premium is $15. • Aligns with program goals of simplicity (as it is the same premium as SCHIP). • It is a reasonable and affordable amount substantially lower than 5% of income for those families who are between 200-300% of FPL. • A $15 premium is typical for other children's health insurance programs for children of the same income. San Mateo (CA) has a $6 premium per child per month for 200-250% and $12 per child per month for 251-300%. Illinois is proposing a $40 premium ($80 max) for this income level.
Deductible	$0	$0	Medicaid & SCHIP do not have a deductible.
Preventive visits	$0	$0	Medicaid & SCHIP do not have copayments for preventive care. The Task Force wants to

	Below 200% FPL	Between 200% - 300% FPL	Rationale
			encourage preventive care, not discourage it.
Office visits copayments	$0	$15	*Below 200% of FPL* • No copay currently exists under Medicaid/Healthy Options. • Copayments lead to poorer health for those with low incomes (low incomes = below 200% FPL). Among low-income adults and children, health status was considerably worse for those who had to make copayments than for those who did not (RAND study). *Between 200%-300% of FPL* • The Task Force believes lower-income middle class families above 250% of FPL have the means to afford a modest copayment for office visits. • A $5 and $10 copayment was dismissed because the administrative costs to process the payment are almost as high as the copayment amount.
Outpatient, radiology, lab, etc.	$0	$0	Medicaid & SCHIP do not charge copayments for outpatient, radiology, etc.
Inpatient hospital	$0	$0	Medicaid & SCHIP do not charge copayments for inpatient hospital visits.
Emergency room visit	$0	$25	*Below 200% of FPL* • No copay currently exists under Medicaid/Healthy Options. A $5 or modest ER copay was dismissed due to the administrative costs to process the payment. *Between 200%-300% of FPL* • The Task Force overall recommended a modest ER copay to encourage preventive care

	Below 200% FPL	Between 200% - 300% FPL	Rationale
			and appropriate ER use.
Prescription drugs	$0 generics; $10 brand name	$0 generics; $10 brand name	The Task Force advises a $0 copay on generics and modest copay on brand name drugs to incent use of generics.

PROPOSED IMPLEMENTATION PLAN

The Task Force has provided the framework for a comprehensive program that will bring health care to thousands of children in King County. Now that the framework is complete, the Task Force recommends that PHSKC staff begin to plan the implementation process described below. The goal is to have the program ready to go once the final policy and funding decisions are made. The Task Force recognizes that this report is a recommendation to the King County Executive and that implementation requires legislative and budgetary action by the Executive and the King County Council. Therefore, while the Task Force strongly recommends that King County implement the program in accordance with the framework described in the report, we understand that the Executive and the Council may need to adjust certain elements or the timeline as the program is enacted.

Phase 1: October – December 2006

Identifying Children Eligible for Existing Programs

Successful implementation of the enhanced outreach and access component of the system calls for staff work to proceed with program design tasks. To bring eligible children into existing health insurance programs during fall and early winter of 2006, PHSKC will convene an Outreach Committee in the summer to begin collaborating with staff on implementation planning for the Access Improvement design. The Committee will assist in determining the most effective methods for:

- Identifying the optimal locations for community health educators, community health workers, and outreach workers

- Establishing the necessary connections with community health providers, Department of Social and Health Services staff, social service agencies, and other entities that serve families

- Determining the appropriate sequencing for adding outreach and access capacity

- Developing evaluation criteria and outcome measures that will be used to assess effectiveness for the Access Improvement component.

Designing Program Operations

The program design for Phase 1 calls for both locating and enrolling children in existing health coverage programs for which they are eligible. The Access Improvement efforts outlined above will identify these children and the actual enrollment of eligible children into these programs must follow as the next step. In addition to the enrollment process, there are a variety of other operational issues to address in order to move forward with Phase 1, including turning the Task Force's recommendations into an operational plan, writing a request for proposals for the health plans that will cover uninsured children in Phase 2, preparing pre-launch promotional activities, collecting baseline evaluation data, and establishing administrative procedures for handling applications.

Phase 2: Coverage and Improved Access for Low-Income Children - January 2007

Identifying Children for the New Program

Running parallel to its work on Phase 1, the Outreach Committee will begin work on elements that are essential for the successful roll-out of Phase 2. While much of the Committee's Phase 1 access improvement work will carry over to Phase 2, additional issues and general guidance will need to be addressed in order to identify children eligible for enrollment in the county's new health insurance program. For example, the Committee will assist in designing methods to address the following issues:

- Linking the program implementation for children involved in Phase 1 of the program to the additional children obtaining coverage during Phase 2

- Defining the outcome measures that will assess the effectiveness of the Phase 2 Access Improvement initiatives.

Defining Program Operations and Policy

The continued participation of many of the Task Force members and the knowledge and expertise that they bring will be important as the program design is refined, and during the implementation of the new program. PHSKC should convene an Operations and Policy Committee to assist staff in moving the program from the drawing board to the field. Among the issues the Committee will address, the following are particularly important:

- Guiding the Children's Health Initiative to ensure the initiative meets programmatic goals and financial guidelines

- Recruiting collaborators and funding partners and articulating the roles that they will play, and defining how these roles fit together, including the participating health plans, Public Health-Seattle & King County, the community clinics, other primary care providers, DSHS, etc.

- Collaborating with the Puget Sound Health Alliance to promote and reward quality health care such as preventive care and improved health status

- Identifying an overall evaluation plan and outcome measures, e.g. improvement in prevention and mental health that will track the effectiveness of the program in improving the ability of low-income families to access health care for their children

Phase 3: Coordinating with State Children's Coverage Expansions

The Task Force recommends continued collaboration and coordination with state efforts to cover all children by 2010. It is the intention of the Task Force that program features of interest to the state could be piloted in the King County program. Consequently, evaluation activities will be critical for the County initiative to demonstrate value for the state process.

Next Steps

As the implementation planning moves forward, the Task Force proposes that Task Force staff continue to finalize the programmatic and financial information necessary to move the proposed program through King County's decision-making process. As stated above, staff should stay in close communication with the Governor's Office and other state leaders to ensure that the King County program creates a strong foundation for future initiatives to expand health care coverage for low-income children.

ENDNOTES

[1] 2004v3M Washington State Population Survey.

[2] Institute of Medicine (IOM). 2002. *Health Insurance is a Family Matter.* Washington, DC: National Academy Press.

[3] Forest, Christopher and A. Riley. September/October 2004. "Childhood Origins of Adult Health: A Basis For Life-Course Health Policy." *Health Affairs* 23 (5): 155-164.

[4] Rosenbach, Margo, C. Irvin, R. Coulam. 1999. "Access for Low-income Children: Is Health Insurance Enough?" *Pediatrics* 103 (6): 1167-1175.

[5] Fiscal Year 2004 Medicaid Utilization Report.

[6] 2005 Year End Demographic Snapshot: Primary Medical Care Patients, Prepared by Tim Burak, February 23, 2006, PHSKC Community Health Center Partnerships Program.

Appendix 5: Analysis of CHI Using the Public Health Operational Master Plan Policy Framework

The Policy Framework for the Public Health Operational Master Plan (PHOMP) offers a structure to examine what public health and the public health department's role should be to improve children's health in King County. This section of the report uses the Policy Framework to analyze the role of Public Health-Seattle & King County and public health sector partners to improve children's health.

I. King County's Mission & Goal for the Health of the Public

King County Government's mission, through its Executive, County Council, Board of Health and the Department of Public Health, is to identify and promote the conditions under which all people can live within healthy communities and can achieve optimum health.

King County's goal is to protect and improve the health and well-being of people in King County, as defined by per person healthy years lived. In the context of achieving this goal, whenever possible, King County will employ strategies, policies and interventions to reduce health disparities across all segments of the population.

II. Guiding Principles
King County's Public Health strategies, policies and programs shall be:

1. **Based on Science and Evidence: King County's public health strategies are based whenever possible on science and evidence.**

The evidence for carrying out culturally tailored outreach and access improvement activities for low-income children come from the research literature analyzed below by Vicki Wilson, PhD, "Cover All Children-Why?," Washington State Office of Financial Management, State Planning Grant for the Uninsured, 2005.

So, can we say beyond reasonable doubt that coverage leads to better outcomes, healthier children, and more productive adults? All in all, yes.

However, to be honest, the pathway is a bit indirect and based on a chain of logic: Coverage leading to better access, access leading to increased and more appropriate use of services, more appropriate use leading to better outcomes, and finally, better outcomes leading to healthier kids growing into healthier, more productive adults. The following quotes serve to illustrate this chain.

- "Uninsured children have less access to health care, are less likely to have a regular source of primary care, and use medical and dental care less often compared to children who have insurance. Children with gaps in health insurance coverage have worse access than do those with continuous coverage."[33]

- "Previously uninsured children experience significant increases in both access to and more appropriate use of health care services following their enrollment in public health insurance programs."[34]

- "Uninsured children often receive care late in the development of a health problem or do not receive any care. As a result, they are at higher risk for hospitalization for conditions amenable to timely outpatient care and for missed diagnoses of serious and even life-threatening conditions."[35]

- "Undiagnosed and untreated conditions that are amenable to control, cure, or prevention can affect children's functioning and opportunities over the course of their lives. Such conditions include iron deficiency anemia, otitis media, asthma, and attention deficit-hyperactivity disorder."[36] (Health Insurance is a Family Matter, page 124)

- "... the connections between health insurance and life chances relate to their [children's] ability to achieve normal developmental milestones and to benefit from schooling." "The Committee concluded ... that providing health insurance to children would improve health outcomes for conditions critical to their normal development and opportunities for success in school."[37]

- "...there is growing evidence that poor health in childhood can have profound effects on future outcomes, both because of effects on adult health, and because of effects on the accumulation of other forms of human capital such as education." "... poor health in childhood is associated with reduced educational attainment. In turn, individuals with less schooling receive lower wages and have weaker labor force attachment."[38]

In sum, researchers' reviews of the literature conclude that the preponderance of evidence supports the following picture:

- health insurance impacts the quantity & quality of medical care used by children (most importantly through facilitating access to a medical home),
- medical care use influences health,
- health affects educational attainment, work effort, productivity, and ultimately income.

The most clear evidence is around the first two bullets – insured children have better access to medical homes , and through medical homes (& more importantly, a specific medical home provider) better access to appropriate and timely prevention, detection and care.

With respect to the third bullet, there is growing evidence that childhood health can have major impacts on future outcomes (e.g., poor childhood health is associated with lower educational attainment, and lower probability of employment and lower earnings in middle-age) but the exact mechanisms that tie health insurance, health, education, and future labor market success are not yet clear. (Vicki Wilson, "Cover All Children-Why?," Washington State Office of Financial Management, State Planning Grant for the Uninsured, 2005)

2. **Focused on Prevention: King County recognizes that the best investments are those that prevent disease and promote good health. Prevention and promotion strategies achieve optimal health impact in the most cost-effective manner.**

Preventive approaches are especially important for children, who can expect many years of healthy life if they have the foundation of a healthy youth. The Children's Health Initiative is based on the premise that many children's physical, mental, developmental and oral health problems can be prevented if identified and treated early on. The outreach and access improvement activities focus on education to parents and social service agency staff about the importance of immunizations and comprehensive preventive care for children. The care coordinators working in safety net medical practices work to assure that when children are treated, coordinated and integrated preventive services are delivered.

The schedule and content of preventive health care visits for children is established by the US Preventive Health Services Task Force[39] and the American Academy of Pediatrics.[40] The Children's Health Initiative outreach and linkage activities are based on these established schedules of comprehensive preventive care.

An assertive case management model can increase access to comprehensive preventive services for low-income children who were currently under-utilizing preventive medical and dental services. The Medicaid program has supported the use of case managers to enable improved access to care by allowing payment for case manager services in the Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT) legislation passed in 1989.[41] More recently, the North Carolina Community Care program has demonstrated the value of using case managers for low-income families to increase access to primary care services while lowering hospital admission rates for children.[42] Case management models also have been used to increase the delivery of primary care services and reduce hospital utilization among groups of children with specific chronic health conditions, such as asthma and diabetes.[43, 44]

By delivering comprehensive preventive services for children, including medical, dental, developmental and mental health care, Kids Get Care provides a holistic strategy to promote prevention.

3. **Centered on the Community: King County's public health solutions require collaboration of the entire community. In order to arrive at solutions which best meet the needs of all, King County's public health system must include partnerships with a wide variety of communities, government agencies and private organizations.**

The Children's Health Initiative is designed to be both shaped and implemented by community agencies. The shaping occurred initially through the community-based Task Force that developed recommendations for King County on how to improve children's health in the spring and summer of 2006. The Task Force was chaired by Dr. Ben Danielson, Medical Director, Odessa Brown Children's Clinic and Dr. Maxine Hayes, State Health Officer, Department of Health.

In 2007, the outreach and access improvement activities are guided by an Outreach and Health Innovation Pilot Project Steering Committee made up of outreach experts from around the county. The Outreach Implementation Committee is chaired by Teresita Batayola, Executive Director, International Community Health Services.
The outreach work will be implemented both by application and health education workers within the department and through contracts with community agencies, with half of the funding going to the department and half to community contracts.

4. **Driven by Social Justice: King County will proactively pursue the elimination of preventable differences in health among different population groups. Public health will be a voice for the needs of the weak, the poor, minorities and the disenfranchised.**

The outreach and access improvement activities of the Children's Health Initiative target the populations that have the highest level of poverty and uninsurance. Using geographic information system analysis allows the program to put the outreach teams to work in South King County. In general, isolated immigrant groups—pockets of immigrants and/or refugees who have significant language, cultural and literacy barriers—will be a particular focus for receiving assistance securing coverage and care. Examples of such groups in King County include Latino, Somali and other East Africans, Russian/Ukrainians and Vietnamese populations, especially those who are new to the U.S. Outreach staff and community agencies speak multiple languages representing the population. Hiring community health workers from the existing social networks allows messages about prevention and health promotion to reach vulnerable families in areas with the highest need. See Appendix 3 for a map of King County showing children living in families below poverty.

III. Public Health Functions

King County acknowledges that public health includes promotion of physical, behavioral, environmental, social, and economic conditions that improve health and well-being; preventing illness, disease, injury, and premature death; and creating health equity.

King County's governmental public health functions include:

1. **Health Protection: King County has fundamental and statutorily defined responsibilities and powers to protect the public's health.** These responsibilities include: tracking disease and other threats to the public's health; preventing communicable diseases; regulating dangerous environmental and workplace exposures; and ensuring the safety of water, air, and food. King County must also prepare for and respond to natural and human-made disaster and plays a leadership role in engaging the community in emergency preparedness.

2. **Health Promotion: King County is responsible for leading efforts to promote health and prevent chronic conditions and injuries** such as heart disease, diabetes, obesity, and traffic accidents. These complex health challenges are best addressed through voluntary actions by individuals and organizations in combination through governmental policies that make the right health choice the easy health choice. **Through a collaborative and**

educational approach, the department of public health encourages voluntary actions with science-based evidence and effective interventions that maximize people's ability to make healthy choices.

The Children's Health Initiative helps fulfill the department's responsibility to carry out health promotion activities through a collaborative and educational approach.

3. **Providing Preventive and Curative Quality Health Care Services:** King County's role in personal health care services is to help assure access to high quality health care for all populations. **Helping to assure access to quality health care includes convening and leading system-wide efforts to improve access and quality, advocating for access to quality health care for all, forming partnerships with services providers,** and/or directly providing individual health services when there are important public health reasons to do so.

The Children's Health Initiative helps assure that access to quality health care is improved for low-income children. Under the CHI this occurs in two ways; linkage to medical and dental homes performed by outreach staff and expanded capacity and service delivery improvements through partnerships with health care providers.

To fulfill its responsibilities in each of three functions listed above, the department undertakes the following types of activities:

A. Assessment: The department of public health must regularly track health status, identify emerging health problems and disease outbreaks, analyze health outcomes and interventions, and report on these to the public. Through this activity, the department supports the development of effective responses by all components of the public health system.

B. Policy Development: The department of public health must work in collaboration with community and government leaders to formulate evidence-based public policies designed to solve health problems.

C. Assurance: **The department of public health must engage policy-makers and the public in determining those services that will be guaranteed to every member of the community and ensure that these services are available through encouraging action by public and private entities,** implementing regulatory requirements, ensuring communities and the public health staff are prepared to respond to public health emergencies or directly providing services.

IV. Organizational Attributes of the Department of Public Health

King County intends that its department of public health shall:

- **Pursue excellence and innovation in public health practice, including prudent risk-taking and applied research;**

The CHI represents a best practice in public health, by partnering with community organizations to deliver health education, linkage to care and comprehensive preventive care.

- **Recruit and retain a talented, dedicated, well-trained and prepared workforce;**

  The CHI workforce will receive training through program leads and managers, and other community experts

- **Provide recognized leadership, both adaptive and directive;**

  Through the CHI, the County is demonstrating leadership by showing that covering all children and linking them to a medical home is feasible and effective.

- **Communicate clearly and accurately with our partners and the public;**

  Communications to partners and the public about the CHI can occur through regular updates to targeted participants and through the King County website.

- **Emphasize collaboration when so indicated;**

  The CHI is a collaboration between the County and community leaders to improve children's Health.

- **Develop and monitor state of the art tools and systems to protect the public's health, promote healthy communities and provide reliable, high quality public health services;**

  Regular data reports will be provided to the CHI Outreach Committee and the King County Council so that the project's effectiveness can be monitored.

- **Lead system-wide strategic planning and performance evaluation in order to continually improve effectiveness and to help assure that resources of the public health system are being effectively deployed to achieve priority health outcomes.**

  The Task Force offered a forum for system-wide strategic planning. Their recommendations show how current resources can be most effectively used to improve health. For example, enrolling uninsured yet eligible families into publicly funded health coverage brings state and federal health care dollars into King County.

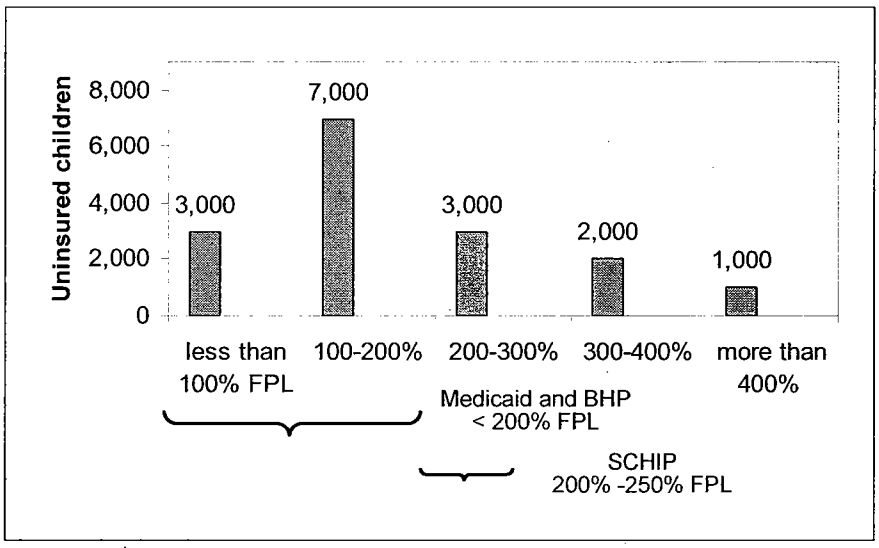
Appendix 6: Description of state and federal children's health programs

Medicaid, SCHIP, BHP, Children's Health Program, Governor's 2010 Goal
The Washington State Department of Social and Health Services (DSHS) operates several programs that provide publicly-funded health care coverage for children under age 19. The joint state-federal Medicaid program provides access to health coverage for children under age 19 living in households with family income at or below 200 percent of the federal poverty level. The joint state-federal State Children's Health Insurance Program (SCHIP) provides access to health coverage for children under age 19 living in households with family income at or below 250 percent of the federal poverty level. The Children's Health Program (CHP) provides state-funded coverage for children under age 18 with family incomes at or below 100 percent of the federal poverty level who are ineligible for Medicaid or SCHIP as a result of their immigration status. Basic Health and Basic Health Plus provide health coverage for children under age 19 in families earning up to 200 percent of the federal poverty level.

The Office of Financial Management's 2006 State Population Survey suggests that there are an estimated 72,600 children living in Washington households who are not covered by health insurance, which is 22,000 fewer than were estimated to be uninsured in 2004. Approximately 45,500 of these children are living in households with family income at or below 250 percent of the federal poverty level who are not covered by health insurance. There are an estimated 4,600 children living in families with household incomes between 250 percent and 300 percent of the federal poverty level who are not covered by health insurance.

An estimated 15,000 children in King County (4%) have no health insurance, according to 2006 survey data.[45] About 60 percent of these 15,000 uninsured children are eligible for existing programs: Medicaid, Washington State Children's Health Insurance Program (SCHIP), Children's Health Program or Basic Health Plan (BHP) coverage.

Chart 1. Uninsured children by family income level in King County, 2004



Legislation enacted in 2005 established the intent of the Legislature to provide health care coverage for all children in Washington by 2010.

Summary of the 2007 Children's Health Bill:

House Bill Report - 2 - 2SSB 5093
The DSHS will provide affordable health care coverage for all children under the age of 19 in families with household incomes of up to 250 percent of the federal poverty level. Effective January 1, 2009, the income eligibility standard will be increased to 300 percent of the federal poverty level, subject to the extent that funds are specifically appropriated for this purpose. In administering the program, the DSHS will take such actions as may be necessary to ensure federal financial participation under the Medicaid and SCHIP. The Caseload Forecast Council and the DSHS will estimate the anticipated caseloads and costs of this program.

The DSHS will modify its eligibility renewal procedures to lower the percentage of children failing to annually renew health care coverage and will report to the appropriate committees of the Legislature by December 2007. Children with family incomes greater than 200 percent of the federal poverty level will be charged premiums for health care coverage. For families with incomes greater than 250 percent of the federal poverty level, the premiums will be established in consultation with the Senate Majority and Minority Leaders and the Speaker and Minority Leader of the House of Representatives. The premiums will be based upon family income and will not exceed the premium limitations in the federal Social Security Act.

Beginning January 1, 2009, children with family incomes above 300 percent of the federal poverty limit will have an opportunity to purchase coverage from the DSHS without state subsidy.

The DSHS will undertake an outreach and education effort to identify and enroll eligible children, including contracting with community organizations and other governmental entities.

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