



Proposed Final Agenda

Wednesday • May 8, 2013 • 9:45 a.m. – 4:00 p.m.

Mount Zion Baptist Church, Fellowship Hall, 1634 19th Avenue, Seattle, WA 98122

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|------------------|--|--|
| 9:45 a.m. | CALL TO ORDER | Emma Medicine White Crow, Council Chair |
| 9:50 a.m. | 1. Approval of Agenda <i>—Action</i> | Emma Medicine White Crow, Council Chair |
| 9:55 a.m. | 2. Approval of February 13, 2013 Minutes <i>—Action</i> | Emma Medicine White Crow, Council Chair |
| 10:00 a.m. | 3. Announcements and Council Business | Christy Hoff, Council Staff |
| 10:15 a.m. | 4. State Partnership Grant Update | Yris Lance, Council Staff |
| 10:30 a.m. | 5. Discussion – Implementation of Environmental Exposures and Hazards Recommendations | Emma Medicine White Crow, Council Chair Christy Hoff, Council Staff |
| 11:15 a.m. | 6. Briefing – Early Achievers Program | Emma Medicine White Crow, Council Chair Jonathan Green, Council Member Char Goodreau, Department of Early Learning |
| 11:45 a.m. | LUNCH | |
| 1:00 p.m. | 7. Briefing – Health Benefit Exchange | Emma Medicine White Crow, Council Chair Pam Cowley, Health Benefit Exchange Board |
| 1:30 p.m. | 8. Public Comment | Emma Medicine White Crow, Council Chair |
| 2:10 p.m. | 9. Discussion – Priority Health Topics <i>—Possible Action</i> | Emma Medicine White Crow, Council Chair Christy Hoff, Council Staff Yris Lance, Council Staff |
| 3:00 p.m. | BREAK | |
| 3:10 p.m. | 10. State Policy Action Plan to Eliminate Health Disparities – Update on 2012 Recommendations <i>—Possible Action</i> | Emma Medicine White Crow, Council Chair Christy Hoff, Council Staff |
| 3:40 p.m. | 11. Council Member Comments | Emma Medicine White Crow, Council Chair |
| 4:00 p.m. | ADJOURNMENT | Emma Medicine White Crow, Council Chair |

PLEASE NOTE: Times above are estimates only. The Council reserves the right to alter the order of the agenda. For information regarding testimony, handouts, other questions, or for people needing special accommodation, please contact Desiree Day Robinson at the Board office at (360) 236-4110 by May 3, 2013. This meeting site is barrier free. Emergency contact number during the meeting is (360) 701-2398.



STATE OF WASHINGTON
GOVERNOR'S INTERAGENCY COUNCIL ON HEALTH DISPARITIES

Washington State Board of Health

PO Box 47990 • Olympia, Washington 98504-7990

March 5, 2013

Antoniette Holt, MPH
President
National Association of State Offices of Minority Health
3737 N. Meridian Street, Suite 300
Indianapolis, IN 46208

Ref: CDC-RFA-OT13-1302, OSLTS Partnerships – Building Capacity of the Public Health System to Improve Population Health through National, Nonprofit Organizations

Dear Ms. Holt:

On behalf of the Governor's Interagency Council on Health Disparities in Washington State, I am pleased to support the National Association of State Offices of Minority Health (NASOMH) competitive proposal for the Building Capacity of the Public Health System to Improve Population Health through National, Nonprofit Organizations funding opportunity.

In Washington State, the Governor's Interagency Council on Health Disparities serves as the state office of minority health. The Health Disparities Council is an advisory body charged with making policy recommendations to eliminate health disparities by race/ethnicity and gender. We work collaboratively with public, private, and community organizations, as well as trusted community leaders, to assess and recommend policy strategies. Over the years, we have relied on NASOMH to learn about priorities and initiatives of other state offices of minority health throughout the country as well as to disseminate information about the Health Disparities Council and the recommendations in our *State Action Plan to Eliminate Health Disparities*.

The Health Disparities Council supports NASOMH's efforts to strengthen the quality and performance of state offices of minority health and state minority health entities and US territories. We are supportive of NASOMH's proposal to build its infrastructure and capacity to serve the state offices of minority health by facilitating the transfer and spread of evidence-based and promising practices to improve the health of communities of color.

We welcome the opportunity to continue to work with NASOMH to promote health equity for communities of color, Tribes, and Tribal health organizations and we thank you for your continued work to eliminate health disparities.

Sincerely,

Emma R. Medicine White Crow

Emma Medicine White Crow, Chair



STATE OF WASHINGTON
GOVERNOR'S INTERAGENCY COUNCIL ON HEALTH DISPARITIES

Washington State Board of Health

PO Box 47990 • Olympia, Washington 98504-7990

March 5, 2013

Victoria J. Robinson
Designated Federal Officer, NEJAC
U.S. Environmental Protection Agency
1200 Pennsylvania Avenue, NW (MC2201A)
Washington, D.C. 20460

Dear Ms. Robinson,

On behalf of the Governor's Interagency Council on Health Disparities, I am providing this letter of support for the nomination of Millie Piazza to the National Environmental Justice Advisory Council.

The Governor's Interagency Council on Health Disparities is dedicated to eliminating health disparities by race/ethnicity and gender in Washington State. For the past five and a half years, Ms. Piazza has represented the Washington State Department of Ecology on the Health Disparities Council. In that role, she has consistently shared information and resources to inform the Council about environmental exposures and hazards in the environment and the disproportionate burden of exposure faced by low-income communities and communities of color. Because of Ms. Piazza's dedication to environmental justice and under her leadership, the Health Disparities Council worked collaboratively with public, private, and community organizations, as well as trusted community leaders, to assess and recommend policy strategies to promote environmental justice. Those recommendations were included in the Health Disparities Council's *State Policy Action Plan to Eliminate Health Disparities*.

Ms. Piazza understands environmental justice issues in Washington State and the Nation and is dedicated to ensuring true community engagement in agency decision making. She has demonstrated her strong communication and facilitation skills as the Chair of the Health Disparities Council's Environmental Exposures and Hazards advisory committee. We are therefore, pleased to offer this letter in support of Millie Piazza's nomination and know she will be an excellent addition to the National Environmental Justice Advisory Council.

Sincerely,

Emma R. Medicine White Crow

Emma Medicine White Crow, Chair



STATE OF WASHINGTON
GOVERNOR'S INTERAGENCY COUNCIL ON HEALTH DISPARITIES

Washington State Board of Health

PO Box 47990 • Olympia, Washington 98504-7990

March 7, 2013

Leo Morales, MD, PhD
Associate Investigator, Group Health Research Institute
Co-Director, ITHS Community Outreach Research Translation Core, University of Washington
Metropolitan Park East
1730 Minor Avenue, Suite 1600
Seattle WA 98101

RE: Latino Health Research, Practice, and Policy: Identifying our Strengths and Growing our Collaborations

Dear Dr. Morales;

On behalf of the Governor's Interagency Council on Health Disparities, I am pleased to provide this letter in support of your application to the National Institute of Health for a grant to hold a regional conference on Latino health research, practice, and policy. We have a great need for high quality, community-oriented, translational health research as a result of the rapidly growing Hispanic/Latino community in our state and region. Your proposed conference will create new opportunities for collaboration to address key health concerns of the Latino communities in our five state region of Washington, Wyoming, Alaska, Montana, and Idaho.

The Governor's Interagency Council on Health Disparities is dedicated to eliminating health disparities by race/ethnicity and gender in Washington State, including disparities faced by the Hispanic/Latino community. The Council works collaboratively with public, private, and community organizations, as well as trusted community leaders, to assess and recommend policy strategies to address disparities and the determinants of health that result in health inequities. The Council values inclusion of those affected by health disparities in the policy making process and we applaud the conference planning committee's efforts to establish a health research agenda that encourages meaningful dialogue and input from stakeholders who serve Latino communities.

We thank you for using community-engaged research principles to create a comprehensive agenda that fits the requirements of the conference grant and meets the needs of our Latino communities.

Sincerely,

Emma R. Medicine White Crow

Emma Medicine White Crow, Chair



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Fostering Health Equity Partnerships

Grant Progress May, 2013 Update

Governor's Interagency Council on Health Disparities

May 8, 2013

Yris Lance, MA

Fostering Health Equity Partnerships

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Year 3 of a three-year grant awarded by the Office of Minority Health from Sept 2010 to August 2013 to:

- Improve communication and coordination, and to leverage resources among public and private organizations that provide outreach to Washington's diverse communities.
- Improve language access to state services and to enhance cultural competency within state agencies.
- Promote/participate in community outreach and education activities.
- Partner with the racial/ethnic Commissions to advance health equity initiatives.

Fostering Health Equity Partnerships

Community Outreach Roundtable – COR

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In April 2013, members of the COR met to share information about their outreach efforts. We had presentations from representatives of:

- Office of the Superintendent of Public Instruction
 - Health Science Program
- Labor and Industries - Hispanic Outreach program
- Health Care Exchange – Outreach program

News and Events on HealthEquity.wa.gov will continue to be regularly updated with outreach and education events available in the community.

Fostering Health Equity Partnerships

Interagency limited-English proficiency (LEP) Workgroup

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Members of the Interagency Limited English Proficiency (LEP) Workgroup met on February 25, 2013.

The meeting's agenda included a presentation from a representative of the federal Office of Civil Rights. Representatives from 15 agencies/organizations attended the meeting and shared information about their current and future activities towards language access policy development and/or implementation.

Fostering Health Equity Partnerships

Commission on Asian Pacific American Affairs-CAPAA

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2013 Health Presentations and Community Fairs

- Promote the Hepatitis B Coalition Forum
- Support and promote health fairs in the Asian Pacific communities such as:
 - Asian and Pacific Islander New Year's Celebration
 - Native Hawaiian/Pacific Islander Youth Fitness Day
 - Chinese and Vietnamese Health Fairs at the CISC

Fostering Health Equity Partnerships

Commission on Asian Pacific American Affairs-CAPAA

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2013 Health Presentations and Community Fairs



Fostering Health Equity Partnerships

Commission on Hispanic Affairs-CHA

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Planning committees

- Latina Health Symposiums - Seattle and Yakima
- Hispanic/Latino Student Mentorship
- Hispanic Health and Safety Fairs
 - Fairs include free screenings, health education, and information about resources and services available in hosting communities.

Fostering Health Equity Partnerships

Commission on Hispanic Affairs-CHA

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2013 Health and Safety Fairs Schedule

| | |
|--------------|--|
| April 28 | Bothell @ St. Elizabeth Ann Seton Church |
| May 18 | Seattle @ South Park Community Center |
| June 9 | Shelton @ St. Edward's Church |
| July | TBD |
| August 8 | Federal Way @ St. Luke Lutheran Church |
| August 10 | Seattle @ Jubilee Reach |
| September 28 | Auburn @ Grace Community Church |
| October 6 | Bellingham @ TBD |
| October 13 | Seattle @ St. Mary's Church |
| November | Centralia @ TBD |

Fostering Health Equity Partnerships

Commission on Hispanic Affairs-CHA

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Other Health Fairs and Symposium

New Futures Health Fair

Latina Health Symposium – Seattle

Latina Health Symposium – Yakima

Fostering Health Equity Partnerships

Commission on Hispanic Affairs-CHA

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Recent Health and Safety Fair

April 28

Bothell @ St. Elizabeth Ann Seton Church



Fostering Health Equity Partnerships

Commission on Hispanic Affairs-CHA

11

Recent Health and Safety Fair

April 28

Bothell @ St. Elizabeth Ann Seton Church



Fostering Health Equity Partnerships

American Indian Health Commission

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Participate, promote and/or support health fairs and other health activities in tribes such as the Chehalis Tribe Healthy Choices, Healthy Lives Health Fair on May 16, 2013.

Work in collaboration with the new representative from the AIHC to identify, develop and/or support health activities in Washington State tribes.

Fostering Health Equity Partnerships

Commission on African American Affairs-CAAA

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Community Outreach Events:

- Co-sponsored a STEM (Science Technology Engineering and Math) Event at the Pacific Science Center on Friday, January 25, 2013.
- Co-sponsored the Annual Health & Wellness Resource Forum at the Central Area Senior Center in Seattle on April 27, 2013
- Supporting Kidney Fest Saturday, June 22, 2013

Fostering Health Equity Partnerships

Commission on African American Affairs-CAAA

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Community Outreach and Education Events

Annual Health & Wellness Resource Forum at the
Central Area Senior Center in Seattle



Fostering Health Equity Partnerships

Commission on African American Affairs-CAAA

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- Supporting organizations included: Fred Hutchinson Cancer Research Center, Prevention Research Center, National Community Committee, Seamar, Asian Counseling and Referral Services, Seattle area Health Experts, Sliders.



Fostering Health Equity Partnerships

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Yris Lance, MA
Community Relations Liaison
Governor's Interagency Council on Health Disparities
HealthEquity.wa.gov
360-480-2057
Yris.Lance@sboh.wa.gov



DATE: May 8, 2013

TO: Members of the Governor's Interagency Council on Health Disparities

FROM: Emma Medicine White Crow, Chair

SUBJECT: IMPLEMENTATION OF 2012 ACTION PLAN RECOMMENDATIONS

Background and Summary:

The Council's 2012 State Policy Action Plan to Eliminate Health Disparities was approved by the Council December 2012. The Council's goal for the 2012 plan was to focus on recommendations that state agencies and their partners could immediately start implementing with existing resources. Further, the Council agreed to track progress on the plan's implementation at its meetings and to document that progress in its future action plan updates, which it will submit to the Governor and Legislature twice a year. The Council's next action plan update is due June 2013.

Today's agenda includes three items related to the implementation, tracking, and reporting of the Council's 2012 action plan recommendations. During this agenda item, we will hear updates from the Council's state agency representatives on activities to implement the Council's environmental exposures and hazards recommendations related to promoting environmental justice and community involvement. Following that, Council Member Jonathan Green has invited his colleague Char Goodreau from the Department of Early Learning to provide a briefing on the Early Achievers Program, the goals of which directly align with the Council's poverty recommendation related to early learning.

This afternoon, we will review draft text of the June 2013 action plan update. Since this is the last time we will meet before that report is due, this will be your opportunity to provide any comments and suggestions for changes.

Recommended Council Action:

Motion: The Council approves in concept the draft text of the June 2013 action plan update as submitted on May 8, 2013, directs staff to incorporate changes from today's discussion as necessary, and authorizes the chair to approve the final report for submission to the Governor and Legislature.

Governor’s Interagency Council on Health Disparities
 2012 Action Plan—Implementation of Environmental Exposures and Hazards Recommendations
 May 8, 2013

| Implementation Status of 2012 Action Plan Environmental Exposures and Hazards Recommendations | |
|--|--|
| Recommendation ¹ | Status |
| EEH²—EJ³ Institutional Awareness and Diversity Ensure agency staff diversity and cultural competency | <p>Department of Ecology is planning to convene an interagency environmental justice network – <i>planning for Spring 2013</i>. The agency is considering whether the interagency environmental justice network could serve as the appropriate forum for promoting best practices and training – <i>currently under consideration</i>.</p> <p>Department of Ecology is participating in the Global Reporting Initiative to measure and report their economic, environmental, and social performance. A number of the indicators used in the GRI align closely with the Council’s environmental exposures and hazards recommendations.</p> <p>The Department of Health’s Office of Healthy Communities plans to work with the agency’s human resources office on writing job descriptions that include measurable actions to promote health equity in staff job responsibilities and providing support for supervisors to help staff meet those responsibilities. The Office provides new staff orientation on health equity twice a year and a tailored skills-building training on health equity is offered every 2-3 months. At the agency level, the Department of Health is creating a one-day new staff orientation that includes a health equity component.</p> <p>The State Board of Health’s Strategic Plan includes a goal to reduce health disparities, which includes a strategy to assure the cultural competence of the Board and its staff. Cultural competency training and government-to-government training are mandatory for all Board staff. In addition, the Board has taken steps to include cultural competency in employee’s annual performance and development planning.</p> |

¹ Recommendations are abbreviated—for the full recommendations’ language, see the [2012 State Policy Action Plan to Eliminate Health Disparities](#).

² EEH: Environmental Exposures and Hazards

³ EJ: Environmental Justice

Governor’s Interagency Council on Health Disparities

2012 Action Plan—Implementation of Environmental Exposures and Hazards Recommendations

May 8, 2013

| Implementation Status of 2012 Action Plan Environmental Exposures and Hazards Recommendations | |
|--|--|
| Recommendation¹ | Status |
| <p>EEH—EJ Service Equity, Accountability, and Metrics Ensure equity is considered in the delivery of services, agency plans, programs, policies, and budget decisions. Ensure data are collected to track disparities. Formalize processes for investigating environmental justice issues. Reconvene an environmental justice workgroup.</p> | <p>Department of Ecology is partnering with the US Environmental Protection Agency to consider adding language in their performance partnership agreement (intergovernmental memorandum of understanding) regarding identifying appropriate measures and baseline indicators for tracking disparate impacts and progress towards reducing disparities.</p> <p>Department of Health and its Office of Healthy Communities address health equity in strategic planning. Health equity is also addressed in the Department’s <i>Statewide Agenda for Change</i> and the <i>State Healthy Communities Plan</i>.</p> <p>The Department of Health has recently developed an Equity Impact Review Guide to proactively assess program and policy decisions on potential impacts on equity. Department staff is currently identifying opportunities to pilot test the guide.</p> <p>The Department of Health’s Office of Health Communities consistently requires the inclusion of health equity in its grant proposals, and similarly ensures health equity is included when it issues requests for proposals and community grants.</p> <p>The State Board of Health’s Strategic Plan includes a goal to reduce health disparities, which includes a strategy to intentionally consider health equity in all reports. The Board’s most recent State Health Report included an essay from the Council that focused on health equity and reducing health disparities. In its most recent strategic plan update, the Board indicated it would identify opportunities to pilot the Department of Health’s Equity Impact Review Guide.</p> |

Governor’s Interagency Council on Health Disparities

2012 Action Plan—Implementation of Environmental Exposures and Hazards Recommendations

May 8, 2013

| Implementation Status of 2012 Action Plan Environmental Exposures and Hazards Recommendations | |
|---|--|
| Recommendation¹ | Status |
| <p>EEH—Community Capacity Building and Involvement Provide community outreach, training, technical assistance. Ensure community engagement in agency decision making. Strengthen Tribal consultation. Dedicate funds to assist communities with environmental justice concerns.</p> | <p>Department of Ecology is partnering with the US Environmental Protection Agency to consider adding language in their performance partnership agreement (intergovernmental memorandum of understanding) regarding Providing outreach, training, and technical assistance to high risk and overburdened communities (e.g., information about environmental justice, grant writing, data access and analysis, and community mobilization and advocacy).</p> <p>Department of Health’s Tribal Liaison is currently drafting a consultation and guidance document. The document will undergo review by the agency and the American Indian Health Commission before being finalized and adopted by the agency.</p> <p>An example of an existing agency’s community engagement strategies is the Department of Commerce’s WorkFirst Local Planning Area Partnerships (LPAs). LPAs serve as forums for coordinating the development and delivery of services and activities to help WorkFirst families become more stable, prepare for employment, and go to work. Through the LPA network local partners stay informed as to changing WorkFirst policies, programs, and priorities. There are currently 28 LPAs across the state with representatives from local and state agencies, community and technical colleges, nonprofit organizations, tribes, contractors, and other community partners that serve those most in need.</p> |
| <p>EEH—Precautionary Approach Ensure a precautionary, prevention-oriented approach to environmental contaminants. Take actions and set tangible goals for reducing harmful environmental exposures. Prioritize children’s health and development.</p> | <p>Department of Ecology is planning to partner with US Environmental Protection Agency to develop a map of high impact communities – <i>planning for Fall 2013</i>.</p> <p>Department of Ecology is in the process of developing guidance for assessing alternatives to chemicals of concern. The purpose of the guidance is to give Ecology better tools to help businesses, especially small and medium sized businesses, and make better informed choices about the chemicals they use in their products and manufacturing processes – <i>currently under development</i>.</p> |



Mission/Vision: Develop and manage high-quality, evidence-based health care programs and purchase services that improve access to appropriate, quality health care for Medicaid clients and Basic Health members.

2012 UPDATE
Environmental Exposures and Hazards
Pages 15 and 16 of the action plan - Recommendations 1 and 2

Governor's Interagency Council on Health Disparities - The Council's *2012 State Policy Action Plan to Eliminate Health Disparities* is now available on the Council's web site: http://healthequity.wa.gov/Pubs/docs/2012HDCActionPlan_Final.pdf.

The Health Care Authority (HCA) is Washington State's primary health care purchasing agency, with numerous responsibilities and many vital functions – all centered on the 1.6 million clients, state employees and retiree members we serve.

HCA works with different administrations in the Department of Social and Health Services (DSHS) on Medicaid projects, including the Developmental Disabilities Administration (DDA), Behavioral Health and Service Integration Administration (BHSIA), and the Aging and Long-Term Support Administration (AL TSA). and the Economic Services Administration (ESA), the operational arm of DSHS in communities across the state.

RECOMMENDATION 1:

ENVIRONMENTAL JUSTICE

Washington State should make a clear commitment to environmental justice. This includes establishing a statewide environmental justice policy that creates accountability for addressing disproportionate exposures and health disparities.

Government policies should advance the principles of environmental justice, and ensure "the fair treatment and meaningful involvement of all people regardless of race, color, national origin, age, or income with respect to the development, implementation, and enforcement of environmental laws, regulations, and policies." Environmental Justice Goals should be reflected in:

A. Institutional Awareness and Diversity:

- Provide staff and management training (e.g., environmental justice, institutional racism, government-to-government, and cultural competence).
 - The HCA partnered with the Department of Social and Health Services, Office of Diversity and Inclusion to develop cultural competence guidelines, policy (Policy 7.22), a cultural competence model, and a planning guide for department. HCA will

utilize resources from this partnership as a foundation for our future efforts to implement cultural competence.

- The HCA Policy Department provides a Government-to-Government training that encompasses 1) review of American Indian historical periods, 2) Government-to-Government and the Federal Trust Responsibility, 3) Emergence of Indian Health Policy and System, 4) Tribal Demographics, and 5) Current.
 - The Department of Personnel diversity training module "The Reason Why Diversity Matters" is mandated by all HCA staff
- Improve diversity of agency staff, particularly leadership and management positions. Prioritize hiring and contracting from impacted communities. Create internships, fellowships, and scholarships for students from affected communities.
 - HCA Administrative Policy 3-10 Affirmative Action and Equal Opportunity Policy, This policy affirms the agency's commitment to provide equal employment opportunity in accordance with the principles, intent, and purposes of the laws and regulations cited below.
 - Agencies whose actions may affect public health or the environment should adopt an ethical policy that acknowledges that children have a right to an environment in which they can reach and maintain their full potential.
 - Washington's Apple Health for Kids (being expanded to Apple Health Plus) is a model umbrella program, combining Medicaid, the Children's Health Insurance Program, and the state-funded Children's Health Program to ensure that any child, in any family that can meet the income eligibility standards, will have access to full-scope Medicaid coverage.
 - School-Based Healthcare Services program enables Medicaid to reimburse school districts for providing direct healthcare services to approximately 20,000 special needs children annually.

B. Service Equity, Accountability, and Metrics:

- Formalize practices that establish service equity to ensure the most underserved and disproportionately overburdened communities are state priorities (e.g., reducing pollution, creating parks, strengthening education, promoting health). This should include routine assessment to ensure services are provided based on need.
 - The Health Benefit Exchange and Medicaid expansion are key elements of reform, and the Health Care Authority has been in the forefront of both projects – Redesigning and aligning the current eligibility and purchasing systems for a new era.
 - Under the Health Care Authority's leadership, seven participating health plans have committed to the use of a medical home model. The model will provide additional administrative funds to medical practices in exchange for targeted reductions in emergency room visits and hospital admissions through improved care coordination.
 - Today, any child in any Washington State family can qualify for health coverage if the family's annual income does not exceed an annual limit of \$55,596 (for a family of three). Coverage is free for families under 200 percent of the Federal Poverty Level, although the state charges small premiums for children between 200 and 300

percent of the federal poverty standard. Immigrant families ineligible for Medicaid or CHIP can obtain coverage over 200 percent by paying the full cost of the state-negotiated premiums, a rate which is still much lower than the premiums available through private coverage.

- The HCA continues to work toward covering all of the children in our state increased the number of children insured by state medical assistance programs by more than 40,000 by December 2011. Two in every five children – nearly 40 percent of all the state’s children – are now covered by state and federal medical assistance programs. Despite the most severe recession in nearly a century, the Legislature stood fast on preserving children’s coverage as a priority for health care. In December 2011, Washington State was awarded its third straight multi-million-dollar bonus for successful outreach and enrollment of uninsured children in state coverage. The state was awarded \$17 million in FY2011, \$20.6 million in FY2010 and \$7.9 million in FY2009.
 - The Medicaid program currently covers more than half of all births in Washington State.
- Systematically and proactively assess proposed changes to agency programs, policies, and budget decisions for potential adverse impacts on health and environmental equity. Ensure resources and services are distributed equitably (e.g., health impact assessment, environmental justice analysis, cumulative impacts analysis, equity impact assessment).
 - In 2012, the HCA MCOs as a group reported race and ethnicity as “unknown” for nearly half of all enrollees. A primary reason for gaps in reporting these data is underreporting at the state level, as these self-reported data are optional when new clients enroll in Medicaid. HCA is seeking ways to work with state policy analysts to determine the best approach to collect reliable race and ethnicity data for Medicaid enrollees.
 - Identify appropriate measures and baseline indicators for tracking disparate impacts and progress towards reducing disparities.
 - HCA partnered with the Puget Sound Health Alliance to collect and stratify Medicaid data by race, ethnicity and language; convene providers to address disparities in diabetes care and raise awareness of disparities with purchasers.

RECOMMENDATION 2: PROMOTE HEALTHY COMMUNITIES THROUGH CAPACITY BUILDING & INVOLVEMENT

Washington State should work to strengthen community capacity to reduce exposures to harmful substances and conditions and increase access to beneficial resources that are health-protective. This includes supporting impacted communities with creating circumstances that promote health, such as access to healthy food, quality schools, unpolluted and safe neighborhoods, and economic security.

- A.** Government agencies should increase community capacity to participate as equal partners in making policy decisions about environmental and community health.

- Provide outreach, training, and technical assistance to high risk and overburdened communities. Examples include information about environmental justice, grant writing, data access and analysis, and community mobilization and advocacy.
 - HCA has a dedicated Health Disparities Specialist to ensure health equity, improved quality, and eliminate health care disparities for low income, racial and ethnic minorities, and all vulnerable residents of the state of Washington. The Health Disparities Specialist works in a leadership capacity for HCA with internal and external stakeholders and community partners to increase awareness of health equity, health disparities and work cooperatively to eliminate them.

- Ensure effective community engagement in agency decision-making. Measures to strengthen community and agency collaboration include: appointing a dedicated agency/community ombudsperson, comprehensive language access services, and public meeting planning that accommodates diverse community needs.
 - The Health Care Authority (HCA) provides Spoken and Sign language Interpreter Services to HCA contracted health care providers to support health care providers meet their federal requirement to offer and provide interpreter services to individual with limited English proficiency (LEP) or who are deaf, deaf-blind, or hard of hearing.

- Strengthen protocols for meaningful **Tribal consultation**.
 - HCA engages Washington State's 29 tribes, the goals of Washington State's Medicaid program are:
 - Partner with tribes and urban tribal clinics to increase access to state-financed health care coverage.
 - Address the health equity issues in Indian Country and increase health resources for the tribes.
 - Facilitate increased participation of the tribes with all state-financed low-income health programs.
 - The highest priorities this year have been:
 - Ensure that tribal programs successfully transferred to the new ProviderOne payment system.
 - Work with tribes on the ability to access Medicaid programs.
 - Work with American Indian Health Commission on tribal mental health reforms.
 - Keep tribes aware of legislative and budget changes to the Medicaid and state health programs, such as the Disability Lifeline-Medical care services program.
 - In addition, for each program change that requires a State Plan Amendment, tribal chairs and tribal health programs on the Indian Health Service (IHS) facility list were sent letters identifying the program changes and possible impacts to tribal health programs in accordance with federal policy.
 - Some parts of Medicaid are engaged with tribes on an on-going basis. The agency has regular communications and meetings in collaboration with the DSHS Indian Policy Advisory Committee and American Indian Health Commission in order to sustain a continual dialogue on health issues. Medicaid also partners with the Indian Health Commission to extend outreach beyond its statutory responsibilities and

communicate more closely on a regular basis with tribal clinic directors and program managers.

- Dedicate funds to assist communities with environmental justice concerns and prioritize underserved and highest risk communities.

Promote Prevention and Healthy Communities

- Washington State is aggressively moving forward with plans to improve care coordination for the Medicaid population, including the implementation of a person-centered health home model for foster children in out-of-home placement and a renewed emphasis on wellness for state employees and Medicaid populations.
- Part of implementing a prevention-based strategy is the recognition that no one agency can do it alone. In order to achieve the goal of a healthier population that uses health care services more appropriately, it will take a partnership between individuals, their providers, and other state and federal agencies to reinforce healthy behaviors. The Health Care Authority works in partnership with the Department of Health to participate in Community Transformation Grant activities to promote prevention and healthy living. Efforts are focused on tobacco free living, healthy eating, active living, and clinical prevention services. For public employees, new low cost consumer-directed health plans and health savings accounts, along with an emphasis on wellness and prevention, were available for the first time.

Better Coordinated Care for the Chronically III

- Approximately five percent of Medicaid clients account for nearly half of the total cost of the program. Understanding that fact has caused the Health Care Authority to approach utilization and care management differently. Across-the-board limits on services that affect the entire Medicaid population have overlooked the fact that the program would usually accomplish more to bend the cost curve by identifying and then targeting a much smaller number of high-end users who disproportionately drive up program costs.
- The identification and coordination of care for these high-needs patients is the real key to sustained reductions in the cost of their care and improvement in their long term health outcomes. Washington is working toward achieving these goals through the application of sophisticated software models to identify and track high-end users or by developing "Health Homes" that provide care coordination for acute care, long-term care, and behavioral health. One example of the success of a public-private partnership to improve access to behavioral health services is the Boeing-based Intensive Outpatient Care Program (ICOP) for state employees.

Health Technology Assessment (HTA) Program

- Many innovations in medicine in the last ten years have improved the health and lives of patients, and health care spending and costs are rising dramatically. But patients in the U.S. overall are not getting healthier. The problem is one of assessment, using health care that is available, recommended, and proven to work. Health care is not advanced by medical products and treatments introduced without independent, scientific evidence about whether they are safe and effective and

whether they provide benefits that are better than existing alternatives. The information age has compounded the problem – there is a flood of information, but doctors and patients don't have the tools or the time to sort through it all.

- The primary purpose of the Health Technology Assessment program is to ensure medical treatments and services paid for with state health care dollars are safe and proven to work. The program serves as a resource for all state agencies purchasing health care. It commissions and reviews scientific, evidence-based reports about whether certain medical devices, procedures, and tests are safe and work as promoted. An independent clinical committee of health care practitioners then uses the reports to determine if the state should pay for the medical device, procedure, or test. Participating state agencies include the Health Care Authority, the Departments of Social and Health Services, Labor and Industries, Corrections and Veterans Affairs. State agencies using the same, evidence-based reports are able to make more informed and consistent coverage decisions. Currently, Health Technology Assessment decisions are estimated to be saving the state more than \$31 million a year.



Early Achievers – Washington’s Quality Rating and Improvement System

Governor’s Interagency Council on Health Disparities
May 8, 2013



Overview

- ⦿ What is a Quality Rating and Improvement System?
- ⦿ Early Achievers Partners and Participants
- ⦿ Washington's Quality Rating Standards
- ⦿ Race to the Top Early Learning Challenge



What is it and why is it important?



What is A Quality Rating and Improvement System (QRIS)?

- ⦿ Choosing childcare is an important decision. Families deserve to know their children are in a quality care environments that foster a love of learning, promote each child's unique skills and cultures, and support the development of the whole child.
- ⦿ A QRIS provides unbiased information about the quality of child care and early learning programs through an easy-to-understand rating system.
- ⦿ By participating in Early Achievers, providers are demonstrating a commitment to improving quality. QRIS provides supports and incentives to aid those efforts.
- ⦿ When parents and caregivers have better information about early learning, demand for high-quality programs will increase

A National Quality Movement

- ⦿ Over 26 states have a fully implemented QRIS
- ⦿ QRIS serve as a quality assurance mechanism and align early learning system
- ⦿ Key strategy of the federal Race to the Top Early Learning Challenge
 - ⦿ Washington's application was ranked 3rd in the nation
 - ⦿ \$60 million dollars of targeted support

What is Early Achievers?

- ⦿ Outreach and support to providers
- ⦿ Technical assistance and financial incentives for providers that focus on improving program quality
- ⦿ Research-based indicators of quality and a clear, accurate method of assessing program quality
- ⦿ Trained observers inspect programs regularly to determine whether they are meeting minimum quality standards
- ⦿ Outreach to parents

Why Early Achievers?

- ⊙ Quality of care matters, particularly for at-risk children
- ⊙ Current quality of care is disparate – some good and some bad
- ⊙ Clear standards set consistent expectations
- ⊙ Support is provided to help providers improve

- ⊙ **EARLY ACHIEVERS RAISES ALL BOATS!**

How do we know Early Achievers works?

- ⊙ 2007 – 2010: QRIS pilots with randomized control evaluation
- ⊙ 2010 – 2012: Modify and finalize QRIS model
 - ⊙ Used evaluation data to refine QRIS model
 - ⊙ Contract with UW to refine, validate, ensure fidelity of model
 - ⊙ Pilots became “early adopters” of statewide system
- ⊙ 2012 – Launch Early Achievers
 - ⊙ Builds and strengthens upon prior work
 - ⊙ Research AND implementation knowledge incorporated
 - ⊙ Part of a national movement

Early Achievers is Child Centered



What Early Achievers Provides

Pre-Early Achievers

Health and safety focus



With Early Achievers

Health and safety AND child development focus



Outcomes

Improved outcomes for children

Sticks only (no rewards for quality)



Carrots AND sticks (encourage quality improvement)



Support for providers

Minimum standards only (licensing)



Progression of standards, starting at licensing



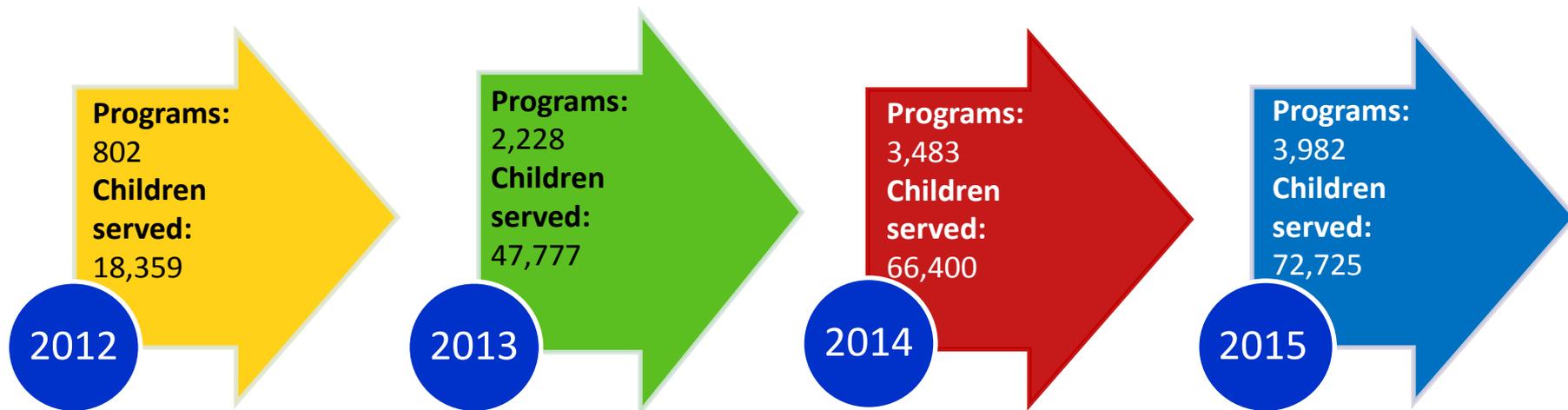
Encourage continuous quality improvement

Early Achievers Targets

All licensed child care, ECEAP and Head Start eligible for Level 1

By 2015:

- 54% of participants in Early Achievers will be Level 2 or higher (20% of participants will be Levels 3-5)
- 60% of children in care will be in Levels 2-5



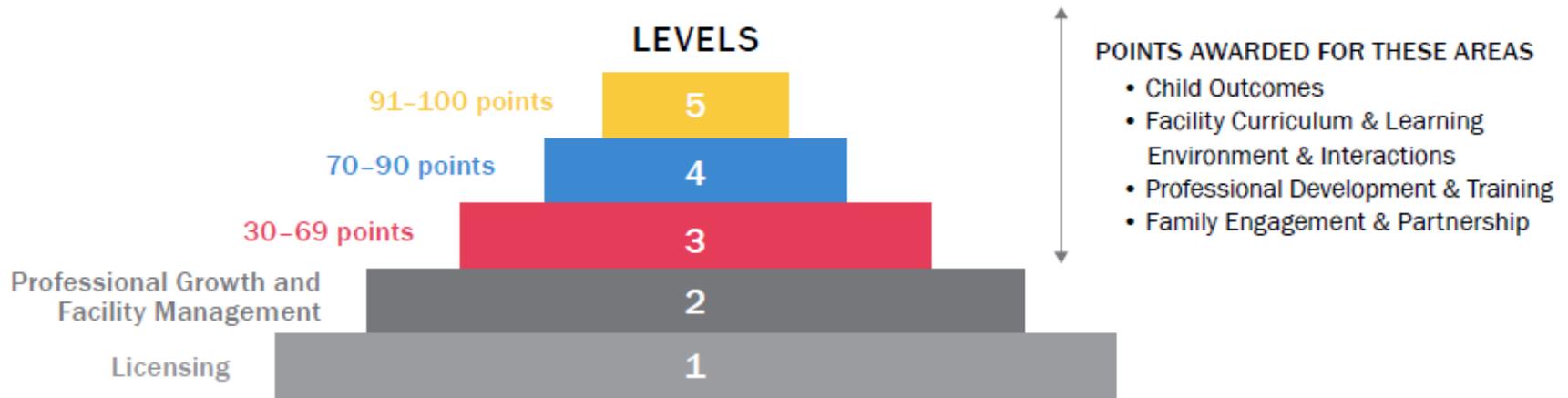


Overview of Early Achievers





Washington's Quality Standards



The model supports facilities to build a strong foundation at Levels 1-2, then gain points by meeting standards that are in line with their program philosophy at Levels 3-5. The model supports continuous quality improvement at all levels.

Partners in Quality

Child Care Aware of
Washington

Department of
Early Learning

University of
Washington

Early Achievers

Technical Assistance
Coaching
Training

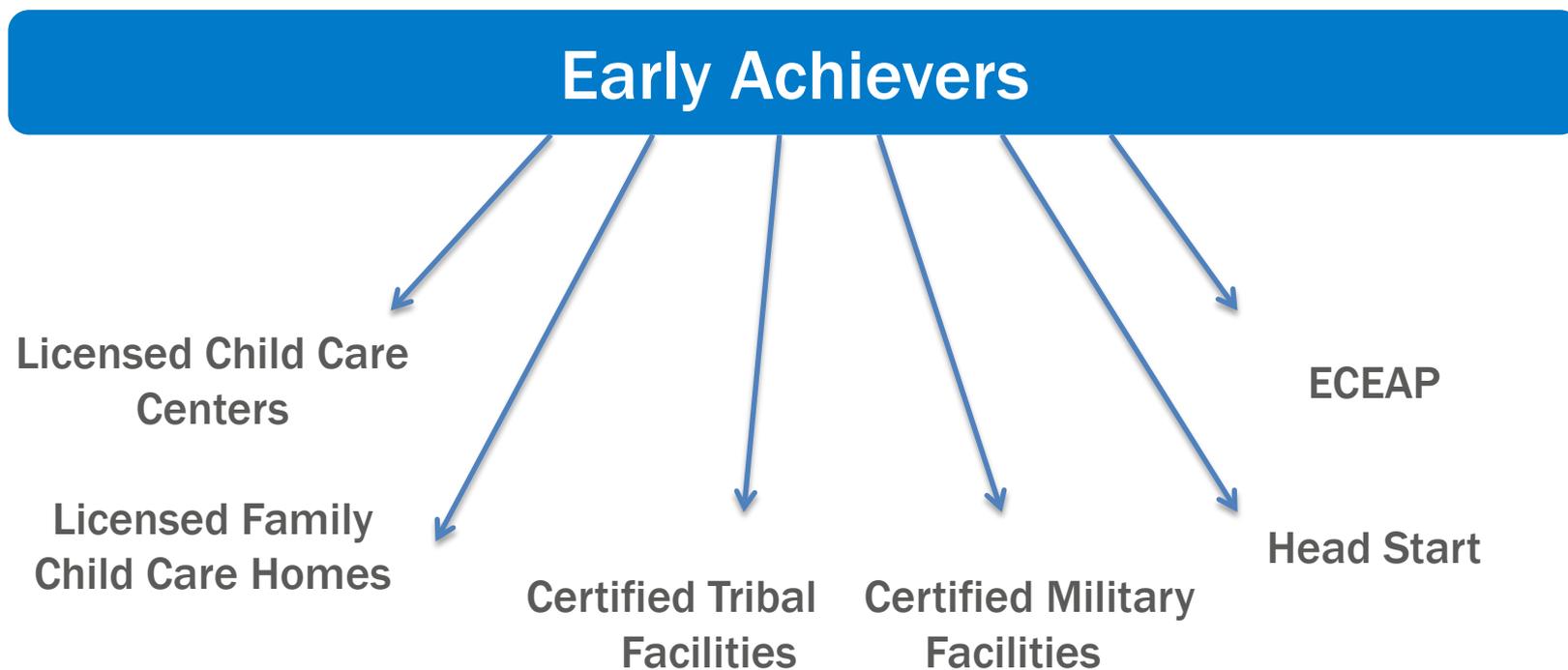
Administration
Licensing
Data Systems

Rating
Evaluation
Coach Model

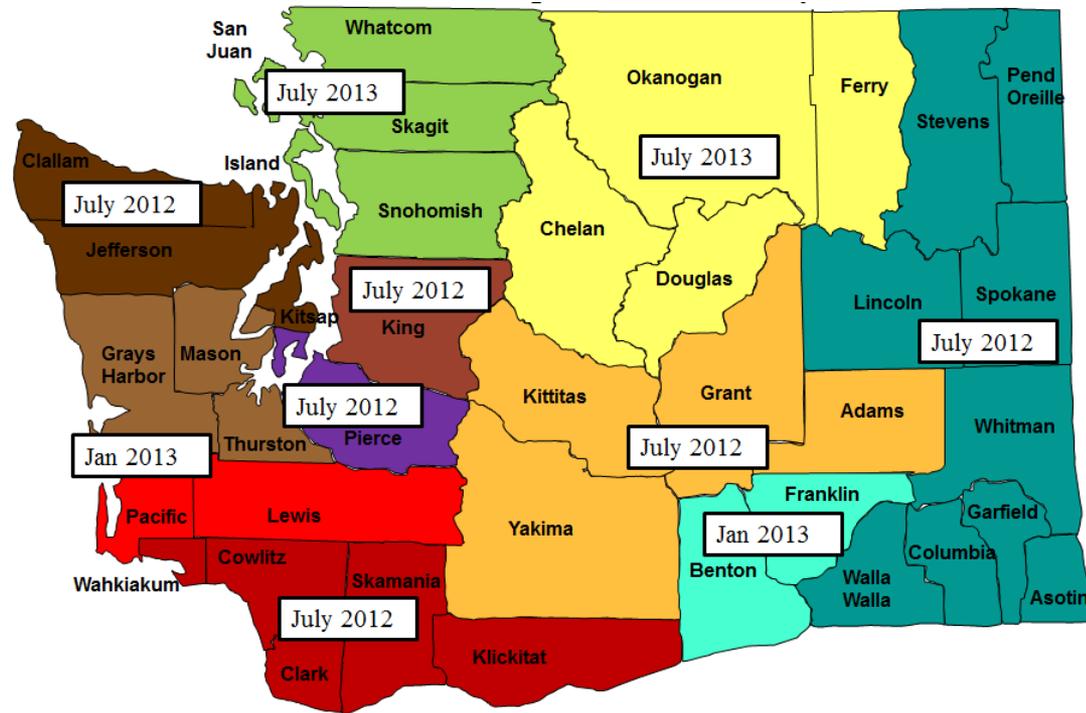
State Board of Community and Technical Colleges

Thrive by Five Washington Early Learning Coalitions

Participants



Regional Roll-out



| Olympic Peninsula | | Southwest WA | | Northwest WA | King County | Tacoma/Pierce County | Central WA | | Eastern WA | |
|---------------------------------------|---|---|--------------------------|---|-------------|----------------------|---|---|--|----------------------------|
| July 2012: Clallam, Kitsap, Jefferson | Jan 2013: Grays Harbor, Mason, Thurston | July 2012: Clark, Cowlitz, Klickitat, Skamania, Wahkiakum | Jan 2013: Lewis, Pacific | July 2013: Island, San Juan, Skagit, Snohomish, Whatcom | July 2012 | July 2012 | July 2012: Adams, Grant, Kittitas, Yakima | July 2013: Chelan, Douglas, Ferry, Okanogan | July 2012: Asotin, Columbia, Garfield, Lincoln, Pend Oreille, Spokane, Stevens, Walla Walla, Whitman | Jan 2013: Benton, Franklin |

Participant Supports and Resources

- ⊙ Training
- ⊙ Technical Assistance
- ⊙ MERIT
- ⊙ Coaching
- ⊙ WELS
- ⊙ Quality Improvement Awards
- ⊙ WA Scholars & Opportunity Awards
- ⊙ Tiered Reimbursement Incentive

Level 2 - Technical Assistance

- ⦿ Accessed through local Child Care Aware office
- ⦿ TA Specialists focus on providing support to Early Achievers participants working through Level 2 requirements
- ⦿ TA focuses on Early Achievers policies and procedures, MERIT-related support and Level 2 trainings.
- ⦿ TA Specialists work with Early Achievers participants to get ready to apply for a rating for Levels 3-5

Coaching

- ◉ Guiding Principles
 - ◉ Cultural Competency
 - ◉ Parallel Processes
 - ◉ Adult Resiliency
- ◉ Practice Based Coaching – a model for supporting the use of effective teaching practices and improving quality ratings.
 - ◉ Creation of shared goals and action plans
 - ◉ Conducting focused observations
 - ◉ Providing reflection and feedback within the context of collaborative relationships

Quality Improvement Awards

Quality improvement awards are distributed annually and are flexible but must be tied to Quality Improvement Plan

- Learning environment materials
 - Curriculum and assessment resources
 - Family engagement and partnership materials
 - Staff development including extra service pay and PD
 - Award amounts increase based on rating levels
- Recipients must retain receipts and be able to show how the funds were spent

| Rated Level | Family Child Care | Child Care Center |
|-------------|-------------------|-------------------|
| Level 3 | \$2000 | \$5000 |
| Level 4 | \$2250 | \$7500 |
| Level 5 | \$2750 | \$9000 |

Current Participation

- ⊙ 1230 Participating Facilities
 - ⊙ Child Care Centers: 460
 - ⊙ Family Child Care: 613
 - ⊙ Head Start/ECEAP Pilot: 157
- ⊙ Total number of children: 29,263
- ⊙ Total number of children receiving subsidy: 10,378
- ⊙ Total number of teaching staff: 5,542

*4/25/2013 data



Questions?





Char.goodreau@del.wa.gov

www.del.wa.gov/care/qris/





YOU HAVE A CHOICE!



WASHINGTON STATE

A Guide to Finding Quality Child Care



Washington State Department of
Early Learning



2 GETTING STARTED

4 CHECKLIST

6 GET INVOLVED

7 GET HELP PAYING
FOR CHILD CARE

8 RESOURCES



We at the Department of Early Learning know choosing child care is a big decision for families. With so many choices and things to think about—such as cost and availability—it's no wonder many families don't know where to start.

As a parent, you are your child's first and most important teacher, and you know what your family needs in a child care setting. This booklet is designed to help you find the child care arrangement that's best for your family.

As you begin your search, you'll probably have plenty of questions. This booklet will help you find answers to many of those questions. A common question for many parents is: How will I know if the child care arrangement I've chosen is the right one? Ask yourself:

Will my child have fun?

Will my child be in a safe and healthy environment?

Will my child develop a love of learning?

If you can answer "yes" to those three questions, chances are you have found a place where your child can thrive!



Washington State Department of
Early Learning

GETTING STARTED

Try to plan ahead. Searching for child care can take some time and thought, and many child care providers have waiting lists. Try to give yourself at least two months to visit child care settings and make a choice.

Who licenses child care providers?

The Washington State Department of Early Learning (DEL) licenses more than 7,400 licensed child care providers in Washington. There are three types of licensed child care: child care centers, those who offer care in their home (family home child care providers) and school-age programs. Each follows their own set of state licensing rules, including minimum standards for health and safety.

Licensed child care providers must post their licenses. Ask the provider to show you the license, which will show the ages and number of children for whom the provider is licensed to care. To find out if a child care home or center is licensed, and to get a complaint history, visit DEL's online Licensed Child Care Information System at www.del.wa.gov or call **1.866.482.4325**.

Who does not need a child care license?

Certain types of care do not need a license, including:

- › Nannies providing care in a family's home
- › Informal parent cooperatives
- › Play groups
- › Educational preschools that operate for less than four hours per day
- › Parks and recreation programs
- › Family, friends and neighbors who provide occasional care

Why should I choose licensed child care?

The latest brain research has given us a much clearer picture of how children learn and grow in their early years. During the early years of life, the brain is forming connections that help determine a lifetime of skills and potential. High-quality child care helps ensure healthy physical, emotional, social and intellectual development.

The benefits of licensed child care include:

- › Health and safety checks on the facilities. DEL staff visit child care centers at least once a year, and visit family home child care providers at least once every 18 months
- › Child development training
- › First aid training
- › CPR training
- › Criminal background checks on the provider and staff (and household members ages 16 and older of family home providers)

To ensure they meet state minimum health and safety standards, licensed child care providers follow specific rules about:

- › The skills and training providers must have
- › Who may be a child care provider
- › How providers interact with children
- › Child care staff to child ratios
- › What children learn
- › Safe food handling and preparation
- › Safe storage of medicine, cleaning supplies and other toxins
- › Safe indoor and outdoor play areas





"HOMES THAT MEET LICENSING REQUIREMENTS PROVIDE A SAFE AND SECURE ATMOSPHERE."

CORRINA
LICENSED CHILD CARE PROVIDER

How do I find licensed child care?

Begin your search by listing the things that are important to you and your child. Then collect the names of potential child care providers from friends, family, co-workers and from the Washington State Child Care Resource & Referral Network: **1.800.446.1114**.

Next, call several providers and ask about:

- > Ability to meet your child's individual needs
- > When they'll be able to offer your child a space
- > Hours of operation, vacation coverage
- > Fees and any financial help available
- > Location and transportation
- > Meals and snacks
- > Anything else that is important to you

What if I need to find child care immediately?

If you need to find child care quickly, your local child care resource and referral agency can help. Call the Washington State Child Care Resource & Referral Network at **1.800.446.1114** or visit **www.childcarenet.org**.

Once you've called several sites, make appointments to visit three or more. It's important to check them out in person. Use the checklist in this booklet during your visit. Talk with parents with children in the program and check DEL's Licensed Child Care Information System for information on the provider's licensing history: **www.del.wa.gov** or **1.866.482.4325**.

Take your child to visit and, if possible, let your child help choose. Trust your feelings about what you see during the visit. No setting is perfect, so you'll need to decide which place will best meet your family's needs.

Finally, read the provider's written policies and procedures. Be sure to sign a contract or agreement form and make clear your expectations about fees, holidays, vacations and refunds.

LICENSED CHILD CARE CENTERS

HOW MANY STAFF MEMBERS WILL BE WITH MY CHILD?

| Age of children | Ratio of staff to children | Maximum size of group |
|---|----------------------------|-----------------------|
| Babies 1 months through 11 months | 1:4 | 8 |
| Toddlers 12 months through 29 months | 1:7 | 14 |
| Preschoolers 30 months through 5 years | 1:10 | 20 |
| School-aged children 5 years through age 12 | 1:15 | 30 |

Family child care homes:

This varies based on providers' licensed capacity and whether they have assistants. Maximum home licensed capacity is 12 children ages birth through 11 years. Check providers' licenses for specific details about their licensed capacity.

CHECKLIST

You know what is important to you and your family when choosing child care. In addition to thinking about affordability and accessibility, it may help you to take this checklist along when visiting sites.

What will my child do during the day?

Are there planned activities that help my child learn?

- Quiet and active?
- Indoor and outdoor?
- Will my child have time each day for running, catching, climbing and throwing?
- Will my child have free play time?
- Is TV watching and computer games limited and appropriate?
- Is the space comfortable, organized, appealing and child-friendly?

Is rest time individualized for each child?

- Infants sleep on their own schedule
- Quiet activities for non-napping children
- Are there plenty of age-appropriate books?
- Are books available to children in their own language?
- Is there circle time, storytelling or reading every day?
- Will my family's culture be respected in daily activities?
- Can children access toys and activities on their own?

What will my child eat, and when?

- Is there a planned menu?
- Are meals and snacks balanced and healthy?
- Are children's food choices, appetites, and religious or cultural restrictions respected?
- What are the expectations about food brought from home?

Is age-appropriate discipline used?

- Do staff set limits that are reasonable, clear, consistent and age-appropriate?
- Do staff use calm voices when talking with children?
- Do staff redirect children to other activities if there's a conflict?
- What happens when children hit, bite or bully other children?
- Do I agree with the discipline policy?

Will my child be safe and healthy in this setting?

- Are there enough staff members to give attention to all the children?
- Are the toys and equipment safe and age-appropriate?
- Is a staff member trained in CPR and first aid present at all times?
- Is the licensed space child-proofed (cleaning supplies up high, electrical outlets covered, medicines locked up)?

Do children and providers wash hands:

- after toileting?
- after blowing noses?
- after changing diapers?
- before eating or handling food?
- when coming back from outdoor play?
- Are there regular fire drills?
- Does the outdoor play area feel safe?
- Do I feel secure with the people who will be caring for my child?
- If my child is school-age, is there a plan for getting him/her to and from school safely?
- Are there guidelines regarding illness?
- How often are diapers changed?
- Is there a plan for contacting parents in case of an emergency?
- Is a staff member trained in CPR and first aid present at all times?





How are the child care providers here supported?

- Do staff have opportunities for training and continuing education?
- Do staff have break time?
- Are staff encouraged to share their ideas on activities and program planning?
- Do staff have time to plan activities?

How are parents included in the child care program?

- Am I encouraged to visit at any time?
- Is there a way for me to watch activities?
- Am I encouraged to spend time with my child as a guest for lunch or as a volunteer?
- How will I hear about my child's day?
- Are there provider-parent meetings?
- Are there chances for families to get to know one another and staff?
- Do I feel respected as my child's first and most important teacher?

Will my child thrive here?

- Are different cultures, ethnicities and abilities valued?
- Do staff smile, talk to and listen to children frequently?
- Does this setting encourage creativity and age-appropriate independence?
- Do staff hold and cuddle with infants and toddlers often, including while feeding or changing diapers?
- Will the same people take care of my child regularly?
- Are children comforted when needed?
- Is the atmosphere bright, pleasant and happy?
- What training and education do staff have that prepared them to help my child learn?
- Will my child have FUN here?



GET INVOLVED



How can I be involved in my child's care?

Spend time at the child care site. Being there sends a strong message to both your child and the provider that you want all children there to thrive, learn and have fun!

- › Spend some time reading or playing with your child at the child care site during drop-off and pick-up
- › Meet regularly with your child care provider to ask questions about how your child is doing
- › Offer to volunteer for cleanup days or to help children with activities
- › Join in special events, such as field trips, career day or on dates that are culturally important for your family
- › If your child care facility has a parent board or parent committee, volunteer to serve on it or try to attend meetings

How do I know if my child is thriving in child care?

Put yourself in your child's shoes.

Try to answer these questions as your child would:

- › Am I usually eager to go to child care?
- › Do I have fun there?
- › Do I feel safe and comfortable there?
- › Am I respected there?
- › Am I heard there?



WHERE CAN I FIND HELP PAYING FOR CHILD CARE?

Child care can be expensive. You may qualify for help—here are some resources:

> **Some child care providers offer:** sliding-scale fees, scholarships, vouchers or other tuition breaks. *Ask providers about this when visiting the site.*

> **The Department of Early Learning** oversees the Early Childhood Education and Assistance Program (ECEAP), a whole-child, family-focused preschool program designed to help low-income and at-risk children and their families succeed in school and life. Four- and three-year-old children and their families that are at 110 percent of the Federal Poverty Level are eligible. This includes families receiving public assistance, children in the foster care system and parents with limited incomes who are working or in school. Contact the Department of Early Learning's state ECEAP office for more information.

1.866.482.4325
www.del.wa.gov

> **Working Connections Child Care** is a state program that helps families with children pay for child care while they work, look for work or are in state-approved training. Families with incomes under 200 percent of the Federal Poverty Level qualify. Parents who receive a subsidy help pay for child care services with a co-payment that depends on family size and income. To find out more about this program, contact your local Community Service Office (listed in your local phone book).

> **Other resources** exist to help families pay for child care and early childhood education programs, including seasonal child care for agricultural workers and homeless child care. Contact your local Child Care Resource & Referral Agency to learn more.

1.800.446.1114
www.childcarenet.org



RESOURCES



For Families

2-1-1

Call this number for information and referrals on many topics, including health care and childcare, housing, job training, education and recreation, retirement, disability and social service information.

End Harm

We all have a shared responsibility to ensure children are safe and healthy in licensed child care. If you suspect a child is being abused or neglected in licensed child care, call toll-free: **1.866.ENDHARM**.

Family Help Line

If you have questions or concerns about a child in your life, or need support or someone to listen, call toll-free: **1.800.932HOPE** (4673).

Licensed Child Care Information System

LCCIS offers information about licensed child care providers. Visit DEL's Web site at **www.del.wa.gov** or call toll-free: **1.866.482.4325**.

Washington State Child Care Resource & Referral Network

For help finding licensed child care and information about subsidy programs, call toll free: **1.800.446.1114** or visit: **www.childcarenet.org**.

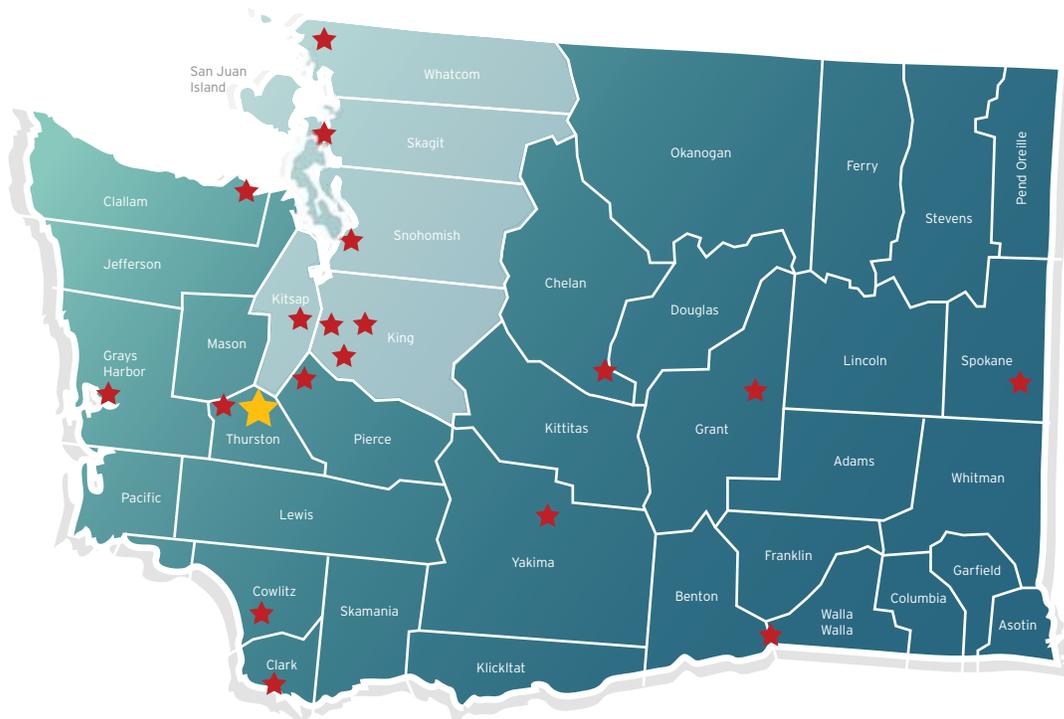


How to contact DEL

DEL STATE OFFICE
 649 Woodland Square Loop SE
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 Olympia, WA 98504-0970
 360.725.4665
 1.866.482.4325
 Fax: 360.413.3482
www.del.wa.gov

DEL office locations

| | | |
|------------|--------------|------------|
| ABERDEEN | KING SOUTH | TACOMA |
| BELLEVUE | MOSES LAKE | TRI-CITIES |
| BELLINGHAM | MOUNT VERNON | TUMWATER |
| BREMERTON | PORT ANGELES | VANCOUVER |
| EVERETT | SEATTLE | WENATCHEE |
| KELSO | SPOKANE | YAKIMA |



Answering your questions about child care options

- > How do I get started?
- > How do I choose a child care facility?
- > How do I get more involved in my child's care?
- > Where can I find help paying for child care?
- > Where can I find family resources?
- > Where is my local DEL office?

DEL



Washington State Department of
Early Learning

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EARLY ACHIEVERS: GOOD FOR FAMILIES, CHILD CARE PROVIDERS, AND WASHINGTON STATE Quality early learning helps children succeed in school and beyond. Early Achievers is a new program that connects families to child care and early learning programs with the help of an easy-to-understand rating system. Early Achievers also offers coaching and resources for child care providers to support each child's learning and development. Research shows that this kind of assistance helps providers improve the quality of their programs. And when more young children are ready for school, we all benefit.

Early Achievers is a key strategy in Washington's Statewide Early Learning Plan to improve the quality of child care and early learning programs. The information from Early Achievers will allow DEL to make the most of its programs and services—such as preschool, licensing, and professional development—by targeting investments in training and technical assistance.

In partnership with the Washington State Child Care Resource and Referral Network and the University of Washington, DEL is working to expand the number of providers participating in Early Achievers across the state. Beginning in 2012, ratings for participating programs will be available through DEL's website.

“We are now providing a higher-quality learning environment for our children.”

—CLARK COUNTY QRIS PARTICIPANT

WHAT IS A QUALITY CHILD CARE PROGRAM?

Choosing child care is an important decision. Families deserve to know that their children are in quality care environments that foster a love of learning, promote each child's unique skills and cultures, and support the development of the whole child. Early Achievers helps identify programs that have:

- ⊙ Nurturing and supportive relationships between adults and children
- ⊙ Care and education that meets each student's individual needs
- ⊙ Facilities that are safe, well-organized, and have age-appropriate resources
- ⊙ Programs that support the development of the whole child
- ⊙ Open communication and genuine engagement with families
- ⊙ Meaningful efforts to embrace diversity

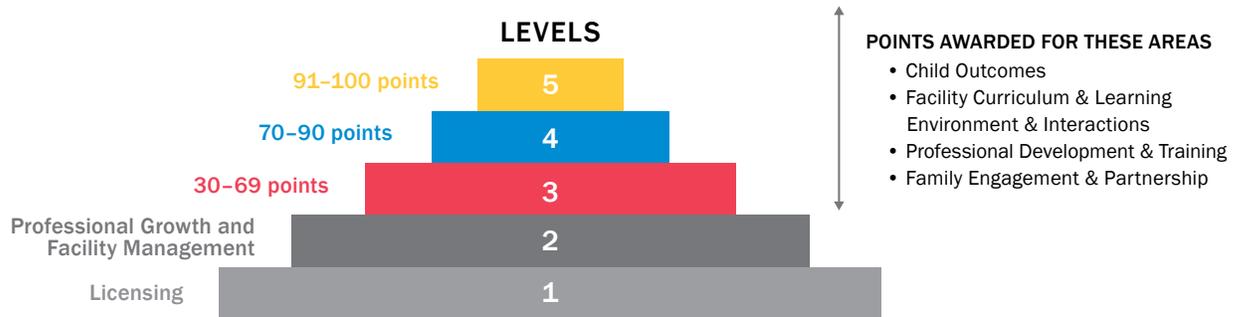
HOW EARLY ACHIEVERS WORKS

Many states have quality rating and improvement systems, but Washington is one of the first to combine the Environment Rating Scale (ERS) and Classroom Assessment Scoring System (CLASS)—along with an evaluation of curriculum, assessment, and staff training—to measure quality in a comprehensive way.

Programs are rated on a scale of one to five. At a minimum all Early Achievers must meet Washington's requirements for health and safety or have recognized certification. All licensed child care programs are eligible to enroll in Early Achievers and can voluntarily decide whether they want to participate and achieve higher ratings.

To achieve a level two rating, providers complete a self-assessment, attend no-cost trainings, and become a part of DEL's statewide professional development registry. Programs with higher ratings—levels three through five—have demonstrated a commitment to strong instruction, training for staff, and family engagement to support student outcomes.

As they move up the rating scale, child care and early learning providers receive additional coaching, professional development, and incentives to help them continue to improve the quality of their programs.



BASED ON RESEARCH, DEVELOPED IN COLLABORATION WITH PROVIDERS

Early Achievers was developed in collaboration with child care providers across the state. For two years, the Department of Early Learning and Thrive by Five Washington worked with approximately 90 providers in five communities to develop the program.

An independent evaluation of the pilot program found that when child care providers receive one-on-one coaching and a modest amount of money to make changes to their program, the quality of the care they give children starts to quickly increase.

Learn more about Early Achievers at www.del.wa.gov/care/qris.

INCENTIVES FOR CHILD CARE PROVIDERS

- ☉ **Quality improvement awards** — Programs receive increasing awards for attaining higher rating levels. Awards are used to carry out their Quality Improvement Plans designed in collaboration with a coach.
- ☉ **Tiered subsidy reimbursement** — Programs that attain higher Early Achievers ratings may receive higher reimbursements in the future.
- ☉ **Professional development incentives and awards** — Early learning staff will receive individual incentives for achieving training and education. Child care programs can increase their ratings by having more highly qualified staff.

FREQUENTLY ASKED QUESTIONS



1. What is Early Achievers? Why is it a focus of the Department of Early Learning?

Early Achievers is Washington's Quality Rating and Improvement System (QRIS), a process for supporting and rewarding child care providers for providing high-quality child care. Because so many of Washington's young children participate in early learning programs, it's important to make sure these programs provide children with the best possible start. DEL has developed Early Achievers to help programs offer high-quality care through training, coaching, and incentives that support high quality for children.

Early Achievers is designed to align, support, and build upon other key early learning programs in Washington, particularly WaKIDS, Washington's Kindergarten Inventory of Developing Skills, and the professional development lattice. We know that creating seamless programs for children and families in Washington is key to helping all children grow, develop, and successfully transition from early childhood into early elementary.

2. Who will participate in Early Achievers? Is participation voluntary or required?

Beginning July 1, 2012, all licensed and certified programs will have the opportunity to enroll in Early Achievers. Level 1 is equal to licensing or certification to recognize the critical importance of health and safety as the foundation of quality. Programs voluntarily decide whether they want to participate further and attain Levels 2 through 5. Programs that opt to participate will have a variety of supports and incentives available to help them achieve higher Early Achievers ratings.

Early Achievers, Washington's Quality Rating Improvement System (QRIS)

This is an exciting time to be in early learning in Washington! As a result of Washington winning the [Race to the Top – Early Learning Challenge](#) grant in December 2011, the Department of Early Learning (DEL) will expand [Early Achievers, Washington's Quality Rating and Improvement System \(QRIS\)](#), statewide. Early Achievers is expanding beginning July 1, 2012 and will serve the entire state within one year. Please check our website to see how Early Achievers will increase quality early learning opportunities in your community.

3. Do providers who accept Working Connections Child Care Subsidy need to participate?

No. Child care providers do not need to participate in Early Achievers to continue to receive child care subsidy. However, DEL is currently developing a “tiered reimbursement system” in which subsidy payments would be higher for programs that achieve a higher Early Achievers rating. The tiered reimbursement will provide additional incentives and rewards for participation in Early Achievers, but facilities will not need to achieve a specific level of quality to be eligible to serve children on subsidy.

4. How will DEL encourage child care providers to participate?

DEL wants to make high-quality care an achievable goal for all child care programs. To support early learning programs on the path to quality, DEL has three primary mechanisms to programs improve and sustain high-quality care:

► **Coaching:** Programs that choose to participate in Early Achievers will be provided with coaching through the Child Care Aware of Washington. Coaching is intended to support programs achieve higher quality ratings. Areas for development include:

- Improving the quality of teacher-child interactions and the learning environment
- Ongoing child assessments
- Implementation research-based curriculum and teaching strategies
- Individualizing teaching and learning, especially for children with special needs or who are having difficulty progressing in certain developmental domains.
- The University of Washington (UW) is finalizing the coaching models. The training framework is expected to be finalized by July 1, 2012.

► **Quality Improvement Awards:** Washington encourages programs to increase their quality and make a positive impact on child outcomes by investing in quality improvement grants for facilities that reach higher Early Achievers quality rating levels. Quality improvement grants are flexible, but coaches help programs prioritize areas of need such as classroom educational materials, teacher training, wage supplements, release time, curriculum materials, or parent trainings/supports.

► **Professional Development opportunities, funds, and supports:** A variety of supports and incentives are available to support programs that employ staff with a CDA/certificate or higher degree, which help them earn points toward the Early Achievers professional development standard.

Scholarships and Opportunity Grants are provided to support participants' ongoing professional development goals once they reach levels three through five. Funding is evenly split between two results-based programs, Washington Scholarships, implemented by Child Care Aware of Washington and Opportunity Grants, implemented by State Board of Community and Technical Colleges.

5. Will the quality ratings be public?

Yes. We know early learning programs will benefit from becoming an Early Achiever and we will promote ratings on DEL's website. DEL will post programs that have chosen to voluntarily participate and that achieved a Level 2 rating or higher. Programs that do not choose to participate (and therefore will remain a Level 1 Early Achiever) will not be publicly listed as a Level 1 program.

6. What are the Early Achievers Quality Levels and what do they mean?

► **Level 1** is Licensing or Certification that includes all licensed child care centers and family child care, military, tribal, Head Start and ECEAP, and other state-funded programs.

► **Level 2** is focused on ensuring that program leaders (specifically child care administrators, directors and owners) understand QRIS, the Program Standards and requirements, and the child outcome and school readiness goals of the system. To attain Level 2, programs must complete a self-assessment (the ERS) and attend free trainings that support program improvements

and policy development. Finally, programs must participate in DEL's statewide professional development registry ([MERIT](#)) by creating program profiles and ensuring all employees have an active record of their educational achievements.

- ▶ **Levels 3 through 5** are points-based ratings based on four program standards:
 - Child outcomes
 - Curriculum, Learning, Environments and Interactions
 - Professional Development and Training
 - Family Engagement and Partnership.

7. What are the standards that programs will be evaluated on to determine their rating?

Levels 3 to 5 will be determined on a 100-point system, based on the following four standards:

- ▶ **Child Outcomes** is worth up to 10 points for implementing screenings and assessments and sharing the results with families. Participants choose a screening from an approved list, allowing for flexibility and the unique needs of each program.
- ▶ **Curriculum, Learning, Environment and Interactions** accounts for 70 points and is based on the strength of the curriculum and teachers supports. In this standard, 55 of the 70 points are determined through assessments conducted by the UW evaluation team, which uses two comprehensive assessment tools, the Environment Rating Scale (ERS) and the Classroom Assessment Scoring System (CLASS).
- ▶ **Professional Development, Training and Coaching**, worth 10 points, is designed to align with the education levels identified in the [Washington State Core Competencies for Early Care and Education Professionals](#). Beginning with the Child Development Associate, providers

can earn points for having staff who achieve high levels of education continuing through the Master's degree level. To help programs advance in this standard, Early Achievers provides incentives such as tuition reimbursement, scholarship, and other inventive awards.

- ▶ **Family Engagement and Partnerships** is worth 10 points and is based on the research-based Strengthening Families Framework. Programs earn points for completing the Strengthening Families assessment and for providing family supports.

The progression for Early Achievers levels is:

- ▶ Programs that have completed Level 2 requirements and have been working with a coach may request an assessment to achieve a Level 3 to 5 rating.
 - Based on the four standards above, programs that receive 30 to 69 points will receive a Level 3 rating.
 - Programs that score 70 to 90 points will receive a Level 4 rating.
 - Programs that score 91 to 100 points will receive a Level 5 rating.

8. How will Early Achievers improve child outcomes?

Early Achievers is unique in the nation because it was built with the specific goal of improving outcomes for kids. The initial pilot was developed, tested and evaluated by Thrive by Five Washington. Based on Thrive by Five's initial work and findings, DEL worked with UW to make revisions that are shown through research to strengthen instruction and affect child outcomes, with a particular emphasis on children with special needs. DEL will continue to work with its research partner, UW, to ensure the strongest alignment between the Early Achievers standards, the rating levels, and the outcomes for children.



WASHINGTON
EARLY ACHIEVERS
PREPARING CHILDREN FOR SUCCESS IN SCHOOL

Revised April 2013



EARLY ACHIEVERS, Washington's Quality Rating and Improvement System Standards

A Framework to Support Positive Child Outcomes

LEVEL 1: Licensing or Certification

Facility must be licensed by the Washington State Department of Early Learning or have recognized, approved certification (Military, Head Start, ECEAP, Tribal).

LEVEL 2: Professional Growth and Facility Management

Facility must meet all Level 1 requirements and serve children birth to age 5 in order to register for Level 2.

LEVEL 2 APPLICATION PROCESS

Applicants must complete prior to beginning Level 2 activities:

- ▶ Attend Early Achievers Orientation.
- ▶ Complete and submit facility registration in MERIT.
- ▶ Complete and submit Early Achievers Registration.

LEVEL 2 ACTIVITIES

Documentation (in MERIT, Early Achievers Application Level 2)

- ▶ Complete Facility Profile
- ▶ Complete and submit Early Achievers self-assessment*
 - ▶ Environment Rating Scale (ERS)
 - ▶ State standards

Complete Professional Training Series (director/owner/program supervisor)

- ▶ Washington State Early Learning and Development Guidelines
- ▶ Washington State Core Competencies for Early Care and Education Professionals
- ▶ Introduction to Cultural Competence
- ▶ QRIS Strengthening Families for Early Learning Professionals
- ▶ Introduction to the Environment Rating Scales (ERS) and Classroom Assessment Scoring System (CLASS)
- ▶ QRIS School Readiness

REQUIREMENTS TO ACHIEVE LEVEL 2 STATUS**

- ▶ Ensure all facility staff caring for children have an active professional record in MERIT.
- ▶ Complete and submit Early Achievers Application for Level 2 within one year.
- ▶ Must be fully licensed (no initial licenses).
- ▶ License cannot be suspended, revoked, or on probation.



*The ERS/CLASS Overview must be taken prior to completing the Early Achievers Self-assessment.

**Facility must meet all of the below requirements and have achieved Level 2 status prior to applying for an evaluation to earn a Level 3 to 5 rating.

LEVELS 3, 4, & 5: Points Accumulation

LEVEL 5

91-100 points

LEVEL 4

70-90 points

LEVEL 3

30-69 points

LEVEL 2

Professional Growth and Facility Management

LEVEL 1

Licensing or Certification

Levels 3 to 5 are based on points. Your facility rating is determined by the number of points you earn during your independent evaluation. Each assessed classroom/family home child care must score at least a 2 on Instructional Support in the CLASS, a 3.5 on Emotional Support and Classroom Organization/Emotional and Behavioral Support in the CLASS and a 3.5 on the ERS to achieve a Level 3 to 5 rating. Facilities that do not meet these minimum thresholds will receive a Level 2 rating.

POINTS AWARDED FOR THESE AREAS:

- ▶ Child Outcomes
- ▶ Facility Curriculum & Learning Environment & Interactions
- ▶ Professional Development & Training
- ▶ Family Engagement & Partnership

Your overall points will determine your final rating. Degrees and credentials must be verified in MERIT in order to earn professional development points. The points are:

| | |
|---|-------------------|
| Child Outcomes | +10 points |
| Facility Curriculum and Learning Environment and Interactions (70 points total) | |
| Classroom/FCC Home Environment (CLASS/ERS) | +55 points |
| Curriculum, Learning and Assessment | +15 points |
| Professional Development and Training | +10 points |
| Family Engagement and Partnership | +10 points |
| Grand Total | 100 points |



POINTS ACCUMULATION

Child Outcomes / 10 points

| Component | Sub-Component One | Sub-Component Two | Total Points |
|--|--------------------------|--------------------------------|--------------|
| Developmental screening is conducted within 90 days of enrollment and results are shared with parents | Records Review (1 point) | | 1 point |
| Daily Individual Child Experience of Quality | Engagement (1 point) | Language (1 point) | 2 points |
| Ongoing assessment of children's strengths and needs to monitor progress (e.g., child portfolio/ work sampling assessments) and inform instruction | Records Review (1 point) | Focal Child Analysis (1 point) | 2 points |
| Share individualized child data with parents | | | 1 point |
| Evidence of family engagement, data sharing, and transition supports for individual children (as measured by Focal Child) | | | 1 point |
| Use of WaKIDS Assessment Tool <u>or</u> demonstration/ documentation of alignment to WaKIDS Assessment process | | | 1 point |
| Individualized Instruction for all children | | | 1 point |
| Periodic review and use of child assessment data for continuous program improvement (e.g., analyze group patterns and behaviors) | | | 1 point |

Facility Curriculum, Learning Environment, Interactions / 70 points

Classroom/FCC Home Environment / 55 Points

| Measurements | Point range options, based on average facility score | | |
|--|--|---------------------------|-----------------------------|
| CLASS: Instructional Support/ Engaged Support for Learning* | 2 to 3.4 (10 points) | 3.5 to 4.4 (15 points) | 4.5 & higher (20 points) |
| CLASS: Emotional Support & Classroom Organization/Emotional and Behavioral Support** | 3.5 to 4.9 (10 points) | 5.0 to 5.9 (15 points) | 6.0 & higher (20 points) |
| ERS** | 3.5 (5 points) | 5 (10 points) | 6 (15 points) |

* No one classroom can score below a 2 to receive a rating of 3 or higher

** No one classroom can score below a 3.5 to receive a rating of 3 or higher

Curriculum and Staff Supports / 15 points

| Component | Sub-Component One | Sub-Component Two | Total Points |
|---|---|--|--------------|
| Curriculum Profile | Show evidence of Program Curriculum Philosophy (1 point) | Demonstrate alignment with Washington State Early Learning and Development Guidelines (2 point) | 3 points |
| Training | Lead Teaching Staff* or FCC Owner trained on Program Curriculum Philosophy (2 points) | Lead Teaching Staff* or FCC Owner trained on Washington State Early Learning and Development Guidelines (3 points) | 5 points |
| Ongoing mentoring of teaching staff** to support improvement in curriculum and teacher child interactions | | | 3 points |
| Dedicated time for teaching staff** planning time on a weekly basis | | | 2 points |
| Dedicated time for teaching staff** to engage in reflective practice with peer group on a monthly basis | | | 2 points |

* Includes family child care assistants

** Includes FCC primary educator/care provider

Professional Development and Training / 10 points

Center Director or Program Supervisor

| | | |
|----------------------------|---|----------|
| AA in ECE or related field | Level 3 of the Core Competencies for Early Care and Education Professionals | 1 point |
| BA in ECE or related field | Level 4 of the Core Competencies for Early Care and Education Professionals | 2 points |
| MA in ECE or related field | Level 5 of the Core Competencies for Early Care | 4 points |

Center Designated Lead Teaching Staff

(at least one staff person per classroom must be designated lead)

| | | |
|---|---|----------|
| 25% have CDA or approved certificate or credential (12 credits or higher) | Level 2 of the Core Competencies for Early Care and Education Professionals | 1 point |
| 25% have AA or higher in ECE or related field | Level 3 of the Core Competencies for Early Care and Education Professionals | 2 points |
| 25% have BA or higher in ECE or related field | Level 4 of the Core Competencies for Early Care and Education Professionals | 3 points |

Center - All Other Teaching Staff (assistants and aides)

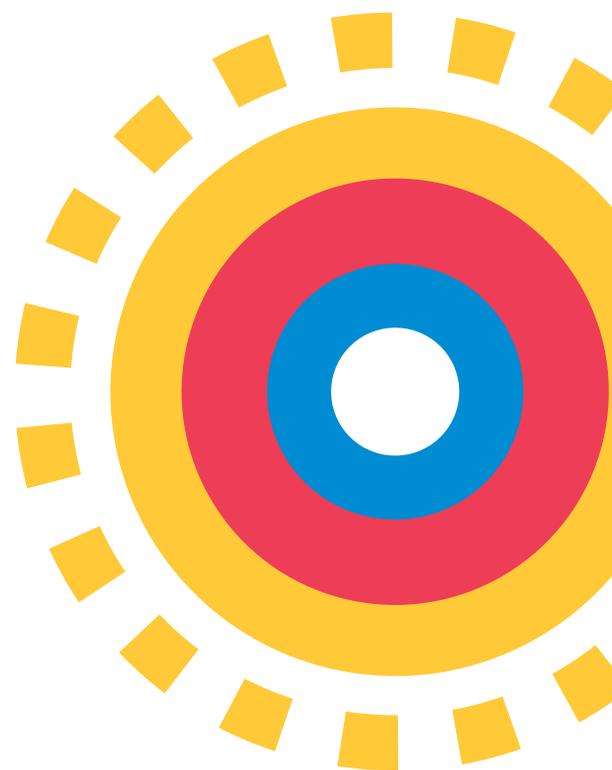
| | | |
|---|---|----------|
| 25% have CDA or approved certificate or credential (12 credits or higher) | Level 2 of the Core Competencies for Early Care and Education Professionals | 1 point |
| 50% have CDA or approved certificate or credential (12 credits or higher) | Level 2 of the Core Competencies for Early Care and Education Professionals | 2 points |
| 25% have AA or higher in ECE or related field | Level 3 of the Core Competencies for Early Care and Education Professionals | 3 points |

Family Child Care Provider or Primary Worker

| | | |
|--|---|-----------|
| CDA or approved certificate or credential (12 credits or higher) | Level 2 of the Core Competencies for Early Care and Education Professionals | 3 points |
| AA in ECE or related field | Level 3 of the Core Competencies for Early Care and Education Professionals | 5 points |
| BA in ECE or related field | Level 4 of the Core Competencies for Early Care and Education Professionals | 7 points |
| MA in ECE or related field | Level 5 of the Core Competencies for Early Care and Education Professionals | 10 points |

Family Engagement and Partnership / 10 points

| Component | Total Points |
|--|--------------|
| Complete modified Strengthening Families Self-assessment (Director/Owner) | 1 point |
| Develop a Plan of Action based on Strengthening Families Self-assessment | 1 point |
| Provide evidence of continuous feedback and improvement (Plan of Action) | 1 point |
| Have a parenting support and education program in place (e.g. Incredible Years, Triple P Parenting, CSEFEL Parenting Modules, Parents as Teachers etc.) | 1 point |
| Provide information about community based programs available for parents in languages represented in the facility (e.g. community mental health, child nutrition, physical fitness, food banks, Child Find, medical/dental resources etc.) | 1 point |
| Evidence of transition plans/policies in place for changes in settings and providers | 3 points |
| Partner with parents to determine perception of child strengths and needs | 2 points |







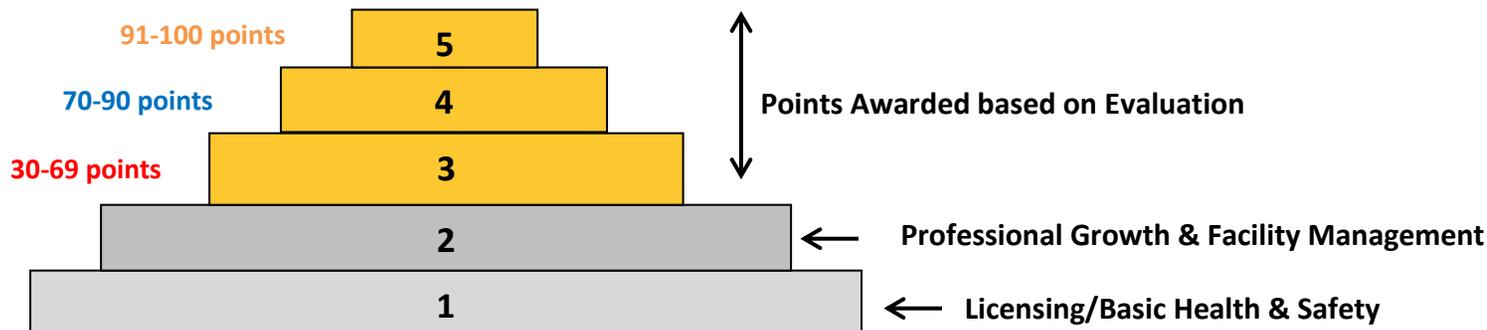
Washington's Quality Standards: An Overview

"Hybrid" Model

- ◉ **Levels 1-2:** All facilities meet the same foundational quality based on licensing/certification and Early Achievers readiness activities
- ◉ **Levels 3-5:** Facilities achieve points through evaluation; facilities have flexibility in how they earn points based on program strengths and philosophy

Levels 3-5 achieved through:

- ◉ Completion of Level 2 requirements
- ◉ On-site evaluation based on Quality Standards which includes:
 - Environment Rating Scales (ERS)
 - Classroom Assessment Scoring System (CLASS)
 - Review of documentation & records
- ◉ Minimum threshold to achieve Level 3:
 - Minimum requirements for ERS and CLASS scores
 - Facilities must earn at least 30 points



| Quality Standard Area | Examples of how facilities earn points in this Standard Area include: |
|--|--|
| <p>Child Outcomes (10 points)</p> | <ul style="list-style-type: none"> • Screen children to spot developmental concerns • Provide on-going assessment to learn about each child’s strengths and needs • Share information about children’s growth and progress with families to support school readiness • Use information about each child’s unique strengths and needs to plan activities and curriculum |
| <p>Curriculum & Learning Environment & Interactions (70 points)</p> | <ul style="list-style-type: none"> • Environment Rating Scales (ERS) Assessment: measures availability and variety of learning materials and activities; organization of space, materials, schedule and routine to enhance learning; interactions between children and providers; use of materials to promote learning • Classroom Assessment Scoring System (CLASS) Assessment: measures how providers interact with children to create supportive, nurturing relationships, enhance learning, and provide instruction • Implement a curriculum that aligns with the Washington Early Learning Guidelines and supports child development and individual instruction • Provide planning time & supports for staff for professional growth & learning |
| <p>Professional Development & Training (10 points)</p> | <ul style="list-style-type: none"> • Provider/staff have qualifications that align with the education levels identified in the Washington State Core Competencies for Early Care and Education Professionals, from a Child Development Associate continuing through the Master’s degree level |
| <p>Family Engagement & Partnership (10 points)</p> | <ul style="list-style-type: none"> • Complete and implement research-based Strengthening Families Framework. • Provide resources to families such as parenting programs and information about community resources • Partner with families to support children’s progress; create open communication and genuine engagement with families • Create inclusive environments that are welcoming to all families |

When you
Join Early Achievers
support in your quality improvement
journey begins

Level 2:
**Professional Growth
and Facility Management**



Level 2 is the beginning of an ongoing journey in quality improvement — a valuable phase for all providers to receive foundational information, support and education.

All facilities receive free training and technical assistance as they prepare for a rating.

1

Attend an Orientation and Connect With a Technical Assistance Specialist to Map Out Your Journey

Follow these steps:

- Attend Orientation
- Complete your professional record and facility profile in MERIT
- Register for Early Achievers in MERIT
- Once accepted, you will immediately be assigned a Technical Assistance Specialist and receive a Welcome Kit from DEL

Level 2 Activities:

- Attend Early Achievers Orientation
- Register for Early Achievers in MERIT
- Submit application with facility profile in MERIT
- Complete ERS and Washington Quality Standards self-assessments
- Complete Professional Training Series
- Ensure all teaching staff have a professional record in MERIT

2

Utilize Your Technical Assistance Specialist for Individualized Support in This Pre-Rating Phase

Your TA Specialist is available to you as a resource throughout Level 2, and will:

- Provide support onsite, by phone, and e-mail
- Help plan and prioritize your activities and quality improvements during this phase
- Connect you with other peer groups for support
- Help in identifying other resources, trainings and information

Level 2 Activities Must be Completed:

- Within one year of Early Achievers Registration in MERIT
- Before a facility can request an on-site evaluation for rating

3

Participate in Free Trainings Focused on Foundational Concepts that Prepare You For a Rating

Six required courses make up the Professional Training Series. Your TA Specialist will help you turn your trainings into action steps.

- Introduction to the Environment Rating Scale and CLASS
- WA Early Learning Guidelines
- WA Core Competencies for ECE Professionals
- Introduction to Cultural Competence
- Strengthening Families
- School Readiness

4

Congratulations! You Are Now Ready to Apply to be Evaluated for a Rating!

You have reached the Early Achievers house! Now it's time to apply what you have learned, and build upon your skills and knowledge with additional resources available, to move children toward school readiness. You will accomplish this through:

- Coaching support
- Professional development incentives
- Quality improvement awards





Professional Training Series

The QRIS Professional Training Series is required for Level 2 participants of Early Achievers. The series has been designed to support Washington's Quality Rating and Improvement System and will help providers as they prepare themselves for quality improvement work. The trainings are intended for child care center directors and family child care primary providers and are offered free of charge.

⦿ **Introduction to the Environment Rating Scale (ERS) and Classroom Assessment Scoring System (CLASS)**

Online, approximately 2 hours

This course provides an overview of the two standardized assessments used in Early Achievers as part of the comprehensive measure of program quality reflected in the rating. The focus of the ERS is on safety, organization and the age-appropriateness of daily schedule and materials within the environment. The CLASS focuses on teacher-child interactions as a means to promote children's social and cognitive development. Together these two assessments provide a comprehensive measure of the learning environment.

⦿ **Washington State Early Learning Guidelines**

Online, approximately 2 hours

This course is an introductory overview of the *Washington State Early Learning and Development Guidelines*, which can help orient adults to child development. The module examines the history and purpose of the Guidelines and who can use Guidelines and for what purpose. Additionally, the module provides an overview of the structure of the 2012 ELGs document and presents examples of how to use the Guidelines to support child development.

⦿ **Washington State Core Competencies for Early Care and Education Professionals**

Online, approximately 2 hours

This course is an introductory overview of the *Washington State Core Competencies for Early Care and Education Professionals*. The goal of this course is for professional providers who care for children 0-8 in Washington to become familiar with the Core Competencies, and identify content areas for professional development.

⦿ **Introduction to Cultural Competence**

In person, 2 hours

The understanding and respect of children's cultural heritage is a foundation stone for their social/emotional well-being as well as their intellectual development. Through this training, early childhood professionals will reflect on their daily care giving and teaching practices of young children, heighten their level of awareness of cultural influences, and increase their ability to interact competently with children and families.

⦿ **QRIS Strengthening Families Training for Early Learning Professionals**

In person, 6 hours

Strengthening Families Protective Factors are new framework for child abuse and neglect prevention and promoting optimal child development. The protective factors shift the focus of child abuse and neglect prevention efforts from family risks and deficits to family strengths and resiliency. By recognizing and building on existing strengths within communities and families, we can support all families in providing a healthy, safe, and loving environment for children.

⦿ **QRIS School Readiness**

In person, 4 hours

School readiness means that children are ready for school, families are ready to support children's learning, and schools are ready for children. Early learning providers have a wonderful opportunity to support this process and ensure success for children. The training will introduce and model instructional techniques measured in the CLASS: emotional support, well organized learning environments, and instructional techniques. Participants can apply these techniques to increase the quality of interactions in their facility and prepare themselves for an Early Achievers on-site evaluation.

EARLY ACHIEVERS SCHOLARSHIP OPPORTUNITIES

Scholarship opportunities are available for students who are employed at an Early Achievers (EA) facility. Scholarships are available for CDA programs, Certificates, Associates Degrees and Bachelor’s Degrees in Early Childhood Education (ECE). Choosing an academic program that supports your career goals is an important decision. Early Achievers Opportunity Grants and Washington Scholarships for Child Care Professionals are two student financial aid resources that are prioritized for students who are employed by Early Achievers facilities. Below is a chart to help you decide which scholarship program would be best for you. You may also be eligible for additional financial aid beyond these scholarship opportunities. Check with your school of choice to learn about additional opportunities.

| | Early Achievers Opportunity Grant | Washington Scholarships for Child Care Professionals General Scholarship | Washington Scholarships for Child Care Professionals Bachelor’s Degree |
|------------------------|---|---|--|
| Funded Programs | <ul style="list-style-type: none"> Associate Degrees in ECE Stackable Certificates CDA Assessment Fee for admitted students pursuing additional coursework in ECE | <ul style="list-style-type: none"> Child Development Associates (CDA) CDA Assessment Fee Associate Degrees in ECE ECE Certificates | Bachelor’s Degrees in ECE or related field |
| Award Amounts | <ul style="list-style-type: none"> \$4000 Tuition, not to exceed 47 credits \$1000/year books | Tuition and Books (amount varies) CDA Assessment fee coverage FCC: 90%, CCC: 75% + center pays 15% | Up to \$6,500 per year for tuition and books |
| Student Responsibility | <ul style="list-style-type: none"> Enroll in an approved Early Childhood Education program. Maintain a minimum of 2.0 grade point average and meet the college’s satisfactory academic progress policy. Complete the Free Application for Federal Student Aid (FAFSA) application. | <ul style="list-style-type: none"> FCC: 10% of tuition and book expenses CCC: Student pays 10% tuition and books, center pays 15% tuition and books Enroll in 12-20 credits annually Remain employed by center for one year following contract completion | <ul style="list-style-type: none"> FCC: \$100 per course for tuition, \$25 per course for books CCC: \$75 per course for tuition, \$25 per course for books Enroll in 15-30 credits annually Remain employed by center for one year following contract completion Apply for federal financial aid |
| Eligibility Criteria | <ul style="list-style-type: none"> Employed at an EA participating facility Family income that is at or below 200 percent of the federal poverty level. Washington Resident as defined in RCW 28B.15.012. | <ul style="list-style-type: none"> Employed in an EA participating facility Have been employed with current child care facility for 6+ months Washington resident as defined by chosen academic institution | <ul style="list-style-type: none"> Employed in an EA participating facility Have a completed AA degree Have been employed with current child care facility for 18+ months Washington resident as defined by chosen academic institution |

| | Early Achievers Opportunity Grant | Washington Scholarships for Child Care Professionals General Scholarship | Washington Scholarships for Child Care Professionals Bachelor's Degree |
|--------------------------------|---|--|--|
| Employment Requirements | <ul style="list-style-type: none"> Employed 10 hours per week or 40 hours per month for a minimum of three months at an EA participating facility. Provide evidence of employment at EA facility. | <ul style="list-style-type: none"> Working 30+ hours per week in child care CCC: Signed Center Participation Agreement Employer contribution: 15% of tuition and books, offer up to 3 hours of paid release time weekly, provide financial incentive upon contract completion | <ul style="list-style-type: none"> Working 20+ hours per week in child care CCC: Signed Center Participation Agreement Employer contribution: \$75/course, \$25/book, offer up to 3 hours of paid release time weekly, provide financial incentive upon contract completion |
| Maximum salary | Family income is at or below 200% of the federal poverty level | Must earn less than \$14.45/hour | Must earn less than \$17.50/hour |
| Other Supports | <ul style="list-style-type: none"> Academic Advising Career Planning Student Mentoring Tutoring eLearning Tutoring or Workshops | <ul style="list-style-type: none"> Travel Stipend: \$50/quarter Release Time: \$9.50/hour up to 3 hours/week \$300 bonus award upon program completion Professional Development navigation support | <ul style="list-style-type: none"> Travel Stipend: \$50/quarter Release Time: \$9.50/hour up to 3 hours/week \$300 bonus award upon program completion Professional Development navigation support |
| Application Process | <ul style="list-style-type: none"> Complete Grant Application <p>Contact Information: Contact your Coach or TA Specialist</p> | <ul style="list-style-type: none"> Complete Washington Scholarships application Submit employment and income verification (ex: pay stub) CCC: Submit signed Center Participation Agreement <p>Contact Information: Phone: (866) 308-3224 http://www.wa.childcareaware.org/providers/scholarships</p> | |
| College Options | <p><u>Participating Community Colleges</u></p> <ul style="list-style-type: none"> Bates Technical College Clark College Highline Community College Lower Columbia College Olympic College Pierce Fort Steilacoom College Yakima Valley Community College | Any Washington State community or technical college | College or university offering BA in Early Childhood Education or related field |

FCC: Indicates requirements for family child care programs

CCC: Indicates requirements for child care center employees



Washington Health Benefit Exchange

**Governor's Interagency Council on Health Disparities
Wednesday, May 8, 2013**

PAM COWLEY

Impact Of The Affordable Care Act

- **Changes to private insurance, e.g.,**
 - Young adults on parent's policies to age 26
 - Prohibit lifetime monetary caps
 - Minimum spending on medical care (medical loss ratio)
- **Closes the prescription “doughnut hole”**
- **Expands coverage**
 - Expands Medicaid to 138%* of Federal Poverty Level (FPL)
 - Exchanges



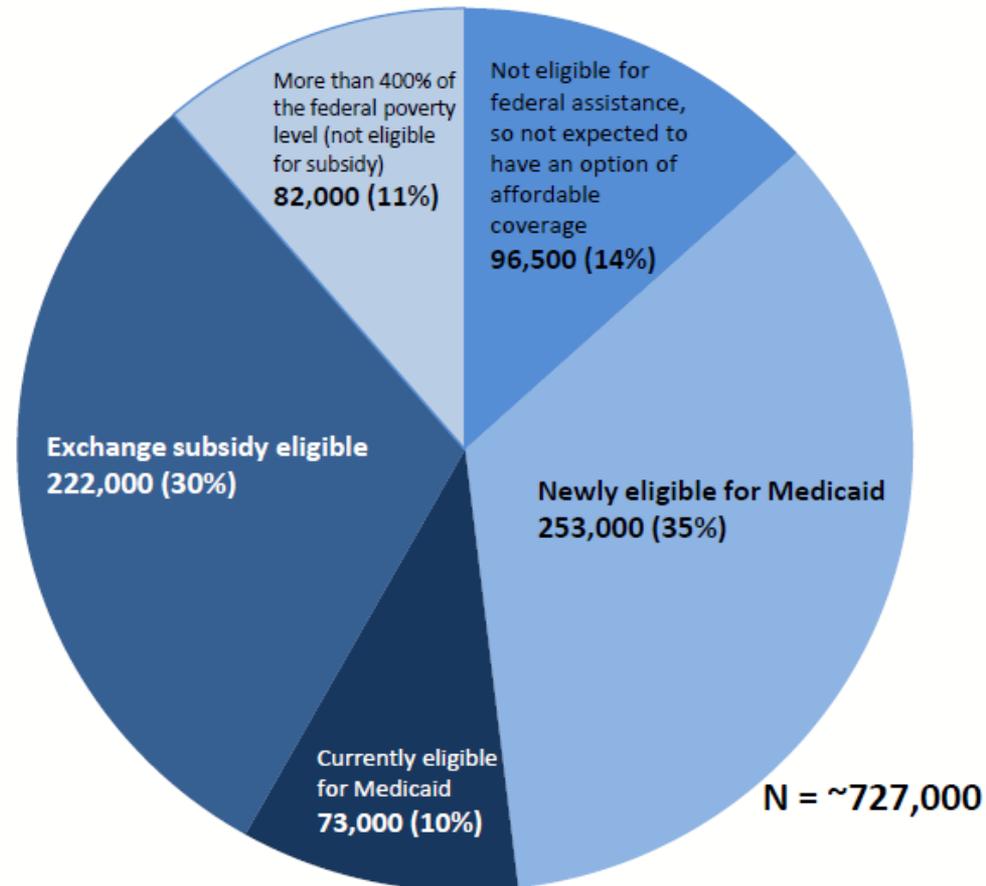
*ACA 133% = 138% due to across the board income disregards

Exchange Basics

- **Single application** for health care coverage
 - Medicaid and Medicaid Expansion populations
 - Adults (without children) up to 138% of FPL
 - Parents 40% to 138% of FPL
 - Modified Adjusted Gross Income (MAGI)
- **New Options** for individuals >138% of FPL and small groups
- **Tax credits** available for individuals 138%-400% of FPL
- **Cost sharing** reductions available for <250% of FPL



~85% of Washington's uninsured adults will have access to affordable coverage under full implementation of the ACA



Source: Urban Institute Analysis of Augmented WA State Database

Federal Poverty Levels by Annual Income

| Federal Poverty Level | Annual Income: Individual | Annual Income Level: Family of 3 |
|-----------------------|------------------------------|-------------------------------------|
| 100% | \$11,170 | \$19,090 |
| 133% | \$14,856 | \$25,390 |
| 138% | \$15,415 | \$26,344 |
| 200% | \$22,340 | \$38,180 |
| 300% | \$33,510 | \$57,270 |
| 400% | \$44,680 | \$76,360 |



Exchange Functions & Services





RFP Update

- Formal notification of federal grant award
- Grant to fund:
 - Statewide In-Person Assistance Program
 - Tribal Assister Program
 - Statewide Partner RFP
- Reduced by 9% (\$8.4 million v. \$9 million)



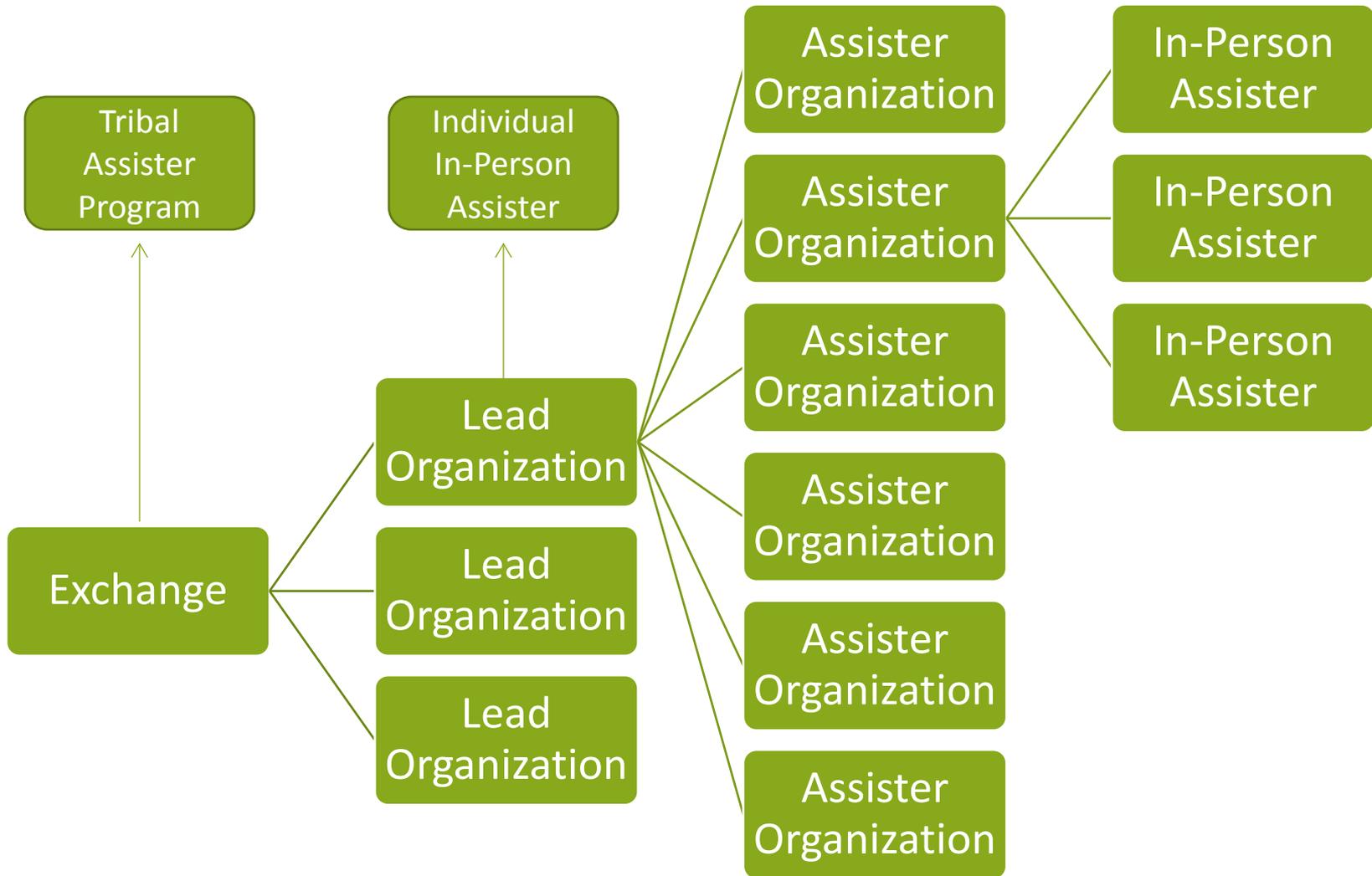
Proposals Received



| | Letters of Intent | Proposals |
|--|-------------------|-----------|
| Nonprofit community based organizations | 15 | 7 |
| County Public Health Districts/Departments | 6 | 5 |
| Aging/Disability Programs | 5 | 1 |
| Statewide Nonprofits | 4 | 2 |
| Miscellaneous | 6 | 4 |
| Total | 36 | 19 |



Navigator-Assister Network



Lead Organization Key Responsibilities

- **Build** local Navigator-Assister Network
- **Coordinate** outreach and education efforts
- **Train** Navigator-Assister Organization staff
- **Monitor** performance and service quality
- **Report** required Exchange data and deliverables
- **Act** as Funding agent



In-Person Assister/Navigator Role

- **Assist** consumers in completing the application
 - **Explain** results
 - **Confirm** consumers understand options/costs
 - **Explain** subsidies/cost reduction
 - **Facilitate** enrollment
- Community **outreach and education**
- Service **coordination**



New Coverage Options

- **“Qualified health plan”** (QHP) offerings
- **Metal tiers** of actuarial value (Bronze, Silver, Gold, Platinum)
- **Apples-to-apples** comparisons for consumers, **one-stop shop**
- **10 essential** health benefits
- **Navigators**, agents/brokers, call center

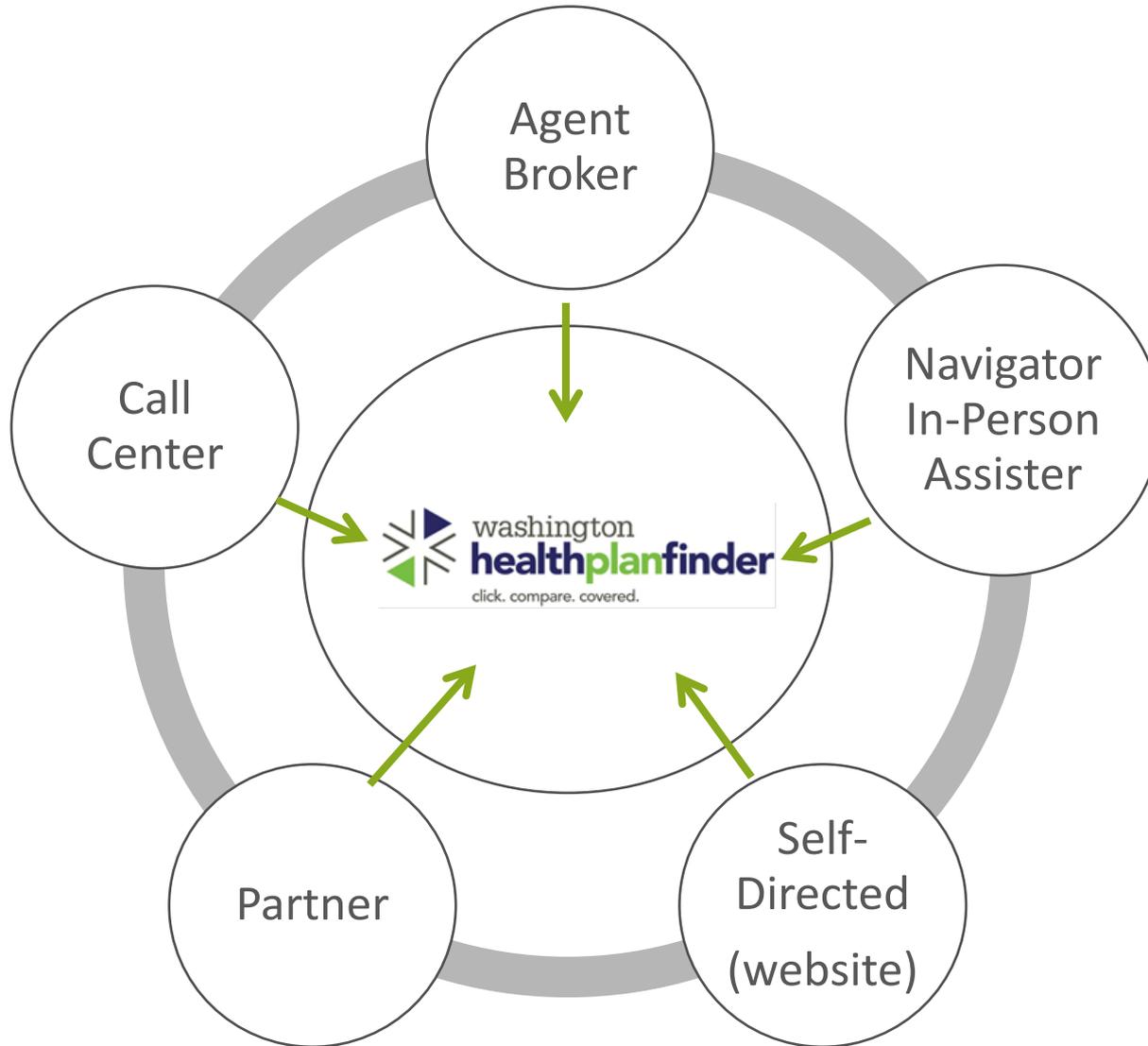


| Bronze Level | Silver Level | Gold Level | Platinum Level |
|--|--|--|--|
| Bronze plan benefit coverage is actuarially* equivalent to: | Silver plan benefit coverage is actuarially* equivalent to: | Gold plan benefit coverage is actuarially* equivalent to: | Platinum plan benefit coverage is actuarially* equivalent to: |
| 60% of the full actuarial value | 70% of the full actuarial value | 80% of the full actuarial value | 90% of the full actuarial value |

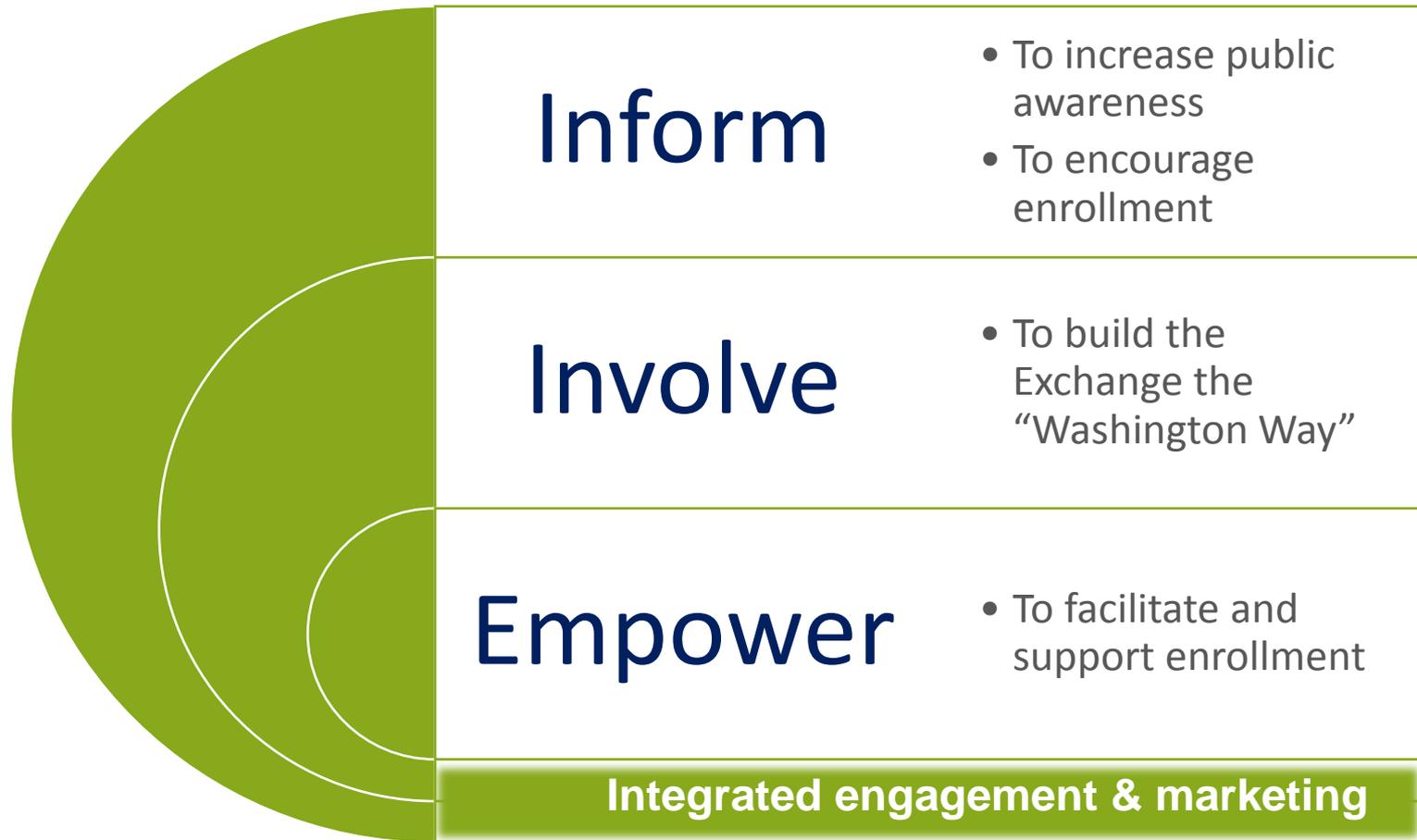
***Actuarial Value:**
the amount (%) of the bill that the insurer will pay



Consumer Entry Points



Engagement Plan



Landing Page



OPEN ENROLLMENT: OCTOBER 1, 2013 TO MARCH 31, 2014

Find the Right Health Insurance for You

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Click. Compare. Covered.

Lorem ipsum dolor sit amet, consectetur adipisicing elit, sed do eiusmod tempor incididunt ut labore et dolore magna aliqua. Lorem ipsum dolor sit amet, consectetur adipisicing elit, sed do eiusmod tempor incididunt ut labore et dolore magna aliqua. Lorem ipsum dolor sit amet, consectetur adipisicing elit.

How the application process works

Step One: Here's what you do

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ESTIMATE YOUR COST
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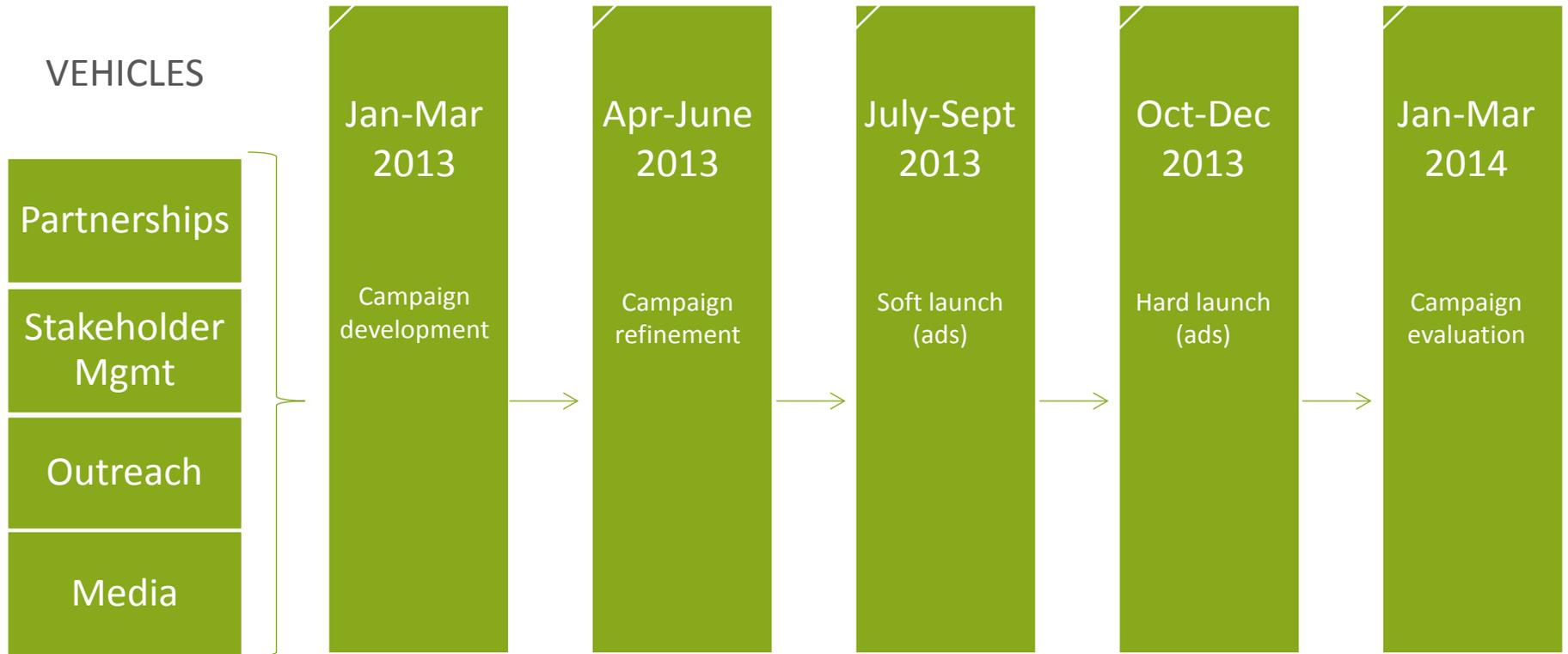
Click Here to launch video
PLAN 1 PLAN 2 PLAN 3



Outreach Updates



Outreach and Education Roadmap



Outreach and Equity Updates

Outreach Workgroup

- Provide recommendation, review and advisement on outreach materials and outreach strategy

Health Equity Technical Advisory

- Provide recommendation, review and advisement on addressing Health Equity through Exchange activities with a focus on language access and health literacy
- Using the HHS Language Access Plan to guide recommendations



Language Access

- **Website** English and Spanish with taglines for information in other languages
- **Lead Organizations** existing networks
- **Call Center** will provide fast connection to interpreter services (150 languages)
- **FTE Position** that manage language access and translation for the Exchange
- **Translated** print materials
- **Storefront Online** ordering
- **Partnering** with health and language equity advocates



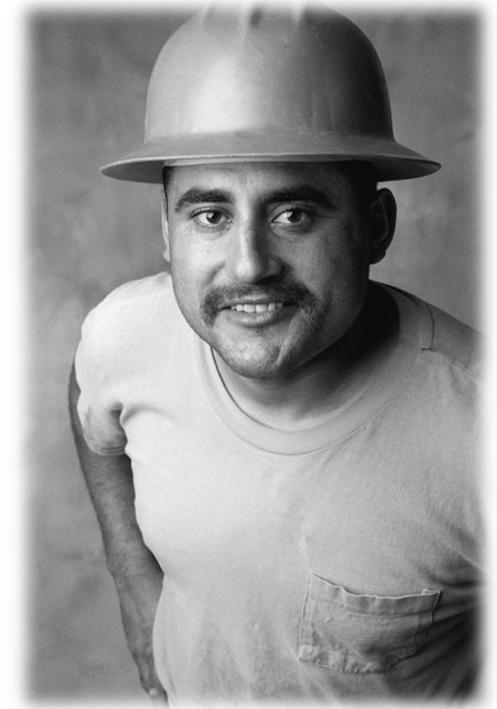
Informal LEP Workgroup Members

Informal LEP Workgroup Members

- NW Health Law Advocates
- One America
- Health Equity TAC member
- NW Justice Project
- Immigration attorney
- WA State Coalition of Language Access
- Exchange Outreach staff



LEP Workgroup Update



Informal LEP Workgroup

recommendations and content for Exchange materials used to inform immigrant residents including:

- information on eligibility
- concerns about citizenship and documentation
- Income guidelines
- tax credits and subsidies



Faith-based Outreach



COUNTDOWN TO COVERAGE

01.01.2014



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WEBINAR SERIES



Training and Certification Workgroup

Countdown to Coverage!

Webinar 1: Overview of the Affordable Care Act

Date: Friday, April 26, 2013 (Closed)

Webinar 2: Washington HBE and Washington Healthplanfinder

Date: Friday, May 10, 2013

Webinar 3: Health Insurance 101

Date: Friday, May 24, 2013

Webinar 4: Medicaid

Date: Friday, June 7, 2013

Webinar 5: Healthplanfinder for Business

Date: Friday, June 21, 2013

Webinar 6: Consumer Support Services

Date: Friday, May 24, 2013 (Not available for registration yet)



Webinars will be posted
on
www.wahbexchange.org



Other Updates

- Story Bank **new!**
- User Acceptance Testing
- www.wahealthplanfinder.org **new!**
- Social media **new!**



follow us on



Key Challenges

- **Language Access**

- Insurance can be complex
- Insurance is a new concept for many cultures
- Diversity of languages in Washington

- **Payment**

- Payment is due with QHP enrollment
- Initial payment is electronic

- **Awareness and Education**

- Changing the way people think about health insurance
- Changing the way people get care once insured



Key Challenges

- **Tight timeline – Oct. 1, 2013**
 - Federal dependencies and guidance
 - IT flight path, trade off of managing scope and resources with fixed schedule
- **Delivery environment**
 - Critical inter-agency interdependencies
- **Managing expectations**
 - Options deferred to 2.0 or 3.0
 - Complex authorizing environment



More on the Exchange

www.wahbexchange.org

Includes information about:

- **Exchange Board**
- **Legislation and grants**
- **Policy discussion**
- **TAC and stakeholder involvement**
- **IT systems development**
- **HHS guidance**
- **Listserv registration**
- info@wahbexchange.org





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DATE: May 8, 2013

TO: Members of the Governor's Interagency Council on Health Disparities

FROM: Emma Medicine White Crow, Chair

SUBJECT: PRIORITY HEALTH TOPICS

Background and Summary:

In accordance with Sections 43.20.270 and 43.20.280 RCW:

“This council shall create an action plan and statewide policy to include health impact reviews that measure and address other social determinants of health that lead to disparities as well as the contributing factors of health that can have broad impacts on improving status, health literacy, physical activity, and nutrition.”

“The council shall consider in its deliberations and by 2012, create an action plan for eliminating health disparities. The action plan must address, but is not limited to, the following diseases, conditions, and health indicators: Diabetes, asthma, infant mortality, HIV/AIDS, heart disease, strokes, breast cancer, cervical cancer, prostate cancer, chronic kidney disease, sudden infant death syndrome (SIDS), mental health, women's health issues, smoking cessation, oral disease, and immunization rates of children and senior citizens. The council shall prioritize the diseases, conditions, and health indicators according to prevalence and severity of the health disparity. The council shall address these priorities on an incremental basis by adding no more than five of the diseases, conditions, and health indicators to each update or revised version of the action plan. The action plan shall be updated biannually.”

The Council's 2010 and 2012 action plans focused on the following priority health topics: education, health insurance coverage, healthcare workforce diversity, obesity, diabetes, poverty, environmental exposures and hazards, and behavioral health. In addition, the Council continues work on two current priorities—health reform implementation and the state system with a focus on language access to state services.

Today, I have asked staff to review the processes we used to select priority health conditions for the 2010 and 2012 action plans, as well as review the health topics we have considered over the years. In addition, staff will share a summary of community input into future Council priorities. Following those presentations, we will have time for Council members to discuss and possibly make decisions about selecting future priorities.

Recommended Council Action:

The Council may choose to consider a motion about future priorities—such a motion may include decisions about which process to use and/or how many priorities to choose.

PRIORITY HEALTH TOPICS

Christy Hoff & Yris Lance

Governor's Interagency Council on Health Disparities

May 8, 2013

HealthEquity.wa.gov

Governor's Interagency Council on Health Disparities



Presentation Overview

2

- First Round Process
- Second Round Process
- Community Input

FIRST ROUND PROCESS

Health Topics Listed in Statute

4

Diabetes

HIV/AIDS

Breast Cancer

Chronic Kidney Disease

Women's Health Issues

Immunization Rates

Stroke

Mental Health

Asthma

Heart Disease

Cervical Cancer

SIDS

Smoking Cessation

Infant Mortality

Prostate Cancer

Oral Disease

Legislative intent to also focus on the social determinants of health

Health Topics Added by the Council

5

| | |
|---------------------------|-------------------------------------|
| Access to Nutritious Food | Opportunities for Physical Activity |
| Colorectal Cancer | CLAS* |
| Education | Exposure to Environmental Hazards |
| Health Literacy | Health Insurance Coverage |
| Income | Lupus |
| Obesity/Overweight | Preventive Services Utilization |
| Social Support | Substance Abuse |
| Parenting/Childcare | Health Workforce Diversity |

*Culturally and Linguistically Appropriate Healthcare Services

Phase I Prioritization

6

- Narrowed list from 32 to 12 health topics
- Health topics scored using three criteria:
 - Magnitude
 - Severity
 - Disparity (weighted x2)
- Epidemiologic briefing documents for the 32 health topics

Phase II Prioritization

7

- Narrowed the list from 12 to 5 health topics
- Health topics scored using three criteria:
 - Readiness
 - Public Input (weighted x2)
 - Epidemiologic Data
- Environmental scan briefing documents for the 12 health topics

Selection of Priorities

8

- Two-tiered prioritization process resulted in 5 priorities:
 - Education
 - Obesity
 - Diabetes
 - Health Care Workforce Diversity
 - Health Insurance Coverage
- Significant public health concern
- Significant community concern
- Balance between health outcomes and social determinants

SECOND ROUND PROCESS

Topics Considered

10

- Topics considered previously:
 - Behavioral Health, Chronic Kidney Disease, Environmental Exposures, Health Literacy, Heart Disease & Stroke, HIV/AIDS, Smoking Rates
- New Topics Considered:
 - Communities/Neighborhoods, Early Life Experience/Early Development, Poverty, Maternal Child Health, Transportation, Housing

Deliberations

- Requested Briefings:
 - Maternal Child Health and Early Development
 - Environmental Exposures and Communities/Neighborhoods
 - Poverty
 - Behavioral Health
- World Café Discussions
 - Insights gained from briefings
 - Health topics to be addressed in next action plan

Selection of Priorities

12

- Deliberative process resulted in 5 priorities:
 - State System
 - Income/Poverty
 - Environment
 - Adverse Childhood Experiences
 - Behavioral Health
- Where possible, include a focus on the population of preconception to age three
- Continue to consider equitable implementation of health reform

COMMUNITY INPUT

Email Input

14

What do you think the Council should focus on next to eliminate health disparities by race/ethnicity and gender in Washington State?

- K-12 education/STEM
- Sexual and intimate partner violence
- Oral health
- Asthma – 2
- Health literacy
- Treatment of addictive disorders
- American Indian youth (behavioral & physical health)
- Physical cultural competence

Central Area Senior Center Annual Health & Wellness Fair/Forum

15

- Healthcare workforce diversity
- Nutrition
- Natural Remedies
- Elder health (cultural, language, literacy) – 3
- Maternal and child health
- Oral health
- Community outreach/education
- Cultural and linguistic competency
- Individual responsibility and patient advocacy

Bothell Health & Safety Fair

16

- Health care access – 2
- Language access to state services
- Health information (literacy) – 3
- Early childhood development
- Health care provider/patient rights and obligations
- Promote health equity and racial justice
- Cultural competence of health care providers
- Poverty, education, health insurance (continue)
- Community health fairs
- Equal pay and treatment

Community Outreach Roundtable

17

- Community outreach and information
 - Primary language of audience
- State agency diversity and cultural competency
- Community engagement and input into state agency decision-making

QUESTIONS?

RCW 43.20.270

Governor's interagency coordinating council on health disparities — Action plan — Statewide policy.

The legislature finds that women and people of color experience significant disparities from men and the general population in education, employment, healthful living conditions, access to health care, and other social determinants of health. The legislature finds that these circumstances coupled with lower, slower, and less culturally appropriate and gender appropriate access to needed medical care result in higher rates of morbidity and mortality for women and persons of color than observed in the general population. Health disparities are defined by the national institute of health as the differences in incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups in the United States.

It is the intent of the Washington state legislature to create the healthiest state in the nation by striving to eliminate health disparities in people of color and between men and women. In meeting the intent of chapter 239, Laws of 2006, the legislature creates the governor's interagency coordinating council on health disparities. This council shall create an action plan and statewide policy to include health impact reviews that measure and address other social determinants of health that lead to disparities as well as the contributing factors of health that can have broad impacts on improving status, health literacy, physical activity, and nutrition.

RCW 43.20.275

Council created — Membership — Duties — Advisory committees.

(1) In collaboration with staff whom the office of financial management may assign, and within funds made expressly available to the state board for these purposes, the state board shall assist the governor by convening and providing assistance to the council. The council shall include one representative from each of the following groups: Each of the commissions, the state board, the department, the department of social and health services, the *department of community, trade, and economic development, the health care authority, the department of agriculture, the department of ecology, the office of the superintendent of public instruction, the department of early learning, the workforce training and education coordinating board, and two members of the public who will represent the interests of health care consumers. The council is a class one group under RCW [43.03.220](#). The two public members shall be paid per diem and travel expenses in accordance with RCW [43.03.050](#) and [43.03.060](#). The council shall reflect diversity in race, ethnicity, and gender. The governor or the governor's designee shall chair the council.

(2) The council shall promote and facilitate communication, coordination, and collaboration among relevant state agencies and communities of color, and the private sector and public sector, to address health disparities. The council shall conduct public hearings, inquiries, studies, or other forms of information gathering to understand how the actions of state government ameliorate or contribute to health disparities. All state agencies must cooperate with the council's efforts.

(3) The council with assistance from the state board, shall assess through public hearings, review of existing data, and other means, and recommend initiatives for improving the availability of culturally appropriate health literature and interpretive services within public and private health-related agencies.

(4) In order to assist with its work, the council shall establish advisory committees to assist in plan development for specific issues and shall include members of other state agencies and local communities.

(5) The advisory committee shall reflect diversity in race, ethnicity, and gender.

[2006 c 239 § 3.]

Notes:

***Reviser's note:** The "department of community, trade, and economic development" was renamed the "department of commerce" by 2009 c 565.

RCW 43.20.280

Action plan for eliminating health disparities — Council meetings — Reports to the legislature.

The council shall consider in its deliberations and by 2012, create an action plan for eliminating health disparities. The action plan must address, but is not limited to, the following diseases, conditions, and health indicators: Diabetes, asthma, infant mortality, HIV/AIDS, heart disease, strokes, breast cancer, cervical cancer, prostate cancer, chronic kidney disease, sudden infant death syndrome (SIDS), mental health, women's health issues, smoking cessation, oral disease, and immunization rates of children and senior citizens. The council shall prioritize the diseases, conditions, and health indicators according to prevalence and severity of the health disparity. The council shall address these priorities on an incremental basis by adding no more than five of the diseases, conditions, and health indicators to each update or revised version of the action plan. The action plan shall be updated biannually. The council shall meet as often as necessary but not less than two times per calendar year. The council shall report its progress with the action plan to the governor and the legislature no later than January 15, 2008. A second report shall be presented no later than January 15, 2010, and a third report from the council shall be presented to the governor and the legislature no later than January 15, 2012. Thereafter, the governor and legislature shall require progress updates from the council every four years in odd-numbered years. The action plan shall recognize the need for flexibility.

RCW 43.20.285

Health impact reviews — Obtaining and allocating federal or private funding to implement chapter.

The state board shall, to the extent that funds are available expressly for this purpose, complete health impact reviews, in collaboration with the council, and with assistance that shall be provided by any state agency of which the board makes a request.

(1) A health impact review may be initiated by a written request submitted according to forms and procedures proposed by the council and approved by the state board before December 1, 2006.

(2) Any state legislator or the governor may request a review of any proposal for a state legislative or budgetary change. Upon receiving a request for a health impact review from the governor or a member of the legislature during a legislative session, the state board shall deliver the health impact review to the requesting party in no more than ten days.

(3) The state board may limit the number of health impact reviews it produces to retain quality while operating within its available resources.

(4) A state agency may decline a request to provide assistance if complying with the request would not be feasible while operating within its available resources.

(5) Upon delivery of the review to the requesting party, it shall be a public document, and shall be available on the state board's web site.

(6) The review shall be based on the best available empirical information and professional assumptions available to the state board within the time required for completing the review. The review should consider direct impacts on health disparities as well as changes in the social determinants of health.

(7) The state board and the department shall collaborate to obtain any federal or private funding that may become available to implement the state board's duties under this chapter. If the department receives such funding, the department shall allocate it to the state board and affected agencies to implement its duties under this chapter, and any state general funds that may have been appropriated but are no longer needed by the state board shall lapse to the state general fund.

RCW 43.20.290

Obtaining and allocating federal or private funding.

The state board and the department shall collaborate to obtain any federal or private funding that may become available to implement the state board's duties under this chapter. If the department receives such funding, the department shall allocate it to the state board to implement its duties under this chapter, and any state general funds that may have been appropriated but are no longer needed by the state board shall lapse to the state general fund.

Asthma Briefing Document
Presented to the Governor's Interagency Council on Health Disparities
September 20, 2007

Asthma is a chronic inflammatory disorder of the airways that makes it hard to breathe. Breathing becomes difficult because the airways tighten, thicken, become inflamed, and fill with mucus. Symptoms of asthma can include wheezing, shortness of breath, chest tightness, and cough.

CRITERION #1: PREVALENCE / INCIDENCE

- The prevalence of current asthma among Washington adults has increased from 7.0% in 1999 to 9.5% in 2005, an increase of 36%. There were an estimated 416,100 adults with asthma in 2005.
- In 2004, 8.7% of Washington youth (6th - 12th graders) reported having current asthma.
- The proportion of Washington adults reporting that at least one child in their household currently had asthma increased from 10.0% in 1999 to 11.5% in 2003.
- The prevalence of asthma is greater in Washington than it is nationally, and has been reported as one of the highest in the nation.

CRITERION #2: SEVERITY

- Deaths from asthma are rare, affecting about 86 Washington residents per year. The asthma death rate declined from 1.9 to 1.4 deaths per 100,000 from 1990 to 2001 and has remained stable since then.
- Between 2000 and 2004, there were about 5,200 hospitalizations for asthma each year.
- In 2002, the estimated costs for medical care due to asthma were almost \$240 million.
- Adults and youth with asthma report having symptoms frequently, often have trouble sleeping, and miss work and school.

CRITERION #3: DISPARITY

- For 2003-2005, asthma prevalence among Washington adults by race and ethnicity was as follows: Native Americans (14%), blacks (11%), non-Hispanic whites (9%), Asians and Pacific Islanders (7%), and Hispanics (7%); for an Index of Disparity of 47%.
- For 2002 and 2004 combined, asthma prevalence among youth was as follows: blacks (10.6%), Native Americans (9.8%), non-Hispanic whites (9.2%), Pacific Islanders (8.0%), Asians (5.9%) and Hispanics (5.8%); with an Index of Disparity of 50.0%.
- Asthma death rates for 1992-2001 combined were significantly higher among blacks (3.6 per 100,000), Native Americans (3.1 per 100,000) and Asians/Pacific Islanders (2.6 per 100,000) than for whites (1.8 per 100,000). Hispanics had a death rate of 1.3%. The Index of Disparity for asthma mortality rates was 113.5%.
- Wide variations exist for Hispanic subgroups, with higher prevalence found among Puerto Ricans. Washington's Hispanic population originates largely from Mexico.
- Among young children, asthma prevalence is higher for boys than girls. By high school and through adulthood these differences reverse and women have higher prevalence than men. From 2003-2005, the prevalence among women (11%) was nearly twice that of men (7%).

The Index of Disparity is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004

Sources: (1) Dilley JA, Pizacani BP, Macdonald SM, Bardin J. The Burden of Asthma in Washington State. Washington State Department of Health. Olympia, WA. June 2005. DOH Pub No. 345-201. (2) Preliminary data from: Washington State Department of Health (2007). Health of Washington State. 2007. Olympia, WA. *In press.*

PRIORITIZATION OF HEALTH CONDITIONS: PHASE I

| CRITERION #1: PREVALENCE / INCIDENCE | | | | | |
|--|---|---------------------|---------------------|---|---------------------|
| <ol style="list-style-type: none"> 1. The prevalence/incidence of the condition is low and has been decreasing or staying the same over time. 2. The prevalence/incidence is low, but has been increasing over time. 3. The prevalence/incidence is moderate. 4. The prevalence/incidence is high, but has been decreasing over time. 5. The prevalence/incidence is high and has been increasing or staying the same over time. | | | | | |
| CRITERION #2: SEVERITY | | | | | |
| <ol style="list-style-type: none"> 1. The condition is not at all likely to result in death or long term disability. 2. The condition is not very likely to result in death or long term disability. 3. The condition is somewhat likely to result in death or long term disability. 4. The condition is very likely to result in death or long term disability. 5. The condition is extremely likely to result in death or long term disability. | | | | | |
| CRITERION #3: DISPARITY | | | | | |
| <ol style="list-style-type: none"> 1. The disparity in prevalence/incidence and/or severity by race, ethnicity, and/or sex is very low. 2. The disparity in prevalence/incidence and/or severity by race, ethnicity, and/or sex is somewhat low. 3. The disparity in prevalence/incidence and/or severity by race, ethnicity, and/or sex is moderate. 4. The disparity in prevalence/incidence and/or severity by race, ethnicity, and/or sex is somewhat high. 5. The disparity in prevalence/incidence and/or severity by race, ethnicity, and/or sex is very high. | | | | | |
| HEALTH CONDITION | For each health condition, score each criterion from 1 to 5. Multiply the score by the assigned weight and enter into the appropriate cell. Add the weighted criterion scores to obtain the total score. | | | Total Score for the Health Condition | |
| | | Criterion #1 | Criterion #2 | | Criterion #3 |
| | Weight: | 1 | 1 | | 2 |
| 1. Asthma | | | | | |
| 2. Cancer, Breast | | | | | |
| 3. Cancer, Cervical | | | | | |
| 4. Cancer, Prostate | | | | | |
| 5. Cancer, Colorectal | | | | | |
| 6. Chronic Kidney Disease | | | | | |
| 7. Diabetes | | | | | |
| 8. HIV/AIDS | | | | | |
| 9. Heart Disease & Stroke | | | | | |
| 10. Infant Mortality | | | | | |
| 11. Lupus | | | | | |

Governor's Interagency Council on Health Disparities
 PO Box 47990, Olympia, WA, 98504-7990
 Phone: (360) 236-4110

PRIORITIZATION OF HEALTH CONDITIONS: PHASE I

| CRITERION #1: PREVALENCE / INCIDENCE | | | | | |
|--|---|--------------|--------------|---|--------------|
| <ol style="list-style-type: none"> 1. The prevalence/incidence of the condition is low and has been decreasing or staying the same over time. 2. The prevalence/incidence is low, but has been increasing over time. 3. The prevalence/incidence is moderate. 4. The prevalence/incidence is high, but has been decreasing over time. 5. The prevalence/incidence is high and has been increasing or staying the same over time. | | | | | |
| CRITERION #2: SEVERITY | | | | | |
| <ol style="list-style-type: none"> 1. The condition is not at all likely to result in death or long term disability. 2. The condition is not very likely to result in death or long term disability. 3. The condition is somewhat likely to result in death or long term disability. 4. The condition is very likely to result in death or long term disability. 5. The condition is extremely likely to result in death or long term disability. | | | | | |
| CRITERION #3: DISPARITY | | | | | |
| <ol style="list-style-type: none"> 1. The disparity in prevalence/incidence and/or severity by race, ethnicity, and/or sex is very low. 2. The disparity in prevalence/incidence and/or severity by race, ethnicity, and/or sex is somewhat low. 3. The disparity in prevalence/incidence and/or severity by race, ethnicity, and/or sex is moderate. 4. The disparity in prevalence/incidence and/or severity by race, ethnicity, and/or sex is somewhat high. 5. The disparity in prevalence/incidence and/or severity by race, ethnicity, and/or sex is very high. | | | | | |
| HEALTH CONDITION | For each health condition, score each criterion from 1 to 5. Multiply the score by the assigned weight and enter into the appropriate cell. Add the weighted criterion scores to obtain the total score. | | | Total Score for the Health Condition | |
| | | Criterion #1 | Criterion #2 | | Criterion #3 |
| | Weight: | 1 | 1 | | 2 |
| 12. Mental Health | | | | | |
| 13. Overweight and Obesity | | | | | |
| 14. Oral Disease | | | | | |
| 15. Sudden Infant Death Syndrome (SIDS) | | | | | |
| 16. Women's Health Issues | | | | | |

PRIORITIZATION OF SOCIAL DETERMINANTS OF HEALTH: PHASE I

| CRITERION #1: MAGNITUDE | | | | | |
|--|--|---------------------|---------------------|---|---------------------|
| <ol style="list-style-type: none"> 1. The magnitude of the problem is low and has been decreasing or staying the same over time. 2. The magnitude of the problem is low but has been increasing over time. 3. The magnitude of the problem is moderate. 4. The magnitude of the problem is high but has been decreasing over time. 5. The magnitude of the problem is high and has been increasing or staying the same over time. | | | | | |
| CRITERION #2: ASSOCIATION TO HEALTH OUTCOMES | | | | | |
| <ol style="list-style-type: none"> 1. The social determinant of health is associated with a very low number of health outcomes. 2. The social determinant of health is associated with a somewhat low number of health outcomes. 3. The social determinant of health is associated with a moderate number of health outcomes. 4. The social determinant of health is associated with a somewhat high number of health outcomes. 5. The social determinant of health is associated with a very high number of health outcomes. | | | | | |
| CRITERION #3: DISPARITY | | | | | |
| <ol style="list-style-type: none"> 1. The disparity in the magnitude of the problem by race, ethnicity, and/or sex is very low. 2. The disparity in the magnitude of the problem by race, ethnicity, and/or sex is somewhat low. 3. The disparity in the magnitude of the problem by race, ethnicity, and/or sex is moderate. 4. The disparity in the magnitude of the problem by race, ethnicity, and/or sex is somewhat high. 5. The disparity in the magnitude of the problem by race, ethnicity, and/or sex is very high. | | | | | |
| SOCIAL DETERMINANT OF HEALTH | For each determinant, score each criterion from 1 to 5. Multiply the score by the assigned weight and enter into the appropriate cell. Add the weighted criterion scores to obtain the total score. | | | Total Score for the Social Determinant of Health | |
| | | Criterion #1 | Criterion #2 | | Criterion #3 |
| | Weight: | 1 | 1 | | 2 |
| 1. Access to Nutritious Food | | | | | |
| 2. Culturally and Linguistically Appropriate Healthcare | | | | | |
| 3. Education | | | | | |
| 4. Environmental Exposures | | | | | |
| 5. Health Insurance Coverage | | | | | |
| 6. Health Literacy | | | | | |
| 7. Healthcare Workforce Diversity | | | | | |
| 8. Immunization Rates | | | | | |
| 9. Income | | | | | |
| 10. Opportunities for Physical Activity | | | | | |
| 11. Preventive Service Utilization | | | | | |

Governor's Interagency Council on Health Disparities
 PO Box 47990, Olympia, WA, 98504-7990
 Phone: (360) 236-4110

PRIORITIZATION OF SOCIAL DETERMINANTS OF HEALTH: PHASE I

| | | | | |
|--|--|---------------------|---------------------|---|
| CRITERION #1: MAGNITUDE | | | | |
| <ol style="list-style-type: none"> 1. The magnitude of the problem is low and has been decreasing or staying the same over time. 2. The magnitude of the problem is low but has been increasing over time. 3. The magnitude of the problem is moderate. 4. The magnitude of the problem is high but has been decreasing over time. 5. The magnitude of the problem is high and has been increasing or staying the same over time. | | | | |
| CRITERION #2: ASSOCIATION TO HEALTH OUTCOMES | | | | |
| <ol style="list-style-type: none"> 1. The social determinant of health is associated with a very low number of health outcomes. 2. The social determinant of health is associated with a somewhat low number of health outcomes. 3. The social determinant of health is associated with a moderate number of health outcomes. 4. The social determinant of health is associated with a somewhat high number of health outcomes. 5. The social determinant of health is associated with a very high number of health outcomes. | | | | |
| CRITERION #3: DISPARITY | | | | |
| <ol style="list-style-type: none"> 1. The disparity in the magnitude of the problem by race, ethnicity, and/or sex is very low. 2. The disparity in the magnitude of the problem by race, ethnicity, and/or sex is somewhat low. 3. The disparity in the magnitude of the problem by race, ethnicity, and/or sex is moderate. 4. The disparity in the magnitude of the problem by race, ethnicity, and/or sex is somewhat high. 5. The disparity in the magnitude of the problem by race, ethnicity, and/or sex is very high. | | | | |
| SOCIAL DETERMINANT OF HEALTH | For each determinant, score each criterion from 1 to 5. Multiply the score by the assigned weight and enter into the appropriate cell. Add the weighted criterion scores to obtain the total score. | | | Total Score for the Social Determinant of Health |
| | Weight: | Criterion #1 | Criterion #2 | |
| | 1 | 1 | 2 | |
| 12. Smoking Rates | | | | |
| 13. Social Support | | | | |
| 14. Substance Abuse | | | | |
| 15. Supportive Parenting & Childcare Systems | | | | |



STATE OF WASHINGTON
GOVERNOR'S INTERAGENCY COUNCIL ON HEALTH DISPARITIES

Washington State Board of Health

PO Box 47990 • Olympia, Washington 98504-7990

October 22, 2007

TO: Members of the Governor's Interagency Council on Health Disparities

FROM: Vickie Ybarra, Chair

SUBJECT: FIRST PHASE PRIORITIZATION RESULTS

Background and Summary

The Governor's Interagency Council on Health Disparities has been charged with creating an action plan to eliminate health disparities. According to RCW 43.20.280:

"The council shall prioritize the diseases, conditions, and health indicators according to prevalence and severity of the health disparity. The council shall address these priorities on an incremental basis by adding no more than five of the diseases, conditions, and health indicators to each update or revised version of the action plan."

At its September 20, 2007 meeting, the Council began the first phase of prioritizing health conditions and social determinants of health. The first phase of prioritization was based on three criteria: the magnitude of the problem, the severity of the health condition or the degree to which the social determinant of health was associated with adverse health outcomes, and the level of disparity. Using scoring guidance for these criteria and briefing documents summarizing epidemiological data and information, Council members individually scored each health condition and social determinant of health. Council staff then compiled the scores.

Today, Council staff will provide a summary of the scoring results. I invite Council members to discuss the results and whether the process resulted in a prioritized list that makes sense and is consistent with Council members' professional judgment, or whether the process may need revision.

If time allows, I also invite Council members to discuss the next phase of the process, which is the creation of advisory committees to identify and assess policy interventions. Due to staffing limitations, we can not create advisory committees for all of the health conditions and social determinants of health at once. Therefore, we will need to provide guidance to staff on how many advisory committees should be created, as well as structure and membership of the committees, and criteria that should be used for identifying and assessing policy interventions.

Recommended Council Action

After discussion, the Council may choose to amend if necessary or adopt the following motion:

Motion: The Council approves the first-phase prioritized list of health conditions and social determinants of health as submitted on October 22, 2007.

Discussion

Fourteen Council members completed the scoring for the first phase of prioritization. Table 1 provides the total score, average score, standard deviation, and range of scores for each health condition and social determinant of health. The standard deviation measures the amount of dispersion in the scores, with a lower standard deviation indicating less dispersion (i.e., the scores are clustered closely around the average score) and a higher standard deviation indicating higher dispersion.

Consistent with previous guidance provided by the Council, staff averaged the scores for breast, cervical, prostate, and colorectal cancers into a composite score. Similarly, scores for infant mortality and SIDS were averaged into a single score. The broken out scores for breast cancer, prostate cancer, colorectal cancer, cervical cancer, infant mortality, and SIDS are provided in Table 1 for reference and highlighted in blue text.

Table 1: Prioritized List of Health Conditions and Social Determinants of Health

| Health Condition or Social Determinant of Health | Total Score | Average Score | Standard Deviation | Score Range |
|---|--------------------|----------------------|---------------------------|--------------------|
| Healthcare Workforce Diversity | 251 | 17.9 | 2.2 | 14-20 |
| Substance Abuse | 248 | 17.7 | 2.2 | 13-20 |
| Health Insurance | 247 | 17.6 | 2.3 | 12-20 |
| Overweight & Obesity | 245 | 17.5 | 2.0 | 13-20 |
| Education | 243 | 17.4 | 3.2 | 11-20 |
| Diabetes | 241 | 17.2 | 2.0 | 14-20 |
| Health Literacy | 231 | 16.5 | 2.4 | 13-20 |
| Culturally & Linguistically Appropriate Healthcare | 231 | 16.5 | 2.7 | 12-20 |
| Environmental Exposures | 229 | 16.4 | 2.9 | 11-20 |
| HIV/AIDS | 228 | 16.3 | 2.1 | 13-20 |
| Chronic Kidney Disease | 226 | 16.1 | 2.4 | 13-20 |
| Smoking Rates | 218 | 15.6 | 3.2 | 9-20 |
| Income | 216 | 15.4 | 2.2 | 13-20 |
| SIDS | 214 | 15.3 | 2.7 | 12-20 |
| Mental Health | 213 | 15.2 | 2.5 | 11-20 |
| Asthma | 210 | 15.0 | 2.1 | 12-20 |
| Women's Health | 208 | 14.9 | 2.6 | 11-20 |
| Infant Mortality & SIDS | 207 | 14.8 | 2.2 | 12-20 |
| Prostate Cancer | 207 | 14.8 | 3.4 | 8-20 |
| Breast Cancer | 201 | 14.4 | 3.0 | 10-20 |
| Supportive Parenting & Childcare Systems | 201 | 14.4 | 3.5 | 8-20 |
| Heart Disease & Stroke | 200 | 14.3 | 2.8 | 10-20 |
| Infant Mortality | 199 | 14.2 | 2.2 | 11-20 |
| Lupus | 195 | 13.9 | 3.8 | 7-20 |
| Colorectal Cancer | 183 | 13.1 | 3.5 | 9-20 |
| Cancer (breast, cervical, prostate, colorectal) | 181 | 12.9 | 3.0 | 9-20 |
| Preventive Services Utilization | 179 | 12.8 | 3.1 | 8-20 |
| Social Support | 173 | 12.4 | 4.2 | 7-20 |
| Access to Nutritious Food | 162 | 11.6 | 3.5 | 6-20 |
| Oral Disease | 161 | 11.5 | 3.2 | 7-20 |
| Immunization Rates | 161 | 11.5 | 3.4 | 6-20 |
| Opportunities for Physical Activity | 161 | 11.5 | 3.5 | 5-20 |
| Cervical Cancer | 132 | 9.4 | 3.7 | 6-20 |

HEALTH LITERACY

Targeted Environmental Scan: Working Document

Prepared for the Governor's Interagency Council on Health Disparities

Updated August 2008

Health literacy is the extent to which individuals have the capacity to obtain, process, and understand the basic health information and services they need to make appropriate health decisions. This document describes some activities and initiatives in Washington State aimed at improving the health literacy of Washingtonians. Some, but not all of the programs described in this document target communities of color in their efforts to improve health literacy.

Washington State Health Care Authority (HCA) Health Literacy Pilot

The HCA, in partnership with the UCLA School of Management, has provided grant funding to Head Start, Early Childhood Education and Assistance Programs and qualifying community clinics to improve health literacy. The program aims to reach 6,800 families through 18 sites in 13 counties with training on how to make informed decisions about their children's health, such as when to go to the emergency room and how to take care of common illnesses. A train-the-trainer session for 83 trainers was held in May 2008 with parent trainings scheduled during Fall 2008.

Puget Sound Health Alliance Health Literacy Initiative

The Puget Sound Health Alliance launched a health literacy initiative that focuses on four areas: (1) developing a Web site clearinghouse with health literacy information and tools, (2) supporting libraries so they can better meet the health literacy needs of their communities, (3) providing tools and resources to help doctors and other health care providers communicate more effectively with their patients, and (4) identifying opportunities to work with patient navigators and other trusted sources to provide consumer friendly health information and other tools to enable patients to take a more active role in their health and self care. As part of this initiative, the Alliance surveyed librarians in Seattle and King, Pierce, Snohomish and Thurston counties and met with library representatives to discuss the results. About 75% of the approximately 250 librarians who responded to the survey indicated that they receive requests for health information "often" or "very often." In response to the survey and follow-up discussions, the Alliance launched a three-month "Prescription for Health Information" pilot in Thurston County with Timberland Regional Library System, CHOICE Regional Health Network, Providence St. Peter's Family Medicine Residency and Boldt Diabetes Center, and the Mental Health Access Program. The pilot runs from July-September. The aims of the pilot are to raise awareness and use of library health information resources, support librarians in responding to health information needs, support patients in taking a more proactive role in their own health. Discussions are underway for a similar program in south King County.

Adult Literacy Programs

There are a number of adult basic education, adult literacy, and family literacy programs throughout Washington State, many of which incorporate health literacy into their curricula to varying degrees. The State Board for Community and Technical Colleges (SBCTC) funds and supports literacy services at community and technical colleges and community-based organizations. SBCTC provides guidance on incorporating health literacy into many of these

HEALTH LITERACY (Cont.)

programs. Health literacy resources for instructors are available on the SBCTC Web site at: www.sbctc.ctc.edu/college/e-abepds_teachersresources.aspx.

Patient Navigator Programs

Patient navigators are primary members of communities and cultures who are knowledgeable about the health care system as well as the culture itself. They help patients negotiate through the unfamiliar health care system, coordinating services, assisting patient-to-provider communications, and resolving access issues that might otherwise delay care. There are currently a number of patient navigator programs in Washington, each with different goals, activities, and target populations. The Cross Cultural Health Care Program (CCHCP) has recently completed an analysis of existing patient navigator programs, which documents current practices and successful strategies. CCHCP will use this assessment to form the foundation for a patient navigator curriculum. The Health and Recovery Services Administration of the Department of Social and Health Services has selected four successful bidders from among 14 applicants in its initiative to create patient navigator programs for Medicaid clients. The Washington navigator programs will be among the first in the nation for Medicaid clients.

Rx for Communication

Rx for Communication is a training program designed to help older adults communicate more effectively with their doctors and pharmacists. The Comprehensive Health Education Foundation (C.H.E.F.) developed the training curriculum and implemented a train-the-trainer program in 2001. Approximately 80-100 participants attended the train-the-trainer event, including representatives from hospitals, parks and recreation groups, and senior centers. Results from a pilot program training of 50 seniors showed that seniors felt they could communicate their needs more effectively, use assertiveness skills, and better manage their medications. While C.H.E.F. is no longer implementing the train-the-trainer program or tracking use of the program, the *Rx for Communication* curriculum, including a step-by-step guide for implementation, is available from C.H.E.F.

Discussion of Statewide Gaps and Sustainability

- To implement the patient navigator project, HRSA requested \$2,888,000 (total funds) and 1.0 FTE to coordinate the administration, monitoring and evaluation of the pilot. Since health navigators function in a number of settings and in both prevention and illness contexts, the pilot included funding to pilot more than one program for a maximum of 2,000 clients. Unfortunately, due to lack of a federal match the pilot was reduced to serving 1,000 clients with \$600,000 with only one year of implementation. Patient navigation is recognized as a best practice model to reduce racial and ethnic health disparities and increase the health literacy of patients regarding their chronic disease. Increased funding would increase the number of programs, health literacy and health outcomes of racial and ethnic minorities in our state. Important to note, DSHS HRSA has submitted an informal State Plan Amendment to attempt to obtain federal match.

HEALTH LITERACY (Cont.)

- There are several initiatives addressing health literacy but little networking among those programs to share best practices, ideas, issues, initiatives and models. These activities could benefit from improved communication and collaboration and avoid duplication of efforts in some cases or enhance current programs.
- The primary challenge is the range of languages spoken here, making it difficult to provide resources for everyone.

Health Literacy Briefing Document
Presented to the Governor's Interagency Council on Health Disparities
September 20, 2007

Health literacy is the extent to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate health decisions. For this briefing document, health literacy measures are drawn from the 2003 National Assessment of Adult Literacy Survey, which uses four literacy levels: below basic, basic, intermediate and proficient.

CRITERION #1: MAGNITUDE

- In 2003, 14% of U.S. adults had below basic health literacy, 22% had basic health literacy, 53% had intermediate health literacy, and 12% had proficient health literacy.

CRITERION #2: ASSOCIATION TO HEALTH OUTCOMES

- Low literacy can affect communication between patients and their health care providers and can inadvertently lead to substandard medical care.
- Increases in health literacy are associated with improvements in self-reported overall health.
- Populations with low levels of health literacy are less likely to obtain screenings for sexually transmitted diseases, cancer screenings, and immunizations, relative to populations with adequate literacy levels.
- Studies have found a significant association between literacy level and knowledge of health issues, such as HIV, diabetes, asthma, and hypertension.
- Low literacy has been shown to be associated with increased smoking rates and decreased rates of breastfeeding.
- Low literacy has been associated with adverse outcomes in diabetes management.
- Some evidence suggests that low literacy may be associated with depression.

CRITERION #3: DISPARITY

- The percentage of adults with below basic health literacy was as follows: 9% for whites, 9% for the multiracial group, 13% for Asians and Pacific Islanders, 24% for blacks, 25% for American Indian and Alaska Natives, and 41% for Hispanics, for an Index of Disparity of 149%.
- Women had higher average health literacy than men; 12% of women had below basic health literacy compared to 16% of men.

The Index of Disparity is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004.

Sources: (1) Kutner M, Greenberg E, Jin Y, and Paulsen C (2006). The Health Literacy of America's Adults: Results From the 2003 National Assessment of Adult Literacy (NCES 2006-483). U.S. Department of Education. Washington, DC: National Center for Education Statistics. (2) Berkman ND, DeWalt DA, Pignone MP et al. (2004). Literacy and Health Outcomes. Summary, Evidence Report/Technology Assessment No. 87. AHRQ Publication No. 04-E007-1. Rockville, MD: Agency for Healthcare Research and Quality. (3) Committee on Health Literacy (2004). Health Literacy: A Prescription to End Confusion. Report Brief. Washington, DC: National Academies Press.

CRITERION #1: OPPORTUNITIES FOR COUNCIL SUPPORT (i.e., READINESS)

Definition: Council members should consider where there has been good work going on in the state to address disparities for the health topic and where stakeholders have identified gaps, particularly at the statewide level, where the Council could lend its support. Such health topics could be considered “low-hanging fruit” and should be scored as higher priorities than health topics where there is little or no momentum.

Resources: The targeted environmental scan briefing documents provide information on activities going on in the state and a discussion on gaps and opportunities for Council support that came out of conversations with stakeholders.

CRITERION #2: IDENTIFIED COMMUNITY NEED

Definition: Identified community need refers to public interest in the health topic, particularly from communities of color. Those health topics that the community perceives to be the greatest problems should be scored as higher priorities than health topics where the community sees less of a problem and has less interest.

Resources: A list of the health topics in order of priority has been created using data from the Council's public input survey. The list includes the number and percentage of individuals who chose each health topic as a top priority that the Council should address in its plan to eliminate health disparities. Legislative priorities identified by the Commissions on Asian Pacific American Affairs, African American Affairs, and Hispanic Affairs, as well as priority health issues identified in the American Indian Health Commission's Health Care Delivery Plan provide additional information on health concerns for communities of color.

CRITERION #3: PRIORITIZATION OF NEED (AS IDENTIFIED BY DATA)

Definition: The 12 health topics under consideration by the Council were chosen during the first phase prioritization process as areas of great need, as identified by data on the magnitude and severity of the problem as well as the level of disparity. Nonetheless, there is quite a bit of variance in the total scores. Health topics that previously scored as the highest priorities (as indicated by greater total score values) should be scored as higher priorities than those which received lower total score values.

Resources: The total scores assigned during the first phase prioritization process are included on the scoring sheet; they are included in parentheses for each health topic.

PHASE 2 PRIORITIZATION OF HEALTH TOPICS FOR STATE ACTION PLAN: SOCIAL DETERMINANTS OF HEALTH

| CRITERION #1: OPPORTUNITIES FOR COUNCIL SUPPORT (i.e., READINESS) | | | | |
|--|--|---------------------|---------------------|---|
| <ol style="list-style-type: none"> 1. Opportunities for the Council to lend support in addressing the health topic are very low. 2. Opportunities for the Council to lend support in addressing the health topic are somewhat low. 3. Opportunities for the Council to lend support in addressing the health topic are moderate. 4. Opportunities for the Council to lend support in addressing the health topic are somewhat high. 5. Opportunities for the Council to lend support in addressing the health topic are very high. | | | | |
| CRITERION #2: IDENTIFIED COMMUNITY NEED | | | | |
| <ol style="list-style-type: none"> 1. The community has identified the health topic as a very low priority. 2. The community has identified the health topic as a somewhat low priority. 3. The community has identified the health topic as a moderate priority. 4. The community has identified the health topic as a somewhat high priority. 5. The community has identified the health topic as a very high priority. | | | | |
| CRITERION #3: PRIORITIZATION OF NEED (AS IDENTIFIED BY DATA) | | | | |
| <p>Use a 5-point scale (5 being the highest priority) to score the health topic. Use the scores previously assigned by the Council using data on magnitude, severity, and disparity. The previously assigned scores are included in parentheses (below) for each health topic.</p> | | | | |
| HEALTH TOPIC | For each health topic score each criterion from 1 to 5. Multiply the score by the assigned weight and enter into the appropriate cell. Add the weighted criterion scores to obtain the total score. | | | Total Score for the Health Topic |
| | Criterion #1 | Criterion #2 | Criterion #3 | |
| Weight: | 1 | 1 | 2 | |
| 1. Health Workforce Diversity (251) | | | | |
| 2. Substance Abuse (248) | | | | |
| 3. Health Insurance Coverage (247) | | | | |
| 4. Education (243) | | | | |
| 5. Health Literacy (231) | | | | |
| 6. Environmental Exposures (229) | | | | |
| 7. Smoking Rates (218) | | | | |

PHASE 2 PRIORITIZATION OF HEALTH TOPICS FOR STATE ACTION PLAN: HEALTH CONDITIONS

| CRITERION #1: OPPORTUNITIES FOR COUNCIL SUPPORT (i.e., READINESS) | | | | |
|--|--|---------------------|---------------------|---|
| <ol style="list-style-type: none"> 1. Opportunities for the Council to lend support in addressing the health topic are very low. 2. Opportunities for the Council to lend support in addressing the health topic are somewhat low. 3. Opportunities for the Council to lend support in addressing the health topic are moderate. 4. Opportunities for the Council to lend support in addressing the health topic are somewhat high. 5. Opportunities for the Council to lend support in addressing the health topic are very high. | | | | |
| CRITERION #2: IDENTIFIED COMMUNITY NEED | | | | |
| <ol style="list-style-type: none"> 1. The community has identified the health topic as a very low priority. 2. The community has identified the health topic as a somewhat low priority. 3. The community has identified the health topic as a moderate priority. 4. The community has identified the health topic as a somewhat high priority. 5. The community has identified the health topic as a very high priority. | | | | |
| CRITERION #3: PRIORITIZATION OF NEED (AS IDENTIFIED BY DATA) | | | | |
| <p>Use a 5-point scale (5 being the highest priority) to score the health topic. Use the scores previously assigned by the Council using data on magnitude, severity, and disparity. The previously assigned scores are included in parentheses (below) for each health topic.</p> | | | | |
| HEALTH TOPIC | For each health topic score each criterion from 1 to 5. Multiply the score by the assigned weight and enter into the appropriate cell. Add the weighted criterion scores to obtain the total score. | | | Total Score for the Health Topic |
| | Criterion #1 | Criterion #2 | Criterion #3 | |
| Weight: | 1 | 1 | 2 | |
| 1. Overweight & Obesity (245) | | | | |
| 2. Diabetes (241) | | | | |
| 3. HIV/AIDS (228) | | | | |
| 4. Chronic Kidney Disease (226) | | | | |
| 5. Heart Disease & Stroke (200) | | | | |



STATE OF WASHINGTON
GOVERNOR'S INTERAGENCY COUNCIL ON HEALTH DISPARITIES

Washington State Board of Health

PO Box 47990 • Olympia, Washington 98504-7990

September 25, 2008

TO: Members of the Governor's Interagency Council on Health Disparities
FROM: Vickie Ybarra, Chair
SUBJECT: SECOND PHASE PRIORITIZATION RESULTS

Background and Summary

The Governor's Interagency Council on Health Disparities has been charged with creating an action plan to eliminate health disparities. According to RCW 43.20.280:

"The council shall prioritize the diseases, conditions, and health indicators according to prevalence and severity of the health disparity. The council shall address these priorities on an incremental basis by adding no more than five of the diseases, conditions, and health indicators to each update or revised version of the action plan."

At our October 10, 2007 meeting, the Council completed the first phase of prioritization, selecting twelve health conditions and social determinants of health for further consideration and research.

At our May 29, 2008 meeting, we approved criteria and a scoring process to narrow the list from twelve to five priorities for the first version of the action plan. This second phase of prioritization was based on three criteria: (1) Opportunities for Council Support, i.e., Readiness, (2) Identified Community Need, i.e., Public Input and (3) Prioritization of Need, as Identified by Data. The Council decided to assign the public input criterion twice the weight of the others. Using scoring guidance for these criteria and a number of resource materials, Council members individually scored each health condition and social determinant of health. Council staff then compiled the scores.

Today, Council staff will provide a summary of the scoring results. I invite Council members to discuss the results and whether the process resulted in prioritized lists that make sense and are consistent with Council members' professional judgment.

Recommended Council Action

After discussion, the Council may choose to amend if necessary or adopt the following motion:

Motion: The Council approves the prioritized lists of health conditions and social determinants of health as submitted on September 25, 2008 and selects the following five priorities for the first version of the action plan [insert five priorities].

Discussion

Fifteen Council members completed the scoring for the first phase of prioritization. Tables 1 and 2 provide the total score, average score, standard deviation, and range of scores for each health condition and social determinant of health, respectively. The standard deviation measures the amount of dispersion in the scores, with a lower standard deviation indicating less dispersion (i.e., the scores are clustered closely around the average score) and a higher standard deviation indicating higher dispersion.

Table 1: Prioritized List of Health Conditions

| Health Condition | Total Score | Average Score | Standard Deviation | Score Range |
|-------------------------|--------------------|----------------------|---------------------------|--------------------|
| Diabetes | 264 | 17.6 | 3.2 | 10-20 |
| Overweight & Obesity | 256 | 17.1 | 2.9 | 11-20 |
| Heart Disease & Stroke | 208 | 13.9 | 4.7 | 4-10 |
| HIV/AIDS | 201 | 13.4 | 3.6 | 8-20 |
| Chronic Kidney Disease | 172 | 11.5 | 4.8 | 4-20 |

Table 2: Prioritized List of Social Determinants of Health

| Social Determinant of Health | Total Score | Average Score | Standard Deviation | Score Range |
|-------------------------------------|--------------------|----------------------|---------------------------|--------------------|
| Education | 254 | 16.9 | 3.3 | 8-20 |
| Health Insurance Coverage | 252 | 16.8 | 2.3 | 13-20 |
| Health Workforce Diversity | 236 | 15.7 | 3.8 | 7-20 |
| Substance Abuse | 221 | 14.7 | 3.6 | 9-20 |
| Health Literacy | 209 | 13.9 | 4.0 | 4-20 |
| Environmental Exposures | 177 | 11.8 | 4.1 | 6-20 |
| Smoking Rates | 171 | 11.4 | 5.2 | 4-20 |

State Policy Action Plan to Eliminate Health Disparities

2013 Update

Note: This is proposed text prepared by staff. It has not been approved by the Governor's Interagency Council on Health Disparities or the Office of Financial Management.

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June 2013

Governor's Interagency Council on Health Disparities

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| | |
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INTRODUCTION

RCW 43.20.280 requires the Governor’s Interagency Council on Health Disparities (Council) to create an action plan to eliminate health disparities by race/ethnicity, and gender. Statutory reporting requirements state:

“The council shall consider in its deliberations and by 2012, create an action plan for eliminating health disparities.”

“The action plan shall be updated biannually.”

“The council shall report its progress with the action plan to the governor and the legislature no later than January 15, 2008. A second report shall be presented no later than January 15, 2010, and a third report from the council shall be presented to the governor and the legislature no later than January 15, 2012.”

In January 2008, the Council submitted its first progress report to the Governor and Legislature. That report detailed the Council’s process to identify an overarching list of 32 health conditions and social determinants of health that it would consider for inclusion in its first state action plan. The report also described the Council’s process to narrow the list from 32 to 12 health topics using criteria on the prevalence, severity, and level of disparity for each. In addition, the 2008 progress report highlighted other Council activities, including contracting with a non-profit organization to assess the availability of culturally and linguistically appropriate health education materials; convening the Public Forum on Language, Culture, and Health Care; applying for and being awarded a State Partnership Grant from the U.S. Department of Health and Human Services’ Office of Minority Health; and co-sponsoring the Each Student Successful Summit with eleven other partners to discuss a whole-child approach to address health disparities and the academic achievement gap, among other activities.

The Council submitted its second progress report in January 2009. That report described the Council’s second phase of its prioritization process, in which it identified its top five priorities using criteria on readiness, community need, and epidemiologic data. In addition, the report highlighted community outreach activities, the Council’s Community Forum on Health Equities, Council member participation in health equity events, participation in national health disparities activities, and the convening of an advisory workgroup to assist with the development of the Council’s *Multicultural Health Communications Directory*.

In January 2010, a third progress report was submitted, which discussed the Council’s selection of its first five priorities—education, health insurance coverage, healthcare workforce diversity, obesity, and diabetes—and described the convening of advisory committees to develop policy recommendations for the Council’s consideration. The report also highlighted Council efforts to link public, private, and community partners together to leverage resources to promote health equity and reduce disparities; to redesign its Web site; and to participate in the National

Partnership for Action to End Health Disparities Initiative and other local, state, and national health equity efforts.

The Council submitted its 2010 *State Policy Action Plan to Eliminate Health Disparities* in June 2010. That plan included policy recommendations aimed at closing the education opportunity gap, increasing health insurance coverage and access to culturally and linguistically appropriate healthcare services, promoting a diverse healthcare workforce, and reducing disparities in obesity and diabetes. With that plan, the Council delivered broad policy recommendations, most of which would have required executive or legislative action to implement.

In 2012, the Council submitted a second action plan, which focused on a new set of priorities and recommendations to reduce behavioral health disparities, promote environmental justice, reduce health disparities from environmental exposures and hazards, and to reduce poverty and the impacts of poverty on health disparities. The Council's focus with its 2012 action plan was to deliver recommendations that state agencies and their partners could take steps toward implementing with existing resources.

All Council reports are available on its Web site: www.HealthEquity.wa.gov.

This report describes the Council's progress toward implementing the recommendations in its 2012 action plan and highlights other activities the Council has initiated or participated in to improve the health and well-being of Washington's diverse communities.

ABOUT THE COUNCIL

In accordance with Section 43.20.275 RCW, the Council has 17 members: a chair appointed by the Governor; representatives of 14 state agencies, boards, and commissions; and two members of the public who represent the interests of health care consumers. A list of current Council members is provided in Box 1.

All meetings of the Council are open to the public as required by the Open Public Meetings Act, Chapter 42.30 RCW. The Council maintains an electronic-mail distribution list of interested members of the public, which it uses to announce meetings, distribute draft and final meeting agendas, and solicit input and feedback to guide its work.

In addition, the Council maintains a Web site which it uses to supply information about the Council; share information and resources on health disparities; announce upcoming meetings; and post meeting agendas, minutes, and materials. Contact information for Council members and staff, Council bylaws, press releases, and other information can be found on the Web site.

Governor's Interagency Council on
Health Disparities

Web site:

HealthEquity.wa.gov

| Box 1: Governor’s Interagency Council on Health Disparities Membership | |
|---|--|
| Governor’s Representative and Council Chair: | Emma Medicine White Crow |
| Consumer Representative and Council Vice Chair: | Frankie T. Manning |
| Consumer Representative: | Gwendolyn Shepherd |
| Commission on African American Affairs: | Winona Hollins-Hauge |
| Commission on Asian Pacific American Affairs: | Sofia Aragon |
| Commission on Hispanic Affairs: | Nora Coronado Diana Lindner (alternate) |
| Department of Agriculture: | Kim Eads |
| Department of Commerce: | Diane Klontz |
| Department of Early Learning: | Jonathan Green |
| Department of Ecology: | Millie Piazza John Ridgway (alternate) |
| Department of Health: | Gail Brandt |
| Department of Social and Health Services: | Marietta Bobba |
| American Indian Health Commission ¹ : | Willie Frank |
| Health Care Authority: | Vazaskia Caldwell |
| Office of Superintendent of Public Instruction: | Dan Newell Greg Williamson (alternate) |
| State Board of Health: | Stephen Kutz |
| Workforce Training and Education Coordinating Board: | <i>Vacant</i> |

¹ The Governor’s Office of Indian Affairs delegated authority to the American Indian Health Commission to appoint a representative to the Council.

STATUS OF 2012 ACTION PLAN RECOMMENDATIONS

Table 1 provides a list of the Council’s recommendations to eliminate health disparities from its 2012 action plan. The plan was completed in December 2012. In the six months since its submission, much work has continued or been initiated to implement the recommendations by the agencies with representation on the Council and others. Table 1 highlights current and planned work toward implementing the recommendations.

| Table 1: Implementation Status of 2012 State Policy Action Plan to Eliminate Health Disparities Recommendations | |
|---|--|
| Recommendation² | Status |
| <p>BH³—Workforce Development Assist students from diverse communities to prepare for careers in health professions, including behavioral health. Improve recruitment from communities of color into health programs.</p> | <p>The Office of Superintendent of Public Instruction (OSPI) hired a Health Sciences Program Supervisor on October 1, 2012 to take the lead on the work related to exploratory Career and Technical Education programs. To date, staff has been working with the Health Science Center of Excellence on a statewide program of study. Future plans are partnering with Systems Biology, Seattle Biomedical, Fred Hutchinson, and the University of Washington in developing a program in Global Health.</p> |
| <p>BH—Workforce Credentialing Ensure input from affected communities to any credentialing or scope of practice changes regarding agency affiliated counselors.</p> | <p>The Health Services Quality Assurance (HSQA) program at the Department of Health will ensure that agencies, facilities, federally recognized Indian Tribes within the State, and counties are informed and provided the opportunity to give feedback regarding any rule changes that are being considered that impact the agency affiliated counselor scope of practice and/or credentialing requirements.</p> |
| <p>BH—Workforce Training Improve access to cultural competency training for continuing education hours for behavioral health professionals.</p> | <p>By July 1, 2013, HSQA will conduct an analysis of rules and identify which behavioral health profession programs currently do not accept cultural competency training and providers of this training for meeting continuing education requirements.</p> <p>By December 31, 2013, those HSQA behavioral health profession programs that do not currently accept cultural competency training and providers of this training for meeting continuing education requirements will consider modifying rules to recognize this training and the training providers.</p> |

² Recommendations are abbreviated—for the full recommendations’ language, see the [2012 State Policy Action Plan to Eliminate Health Disparities](#).

³ BH: Behavioral Health

Table 1: Implementation Status of 2012 State Policy Action Plan to Eliminate Health Disparities Recommendations

| Recommendation ² | Status |
|---|---|
| <p>BH—Data Ensure behavioral health data are disaggregated to the finest subpopulation level possible.</p> | <p>In the 2013 legislative session, ESHB 1519 “An Act Related to Establishing Accountability Measures for Service Coordination,” has passed both houses and is likely to be signed into Law by Governor Inslee. This legislation requires the Health Care Authority (HCA) and Department of Social and Health Services (DSHS) to develop performance measures and outcomes to incorporate into contracts with service coordination organizations including Regional Support Network contract mental health programs, county contracted chemical dependency providers, Medicaid Managed Care Organizations and Area Agencies on Aging. The legislation requires reductions in population level health disparities and the identification of programs effective with ethnically diverse clients. A report will be due to Legislature in December of 2014s.</p> <p>DSHS is currently able to measure disparity related demographic dimensions, but resources have not been available to routinely disseminate this data.</p> |
| <p>BH—Qualified Health Homes Ensure Tribal, urban Indian, and community-based organizations can be part of qualified health homes.</p> | <p>The first Qualified Health Homes are being implemented using a “phase-in” approach that will eventually be statewide. The organizations contracted to provide care coordination under health homes may include Tribes, urban Indian health organizations, community-based organizations and school-based health centers, but it is too early in the process to know exactly which organizations will indicate an interest in contracting.</p> |

Table 1: Implementation Status of 2012 State Policy Action Plan to Eliminate Health Disparities Recommendations

| Recommendation ² | Status |
|--|--|
| <p>BH—Culturally Competent Care Incentivize culturally competent care coordination and other supports and services that promote engagement and positive health.</p> | <p>Payment models have been developed to incentivize high quality service delivery and care coordination. Inclusive in the models being developed is the expectation that care coordination will be based on informed interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural, and environmental factors impacting health and health care choices. Elements of the models include: wellness and prevention education specific to the individual’s chronic conditions, assessment of need and facilitation of receipt of routine preventive care, support for improving social connections to community networks, and linking individuals with resources that support a health promoting lifestyle and recognizing and applying cultural norms when creating Health Action Plans. Expected linkages may include but not be limited to resources for smoking prevention and cessation, substance use disorder prevention, nutritional counseling, obesity reduction and prevention, increasing physical activity, disease specific or chronic care management self-help resources, and other services, such as housing, based on individual needs, and preferences. Models are in development and being negotiated with CMS.</p> |
| <p>BH—Access and Engagement Ensure Tribal, urban Indian, and community-based organizations can serve as navigators. Ensuring any mandated evidence-based practices allow for flexibility and adaptation.</p> | <p>The Health Disparities Council submitted a letter to the Health Benefit Exchange Board encouraging the Board to ensure meaningful language access to the Exchange and its services. The letter also asked the Board to ensure community-based organizations, tribes, and urban Indian health organizations are eligible to serve as navigators. The Exchange Board has since released a fact sheet called, “Meeting the Needs of Washington’s Diverse Populations”, which outlines processes to ensure the Exchange meets the cultural and linguistic needs of diverse communities. The Health Benefit Exchange Board released its Request for Proposals for the In-Person Assister Program—Lead Organization Services on March 8, 2013 and its Request for Proposals for the Tribal-Assister Program on April 5, 2013.</p> <p>The Health Disparities Council received an update on the implementation of HB 2536, Concerning the Use of Evidence-based Practices for the Delivery of Services to Children and Juveniles, on December 6, 2012. Members provided guidance on the need to ensure promising practices be considered and that practices allow for flexibility and cultural adaptation.</p> |

Table 1: Implementation Status of 2012 State Policy Action Plan to Eliminate Health Disparities Recommendations

| Recommendation ² | Status |
|---|--|
| <p>EEH⁴—EJ⁵ Institutional Awareness and Diversity Ensure agency staff diversity and cultural competency</p> | <p>Department of Ecology is planning to convene an interagency environmental justice network – <i>planning for Spring 2013</i>. The agency is considering whether the interagency environmental justice network could serve as the appropriate forum for promoting best practices and training – <i>currently under consideration</i>.</p> <p>Department of Ecology is participating in the Global Reporting Initiative to measure and report their economic, environmental, and social performance. A number of the indicators used in the GRI align closely with the Council’s environmental exposures and hazards recommendations.</p> <p>The Department of Health’s Office of Healthy Communities plans to work with the agency’s human resources office on writing job descriptions that include measurable actions to promote health equity in staff job responsibilities and providing support for supervisors to help staff meet those responsibilities. The Office provides new staff orientation on health equity twice a year and a tailored skills-building training on health equity is offered every 2-3 months. At the agency level, the Department of Health is creating a one-day new staff orientation that includes a health equity component.</p> <p>The State Board of Health’s Strategic Plan includes a goal to reduce health disparities, which includes a strategy to assure the cultural competence of the Board and its staff. Cultural competency training and government-to-government training are mandatory for all Board staff. In addition, the Board has taken steps to include cultural competency in employee’s annual performance and development planning.</p> |

⁴ EEH: Environmental Exposures and Hazards

⁵ EJ: Environmental Justice

Table 1: Implementation Status of 2012 State Policy Action Plan to Eliminate Health Disparities Recommendations

| Recommendation ² | Status |
|--|--|
| <p>EEH—EJ Service Equity, Accountability, and Metrics Ensure equity is considered in the delivery of services, agency plans, programs, policies, and budget decisions. Ensure data are collected to track disparities. Formalize processes for investigating environmental justice issues. Reconvene an environmental justice workgroup.</p> | <p>Department of Ecology is partnering with the US Environmental Protection Agency to consider adding language in their performance partnership agreement (intergovernmental memorandum of understanding) regarding identifying appropriate measures and baseline indicators for tracking disparate impacts and progress towards reducing disparities.</p> <p>Department of Health and its Office of Healthy Communities address health equity in strategic planning. Health equity is also addressed in the Department’s <i>Statewide Agenda for Change</i> and the <i>State Healthy Communities Plan</i>.</p> <p>The Department of Health has recently developed an Equity Impact Review Guide to proactively assess program and policy decisions on potential impacts on equity. Department staff is currently identifying opportunities to pilot test the guide.</p> <p>The Department of Health’s Office of Health Communities consistently requires the inclusion of health equity in its grant proposals, and similarly ensures health equity is included when it issues requests for proposals and community grants.</p> <p>The State Board of Health’s Strategic Plan includes a goal to reduce health disparities, which includes a strategy to intentionally consider health equity in all reports. The Board’s most recent State Health Report included an essay from the Council that focused on health equity and reducing health disparities. In its most recent strategic plan update, the Board indicated it would identify opportunities to pilot the Department of Health’s Equity Impact Review Guide.</p> |

Table 1: Implementation Status of 2012 State Policy Action Plan to Eliminate Health Disparities Recommendations

| Recommendation ² | Status |
|--|--|
| <p>EEH—Community Capacity Building and Involvement Provide community outreach, training, technical assistance. Ensure community engagement in agency decision making. Strengthen Tribal consultation. Dedicate funds to assist communities with environmental justice concerns.</p> | <p>Department of Ecology is partnering with the US Environmental Protection Agency to consider adding language in their performance partnership agreement (intergovernmental memorandum of understanding) regarding Providing outreach, training, and technical assistance to high risk and overburdened communities (e.g., information about environmental justice, grant writing, data access and analysis, and community mobilization and advocacy).</p> <p>Department of Health’s Tribal Liaison is currently drafting a consultation and guidance document. The document will undergo review by the agency and the American Indian Health Commission before being finalized and adopted by the agency.</p> <p>An example of an existing agency’s community engagement strategies is the Department of Commerce’s WorkFirst Local Planning Area Partnerships (LPAs). LPAs serve as forums for coordinating the development and delivery of services and activities to help WorkFirst families become more stable, prepare for employment, and go to work. Through the LPA network local partners stay informed as to changing WorkFirst policies, programs, and priorities. There are currently 28 LPAs across the state with representatives from local and state agencies, community and technical colleges, nonprofit organizations, tribes, contractors, and other community partners that serve those most in need.</p> |
| <p>EEH—Precautionary Approach Ensure a precautionary, prevention-oriented approach to environmental contaminants. Take actions and set tangible goals for reducing harmful environmental exposures. Prioritize children’s health and development.</p> | <p>Department of Ecology is planning to partner with US Environmental Protection Agency to develop a map of high impact communities – <i>planning for Fall 2013</i>.</p> <p>Department of Ecology is in the process of developing guidance for assessing alternatives to chemicals of concern. The purpose of the guidance is to give Ecology better tools to help businesses, especially small and medium sized businesses, and make better informed choices about the chemicals they use in their products and manufacturing processes – <i>currently under development</i>.</p> |
| <p>Poverty—Early Learning Create capacity for bilingual/bicultural early learning programs. Promote cultural competency training for early learning professionals.</p> | <p>To date, the Department of Early Learning has provided 34 cultural competency trainings statewide, reaching an estimated 500 early learning professionals. To date, 304 state-approved trainers have access to cultural competency training focused on creating training that is culturally responsive and facilitating training to meet the needs of all participants.</p> |

Table 1: Implementation Status of 2012 State Policy Action Plan to Eliminate Health Disparities Recommendations

| Recommendation ² | Status |
|--|--|
| <p>Poverty – Rural Healthcare Support the strategies in the 2012 Rural Health Care Strategic Plan for Washington State</p> | <p>Health Disparities Council’s action plan was disseminated to the Legislature on January 14, 2013. Council staff shared the recommendation with Department of Health Office of Rural Health program. Council staff met with Washington State Hospital Association staff involved in the strategic plan development to share information about the Council and its recommendation. WSHA staff will share implementation updates and possibly present on implementation in rural communities at the Council’s May 2013 meeting.</p> |
| <p>Poverty—Healthy Foods in Diverse Communities Convene the Food System Roundtable. Ensure diverse community input into the 25 year vision.</p> | <p>The Department of Health and the Department of Social and Health Services in collaboration with the Department of Agriculture, Office of Superintendent of Public Instruction and the Washington State Conservation Commission convened the Food System Roundtable on January 8, 2013. At that meeting, the group discussed membership needs and overall goals for the Roundtable. It was decided that a workgroup should be established to formalize the Roundtable by drafting a charter. Special emphasis on diverse, tiered membership and guiding principles were discussed, agreed upon, and woven into the draft charter by the Workgroup. After meeting several times, the Workgroup presented the draft charter to the Roundtable on March 22, 2013. It was well received, especially the guiding principles, which included “A belief in social justice and health equity values.” But due to the complexity of issues and perspectives, the Roundtable recommended further revisions. The workgroup is planning on consulting field experts as they revise and finalize the Roundtable Charter. The charter will be shared with the Roundtable in July 2013.</p> |

ADDITIONAL COUNCIL ACTIVITIES

Fostering Communication, Coordination, and Collaboration

The Council has the responsibility under Subsection 2 of RCW 43.20.275 to:

“...promote and facilitate communication, coordination, and collaboration among relevant state agencies and communities of color; and the private and public sector, to address health disparities.”

Much of this work is accomplished through the Council’s State Partnership Grant from the federal Office of Minority Health at the Department of Health and Human Services. In 2007, the Council applied for and was awarded a three year State Partnership Grant—a second three-year grant was reissued through a competitive process in 2010.

Through its State Partnership Grant, the Council supports a Community Relations Liaison, whose primary responsibilities are to connect with communities affected by health disparities and other stakeholders to share information about the Council and seek input and encourage engagement into the Council’s work. The Council’s Community Relations Liaison works closely with the commissions on African American Affairs, Asian Pacific American Affairs, Hispanic Affairs, and the American Indian Health Commission to advance health equity initiatives by addressing specific health issues impacting each community. Following, are a selection of events and activities over the past year.

- The Council sponsored health presentations targeting the Filipino and Native Hawaiian and Pacific Islander communities, as well as general health information for all Asian and Pacific Islanders, at Commission on Asian Pacific American Affairs Board meetings. These presentations supported the Commission’s health disparities initiative.
- We worked with the Asian Pacific Cultural Center to sponsor its second annual Native Hawaiian and Pacific Islander Health and Fitness Day, entitled “Move It”. More than 500 people attended, included many children and youth. Samoan and other Pacific Islander community leaders and role models attended and shared information about physical fitness and healthy eating with the community.
- In collaboration with the Chinese Information and Service Center, the Council sponsored and attended two health fairs for the Chinese and Vietnamese communities. Community members in attendance were able to obtain health information in their primary language, including information on new health benefits through health reform, as well as health screenings and referrals.
- The Council worked with the Commission on African American Affairs, the University of Washington Health Promotion and Research Center, and the Central Area Senior Center to sponsor a health information breakfast for African American seniors.

- Along with the Commission on African American Affairs, the council supported the annual Youth Leadership Summit for African American high school students—summit presentations focused on teen pregnancy prevention, self-expression, technology, and STEM education.
- The Council sponsored and provided health information at Kidney Fest, Juneteenth Festival, and Festival Sundiata, in collaboration with the Commission on African American Affairs.
- The Council worked with the Commission on African American Affairs and local partners to sponsor community health forums on nutrition, weight management, and obesity prevention.
- The Council’s Community Relations Liaison participates on the planning committee for the Latino Family Health and Safety Fairs. Every year, this group coordinates between 18-24 health and safety fairs targeting the Hispanic/Latino population across the state. Fairs provide local community members with health information in their own language as well as health screenings and referrals.
- In collaboration with a variety of partners, the Council participated in and promoted the Latino Health forum and two Latino Healthy Symposiums in Seattle and Yakima.
- In partnership with the Commission on Hispanic Affairs and representatives from the University of Washington, Fred Hutchinson Cancer Research Center, and Group Health, the Council’s Community Relations Liaison worked to support a mentorship program for Hispanic/Latino health sciences students.
- The Council participated in the Society for the Advancement of Chicanos and Native Americans in Sciences (SACNAS) National Conference.
- The Council has continued to support the American Indian Health Commission and their efforts to integrate health disparities into their strategic planning efforts.
- The Council’s Community relation Liaison participated in the conference “Leveraging Culture to Address Health Inequalities: Examples from Native Communities” hosted by the Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities.
- The Council promoted and supported the Chehalis Tribal Wellness Center health fair “Walking with you on your path to Wellness” hosted at the Chehalis Tribal Community Center.

The Council and its staff also give presentations, share expertise, and provide technical assistance to a variety of organizations working to promote health equity and reduce

disparities. As just one example, the Council's Community Relations Liaison provided a presentation about how culture and values affect health at an event sponsored by the City of Bellevue.

Through the State Partnership Grant, the Council also facilitates a Community Outreach Roundtable and an Interagency Limited English Proficiency (LEP) Workgroup. Both groups include representatives from state agencies and serve as forums for the sharing of best practices and leveraging of resources. The Community Outreach Roundtable's focus is to improve outreach to and engagement of diverse communities in state agency programs. During Community Outreach Roundtable meetings, representatives from the racial/ethnic commissions and local community-based organizations share challenges, successes, and lessons learned regarding providing effective outreach to communities of color. The focus of the Interagency LEP Workgroup is improving access to state agency information and services for people with limited English proficiency.

Linkages with Other State and National Health Disparities Efforts

The Council is dedicated to working collaboratively with other entities within Washington State to improve health equity for Washingtonians. In addition, the Council has been actively involved in contributing toward national health disparities reduction efforts.

The Council is a member of the National Association of State Offices of Minority Health (NASOMH), which is an affiliate of the Association of State and Territorial Health Officers. NASOMH is an organization dedicated to protecting and promoting the health and well-being of communities of color and Tribal organizations and nations. Council staff serves on the NASOMH of Directors representing Region X. One objective of NASOMH is to communicate, document, and champion best practices at the state level in eliminating health disparities. Through its partnership with NASOMH, the Council remains informed about activities in other states to eliminate racial and ethnic health disparities so that it can more effectively complete its work.

The Office of Minority Health at the U.S. Department of Health and Human Services has a National Partnership for Action (NPA) to Eliminate Health Disparities initiative. As a recipient of an OMH State Partnership grant and through its affiliation with NASOMH, the Council is a member of the NPA. A current focus of the NPA is health reform implementation. Regional Health Equity Councils were created through the NPA, and several Council members serve on the regional council.

NEXT STEPS FOR THE COUNCIL

The Council is currently working, in collaboration with its member agencies and community partners to identify new health priorities. As it has in the past, it will convene diverse advisory committees made up of public, private, and community representatives around each of its priority health topics to identify recommendations for eliminating health disparities. Those recommendations will be incorporated into future updates of the Council's *State Policy Action Plan to Eliminate Health Disparities*.

[1](#)

Receive Updates



DEL Update - April 2013

Washington State Department of Early Learning sent this bulletin at 04/10/2013 12:38 PM PDT

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DEL Update | April 2013

Director's Note

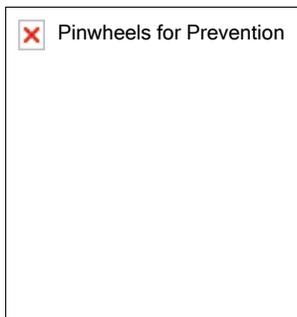


**DEL Director
Dr. Bette Hyde**

In This Issue

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The Department of Early Learning (DEL) is observing National Child Abuse Prevention Month in April by raising awareness in the community about child abuse and neglect prevention. In support of our work, Gov. Jay Inslee



has [proclaimed April as Child Abuse Prevention Month](#) in Washington.

[Strengthening Families Washington](#), which is part of the work we do here at DEL, is also the Prevent Child Abuse Washington State Chapter. We've organized an initiative called Pinwheels for Prevention, which uses pinwheels—a timeless symbol of childhood—to represent its campaign to raise awareness of the campaign to prevent child abuse and neglect.

DEL has distributed more than 9,500 pinwheels to communities around the state. They're popping up in front yards and at community events. The Capitol grounds in Olympia will turn silver and blue with pinwheels planted in the ground the week of April 15-19.

Pinwheels for Prevention is a reminder that it is not enough to respond to child abuse and neglect—we must build and support strong families through community engagement, programs, and policies. This grassroots movement works towards developing communities that are healthy, safe, and nurturing for all children and all families.

Follow this work--and more--on [DEL's Facebook page](#).

What you can do to support strong families

- Whether you are a parent, an early learning provider or a community member, you can help build and support strong families in your community every day in simple ways. [Check out these calendars that offer an idea a day](#), such as offering a board game library in your facility for families, and holding family potlucks or movie nights at community centers with time for discussion.
- Tell us what's happening in your community to support strong families.
Email strengtheningfamilies@del.wa.gov.
- Join us at the fountain!

Where: Tivoli Fountain, on State Capitol Grounds near Capitol Way, Olympia

When: April 15, 2013 at noon

Help raise awareness by taking a pinwheel and sharing with us how you've helped a child.

News you can use for providers and families

New state benefit income guidelines begin April 1

Income guidelines for state benefit insurance programs (Medicaid/CHIP) and food assistance programs (Basic Food) increased on April 1. Families who may not have qualified in the past may now qualify under the new income levels.

[Review the new guidelines.](#)

Free developmental screening

[Help Me Grow WA](#) offers free developmental screening for all families with children under age 5. There are no income guidelines or waiting list. Additional services include age-specific activities and games; connections to community resources and state benefit programs; and verified referrals into the early intervention system. Access to these systems significantly improves a child's chances for healthy development and school readiness.

Nominations accepted for Golden Apple Award

Get to know DEL's Early Achievers team



DEL's Early Achievers team. Back row, from left: Kasondra Kugler, Char Goodreau, Adie Fatur. Front row, from left: Justine Waymire, Carrie Gonzalez, Amy Russell, Ava Russell.

The Early Achievers team at the Department of Early Learning is committed to supporting Washington's early learning professionals and the children and families they serve. The team brings a combine century of early learning experience--some have worked in licensed child care centers, family homes, tribal centers, school-age settings and Head Start. We asked the team what they like most about working on Early Achievers and here are their responses:

Carrie Gonzales, QRIS Customer Support Specialist: What I enjoy most about working with Early Achievers is the knowledge that my work really does make a difference; it's an opportunity to help build a new program for Washington which will improve the quality of care for our youngest residents, provide resources and incentives for participants, and give parents an exciting new way to make informed decisions about where their children will learn and grow.

Kasondra Kugler, QRIS Intake Supervisor: I love working on a system that will benefit our children and providers by helping providers gain recognition for the hard work they already do. I love working with technology and am so excited to assist providers in working with the technological aspects of Early Achievers in MERIT and the WELS Provider Portal.

Adie Fatur, QRIS Manager: As someone who was involved in the QRIS field test, it is

Do you know someone who deserves a Golden Apple? There are thousands of great teachers, administrators, staff, volunteers, community organizations and businesses working to make Washington state's schools innovative and exciting places to learn. The KCTS 9 Golden Apple Awards recognize outstanding contributions made by these people and programs serving children in preK-12th grade. Golden Apple winners will receive a cash award and be featured in a statewide primetime special on public television.

If you know of a deserving teacher or programs making a difference in our schools, please visit KCTS9.org/goldenapple or call 1.800.766.0900 to obtain a nomination form. All nominations must be postmarked by **May 6, 2013**.

Chicks, ducklings can carry salmonella, put kids at risk

Each year, people get infected with Salmonella after handling chicks or ducklings. Last year, 10 people in Washington got sick with Salmonella illness after handling chicks, ducklings, and other poultry from a hatchery linked to an 11-state outbreak. Half of the cases in Washington were children under 13 years old. Nationally, more than 450 illnesses were linked to Salmonella outbreaks related to live poultry.

Spring is the season when many people who keep chickens or ducks in backyard flocks order baby birds. Children should be supervised carefully when they're touching these animals or their environments, to make sure they wash their hands right away. Make sure children don't nuzzle or kiss animals.

Kids under age 5, elderly adults, and people with weakened immune systems are most likely to get very sick from Salmonella. People in these groups should avoid handling live poultry.

Salmonella infection can cause diarrhea, fever, stomach pain, nausea, and vomiting. Symptoms usually last several days. Severe cases may require hospitalization, and occasionally result in death.

Raising chickens or other poultry for their eggs is becoming more popular. By following the recommendations of the [Washington State Department of Agriculture](#) people can keep their families, and their birds, healthy.

More tips for [avoiding Salmonella infection from chicks and ducklings](#) are available from the state Department of Health.

Immunization town hall in Seattle on April 23

[Infant Immunization Week](#) is an annual observance to highlight the importance of protecting infants from vaccine-preventable diseases and promoting healthy communities. WithinReach is co-hosting a lively discussion with [The Panic Virus](#) author Seth Mnookin and 'Seattle Mama Doc' Wendy Sue Swanson to discuss Vaccine Myths, Parents & Modern Health Information. They will discuss how parents can find accurate vaccine information and make the right decisions for their families. [Learn more and register here.](#)

EPA provides environmental health resources for child care providers and families

EPA has launched a new website containing environmental health information for child care providers, parents, and state and local agencies at www2.epa.gov/childcare. The site includes fact sheets, presentations, training, assessment tools, reports, prevention and intervention guidance about asthma, chemical hazards, environmental tobacco smoke, green cleaning, indoor air quality, lead, mercury, mold,

especially rewarding to see the hard work and input of so many stakeholders, including child care providers reflected in the system that will ultimately benefit so many children and families. I feel fortunate to be involved with the statewide rollout of Early Achievers.

Amy Russell, QRIS Project Coordinator: I enjoy working with people who are truly passionate about creating positive change for our youngest learners. As a parent of a young child, I am honored to take part in building a system that will make high quality childcare the norm and help parents make informed choices.

Justine Waymire, QRIS Specialist: What I like most about working on Early Achievers is knowing that children across Washington will have access to a high-quality care.

Char Goodreau, QRIS Administrator: Early Achievers is one of the unique programs that has a universal impact. Child care providers receive support and resources to build upon the great work that they are already doing; families receive information about high-quality care and can help drive quality improvement efforts in their child's early learning facility; and most importantly, all children will have access to high-quality early learning opportunities, which has a lifelong benefit.

DEL news in brief

Funding available for community-based child abuse prevention programs

The [Department of Early Learning's Strengthening Families Washington](#) is pleased to announce that funding is available for community-based family support and child abuse prevention programs throughout Washington state. We are requesting letters of interest from Washington state organizations that are engaged in child abuse prevention activities. We want to work with local communities to increase program capacity to use and expand the Strengthening Families Protective Factors Framework for children birth through age 5.

Please share this opportunity with community partners and organizations throughout the state.

The letter of interest template, application cover sheet, and more information is available [on our website](#). The letter is due to DEL by April 30.

Public comment accepted on CCDF plan

The Child Care and Development Fund (CCDF) is a federal grant administered by the U.S. Department of Health and Human Services Administration for Children & Families Child Care Bureau (ACF).

As the lead state agency for the CCDF block grant, DEL must submit a plan every two years for how the funding will be used to

pesticides and plastics. The information is available in English, Spanish, Chinese, Vietnamese and Korean.

Have you received a portable background check?



At the end of March, DEL licensors and staff helped child care professionals from the Washington State Migrant Council register for portable background checks in Yakima. All child care professionals must have a portable background check by July 1. [Read more about portable background checks.](#)

improve accessibility and quality of child care in our state. In Washington, CCDF pays for Working Connections Child Care subsidies, child care resource and referral and other research and technical assistance.

DEL has posted its draft plan for federal fiscal year 2014-15. We are accepting public comment on the proposed 2014-15 plan until May 20, 2013.

- View the [draft plan for 2014-15](#).
- Email comments and suggestions to CCDF2013@del.wa.gov.

DEL legislative update

[View the most recent update](#) on the status of the bills that DEL is tracking this legislative session.

FAQs for school-age rules

DEL has compiled answers to [frequently-asked questions about the new school-age rules](#) that took effect in December 2012. The revised rules pertain to the 450 licensed school-age programs around the state, which serve up to 20,000 children ages 5 through 12 with before- and after-school care. The rules were last updated in 2001.

You can read a [summary of the revised rules](#) on the DEL blog.



Questions?
[Contact Us](#)

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Department of Commerce

Innovation is in our nature.

Family Housing Initiative

This year the Office of Superintendent of Public Instruction reported 27,390 homeless students in the 2011-12 school year; 18,332 doubled-up with family or friends and 7,853 in shelters or motels. Worse yet there are approximately 1,205 children who are living outside, in a car, or in a building not meant for human habitation.

In response to that announcement, Governor Inslee directed DSHS and Commerce to create a plan for addressing homelessness among children in Washington. We brought our departments together to develop a cross-silo strategy to meet his directive.

State investments, smarter strategies, and improved data and analysis helped reduce unsheltered family homelessness by 65 percent since 2006. This initiative will build on this success to reduce homelessness for families with children who are unsheltered or living in shelters and motels an additional 50 percent by 2015. This effort will inform strategies to eliminate all chronic homelessness for families with children.

How will DSHS and Commerce reduce family homelessness?

Commerce and the DSHS will work to reduce homelessness by 50 percent in two years for the 9,058 children who are unsheltered or living in shelters or motels. We estimate that those children are in 5,032 families.

To accomplish this goal we will:

- Link DSHS to Commerce-contracted local housing providers by funding rent assistance for families eligible for Temporary Aid for Needy Families (TANF) or Diversion Assistance.
- Screen for TANF families or families eligible for TANF eligible for this effort.
- Immediately begin rapid rehousing at a few initial sites to help prepare for implementation statewide (existing homeless grant contracts will be amended to expedite implementation).
- Use performance-based contracts to incent providers to keep clients permanently housed.
- Formalize the process for DSHS, school districts, and health care providers to refer families to housing services.
- Advocate for the maintenance of current funding for existing homeless programs including Housing and Essential Needs.
- Recommend that the Interagency Council on Homelessness develop outcome measures and a plan to continuously improve this initiative.

What will it cost?

This initiative will cost \$15.8 million per year to serve 2,516 families for an average of six months (rent assistance and case management at \$6,271 per family). DSHS and Commerce have identified existing TANF funds and document recording fees which can be used for this project. These funds will be appropriated in order to implement this plan; no new State General Funds will be required.



Biography of Secretary of Health, John Wiesman, DrPH, MPH

John Wiesman, DrPH, MPH was appointed Secretary of Health by Governor Jay Inslee and joined the Department of Health in April 2013. He's an accomplished transformational leader with more than 22 years of local public health experience.

John has been passionate about public health since reading a 1983 Time magazine article about disease detectives tracking Legionnaires' Disease, toxic shock syndrome, and HIV. It was the impetus for him to enter the profession.

He has worked in four local public health departments in Washington and Connecticut. He started his public health career in Connecticut in 1986 and was in its first group trained to provide HIV counseling and testing. During his career John has:



- Transformed health departments from providing individual clinical services to implementing policies, systems and environmental changes that make healthy choices easier and less expensive.

- Partnered with a community clinic to provide integrated primary care and behavioral health.

- Transformed Clark County Public Health into a first responder organization.

John also worked at the University of Washington, School of Public Health as a project director on a back pain outcome assessment team grant.

He earned his doctor of public health (DrPH) in public health executive leadership from the University of North Carolina-Chapel Hill in 2012. He received his master of public health (MPH) in chronic disease epidemiology from Yale University in 1987 and his bachelor of arts (BA) in biology from Lawrence University in Wisconsin in 1983.

John was born and raised in Wisconsin. He and his husband have lived in Washington State since 1989.

JOIN US!

The Commission on African American Affairs &
Governors Interagency Council on Health Disparities
Presents:

Annual Health & Wellness Resource Forum
Thursday, April 11th
8 am– 12pm
FREE

**Health & Wellness Vendors *Drawings *Arts & Crafts *Prizes*

Medical professionals and experts on health care will be discussing education, prevention, how to access community resources and more. The panel will include, **Dr. Maxine Hayes, Dr. Michelle Tery, Dr. Beti Thompson, Dr. Sandra Walker, Dr. Anita Connell, Dr. George Counts, Dr. Rayburn Lewis, Dr. Fredricka Overstreet, Dr. Patricia Dawson and Norman Johnson** moderated by **Commissioner Winona Holins-Hauge, MSW** and a host of health exhibitors and community resources.

Heart Healthy Free Breakfast Roundtable @ 8:30 a.m.

Keynote Speaker:

Dr. Paul S. Casamassimo, DDS, MS, Nationwide Children's

Breakfast Registration, please call 206-726-4926

Vendors, please call 206-726-4926 ext.202

the
central

500 30th Ave. S.
Seattle, WA 98144



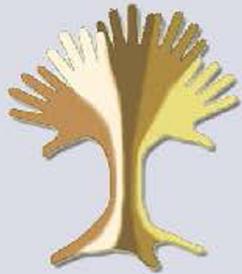
www.caa.wa.gov



www.healthequitty.wa.gov

YOU'RE

Invited!



**ATTORNEY GENERAL BOB FERGUSON and
OPEN DOORS FOR MULTICULTURAL FAMILIES**

invites you to a reception celebrating the

**AUTISM EQUAL
ACCESS GRANT**

When: **May 9th, 2013 at 3:30 pm**

Where: **Mt. Zion Baptist Church of Seattle
1634 19th Avenue
Seattle, WA 98122**

with Honorable Judge
Richard Jones,
Distinguished Guest



PLEASE RSVP: INFO@MULTICULTURALFAMILIES.ORG OR 425-771-8165

The Inequity in Breastfeeding Support Summit

The impact of institutional racism, power, and white privilege on breastfeeding rates and maternal child health.

A collaboration of the Breastfeeding Coalition of Washington, Mahogany Moms, Breastfeeding Coalition, Native American Breastfeeding Coalition of Washington, and community breastfeeding activists.

Register at www.brownpapertickets.com.

Search for inequity in breastfeeding support

Early bird registration (ends May 15): \$175

Regular registration (begins May 16): \$225

Registration includes:

- Breakfast, lunch and snack on both days of the conference
- Access to 2 pre-summit webinars on anti-racism and equity work on:

Tuesday, May 21st, 6-8pm PST

Tuesday, June 4th, 6-8pm PST

- IBCLC CERPS and RD CEUs have been applied for

**** A limited number of scholarships are available to cover registration.**

To apply for a scholarship, please e-mail inequitiesinbreastfeeding@gmail.com. **

The purpose of this conference is to collaborate, educate and act together as a community of breastfeeding supporters to learn about and counter institutional racism and social injustice in perinatal support services. The goals of this Summit:

- Raise awareness in the breastfeeding support community and other perinatal support fields, of significant health disparities between women of color and white women and the impact of racism, injustice, and white privilege on maternal-infant health services and outcomes.
- Facilitate the development of an action plan to address disparities and identify actions that individuals, organizations, and communities can take, in line with the Surgeon General's Call to Action.

WHEN:

Friday, June 21 and Saturday, June 22, 2013

8:30am-5:30pm both days. Registration and breakfast begin at 8am.

WHERE:

South Seattle Community College's Brockey Conference Center.

6000 16th Ave SW Seattle, WA 98106

To receive updates about the Summit, 'like' the [Facebook event page](#).

Register at [Brown Paper Tickets](#)

Register now and please help distribute widely.

Please e-mail inequityinbreastfeeding@gmail.com or call 206-281-8032 with questions.

