



## Proposed Final Agenda

Wednesday • September 11, 2013 • 10:00 a.m. – 4:30 p.m.  
Department of Health, Point Plaza East, Rooms 152/153  
310 Israel Road S.E., Tumwater, WA 98501

- 10:00 a.m. CALL TO ORDER & INTRODUCTIONS** Emma Medicine White Crow, Council Chair
- 10:05 a.m. 1. Approval of Agenda Emma Medicine White Crow, Council Chair  
—*Action*
- 10:10 a.m. 2. Approval of May 10, 2013 Minutes Emma Medicine White Crow, Council Chair  
—*Action*
- 10:15 a.m. 3. Announcements and Council Business Christy Hoff, Council Staff
- 10:30 a.m. 4. Discussion—Future Directions for Council Outreach and Engagement Emma Medicine White Crow, Council Chair  
Timothy Grisham, Council Staff  
Christy Hoff, Council Staff
- 11:15 a.m. 5. Briefing—State Partnership Grant, *Implementing National CLAS Standards in Washington State* Emma Medicine White Crow, Council Chair  
Don Martin, Department of Health  
Yris Lance, Council Staff  
Christy Hoff, Council Staff
- 12:00 p.m. **LUNCH**
- 1:00 p.m. 6. Public Comment
- 1:20 p.m. 7. Briefing—Governor's Health Priorities Emma Medicine White Crow, Council Chair  
Jason McGill, Governor's Executive Policy Office
- 2:00 p.m. 8. Briefing—Resources for Navigating the Healthcare System for the Newly Insured Emma Medicine White Crow, Council Chair  
Vazaskia Caldwell, Council Member  
Sarah Rafton, Seattle Children's Hospital  
Alison Robbins, Health Care Authority  
Yolanda Lovato, Department Social Health Services
- 2:45 p.m. **BREAK**
- 3:00 p.m. 9. Discussion—Future Priorities Emma Medicine White Crow, Council Chair  
—*Potential Action*  
Christy Hoff, Council Staff
- 4:00 p.m. 10. Council Member Announcements
- 4:30 p.m. ADJOURNMENT**

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 Sept. 6, 2012. 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

August 21, 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

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 grant proposal, "Yakima Valley Asthma Care Improvement Project". Asthma is a significant health concern for Hispanic children in Washington state. Nationally, over 7 million children are afflicted by asthma. Three million Hispanics live with asthma. Over the last 30 years, the asthma rates have doubled to more than 8% in the US population. Children and those living in poverty are more likely to have asthma and suffer from severe asthma attacks that lead to hospitalization.

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. We are excited to hear that you will be working with the Yakima Valley Farmworkers Clinic to implement this Hispanic Pediatric asthma study.

We hope for a successful grant application and look forward to hearing back about the data you have collected on this issue that impacts so many of our families in the Yakima Valley.

Best of luck to you!

Sincerely,

*Emma R. Medicine White Crow*

Emma Medicine White Crow, Chair



**DATE:** September 11, 2013

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

**FROM:** Emma Medicine White Crow, Chair

**SUBJECT: DISCUSSION—FUTURE DIRECTIONS FOR COUNCIL OUTREACH AND ENGAGEMENT**

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### **Background and Summary:**

Since September 1, 2007 the Council has received grant funds from the U.S. Department of Health and Human Services Office of Minority Health through its State Partnership Program to Improve Minority Health. The Council has used its grant funding to support its Community Relations Liaison position, its community outreach activities, and to support community-led events aimed at promoting health equity and reducing health disparities.

With its 2013 State Partnership Grant Program, the federal Office of Minority Health substantially limited the types of activities that states could apply for grant funding to implement. This has a significant impact on the Council as we can no longer rely on these resources to fund the Council's general community outreach and engagement efforts.

During this agenda item, I've asked Council staff to share their plans for reshaping the Council's outreach and engagement strategies and developing a communications plan for moving forward. Following the staff presentation I invite Council members to share their suggestions for ensuring effective outreach and meaningful community engagement, particularly with limited resources. I ask Council members to consider how collectively we can all work together to ensure our linkages and partnerships with the communities we serve stay strong into the future.

### **Recommended Council Action:**

No recommended action at this time.

# FUTURE DIRECTIONS FOR COUNCIL OUTREACH & ENGAGEMENT

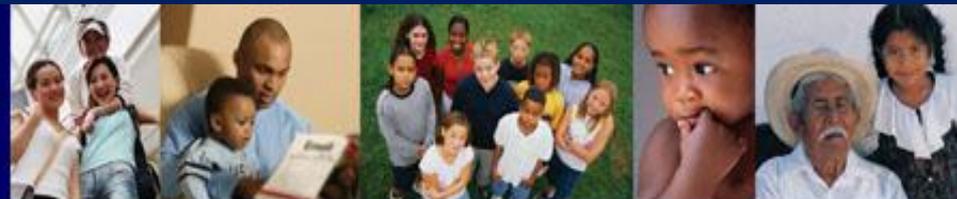
Timothy Grisham & Christy Hoff

Governor's Interagency Council on Health Disparities

September 11, 2013

*HealthEquity.wa.gov*

Governor's Interagency Council on Health Disparities



# Presentation Overview

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- State Partnership Program
- Future Communications Planning
  - Web site
  - Facebook, Twitter
- Council Discussion

# State Partnership Program

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- **First round funding: 2007-2010**
  - Develop the capacity to effectively communicate with diverse communities
  - Support Council outreach and engagement
- **Second round funding: 2010-2013**
  - Develop community partnerships to promote health equity and reduce disparities
  - Support Council outreach and engagement
- **Third round funding: 2013-2015**
  - Promote the adoption of the enhanced National CLAS Standards

# State Partnership Program

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Past outreach and engagement strategies:

- Sharing information and resources
- Creating linkages
- Obtaining input (surveys, testimony)
- Supporting community events (financial & staff support)
- Sharing in decision making (advisory committees)

# Future Communications Planning

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## Utilizing the Internet for Outreach:

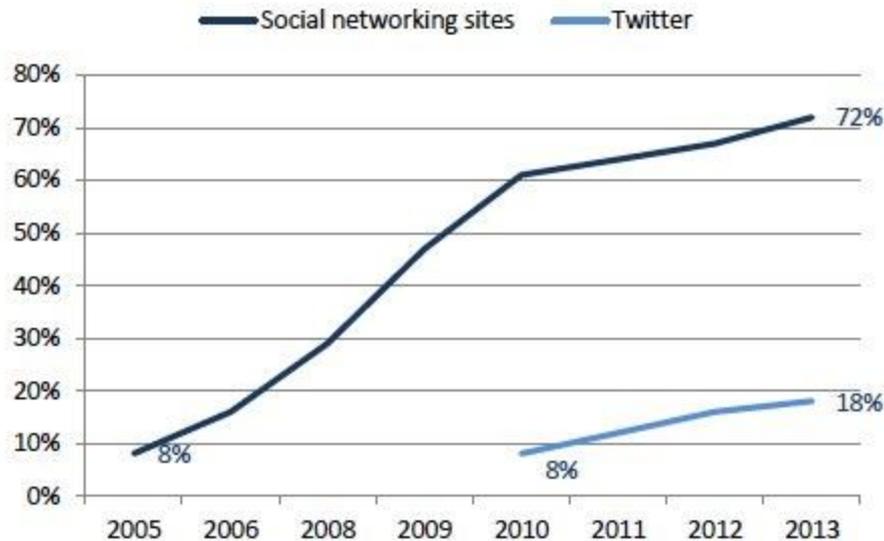
- Demographic information on online usage
- Twitter as a tool for info sharing and networking
- Facebook as a tool for info sharing and networking
- Overview of the new [Healthequity.wa.gov](http://Healthequity.wa.gov) website

# Future Communications Planning

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## Adult use of social networking sites and Twitter—change over time

*% of adult internet users who use social networking sites or Twitter, over time*



Source: Pew Research Center's Internet & American Life Project tracking surveys 2005-2013. Spring Tracking Survey, April 17 – May 19, 2013. N=1,895 adult internet users ages 18+. Interviews were conducted in English and Spanish and on landline and cell phones. The margin of error for results based on all internet users is +/- 2.5 percentage points.

# Future Communications Planning

## Who uses social networking sites

*% of internet users within each group who use social networking sites*

	All internet users (n=1,895)	72%
a	Men (n=874)	70
b	Women (n=1,021)	74
<b>Race/ethnicity</b>		
a	White, Non-Hispanic (n=1,331)	70
b	Black, Non-Hispanic (n=207)	75
c	Hispanic (n=196)	80 <sup>a</sup>
<b>Age</b>		
a	18-29 (n=395)	89 <sup>bcd</sup>
b	30-49 (n=542)	78 <sup>cd</sup>
c	50-64 (n=553)	60 <sup>d</sup>
d	65+ (n=356)	43
<b>Education level</b>		
a	No high school diploma (n=99)	67
b	High school grad (n=473)	72
c	Some College (n=517)	73
d	College + (n=790)	72
<b>Annual household income</b>		
a	Less than \$30,000/yr (n=417)	75
b	\$30,000-\$49,999 (n=320)	72
c	\$50,000-\$74,999 (n=279)	74
d	\$75,000+ (n=559)	71
<b>Urbanity</b>		
a	Urban (n=649)	74
b	Suburban (n=893)	71
c	Rural (n=351)	69

Source: Pew Research Center's Internet & American Life Project Spring Tracking Survey, April 17 – May 19, 2013. N=1,895 adult internet users ages 18+. Interviews were conducted in English and Spanish and on landline and cell phones. The margin of error for results based on all internet users is +/- 2.5 percentage points.

Note: Percentages marked with a superscript letter (e.g., <sup>a</sup>) indicate a statistically significant difference between that row and the row designated by that superscript letter, among categories of each demographic characteristic (e.g. age).

# Future Communications Planning

Young adults are more likely to:

- Use online means for participating in politics
- Be early adopters of emerging applications or social platforms
- Operate with great independence in opinion
- Participate to facilitate a renegotiation of power and control of traditional political structures
- Use more creativity in voice
- Use social media to network and mobilize

# Future Communications Planning

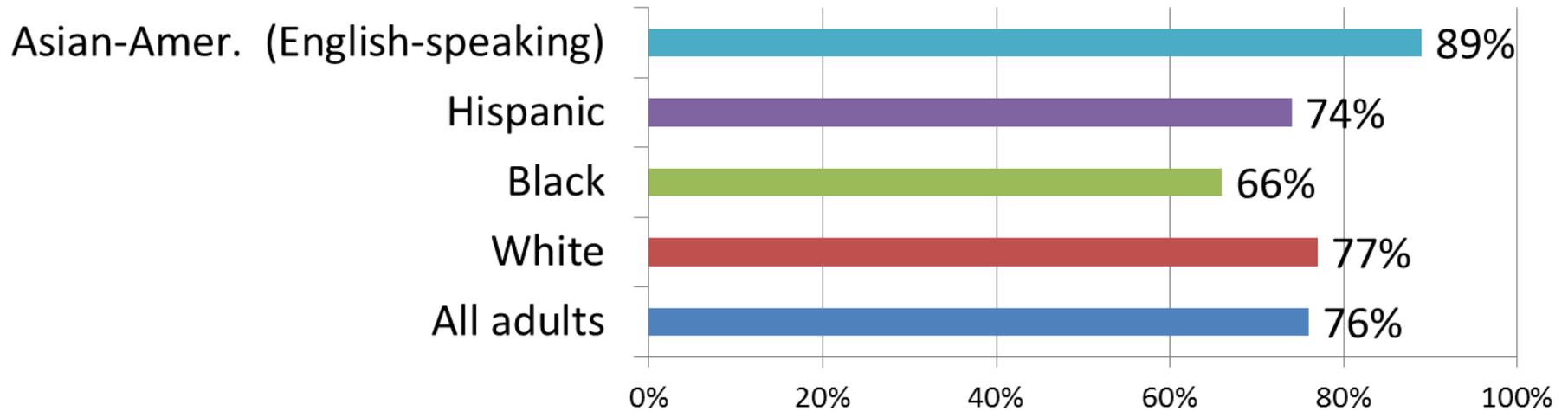
“Contrary to the traditional notion of a technological digital divide, the YPP study finds young people across racial and ethnic groups are connected online. (98 percent) youth report having access to a computer that connects to the Internet. (57 percent), Latino (49 percent), and Asian American (52 percent) youth report sending messages, sharing status updates and links, or chatting online daily.” – New Media and Youth Political Action

# Future Communications Planning

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## Asian-American Internet Usage

### Online "yesterday"

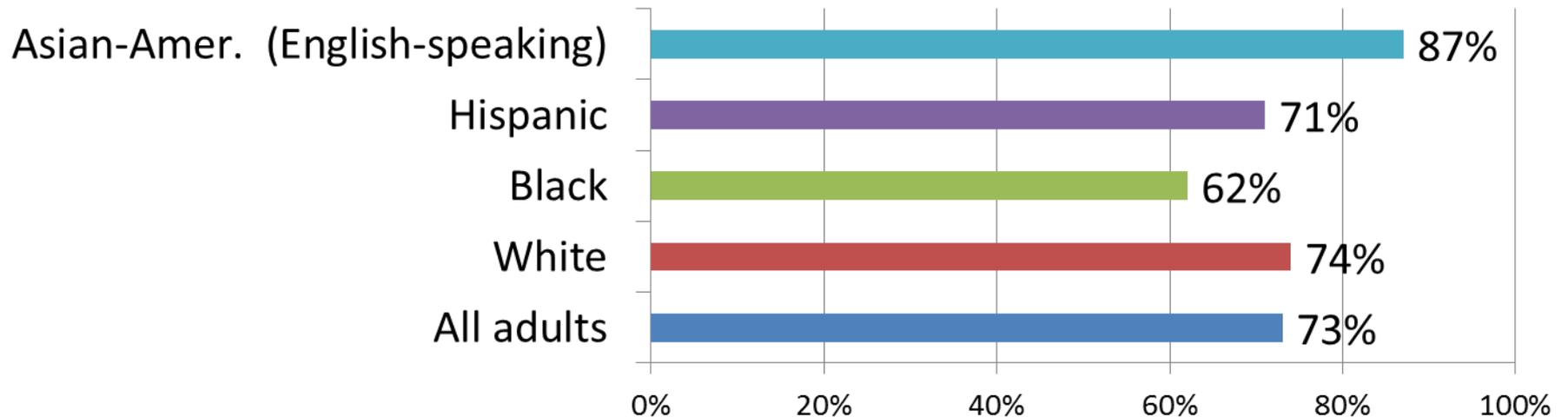


# Future Communications Planning

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## Asian-American Internet Usage

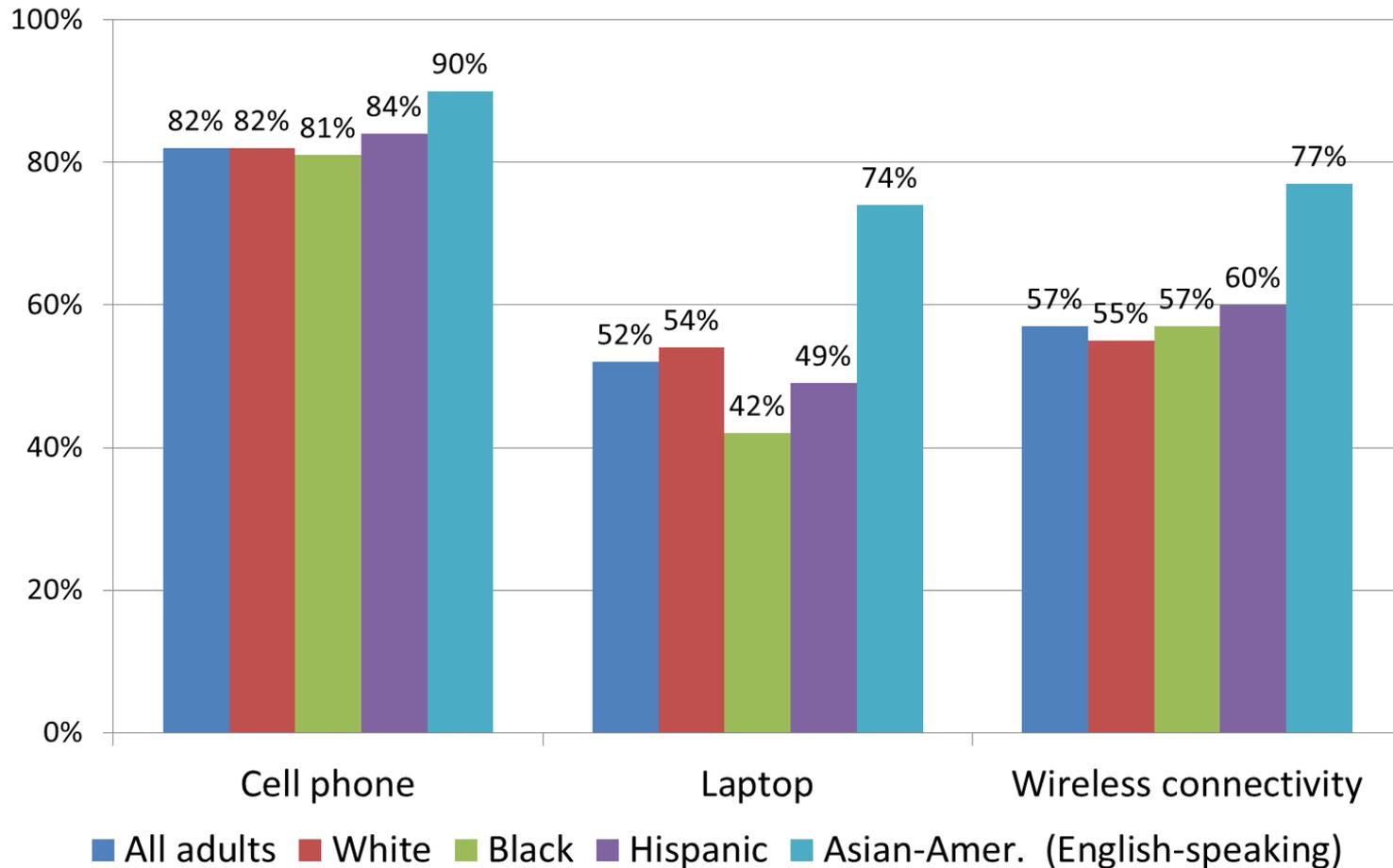
### Online every day



# Future Communications Planning

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## Asian-American Internet Usage



# Future Communications Planning

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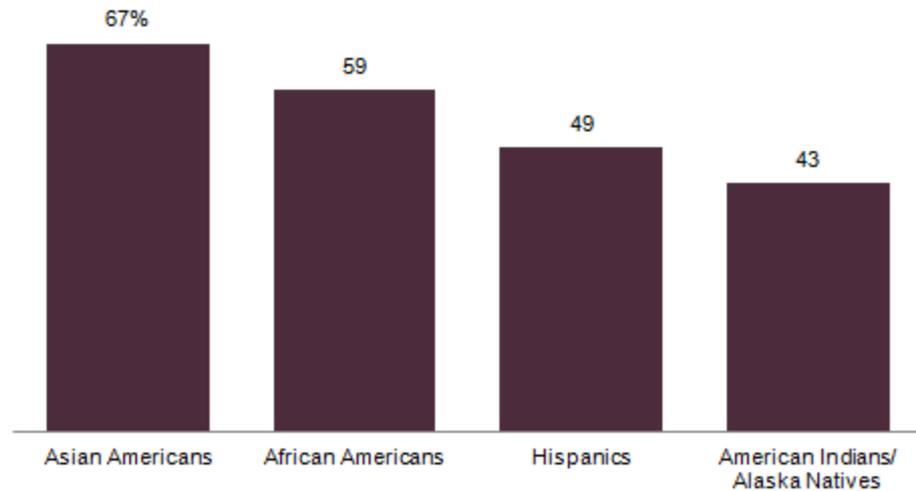
- Young, relatively well-off, Asian-American men are most likely to be wireless
- Not quite as much texting and instant messaging as Blacks, Hispanic/Latinos
- Equivalent browsing and email usage as Blacks, Hispanic/Latinos

# Future Communications Planning

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## Broadband Adoption Among Native Americans Is Lower Than Other Demographic Groups

*Adoption Rates in Percentage*



Source: National Broadband Plan and Telecommunications and Information Administration

PEW RESEARCH CENTER'S PROJECT FOR EXCELLENCE IN JOURNALISM  
2012 STATE OF THE NEWS MEDIA

# Future Communications Planning

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- Lower economic status = lower broadband access
- Federal stimulus grant created to help offset digital divide
- Increase in cellphone use to access internet, cellphone apps more utilized than websites

# Future Communications Planning

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- Launch Twitter and begin tweeting both Council specific, and re-tweeting related, content
- Reach non-traditional audiences
- Enables the Council for online collaborative messaging and info sharing with partners

# Future Communications Planning

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# twitter

 **WA Board of Health** @WASBOH 1h  
Help make the Health Equity brand now, vote on your fav mock-logo for the health disparities council #PublicHealth4WA  
[pic.twitter.com/ijLusfvZs9](https://pic.twitter.com/ijLusfvZs9)  
[View photo](#)

 **Hayden Mack** @haydenmack 1h  
.@WASBOH A couple of those look like the Nigerian flag  
[Expand](#)

 **WA Board of Health** @WASBOH 32m  
.@haydenmack U think so? I thought the Nigerian flag had vertical stripes not horizontal gradient stripes. Thanks 4 the feedback, it helps!  
[Expand](#)

 **Hayden Mack** @haydenmack 30m  
@WASBOH You know your flags! The flag of Herzogtum Sachsen-Coburg-Gotha (1911-1920) on the other hand... [bit.ly/1abEEqa](https://bit.ly/1abEEqa)  
[Expand](#)

 **WA Board of Health** @WASBOH 19m  
@haydenmack LOL! We'll take the slightly out of date, obscure flag as a point of reference. You win this round Hayden Mack!  
[Hide conversation](#) [Reply](#) [Delete](#) [Favorite](#) [More](#)

12:44 PM - 25 Jun 13 · [Details](#)

# Future Communications Planning

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# twitter

 **WA Board of Health** @WASBOH 13 Aug  
Would this new app [n.pr/13yiC9W](https://n.pr/13yiC9W) break WA food services rules? [apps.leg.wa.gov/WAC/default.aspx](https://apps.leg.wa.gov/WAC/default.aspx)... Perhaps? You can check it out!  
#FoodSafety  
[Hide summary](#) [Reply](#) [Delete](#) [Favorite](#) [More](#)

 **NPR News**  
**A New App Will Let You Share Your Leftovers With Strangers : NPR**  
As part of a bid to reduce wasted food, two former college roommates have come up with Leftover Swap, an app in which you post photos of leftovers for other users to claim.  
[View on web](#)

**1** RETWEET 

1:39 PM - 13 Aug 13 · Details [Flag media](#)

Reply to @WASBOH

 **LeftoverSwap** @leftoverswap 13 Aug  
[@WASBOH](#) wait...do we? Shouldn't you know? We'd really like to know... We don't think we do... But do we? Only answer if it's good news.  
[Expand](#)

 **WA Board of Health** @WASBOH 42s  
[@leftoverswap](#) Sorry to say, it would break WA food services rules according 2 WAC 246-215. Thanks 4 the question!  
[Expand](#)

# Future Communications Planning

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twitter

So Close You Can Smell It



 WASHINGTON STATE  
BOARD OF HEALTH  
Working for a safer and healthier Washington since 1889

# Future Communications Planning

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**WA Board of Health @WASBOH** 17 Jul  
It's live!!!! #PublicHealth4WA sboh.wa.gov  
[pic.twitter.com/wkGlqQDhMk](http://pic.twitter.com/wkGlqQDhMk)  
[View photo](#)

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**Public Health WA @WSALPHO** 17 Jul  
 **@WASBOH** Looks great! Nicely done SBOH team.  
[Hide conversation](#) [Reply](#) [Retweet](#) [Favorited](#) [More](#)

**1**  
FAVORITE 

---

4:32 PM - 17 Jul 13 · [Details](#)

Reply to [@WSALPHO](#)

---

**WA Board of Health @WASBOH** 18 Jul  
 **"@WSALPHO: @WASBOH** Looks great! Nicely done SBOH team."  
Thanks!  
[Expand](#)

# Future Communications Planning

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# facebook



Sandi

I AM TRYING TO FIND THE IMMUNIZATION RECORDS FOR KATHLEEN WHO WAS BORN IN WASHINGTON STATE ON JANUARY 25, 1956 TO Rita



Washington State Board of Health

Sandi

Than you for reaching out to the Washington State Board of Health via Facebook.

Unfortunantly the Washington State Board of Health does not keep shot records. Washington State Board of Health is a rule-making body with a wide statutory authority to make rules regulating our public health system.

The following is a link on how to request a public record:  
<http://sboh.wa.gov/HowDoI/RequestPublicRecords.aspx>

I am providing this, because the procedure will be similar with any state agency you contact in the State of Washington.

Two places I would check for information would be:  
<https://fortress.wa.gov/doh/cpir/iweb/>

which is a immunization registry.

or ask for guidance from:  
<http://www.doh.wa.gov/LicensesPermitsandCertificates/BirthDeathMarriageandDivorce.aspx>

which is the Department of Health's vital records section.

You may come up against HIPAA (privacy) issues. So I would get aquainted with that: <http://www.hhs.gov/ocr/privacy/>

The very simplified version, is you have to have permission to view health records of an individual.

For more information about the Board of Health, please visit our newly-redesigned webpage: <http://sboh.wa.gov/>

# Future Communications Planning

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The screenshot displays the website for the Governor's Interagency Council on Health Disparities. At the top left is the logo with a green map of Washington and the text "HEALTH EQUITY Governor's Interagency Council on Health Disparities". To the right are navigation links for "Home" and "Topics A-Z", and a search box. Below this is a horizontal menu with "About Us", "The Council's Work", "Council Meetings", "Council Documents", and "Help".

The main content area features a large photograph of a smiling family (a woman, a man, and a young child) sitting together. To the right of the photo is an "Announcements" section with the following text:

**Announcements**  
**The Washington State Board of Health is hiring!**  
*Publish Date: Wednesday, August 14, 2013*  
The Washington State Board of Health is seeking a public health or public policy professional with experience in research and policy analysis to serve as the Board's technical specialist for Health Impact Reviews. Health Impact Reviews are analyses of proposed legislative or budgetary proposals to determine the effect of the proposals on health disparities. This position will also provide health policy research to the Board and the Governor's Interagency Council on Health Disparities.

You can view the complete position announcement and apply via [careers.wa.gov](http://careers.wa.gov) by following the provided link: <http://bit.ly/14zpwee>

Below this is another announcement:

**Improving the Health and Well-Being of Latinas Symposiums**  
*Publish Date: Tuesday, August 13, 2013*  
Improving the Health and Well-Being of Latinas: Tools for Public Health and Social Services is holding two symposiums.

- Thursday, September 5, 2013 in Seattle, WA
- Thursday September 19, 2013 in Granger, WA

The registration deadline: August 30, 2013. [REGISTER HERE](#)

On the left side of the main content area, there are two sections:

**Quick Links**

- September 11 - Our Next Meeting
- Press Releases

**Partners**

- Washington State Board of Health
- Washington State Department of Health
- Local Health Jurisdictions
- Washington State Association of Public Health Officials
- Access Washington

At the bottom of the page, there is a dark blue footer bar containing the text "Copyright 2013 by Washington State Board of Health" on the left and "Privacy Notice" on the right.

# Future Communications Planning

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The screenshot shows the website for the Health Equity Governor's Interagency Council on Health Disparities. The header includes the organization's name and logo, a navigation menu with links for 'About Us', 'The Council's Work', 'Council Meetings', 'Council Documents', and 'Help', and a search bar. A red arrow points from the 'Council Documents' link to a hiring announcement. The announcement is titled 'The Washington State Board of Health is hiring!' and is dated Wednesday, August 14, 2013. The text describes a position for a public health or public policy professional. Below the announcement, there are sections for 'Quick Links' and 'Partners'. The footer contains copyright information and a privacy notice.

**HEALTH EQUITY**  
Governor's Interagency Council on Health Disparities

Home | Topics A-Z

Search

About Us | The Council's Work | Council Meetings | Council Documents | Help

## Announcements

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### Improving the Health and Well-Being of Latinas Symposiums

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- Press Releases

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- Washington State Department of Health
- Local Health Jurisdictions
- Washington State Association of Public Health Officials
- Access Washington

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Privacy Notice

# Future Communications Planning

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The screenshot displays the website for the Washington State Board of Health's Health Equity program. The header includes the logo, navigation links (Home, Topics A-Z, Search), and a menu with categories: About Us, The Council's Work, Council Meetings, Council Documents, and Help. A red arrow points to the 'Council Documents' link. The main content area features a large photo of a family and several text-based announcements. The first announcement is a hiring notice for a technical specialist for Health Impact Reviews, published on August 14, 2013. The second announcement is about symposiums for improving the health of Latinas, published on August 13, 2013, with specific dates in Seattle and Granger, WA. Below the announcements are sections for 'Quick Links' and 'Partners'.

**HEALTH EQUITY**  
Governor's Interagency Council on Health Disparities

Home | Topics A-Z | Search

About Us | The Council's Work | Council Meetings | **Council Documents** | Help

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- Washington State Department of Health
- Local Health Jurisdictions
- Washington State Association of Public Health Officials
- Access Washington

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# Future Communications Planning

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## Resources

- <http://bit.ly/1bDXW5I>
- <http://bit.ly/14GybM0>
- <http://bit.ly/16UnOch>
- <http://healthequity.wa.gov>

# Council Discussion

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- How do we ensure effective community outreach?
- How do we ensure meaningful community engagement?
- Other thoughts?

# Enhanced CLAS Standards

## Cultural Competency and Language Access

Don Martin

Health Promotion Practice and Policy  
Prevention and Community Health

# Definitions

- **Limited English Proficiency**—speaking, hearing or reading English less than “very well” or insufficiently to ensure equal access to public services without language assistance
- **Language assistance (access)**—interpretation (spoken or signed) and translation (written)
- **CLAS**—Culturally and Linguistically Appropriate Services that are respectful and responsive to cultural practices, language, literacy, and communication needs

# Civil Rights Act of 1964

## Title VI

No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

**Department of Justice**  
**35+ years of judicial rulings**

**Executive Order 13166**  
**Since 2000—Clinton, Bush, Obama**

**Federal Agency Guidance**  
**USDHHS—Office of Minority Health**

# 4 Factors—Reasonable Balance

1. Number or proportion of populations with limited English
2. Frequency that people with limited English come in contact with the program
3. The importance of the program to people's lives and well-being
4. Resources to provide language access

# National CLAS Standards Initiative

- 2000: Original 14 CLAS Standards issued public comment, advisory committee, literature review
- 2010-2012: OMH analysis, committee work, project teams, publication
- 2013: Enhanced CLAS Standards and Blueprint for Implementation

# Statement of Intent

**The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations.**

# Enhanced CLAS Standards help:

- To respond to demographic changes
- To eliminate long-standing disparities
- To improve quality of services and outcomes
- To meet legislative and accreditation mandates
- To gain a competitive edge in the market place
- To decrease likelihood of liability claims

# 15 Enhanced CLAS Standards

## Themes

- Principal Standard (1)
- Governance, Leadership, Workforce (2-4)
- Communication and Language Assistance (5-8)
- Engagement, Improvement, Accountability (9-15)

# Principal Standard

**Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred language, health literacy, and other communication needs.**

# Governance, Leadership, and Workforce



# Communication and Language Assistance



# Engagement, Continuous Improvement, and Accountability



## Consider this:

Pew Research Center predicts that more than 80 percent of the country's population growth during the next half century will be due to immigration.



# Resources:

- **Enhanced CLAS Standards and the Blueprint for Advancing and Sustaining CLAS Policy and Practice**  
Think Cultural Health  
<https://www.thinkculturalhealth.hhs.gov/>
- **Limited English Proficiency—A Federal Interagency Website**  
U.S. Department of Justice  
<http://www.justice.gov/crt/lep/>
- **Don Martin, Health Educator**  
DOH Health Promotion Practice and Policy Section  
[don.martin@doh.wa.gov](mailto:don.martin@doh.wa.gov)

# Enhanced Standards for Culturally and Linguistically Appropriate Services 2013

## Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

## Governance, Leadership and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

- Promote CLAS at all levels of the agency
- Build a diverse workforce
- Develop skills in CLAS

## Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

- Offer language assistance
- Inform people they can get assistance
- Ensure competence of those providing language services
- Provide easy-to-understand materials

## Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

- Infuse CLAS in planning and operations
- Conduct organizational assessments
- Collect and maintain demographic and language data
- Assess community assets and needs
- Partner with the community
- Create grievance processes
- Communicate progress on CLAS

## Examples of Implementation Strategies

### Standard 1: Principal Standard

- All the strategies below for each of the others standards contribute to achieving the Principal Standard.
- Generally, HHS recommends establishing a cross-departmental or interdisciplinary group to develop, sustain, and monitor an overall plan

### Standard 2: Promote CLAS at All Levels of the Agency

- Sustain an environment of cultural competency
- Identify champions in the agency
- Commit to cultural competency in mission and vision statements
- Recruit and retain a diverse workforce and leadership
- Create policies and systems to support CLAS
- Allocate resources to achieve CLAS

### Standard 3: Build a Diverse Workforce

- Advertise job openings in multiple languages
- Develop relationships with schools, trade programs, related organizations
- Collaborate with public schools, state colleges and universities
- Cultivate relationships with organizations, agencies, and institutions that offer health career training and internships
- Assess staff language proficiency
- Promote continuing education
- Assess and monitor assignments and workload of staff providing language services
- Promote mentoring and coaching
- Cultivate staff at all levels as “cultural brokers”

### Standard 4: Develop Skills in CLAS

- Engage in dialog on meeting unique needs of state populations
- Conduct in-service training
- Leverage resources for improving skills
- Incorporate CLAS in evaluating all staff
- Schedule regular formal and informal training sessions
- Evaluate and improve training sessions
- Publicize available training

**Standard 5: Offer Language Assistance**

- Ensure staff know and are trained in language services
- Develop processes and systems for identifying a person's language needs ("I speak" cards)
- Use qualified translators and interpreters
- Establish contracts for a variety of language services
- Use cultural brokers

**Standard 6: Inform People of the Availability of Language Assistance**

- Determine appropriate messages and media
- State that assistance is free
- Ensure notification is appropriate for low-literacy audiences
- Conduct outreach to community organizations and non-English media
- Train staff who serve as initial points of contact with the LEP public
- Offer written notification at points of contact

**Standard 7: Ensure Competence of Individuals Providing Language Assistance**

- Follow a standard and rating scale for proficiency
- Assess services and individual skills
- Use multiple systems and models depending on needs of the agency

**Standard 8: Provide Easy-to-Understand Materials and Signs**

- Establish priorities and a plan (using the 4 Factors)
- Use plain-talk models and guidelines for low-literacy audiences
- Create easy to use and understand forms
- Work with libraries to provide priority materials
- Formalize processes and systems for translation
- Develop materials in alternative formats
- Test materials and messages with the audiences in their native language

**Standard 9: Infuse CLAS in Planning and Operations**

- Allocate resources to development and implementation of services
- Establish training requirements
- Identify champions and advocates
- Set goals and timetables
- Establish accountability mechanisms
- Gather data on plans and accomplishments
- Involve LEP populations in strategic plans

**Standard 10: Conduct Organizational Assessments**

- Use or adapt established organizational assessment tools
- Integrate with performance and quality improvement measures
- Identify assets, opportunities, and areas needing improvement
- Create plans and time lines
- Identify various metrics and outcome goals

**Standard 11: Collect and Maintain Demographic Data**

- Identify a standard for data collection for all programs
- Consider federal guidelines for the content, collection, use, and maintenance of data
- Include state populations, individuals served, and agency staff

**Standard 12: Assess Partner and Community Needs**

- Partner on data sharing and linking
- Collaborate on data collection and analysis
- Review demographic data available
- Conduct formative research (such as focus groups and interviews)
- Describe the types, sources, and quality of data
- Describe what matters to the community and stakeholders
- Describe evidence indicating that a problem or goal should be a priority
- Identify barriers and resources to address problems or goals

**Standard 13: Partner with the Community**

- Establish connections with community media
- Build relations, coalitions with organizations
- Hold community meetings, discussion groups, etc.
- Identify and cultivate outside cultural brokers
- Identify, build relations, and train community health workers

**Standard 14: Create Conflict Resolution and Grievance Processes**

- Provide cross-cultural communication training including how to work with interpreters
- Notify people of their right to file a complaint
- Add culture and language to other grievance processes
- Get regular feedback

**Standard 15: Communicate Progress on CLAS**

- Provide data on demographics, language services, staff trained, expenditures and savings
- Make available reports on completed assessments, major projects, community involvement
- Report improvements and outcomes

## Key Definitions: Blueprint for Advancing and Sustaining CLAS Policy and Practice

### Cultural Competency

A developmental process in which individuals or institutions achieve increasing levels of awareness, knowledge, and skill along a cultural competence continuum. Cultural competence involves valuing diversity, conducting self-assessments, avoiding stereotypes, managing the dynamics of difference, acquiring and institutionalizing cultural knowledge, and adapting to diversity and cultural contexts in communities.

### Culture

The integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups as well as religious, spiritual, biological, geographical, or sociological characteristics. Culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetimes.

Elements of culture include, but are not limited to, the following:

- Age
- Cognitive ability or limitations
- Country of origin
- Degree of acculturation
- Educational level attained
- Environment and surroundings
- Family and household composition
- Gender identity
- Generation
- Health practices, including traditional healer techniques such as Reiki and acupuncture
- Linguistic characteristics, including language(s) spoken, written, or signed; dialects or regional variants; literacy levels; and other related communication needs
- Military affiliation
- Occupational groups
- Perceptions of health and well-being and related practices
- Perceptions/beliefs regarding diet and nutrition
- Physical ability or limitations
- Political beliefs
- Racial and ethnic groups, including—but not limited to—those defined by the U.S. Census Bureau
- Religious and spiritual characteristics, including beliefs, practices, and support systems related to how an individual finds and defines meaning in his/her life
- Residence (i.e., urban, rural, or suburban)
- Sex
- Sexual orientation
- Socioeconomic status

**Health Disparity**

A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

**Health Equity**

Attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally, with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

# STATE PARTNERSHIP GRANT: Implementing National CLAS Standards in Washington State

Governor's Interagency Council on Health Disparities  
September 11, 2013

*HealthEquity.wa.gov*

Governor's Interagency Council on Health Disparities



# Why a Focus on CLAS Standards?

2

- Office of Minority Health priority
- Council priority
- Council responsibility

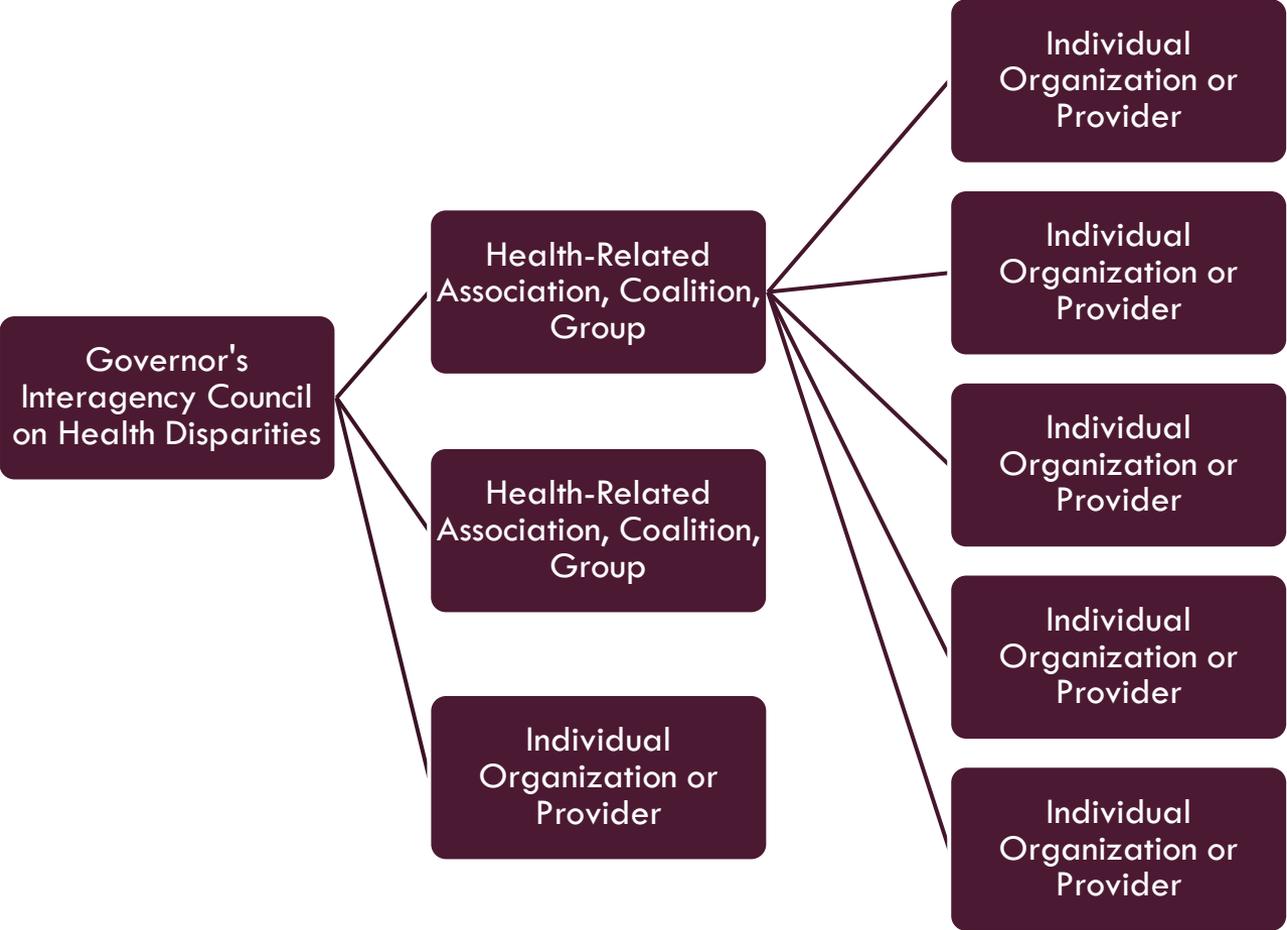
*RCW 43.20.275(3): The council with assistance from the state board, shall assess through public hearings, review of existing data, and other means, and recommend initiatives for improving the availability of culturally appropriate health literature and interpretive services within public and private health-related agencies.*

# Project Overview

3

- Develop project partnerships
- Collect baseline data
- Provide information, resources, training, and technical assistance
- Track progress toward implementation
  - Accountable for increasing adoption of the CLAS standards by 10% per year.

# Project Partnerships



# Council Discussion

5

- Questions?
- Ideas for Project Partners?
- Other Suggestions?

Dear Emma and members of the Council on Health Disparities:

As a community Pediatrician and alternate member of this Council I wish to endorse the letter from my fellow WCAAP members.

Quality preventive care for children should be held to the best evidence- based standards for all children including those on Medicaid Apple Health for Kids.

I trust that the Council will hear with great interest and suggest ways to help implement this principle.

It is a pleasure, an honor and a great learning experience to have served in the Council.

Regards to all my friends there.

Diana.

Diana Lindner MD, FAAP.  
7240 86 AVE SE Mercer Island, WA 98040



August 29, 2013

To Members of the Health Disparities Council:

Re: Standard of Preventive Care for Children

The Washington Chapter of the American Academy of Pediatrics would like to stress the importance of having Washington State EPSDT for Medicaid/Apple Health match the standard schedule of preventive services called Bright Futures. This standard is recognized federally as the standard of care in the Affordable Care Act and as the standard benefit in Washington State's Health Benefit Exchange.

Currently 46% of Washington State children are on Medicaid Apple Health for Kids administered through managed care companies. More than 100,000 children are still uninsured and potentially eligible for the Health Benefit Exchange. Approximately 32% of children on Medicaid/Apple Health are children of color, 26% are in single parent homes and 8.3% of children on Medicaid have fair to poor health compared to 1.1% of children with private commercial insurance.

Currently primary care physicians in Washington State are being asked to provide 2 standards of preventive care for our children: Bright Futures for privately insured children and fewer visits without developmental or autism screening to those on Apple Health.

The additional services that need to be covered for our state Medicaid program to match Bright Futures are:

- newborn, 15-month and 30-month exams;
- yearly exams after age 6;
- developmental screens at 9, 18 and 24-30 months of age; and
- autism screening at 18 and 24 months. (See attachment)

Bright Futures was launched 22 years ago and developed out of the federal Health Resources Service Administration with involvement of over 30 stakeholder groups and expert panels. The recommendations are evidence-based and evidence-informed.

Quality preventive care for children in health homes is a smart investment that can reap lifespan cost savings in healthcare and educational budgets today and in the future.

Sincerely,

A handwritten signature in black ink that reads 'Maggie E. Hood, MD'.

Maggie Hood, MD, FAAP  
President, WCAAP

A handwritten signature in black ink that reads 'Beth Harvey, MD'.

Beth Harvey, MD, FAAP  
Past President, WCAAP

**Bright Futures for All of Washington's Children**  
*The nationally-recognized standard of preventive care for children*

**Well Child Visit Schedule**

Age	Washington Medicaid EPSDT	Bright Futures
Birth to 11 months	5 visits	6 visits
12-24 months	3 visits	4 visits
30 months	No visits	1 visit
3-6 years	Annual visits	Annual visits
7-20 years	Biennial visits	Annual visits

**Screening Schedule**

Age	Washington Medicaid	Bright Futures
18 and 24 month autism screens	Not covered	Recommended
9, 18 and 24-30 month developmental screens	Not covered, unless performed by a developmental psychologist	Recommended

***CPT code 96110 used for autism, developmental and mental health screens is only paid to psychologists by Washington State Medicaid***

**About Bright Futures**

Bright Futures (BF)<sup>i</sup>, the nationally recognized standard of preventive care for children, was launched in 1990 and developed out of the federal Health Resources Service Administration with involvement of over 30 stakeholder groups and expert panels. The Affordable Care Act recognized *Bright Futures: Guidelines for Health Supervision for Infants, Children and Adolescents, 3<sup>rd</sup> Edition* as the authoritative standard for pediatric preventive health insurance coverage, requiring all private plans to cover BF preventive services without patient/family cost-sharing.<sup>ii</sup> Washington Healthplan Finder (our health benefit exchange) recommends using BF guidelines as the standard for essential health benefits in Washington State.

**Bright Futures in Other States**

The AAP recommends BF should be part of the final coverage rules for Medicaid.<sup>iii</sup> Most other states already use BF as their standard for Medicaid EPSDT schedules. Thirty states completely cover the BF schedule; six cover all but the 30 month check-up and six cover all but developmental and autism screening. Washington is lagging behind other states by not covering the BF standard of care.

### Research Shows Results

In Colorado's Medical Homes for Children Initiative they used BF as their standard and found that children in medical homes had lower emergency room admissions and more well-child visits than children not in medical homes. This resulted in state costs that were 22% lower, with more preventive care provided.<sup>iv</sup>

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<sup>i</sup> <http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf>

<sup>ii</sup> [http://www.amchp.org/AboutAMCHP/Newsletters/Pulse/June 2011/Pages/Feature2.aspx](http://www.amchp.org/AboutAMCHP/Newsletters/Pulse/June%202011/Pages/Feature2.aspx)

<sup>iii</sup> <http://aapnews.aappublications.org/content/31/12/9.full>

<sup>iv</sup> S.Silow-Carroll, J. Bitterman, "Colorado Children's Healthcare Access Program: Helping Pediatric Practices Become Medical Homes for Low-Income Children" Case Study The Commonwealth Fund June 2010

Hello, Ms. Medicine White Crow,

I am writing to you because you are the Chair of the Governor's Interagency Council on Health Disparities, and I believe you and this council should be aware of an Environmental Justice and health disparity concern in Longview, WA.

I am sure you are aware of the proposed coal export terminals in Washington by Millennium Bulk Terminals in Longview and Pacific International Terminals in Bellingham. These terminals would ship over 100 million metric tons of coal per year to China. In Longview, the terminal would bring with it 16 coal trains passing through our communities per day - 8 full and 8 empty.

I am not writing to just inform you about the coal; I am writing to tell you how this will impact a particular Environmental Justice community in Longview, WA. My name is Dawn Hanson and I am a resident and landlord in the Highlands neighborhood in the City of Longview, about one mile from the proposed coal terminal and adjacent to the rail line that leads into the terminal. I am also a registered nurse, public health professional and urban planner by education and trade.

The Highlands neighborhood sits on the South end of the City of Longview within a half-mile of the Columbia River. Industrial lands separate the Highland's community from the Columbia River to the south with additional heavy industrial land uses located immediately to the west and east of the neighborhood (*See map of TRI sites below*). Most of the industries that surround the Highlands' Community are EPA Toxic Release Inventory (TRI) Sites. EPA TRI data indicates that directly across the street from the neighborhood is one of the biggest emitters of air and surface water pollutants in WA State – Weyerhaeuser.

MBT is proposing a coal terminal about one mile from the neighborhood. An estimated eight additional trains per day carrying coal to the facility **will pass by the neighborhood** on its southern boundary, and the same eight trains will pass in the opposite direction once they are empty. Coal dust from the export facility and the trains, diesel train emissions, and extra air pollution emissions from trucks and automobiles idling at train crossings will increase harmful exposures and worsen health disparities in the Highlands. Particulate Matter from rail and truck traffic contributes to heart disease, lung disease, and coal dust contributes to lung disease and asthma, and neurological health concerns related to the exposure of toxic heavy metals, such as mercury - all of which are concerning for a population that already has disparate poor health outcomes and disproportionate exposure to pollutants.

The Highlands neighborhood holds a much higher percentage of: a) persons living below the poverty line; b) Hispanic population; c) minority population; and d) population under the age of 18 in comparison to the City of Longview, Cowlitz County, and Washington State (*See chart below*). The residents of Highlands already experience disproportionate poor health outcomes with respiratory illnesses, cancer, and heart disease in comparison to their more affluent counterparts and other Cowlitz County communities. Adding another polluting industry in the vicinity of the neighborhood will only make their health concerns worsen.

All citizens, regardless of their ethnicity or socioeconomic status, should **equally** share the environmental amenities and the burdens of environmental health hazards. The proposed

terminal will cause the Highlands community to once again be overburdened with the health hazards, a form of *injustice* and *unfairness*.

Please bring this to the attention of your council and the governor! ***This injustice should not be tolerated or accepted.*** You could say that 100 years ago when the pulp and paper mill were built that we were not aware of the effects that it could have on those living nearby but today, we know! We have the knowledge on how heavy industries affect nearby communities, and we know that this particular industry will have a disproportionate negative effect on the health of nearby low-income and minority residents - this cannot be tolerated.

The health impacts (asthma, heart disease, and cancer) that the proposed coal terminal, coal dust, additional trains, and idling traffic can have on the Highlands neighborhood in comparison to other communities in Washington and Cowlitz County should be studied thoroughly! This should include an in-depth asthma survey and study in the neighborhood, and other neighborhoods for comparison.

I urge you to take action and speak up on this issue. I would be happy to discuss this further with you, if you'd like.

Best,

Dawn Hanson, resident of the Highlands Neighborhood and City of Longview

[hansondawny@gmail.com](mailto:hansondawny@gmail.com)

[503-381-3178](tel:503-381-3178)

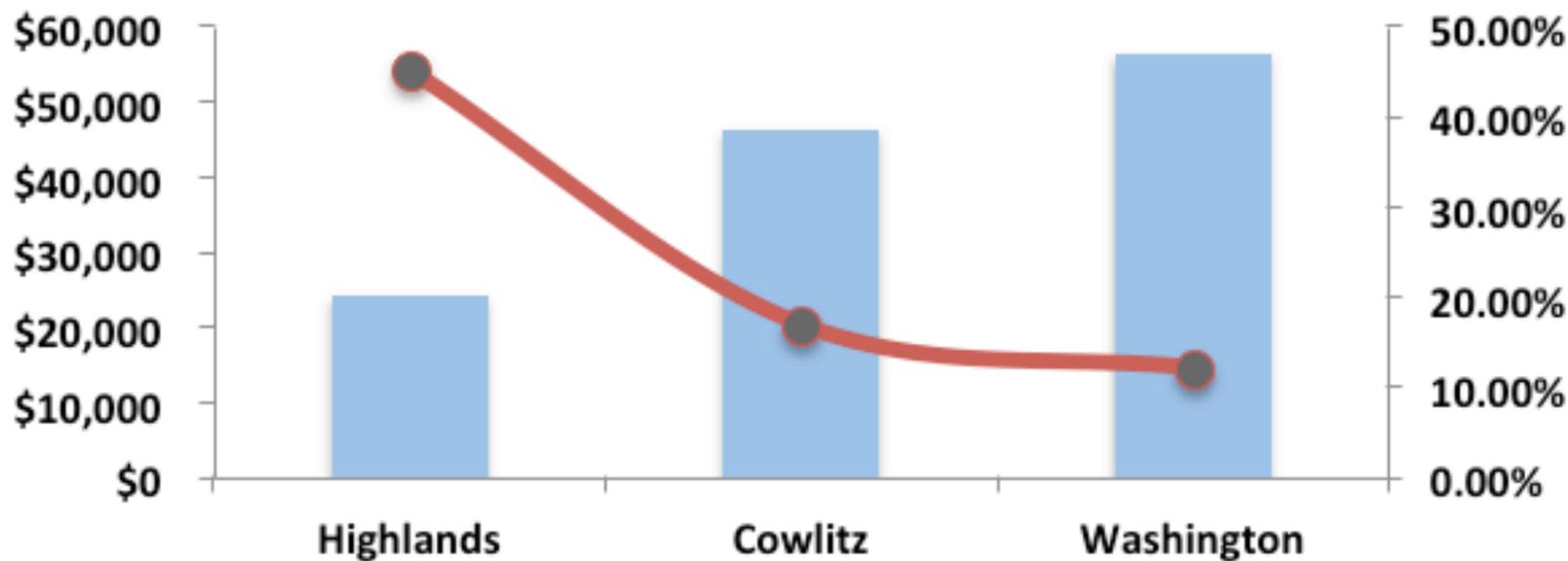
Census Tract or Geography	Population	% Minority	% Hispanic	Median Family Income	% Below Poverty Line	% Under 18 years old
<b>Highlands (5.02)</b>	5,122	<b>31.41</b>	<b>20.5</b>	<b>\$23,913</b>	<b>47.9</b>	<b>33.3</b>
<b>Cowlitz County</b>	100,472	14.0	7.6	\$53,400	17.5	23.3
<b>City of Longview</b>	35,840	18.0	9.6	\$40,226	22.3	22.1
<b>Washington State</b>	6,519,490	26.8	10.9	\$55,002	12.5	23.6

### Map of Toxic Release Inventory Sites in Kelso-Longview, WA

Number	Name	TRI ID	Existing
1	COOPER OIL INC LONGVIEW BULK PLANT	98632CPRLN940IN	Yes
2	FLEXIBLE FOAM PRODUCTS INC	98632FLXBL125PR	Yes
3	HASA INC	98632HSNCX341IN	Yes
4	PPG INDUSTRIES INC	98632QCHLR3541I	Yes
5	SOLVAY CHEMICALS INC	98632NTRXM3500I	Yes
6	WEYERHAEUSER NR CO - LONGVIEW	98632WYRHS3401I	Yes
7	WILTECH CORP.	98632WLTCH1203C	Yes
8	AMERICAN CABINET CONCEPTS INC.	98632MRCNC1021C	Yes
9	CONRAD WOOD PRESERVING CO	97048CNRDW29175	Yes
10	US GYPSUM CO	97048NTDST29073	Yes
11	<b>MILLENIUM BULK TERMINALS</b>	<b>NONE</b>	<b>Proposed</b>
12	FOSTER POULTRY FARMS KELSO PLANT	98626FSTRP1700S	Yes

13	GLACIER NW INC LONGVIEW READY-MIX PLANT	98632GLCRN11003	Yes
14	KEMIRA WATER SOLUTIONS INC	98632MRCNC850TH	Yes
15	ALL PURE CHEMICAL CO.	98625LLPRC1265N	Yes
16	TOLLYCRAFT ACQUISITION CORP.	98626TLLYC2200C	Yes
17	LONGVIEW FIBRE PAPER & PACKAGING INC	98632LNGVWSOUTH	Yes
18	PACIFIC COATING & LAMINATING	98626PCFCC500CL	Yes
19	SIMPSON LUMBER CO LONGVIEW LUMBER OPS	98632LNGVW54THI	Yes
20	STOWE WOODWARD	98626STWWD2209T	Yes

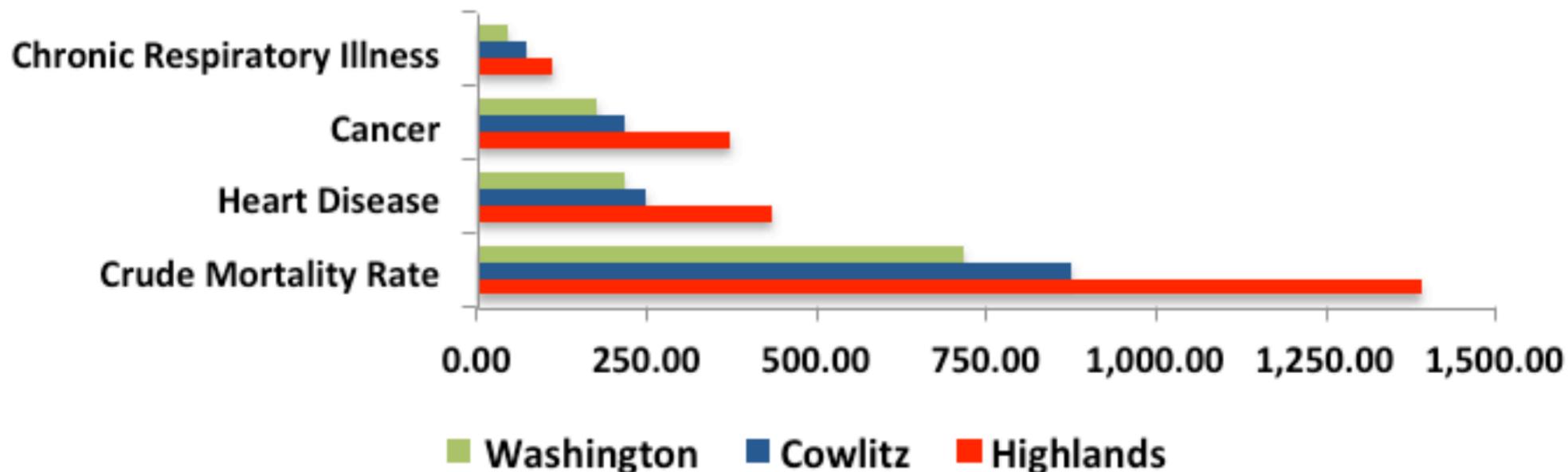
**Chart 1. Comparisons of Median HH Income and Poverty Rates for Highlands, Cowlitz County, and WA State**



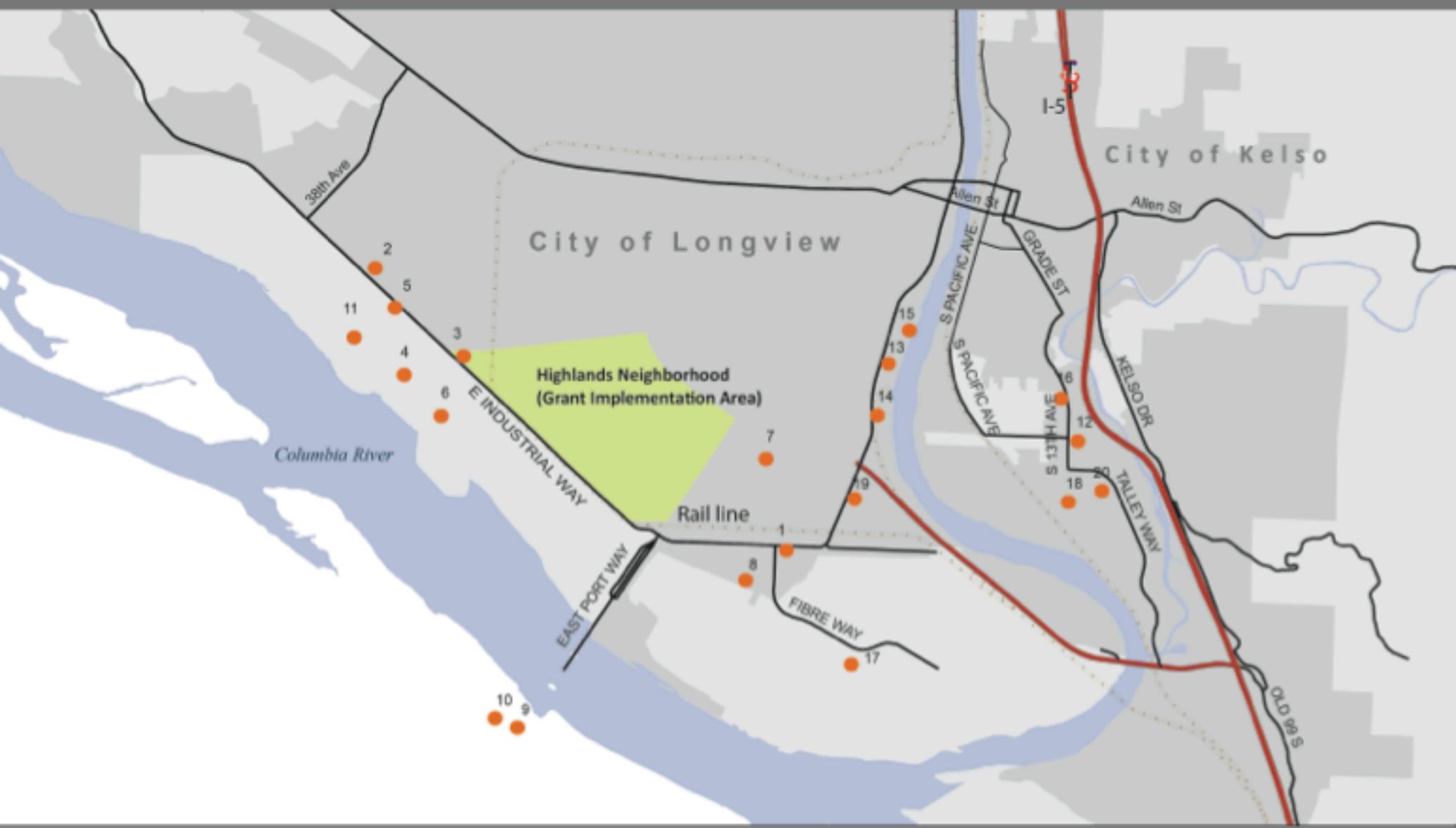
■ Median Household Income (U.S. Census 2010)

● Percent Below Poverty Level (U.S. Census, 2010 5-yr ACS)

**Chart 2. Age-Adjusted Mortality Rates (per 100,000 people) for Highlands, Cowlitz County, and Washington State (2007-2009**  
Death Certificate Data, WA State Department of Health, Center for Health Statistics)



# Highlands Neighborhood



N



1:50,000

● TRI Sites





Biography of Jason T. McGill:

Jason serves as Health Policy Advisor for Governor Jay Inslee's Legislative Affairs & Policy Office. He helps lead the Governor's health care strategic vision, goals and policy initiatives. In this role, he serves as the Governor's liaison to agencies, stakeholders and the health care community at large. He has a deep interest in evidence based medicine and health systems improvement. He previously served in a similar position for Governor Chris Gregoire's Executive Policy Office. He is a lifelong Washingtonian and earned both a Bachelor of Arts in Business Administration and a law degree from Seattle University, with a focus in health law. He later earned an executive management certificate from the University of Washington, Evans School of Public Affairs. Jason worked in private law practice for several years before rejoining the Attorney General's Office where he was lead counsel and represented the health care related programs of the Department of Labor and Industries. He became the Medical Administrator for the Department of Labor and Industries. In that capacity he was an Executive Management Team member and responsible for setting strategic vision, management of health care medical and policy staff of the agency.

# Washington State Health Care Authority

## Patient Navigation

Governor's Interagency Council on Health Disparities  
September 11, 2013

Vazaskia V. C. Caldwell, Health Disparities Manager, Health Care Services

# Outline of Presentation

- Background on Patient Navigation
  - National Program: Dr. Harold P. Freeman
  - Washington State
- Overview of Previous Patient Navigator Pilots

# Dr. Harold P. Freeman



**Harold P. Freeman, M.D.**

Chairman Emeritus and Founder  
Ralph Lauren Center for Cancer Care and  
Prevention  
Senior Advisor to the Director, National  
Cancer Institute

- Harold P. Freeman, MD
  - 1989 National American Cancer Society Hearings
    - *Report to the Nation: Cancer in the Poor*
      - 1964-1986 39% of African American Women had a 5 year survival
  - 1990 Harlem Cancer Education & Demonstration Project
    - *Results*
      - 1990-2001 70%+ of African American Women had a 5 year survival rate
  - 2004 DHHS Study on Eliminating the Unequal Burden of Suffering
  - 2005 President Bush signed the Patient Navigation and Chronic Disease Prevention Act
  - 2007 \$2.9M appropriation – CMS, 6 demonstration Pilot
  - 2007 \$2.5M grant from Amgen Foundation, Ralph Lauren Center for Cancer Care and Prevention established the Harold P. Freeman Patient Navigation Institute to offer Patient Navigator Training

# Washington State History



- Washington State
  - 2001 Breast and Cervical Cancer Study - Voices of a Broken System
    - African-American urban women
    - Medicaid recipients
    - Late-stage diagnosis
    - Lower odds of survival
  - 2006 Title XIX Search for an Intervention Program
  - 2007 Legislature
    - \$1.5 million
    - One-year pilot
    - 1,000 Medicaid eligible racial and ethnic populations with a chronic disease

# What do Patient Navigators do?

- Patient Navigators
  - Decrease disparities in the provision of services
  - Have familiarity with the communities in which they work
  - Decrease patients' fears regarding financial, communication, and medical system concerns
  - Facilitate access to programs through community collaboration
  - Provide health education to patients and providers
  - Improve the likelihood that an individual will receive screening, diagnosis, and treatment
  - Be a patient advocate

# The “Plan”

- Program Goals:
  - Develop a sustainable outreach program
  - Reduce barriers to accessing health care
  - Improve health and health care outcomes
- Program Qualifications:
  - Ethnic and racial population to be served
  - Geographical service area
  - Chronic Disease
  - Collaborative partnerships with health systems and community based organizations

# The “Pilot”

- ***4 apparently successful bidders (in contract negotiations)***
  - Children’s Hospital & Regional Medical Center
  - Yakima Valley Farm Workers Clinic
  - Colville Confederated Tribes
  - CHOICE Regional Health Network

Helping 2.1 million children & families each year.

# DSHS

## People Helping People

Washington State  
Department of  
Social and Health  
Services



Seattle Children's  
HOSPITAL • RESEARCH • FOUNDATION

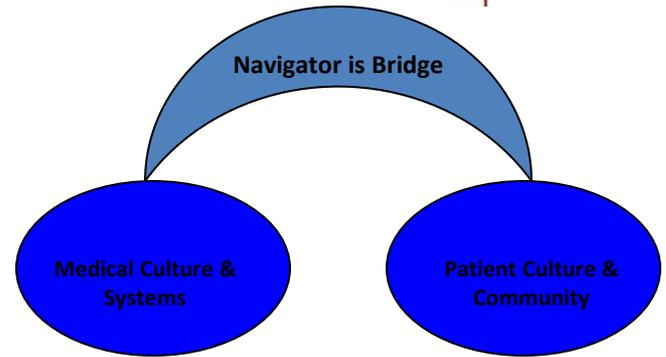
### Seattle Children's Hospital and Regional Medical Center:

The Patient Navigator Program at CHRMC serves Spanish- and Somali-speaking families with asthma and diabetes. Children's navigators work in partnership with community clinics and help families overcome barriers to care. Navigators encourage families to actively participate in their children's care and serve as strong partners with medical teams. Children's Navigators are bilingual and have extensive experience in the health care system, advocacy and community volunteerism.

**CHOICE Regional Health Network:** The Patient Navigator Program serves Hispanic and Southeast Asian individuals with cancer and diabetes who live in Grays Harbor, Mason and Thurston counties. Navigators are fluent in Cambodian, Spanish and Vietnamese. Patient Navigators are trusted source of encouragement, information and cultural 'translation'. "CHOICE is a non-profit community collaborative organization dedicated to improving access and quality of services needed for health.

**Yakima Valley Farm Workers Clinic:** Patient Navigator Program serves Hispanic families with diabetes and asthma. YVFWC work in collaboration with the area's largest provider of primary medical care for the target population. Navigators work to increased access to diabetes and asthma preventative care and treatment. A key function of the patient navigators is to identify, recruit, and sustain participants for these asthma and chronic disease self-management interventions.

**Colville Confederated Tribes – Tribal Health Program:** The Patient Navigator Program on the Colville reservation serves tribal members in southern Ferry and Okanogan counties with cancer and diabetes. The navigators work to identify patients who have cancer/diabetes and need assistance to traverse available medical resources. The Colville project networking system with the medical system and other resources that can be used to help other cancer/diabetes patients, their families and the community as a whole.



### Program Focus:

DSHS/HRSA Patient Navigator Program *serves Medicaid eligible, racial and ethnic populations who have or are at a high risk for a chronic conditions such as diabetes, asthma, cancer, and heart disease*. One thousand clients will be served in FY'08-09 by Seattle Children's Hospital and Regional Medical Center, Choice Regional Health Network, Colville Confederated Tribes and Yakima Valley Farm Workers Clinics.

### Intended Impact:

The goals of DSHS/HRSA's Patient Navigator Program is to *eliminate racial and ethnic health disparities of Medicaid eligible populations suffering from or at risk for a chronic disease's*, through increased client access to quality medical care, increased client knowledge of chronic disease, increased cultural and linguistics competency of healthcare providers and institutions, while increasing the health and health care outcomes of the most vulnerable populations in Washington state.



# Children's Hospital & Regional Medical Center

- Pilot Location: King County
- Target Population: Somali and Spanish Speaking
- Chronic Disease: Asthma
- Partnerships: Odessa, SeaMar, Harborview Child and Teen, Columbia Health Clinics
- Program goal:
  - Increase patient access and ease navigation of services
  - Assist in transportation issues
  - Increase coordination and continuity of care
  - Increase families knowledge to ensure effective asthma care
  - Increase family voice and involvement in care
  - Increase provider knowledge about culturally appropriate care

# Yakima Valley Farm Worker's Clinic

- Pilot Location: Yakima County and Western Benton County
- Targeted Population: Hispanic
- Chronic Disease: Diabetes and Asthma
- Partnerships: Hospitals, ALA of WA, WAMHC
- Program goal:
  - Increase participation in Tomando (CDSM)
  - Increase participation in Asthma Project
  - Improve the continuity of care
  - Increase receipt of culturally competent care

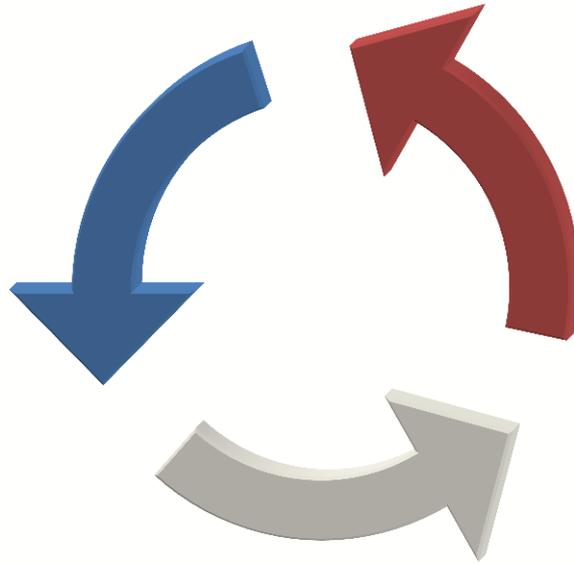
# Colville Confederated Tribes

- Pilot Location: The Confederated Tribes of the Colville Reservation
- Target Population: Tribal members, and individuals who live on the Colville Reservation
- Chronic Disease: Diabetes and Cancer
- Partnerships: Hospital's and social service organizations
- Program goal:
  - Increase health knowledge
  - Assist patient through navigation of services
  - Strengthen capacity
  - Engage supportive tribal leadership
  - Improve access to culturally competent care
  - Reduction in incidence and prevalence of chronic disease

# CHOICE Regional Health Network

- Pilot Location: Thurston, Grays Harbor, and Mason Counties
- Target Population: Hispanic, Vietnamese, Cambodian, Laotian, and Thai immigrants and refugees
- Chronic Disease: Diabetes and Cancer
- Partnerships: Social Service Org, Health Systems and Clinics, Schools, Missions and others
- Program goals:
  - Increase health insurance enrollment
  - Increase outreach and application assistance for basic food
  - Provide breast and cervical health outreach
  - Increase access to services
  - Ensure clients are connected to a primary care provider

# Question & Answers



# Patient Navigation Improves Access to Care for Children and Families with Limited English Proficiency

Sarah A. Rafton, MSW

Director, Center for Diversity and Health Equity

# Background: Patient Navigation

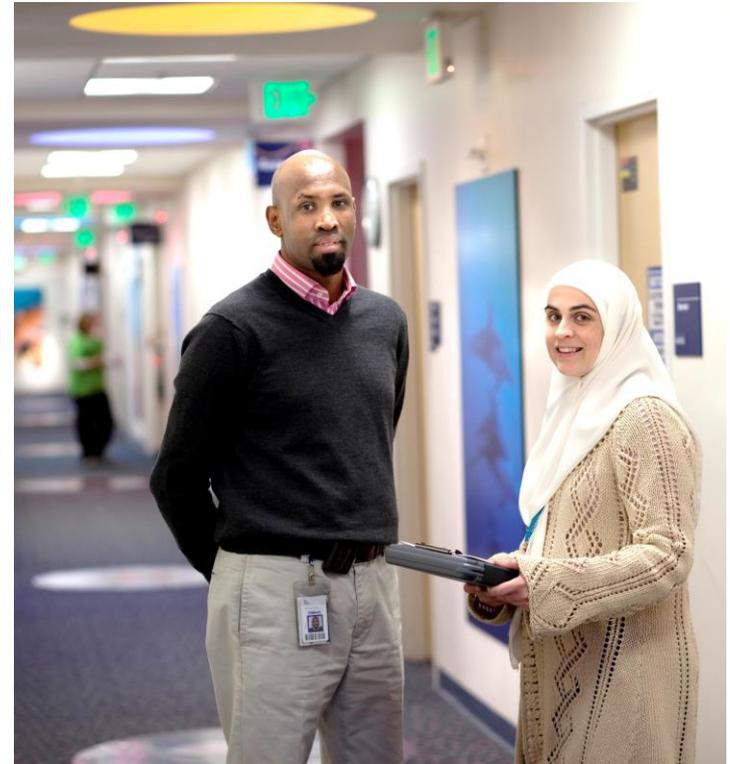
- Patient Navigators are respected members of an ethnic community who are knowledgeable about health care system
- Seattle Children's Navigators (3.0FTE) are certified medical interpreters
- Seattle Children's Navigators teach immigrant parents to effectively use health care system for chronic and complex pediatric disease and empower parent participation in care
- Navigators aim to “graduate” families from service

# Criteria for Patient Navigation

- Referral from community or hospital physician, nurse or social worker
- Child with ongoing medical condition necessitating care at Children's
- Identified language need (*Spanish or Somali*)
- Low acculturation, with culture, religion or communication impacting care

# Navigation Services

- Care coordination
- Schedule appointments
- Coordinate transportation
- Prepare families for upcoming appointments or procedures
- Follow-up with families in the hospital or at outpatient visits
- Assist with medications (prescription fulfillment, education)

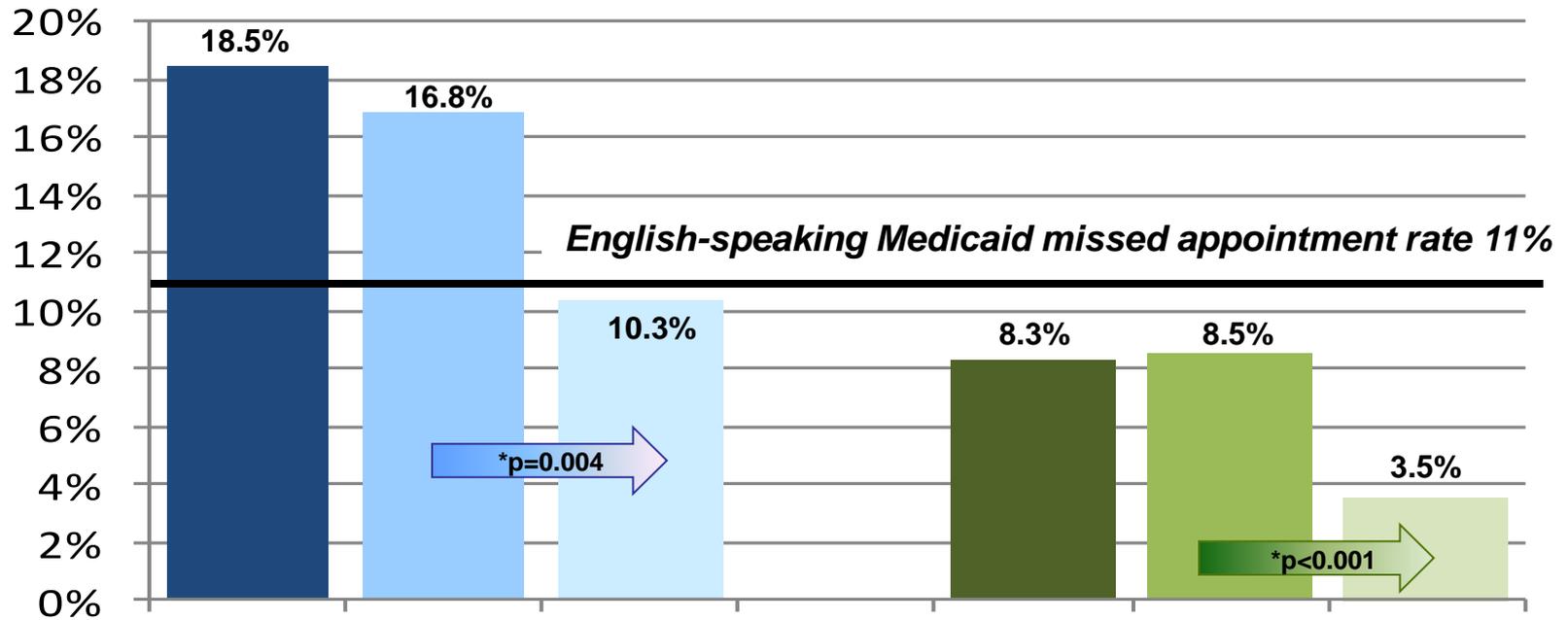


# Parent Demographics

## Parent education level (N=90)

	Somali	Spanish
Never attended school or only attended kindergarten	25%	1%
Grades 1 through 8	55%	53%
Grades 9 through 11	0%	29%
Grade 12 or GED	15%	11%
Some college/technical school or more	5%	6%

# Outcomes: Missed Outpatient Appointments



Somali - Non Patient Navigator

Somali - Pre-NAVigation

Somali - Post-NAVigator

Spanish - Non Patient Navigator

Spanish - Pre-NAVigation

Spanish - Post-NAVigator

# Outcomes: Completed Specialty Referrals

Population	Proportion with No Appt
All Ambulatory Appts	20%
Somali – No Patient Navigator	19%
Somali – Patient Navigator	5%
Spanish – No Patient Navigator	17%
Spanish – Patient Navigator	9%

Reflects a PCP referring a child to Seattle Children's Hospital for specialty care.

Reasons referrals do not result in an appointment:

- family failure to schedule appointments
- duplicate referrals
- inappropriate referrals

# Outcomes: Inpatient Utilization

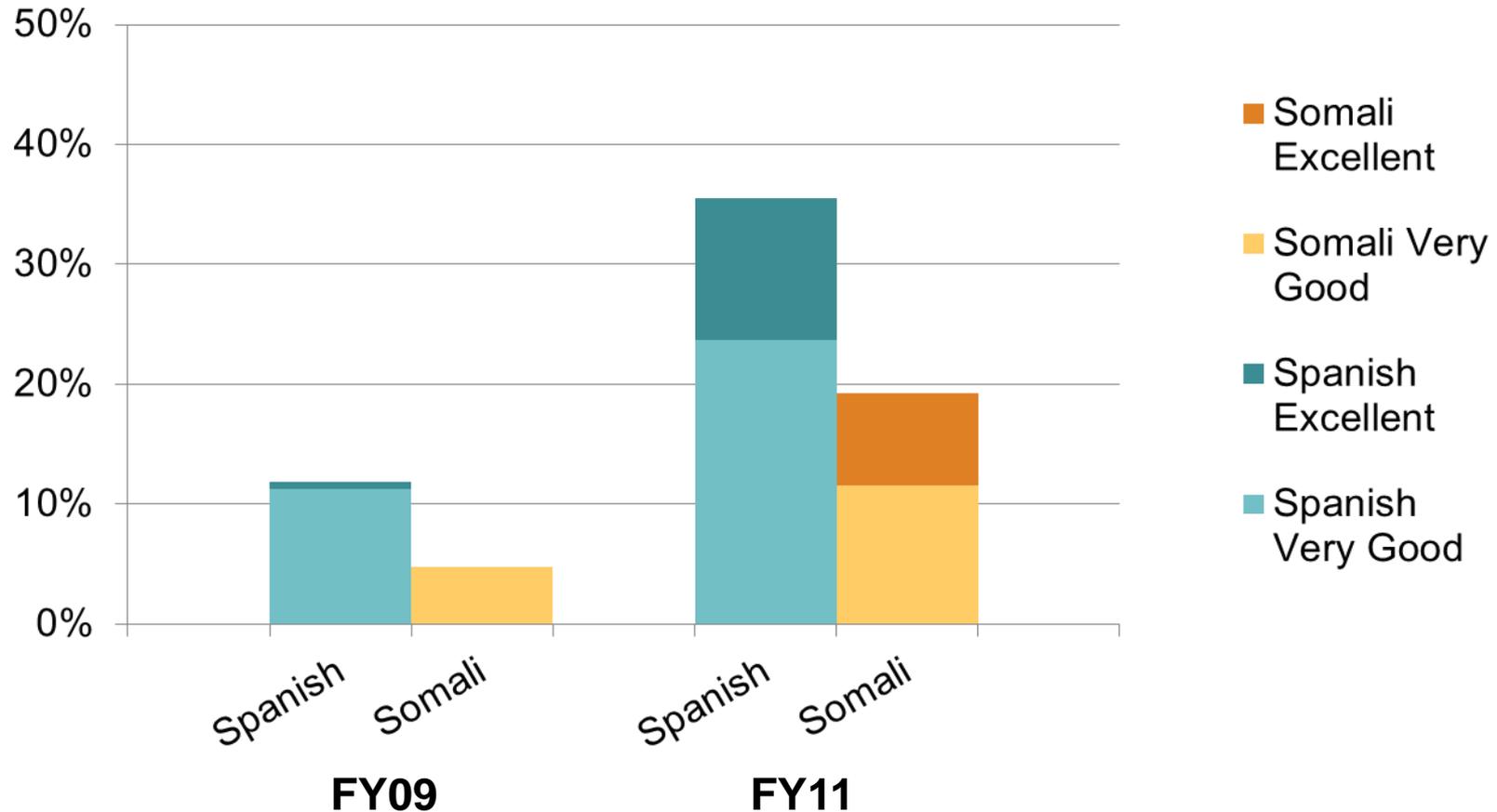
## Inpatient Admissions per Year

	N size	Before Patient Navigation	After Graduation	P-Value
Inpatient admissions / 300 days	83	3.68	1.01	P< .001

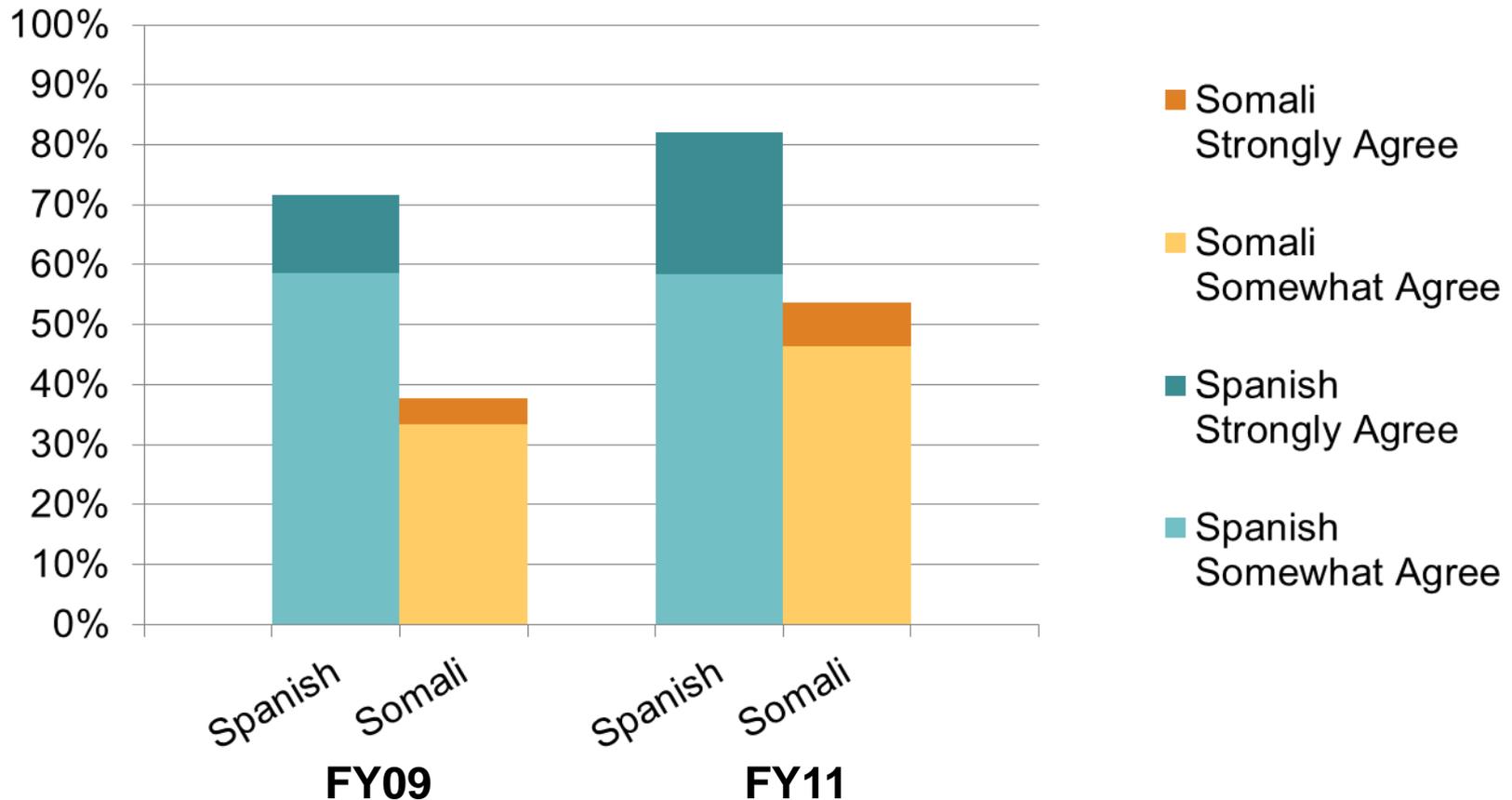
## Average Length of Stay

	N size	Before Patient Navigation	After Graduation	P-Value
ALOS	27	14.8	6.5	P< .001

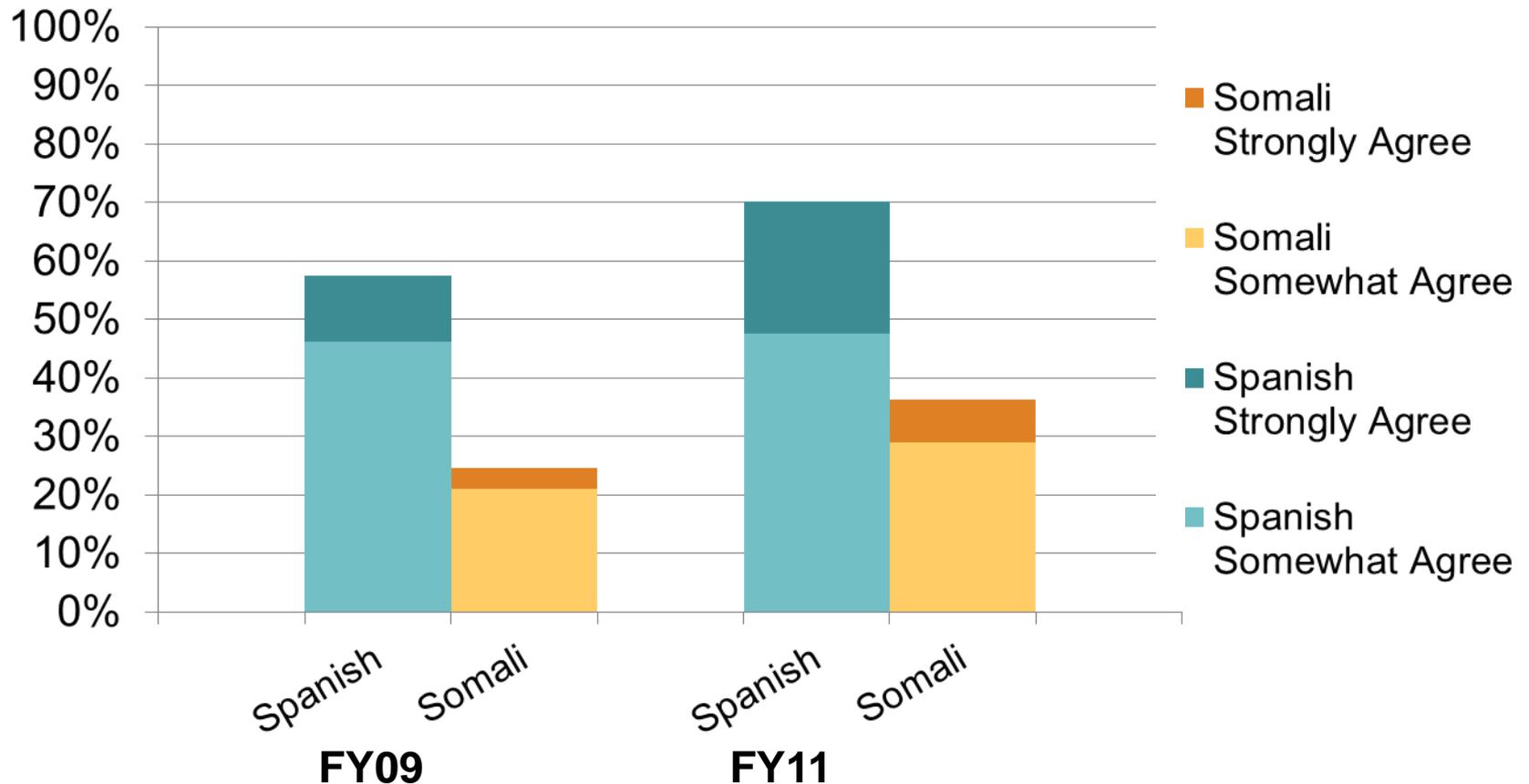
# Outcomes: Coordination of Care



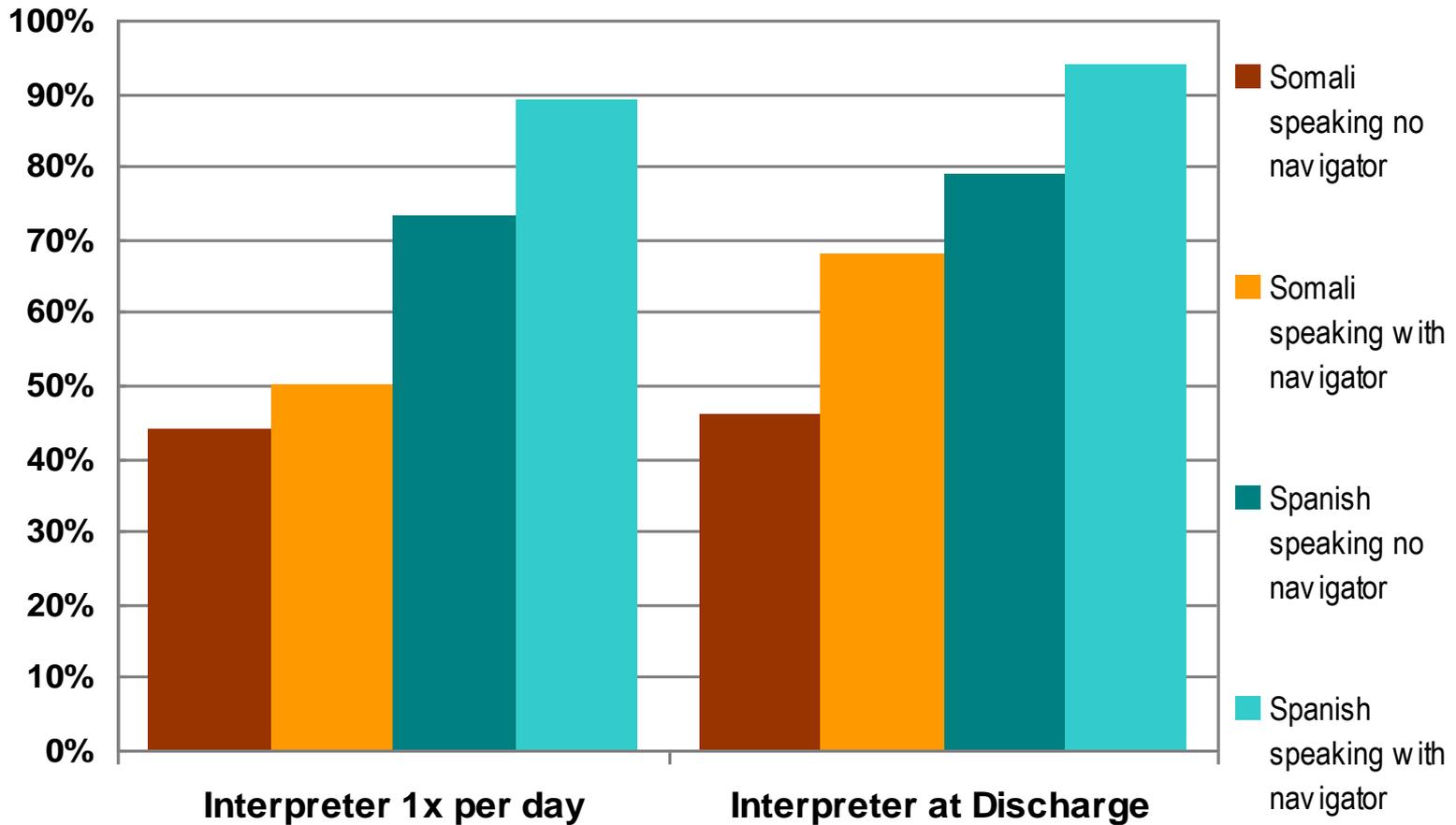
# Outcomes: Caring for the Child at Home



# Outcomes: Who to Call, or Turn To For Help



# Outcomes: Professional Interpretation During Inpatient Hospitalization



# Next steps

- Potential navigation dedicated to cancer care
- Potential increased navigation (1.0) as we explore care management for SSI children in the community
- How to expand / how to identify families in need – who are English proficient
  - *literacy?*
  - *SES?*
- Increasing program efficiency (Plan-Do-Check-Act)

Washington State  
Health Care Authority

Basics of Healthy Options/  
Washington Apple Health  
(Managed Care)

September 11, 2013

# How does Managed Care Work?

- Beneficiaries become eligible for managed care
  - Newly eligible beneficiary either enrolls in managed care or
  - Beneficiary is assigned by Health Care Authority to a managed care plan (MCO)
- HCA does not assign to PCP level – only to plan level
  - Beneficiary may either select Primary Care Provider (PCP) OR plan will assign PCP

# How Does Managed Care Work?

- Monthly premium is paid to MCO for all covered benefits
  - All MCOs cover same benefits and have same contract requirements, but
  - MCOs may not cover the benefits in the same way. Some plans require authorization of services that others do not.

# Care Management/ Care Coordination

- All MCOs have a care management unit that provides enrollees with assistance in coordinating services:
  - Each new enrollee is screened for health care conditions and needs;
  - Those who need further assistance receive a Health Risk Assessment and care planning;
  - Enrollees with high needs may be referred to Health Homes.

# Care Management/ Care Coordination

- Care Management services may include:
  - Ensuring enrollees are using health care services appropriately – not under- or over-utilizing;
  - Ensuring enrollees have access to needed services;
  - Assistance in coordinating services that are covered by the managed care program with those that are not, including interpreter services, transportation, etc.

# Managed Care vs Fee for Service

- Health Plans must ensure:
  - Guaranteed access to a Primary Care Provider
  - Choice of multiple Primary Care Providers and Specialists
  - 24/7 access to a Nurse Advice Line
  - Coordination of care among providers and systems of care: for example, between medical and mental health systems
  - Prescription coverage

# Healthy Options enrollment process

- Clients receive:
  - Notice of enrollment in a health plan and instructions on how to change plans
  - Enrollment Handbook with information about Healthy Options
  - Enrollment form

# Managed Care Facts

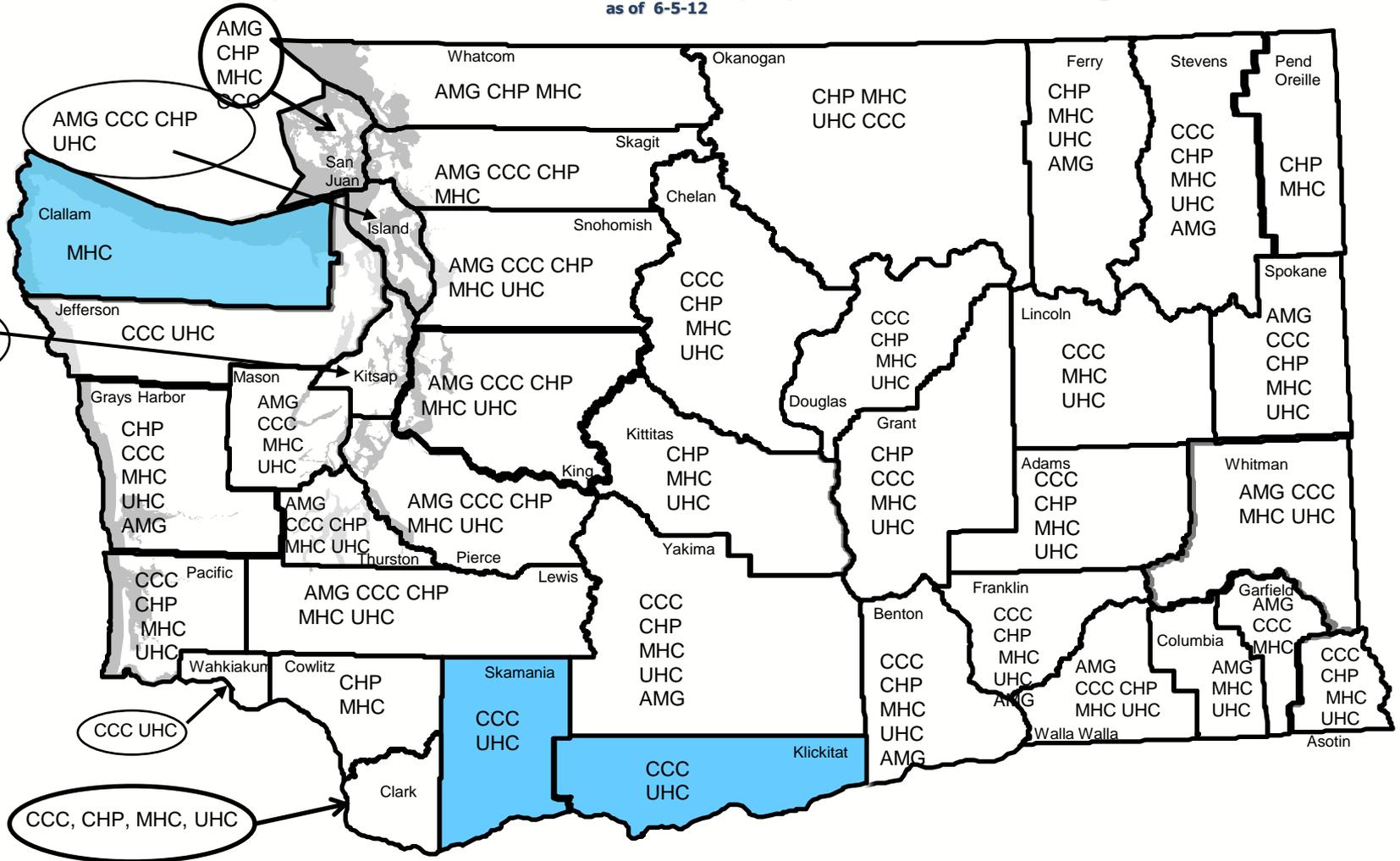
- Enrollees:
  - May change plans every month – most don't
  - Are allowed to get second opinions through the plan
  - New Enrollees: May keep current prescriptions, care plans and providers for 30 days or until accessed by the new plan
  - There is no balance billing; no co-pays for Medicaid clients

# Managed Care Organizations

Effective July 1, 2012



# Effective 8-1-2012 Service Areas for Healthy Options, Children's Health Insurance Program, Healthy Options Blind/Disabled, and Healthy Options Foster Care Programs as of 6-5-12



County enrollment in managed care is voluntary.

# Health Plan Contact Information



**Customer Services: 1-800-600-4441**  
**Website: [www.amerigroup.com](http://www.amerigroup.com)**  
**Provider line - 1-800-454-3730**  
**Website: <http://washington.joinagp.com>**



**Customer Service: 1-800-440-1561**  
**Website: [www.chpw.org](http://www.chpw.org)**  
**Provider line - 1-800-440-1561**  
**Website: <http://www.chpw.org/for-providers/>**



**Customer Service: 1-877-644-4613**  
**Website: [www.coordinatedcarehealth.com](http://www.coordinatedcarehealth.com)**  
**Provider line - 1-877-644-4613**  
**Website: <http://www.coordinatedcarehealth.com/for-providers/become-a-provider/>**



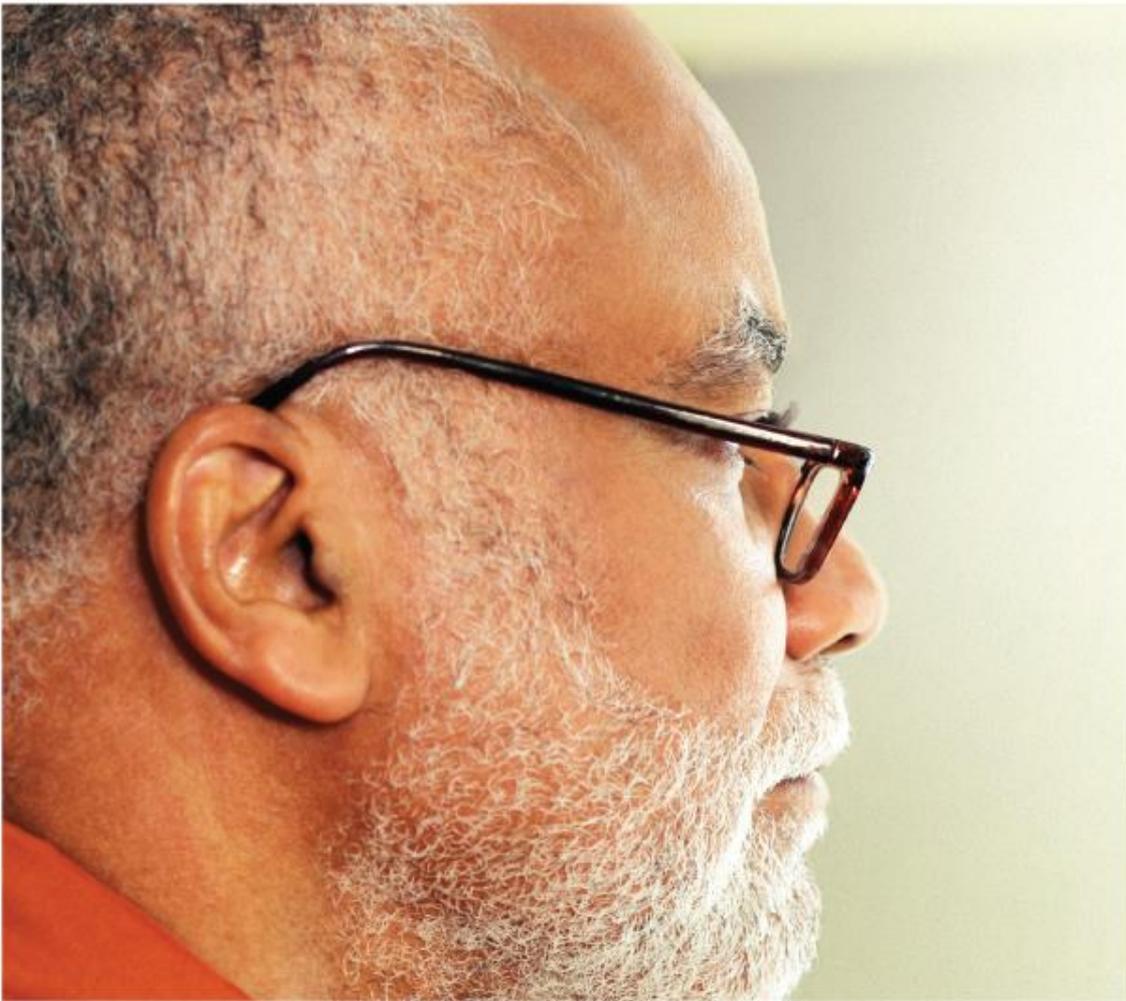
**Customer Service: 1-800-869-7165**  
**Website: [www.molinhealthcare.com](http://www.molinhealthcare.com)**  
**Provider line - Phone: 1-800-869-7175**  
**Website: <http://www.molinahealthcare.com/medicaid/providers/wa/Pages/home.aspx>**



**Customer Service: 1-877-542-8997**  
**Website: [www.uhcommunityplan.com](http://www.uhcommunityplan.com)**  
**Provider Line - 1-877-542-9231**  
**Website: <http://www.uhcommunityplan.com/health-professionals>**

# Questions

- Healthy Options
  - <http://hrsa.dshs.wa.gov/HealthyOptions/>
- Health Homes: [http://www.hca.wa.gov/health\\_homes.html](http://www.hca.wa.gov/health_homes.html)
- Contact us with questions or comments about Healthy Options:
  - [hcamcprograms@hca.wa.gov](mailto:hcamcprograms@hca.wa.gov)



# HealthPathWashington



HealthPath  
Washington

# HealthPath Washington Integration

*Achieving Washington State's vision of integrated Medicare and Medicaid services*

- Approved April 2012
- Partnership:
  - DSHS Aging and Disability and Health Care Authority are partnering with the Centers for Medicare and Medicaid Services (CMS)
- The primary goals of HealthPath Washington include:
  - Improve quality and coordination of care
  - Reduce expenditures
  - Foster relationships with diverse stakeholders
  - Share savings with the federal government
- Two approaches:
  - Health Homes
  - Fully Integration Capitation



HealthPath  
Washington

Washington State  
Health Care Authority



# Strategy One: Health Homes (Managed Fee-For-Service)

- Project Implemented July 1, 2013 with second phase October 1, 2013
- Targeted to high-cost high-risk to reduce health care costs
- Available in 37 of the state's 39 counties
- Target Population: 30,000 highest-need dual eligibles
- Health Home Leads: Coordinated Care, Community Health Plan of Washington, United, Optum RSN, SE Washington Aging and Long-Term Care, Molina, and NW Regional AAA, and Choice
  - The six Health Homes services are:
    - Comprehensive care management;
    - Care coordination and health promotion;
    - Comprehensive transitional care from inpatient to other settings, including; appropriate follow-up;
    - Individual and family support, which includes authorized representatives;
    - Referral to community and social support services, if relevant; and The
    - use of health information technology (HIT) to link services, as feasible and applicable.



# Health Home Coverage Areas

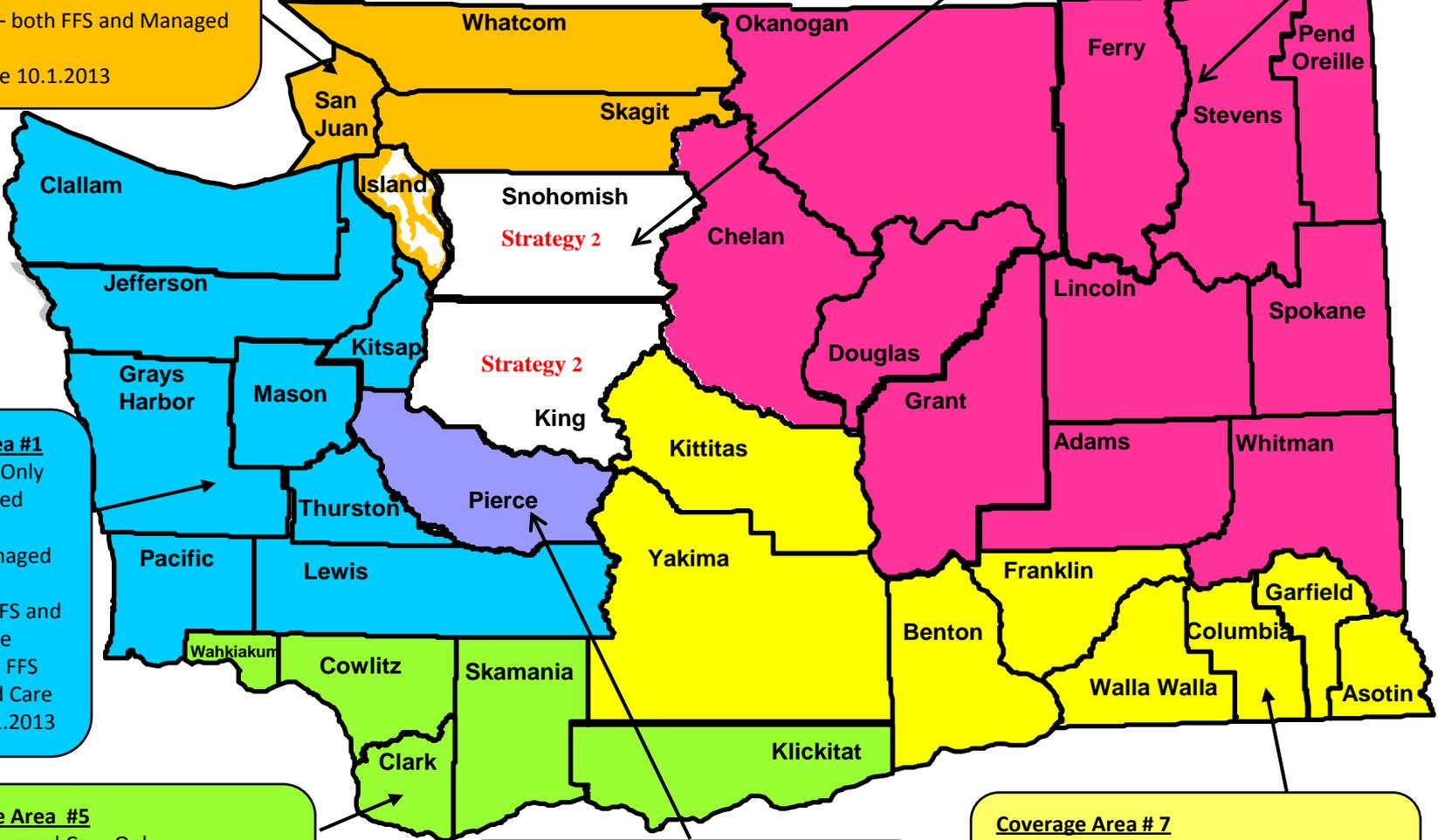
## Coverage Area #2

NWRC – FFS Only  
 CCC – Managed Care Only  
 Molina – Managed Care Only  
 UHC – both FFS and Managed Care  
 CHPW – both FFS and Managed Care  
 Effective 10.1.2013

**Strategy 2** – Medicare/Medicaid Integration Project (Managed Care)  
 Regence Blue Shield and UnitedHealthCare  
 Voluntary Enrollment 5.1.2014 and Passive Enrollment 7.1.2014

## Coverage Area #6

Community Choice – FFS only  
 CCC – Managed Care Only  
 Molina – Managed Care Only  
 UHC – both FFS and Managed Care  
 CHPW – both FFS and Managed Care  
 Effective 10.1.2013



## Coverage Area #1

Optum – FFS Only  
 CCC – Managed Care Only  
 Molina – Managed Care Only  
 UHC – both FFS and Managed Care  
 CHPW – both FFS and Managed Care  
 Effective 10.1.2013

## Coverage Area #5

CCC - Managed Care Only  
 CHPW & UHC - both Managed Care and FFS  
 OPTUM - FFS Only  
 Effective 7.1.2013

## Coverage Area #4

CCC & CHPW - Managed Care Only  
 UHC - both Managed Care & FFS  
 Optum - FFS Only  
 Effective 7.1.2013

## Coverage Area #7

CCC & CHPW - Managed Care Only  
 UHC – Managed Care and FFS  
 OPTUM & SE WA ALTC - FFS Only  
 Effective 7.1.2013

## Strategy 2: Full Integration Capitation (*Three Way Contracts between Health Plan/State/CMS*)

- Begins: July 2014
  - Focus: Improving chronic care coordination through integrate primary and specialty care, behavioral health, and long-term services for dual eligible clients
  - Target Population: 40,000 “dual eligible” residents of Snohomish and King counties
- Health plans responsible for all Medicare and Medicaid services
- Beneficiaries access services through Regence or United
- Health plans receive a capitated per member/per month payment that includes intensive care coordination for high-cost, high-risk
- Health plans at full risk for costs, some payment contingent on specified outcomes



HealthPath  
Washington

Washington State  
Health Care Authority



## 2008 Fact Sheet:

# Patient navigator program update

### THE BACKGROUND:

At the direction of Washington's State Legislature, four patient navigator pilot programs began operations in mid-2008, offering specialized services to minority communities across the state. Patient navigators are an intervention that recognizes the disparities in health status that exist between racial and ethnic groups and the majority population. The navigators are members of the community who are knowledgeable about the health care system. They help patients find their way in the health-care system by coordinating services, improving communications, and resolving problems that otherwise might delay care.

### THE FOUR PILOTS:

**1. Seattle Children's Hospital and Regional Medical Center:** The Patient Navigator Program at Children's Hospital and Regional Medical Center serves Spanish- and Somali-speaking families. Children's navigators work in partnership with community clinics and help families overcome barriers to care. Navigators encourage families to actively participate in their children's care and serve as strong partners with medical teams. Children's Navigators are bilingual and have extensive experience in the health care system, advocacy and community volunteerism. Through a partnership with Harborview Medical Center's nationally-renowned Community House Calls program, Children's navigators also are trained in cultural mediation in large medical centers. "A child's health crisis can be a frightening time for any family, but especially for those who also experience cultural and language barriers," said Dr. Ben Danielson, medical director of Odessa Brown Children's Clinic, which is associated with Children's Hospital. "Those families deserve to have a partner help navigate their child's care. Children's Patient Navigator Program is a vital step to assuring all families have the very best care."

**2. CHOICE Regional Health Network:** The Patient Navigator Program at CHOICE Regional Health Network serves Hispanic and Southeast Asian individuals with cancer and diabetes who live in Grays Harbor, Mason and Thurston counties. CHOICE is a non-profit community collaborative organization dedicated to improving access and quality of services needed for health. Patient Navigators work with their clients regardless of where in the community they receive medical care. "The DSHS contract allows us to devote much more intensive staff time to clients who need a trusted source of encouragement, information and cultural 'translation' as they engage with treatment for serious health conditions," said Dan Rubin, CHOICE's Project Director. "Our Navigators are very well known in the community and are fluent in Cambodian, Spanish and Vietnamese. We are starting with clients already known to us but soon we will start soliciting other referrals from the many health care providers we work with."

**3. Yakima Valley Farm Workers Clinic:** The Yakima Valley Farm Workers Clinic Community Patient Navigator Program is serving Yakima County and Western Benton County as a collaborative effort among: the area's largest provider of primary medical care for the target population -- Yakima Valley Farm Workers Clinic (YVFWC); the only birthing center in Yakima, Yakima Valley Memorial Hospital (YVMH); the primary hospital serving western Benton County, Prosser Memorial Hospital (PMH); the American Lung Association of Washington (ALAW) Central Region; and the Washington Association for Community and Migrant Health Centers (WACMHC). The need for increased access to diabetes and asthma preventative care and treatment for low-income and Hispanic populations in the service area is staggering. There is evidence that Hispanics in Yakima and Benton Counties are less likely to have a primary care provider/medical home (and therefore less likely to have been given a diagnosis of asthma) and are more likely to be treated for asthma-related problems in the emergency room. A key function of the patient navigators is to identify, recruit, and sustain participants for these asthma and chronic disease self-management interventions.

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**FOR MORE INFORMATION, CONTACT:**

**Vazaskia Caldwell, HRSA, 360-725-2129, [caldwv@dshs.wa.gov](mailto:caldwv@dshs.wa.gov)**

**Colville Confederated Tribes – Tribal Health Program:** Last of the projects to get under way, the Community Health Representative/Patient Navigators (CHR/N) did not finalize its state contract until early September. But the pilot has been moving quickly since then to bring navigator interventions to the Colville reservation in southern Ferry and Okanagon counties. The navigators will work among tribal members and the tribal health clinics to help identify patients who have cancer/diabetes and need assistance to traverse available medical resources. The Colville project will develop a networking system with the medical system and other resources that can be used to help other cancer/diabetes patients, their families and the community as a whole.

### **WHY ARE PATIENT NAVIGATORS IMPORTANT?**

Factors like cultural background, geography, economics, and education influence people's access to quality care and optimal use of health care, especially for people with chronic health conditions. Patients, family members, caregivers, and physicians often lack the information they need to determine the most appropriate treatment plan. The policies of health care organizations are not adapted to the needs and cultural values of all those they treat. Patient navigators can bridge these gaps, and they can improve care and lower costs in the process.

Tara Svay, CHOICE's Cambodian Patient Navigator, offers an example of a client whose perspective on his diabetes was affected by culture and by privation in Cambodia under the Khmer Rouge. Although he went through diabetes education, he was unwilling to modify a traditional diet heavy on rice and noodles. "I'd rather die from overeating than from being starved," he told Svay. Over time, Svay's contact with the patient and his physician led to much better adherence with recommended care, including keeping medical appointments, dietary changes and cooperation with specialty referrals. His condition has improved to the point that he was recently able to receive eye surgery. Ultimately, he asked Svay to convey his thanks, translated from the Khmer language: "I hope this program will help me and many of the Cambodian people who need this kind of service. Without Tara's help I would be lost in this big world of medical misunderstanding."

### **CHARACTERISTICS OF A SUCCESSFUL PATIENT NAVIGATOR**

Patient navigators combine wisdom about their community's culture with knowledge of the health-care system. In order to achieve the goal of reducing health disparities, the patient navigator must be:

- A respected source of information among people in the target community, able to interpret the medical culture to those unfamiliar with it, and to help overcome barriers to the use of services.
- Sensitive and compassionate about the concerns and fears of patients and their families
- Very knowledgeable about the environment and health care system through which the patient must move in order to obtain care
- Skilled at communicating with health care providers and institutions about patients' cultural needs
- Able to link people to health care resources in a timely fashion

In addition, health care providers and institutions such as hospitals must be willing to establish rapport with navigators. Higher level authority within the health care system must recognize, accept, and support the role of navigators with respect to:

- Enabling patients to access care
- Facilitating timely care for patients
- Catalyzing changes in the system of care when necessary to respond to client needs and reach the objectives of improved care

### **WHAT IS HAPPENING IN WASHINGTON?**

The Department of Social and Health Services has been working to develop patient navigator programs over the past five years, working in conjunction with the Governor's Health Disparities Council. The DSHS pilot programs are coordinated by Patient Navigator Coordinator Vazaskia Caldwell, who joined the staff in late 2008. Next steps will involve a comprehensive evaluation of the pilot projects and their effect on disparities and clients' progress toward eliminating the systemic barriers that interfere with health care -- the history of discrimination, communities' lack of trust of authority, absence of the institutional support for navigators needed to effect changes in systems, and lack of financial sustainability of pilot projects, among others.

One Hundred Ninth Congress  
of the  
United States of America

AT THE FIRST SESSION

*Begun and held at the City of Washington on Tuesday,  
the fourth day of January, two thousand and five*

An Act

To amend the Public Health Service Act to authorize a demonstration grant program to provide patient navigator services to reduce barriers and improve health care outcomes, and for other purposes.

*Be it enacted by the Senate and House of Representatives of  
the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the “Patient Navigator Outreach and Chronic Disease Prevention Act of 2005”.

**SEC. 2. PATIENT NAVIGATOR GRANTS.**

Subpart V of part D of title III of the Public Health Service Act (42 U.S.C. 256) is amended by adding at the end the following:

**“SEC. 340A. PATIENT NAVIGATOR GRANTS.**

“(a) GRANTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may make grants to eligible entities for the development and operation of demonstration programs to provide patient navigator services to improve health care outcomes. The Secretary shall coordinate with, and ensure the participation of, the Indian Health Service, the National Cancer Institute, the Office of Rural Health Policy, and such other offices and agencies as deemed appropriate by the Secretary, regarding the design and evaluation of the demonstration programs.

“(b) USE OF FUNDS.—The Secretary shall require each recipient of a grant under this section to use the grant to recruit, assign, train, and employ patient navigators who have direct knowledge of the communities they serve to facilitate the care of individuals, including by performing each of the following duties:

“(1) Acting as contacts, including by assisting in the coordination of health care services and provider referrals, for individuals who are seeking prevention or early detection services for, or who following a screening or early detection service are found to have a symptom, abnormal finding, or diagnosis of, cancer or other chronic disease.

“(2) Facilitating the involvement of community organizations in assisting individuals who are at risk for or who have cancer or other chronic diseases to receive better access to high-quality health care services (such as by creating partnerships with patient advocacy groups, charities, health care centers, community hospice centers, other health care providers, or other organizations in the targeted community).

“(3) Notifying individuals of clinical trials and, on request, facilitating enrollment of eligible individuals in these trials.

“(4) Anticipating, identifying, and helping patients to overcome barriers within the health care system to ensure prompt diagnostic and treatment resolution of an abnormal finding of cancer or other chronic disease.

“(5) Coordinating with the relevant health insurance ombudsman programs to provide information to individuals who are at risk for or who have cancer or other chronic diseases about health coverage, including private insurance, health care savings accounts, and other publicly funded programs (such as Medicare, Medicaid, health programs operated by the Department of Veterans Affairs or the Department of Defense, the State children’s health insurance program, and any private or governmental prescription assistance programs).

“(6) Conducting ongoing outreach to health disparity populations, including the uninsured, rural populations, and other medically underserved populations, in addition to assisting other individuals who are at risk for or who have cancer or other chronic diseases to seek preventative care.

“(c) PROHIBITIONS.—

“(1) REFERRAL FEES.—The Secretary shall require each recipient of a grant under this section to prohibit any patient navigator providing services under the grant from accepting any referral fee, kickback, or other thing of value in return for referring an individual to a particular health care provider.

“(2) LEGAL FEES AND COSTS.—The Secretary shall prohibit the use of any grant funds received under this section to pay any fees or costs resulting from any litigation, arbitration, mediation, or other proceeding to resolve a legal dispute.

“(d) GRANT PERIOD.—

“(1) IN GENERAL.—Subject to paragraphs (2) and (3), the Secretary may award grants under this section for periods of not more than 3 years.

“(2) EXTENSIONS.—Subject to paragraph (3), the Secretary may extend the period of a grant under this section. Each such extension shall be for a period of not more than 1 year.

“(3) LIMITATIONS ON GRANT PERIOD.—In carrying out this section, the Secretary—

“(A) shall ensure that the total period of a grant does not exceed 4 years; and

“(B) may not authorize any grant period ending after September 30, 2010.

“(e) APPLICATION.—

“(1) IN GENERAL.—To seek a grant under this section, an eligible entity shall submit an application to the Secretary in such form, in such manner, and containing such information as the Secretary may require.

“(2) CONTENTS.—At a minimum, the Secretary shall require each such application to outline how the eligible entity will establish baseline measures and benchmarks that meet the Secretary’s requirements to evaluate program outcomes.

“(f) UNIFORM BASELINE MEASURES.—The Secretary shall establish uniform baseline measures in order to properly evaluate the impact of the demonstration projects under this section.

“(g) PREFERENCE.—In making grants under this section, the Secretary shall give preference to eligible entities that demonstrate

in their applications plans to utilize patient navigator services to overcome significant barriers in order to improve health care outcomes in their respective communities.

“(h) **DUPLICATION OF SERVICES.**—An eligible entity that is receiving Federal funds for activities described in subsection (b) on the date on which the entity submits an application under subsection (e) may not receive a grant under this section unless the entity can demonstrate that amounts received under the grant will be utilized to expand services or provide new services to individuals who would not otherwise be served.

“(i) **COORDINATION WITH OTHER PROGRAMS.**—The Secretary shall ensure coordination of the demonstration grant program under this section with existing authorized programs in order to facilitate access to high-quality health care services.

“(j) **STUDY; REPORTS.**—

“(1) **FINAL REPORT BY SECRETARY.**—Not later than 6 months after the completion of the demonstration grant program under this section, the Secretary shall conduct a study of the results of the program and submit to the Congress a report on such results that includes the following:

“(A) An evaluation of the program outcomes, including—

“(i) quantitative analysis of baseline and benchmark measures; and

“(ii) aggregate information about the patients served and program activities.

“(B) Recommendations on whether patient navigator programs could be used to improve patient outcomes in other public health areas.

“(2) **INTERIM REPORTS BY SECRETARY.**—The Secretary may provide interim reports to the Congress on the demonstration grant program under this section at such intervals as the Secretary determines to be appropriate.

“(3) **REPORTS BY GRANTEES.**—The Secretary may require grant recipients under this section to submit interim and final reports on grant program outcomes.

“(k) **RULE OF CONSTRUCTION.**—This section shall not be construed to authorize funding for the delivery of health care services (other than the patient navigator duties listed in subsection (b)).

“(l) **DEFINITIONS.**—In this section:

“(1) The term ‘eligible entity’ means a public or nonprofit private health center (including a Federally qualified health center (as that term is defined in section 1861(aa)(4) of the Social Security Act)), a health facility operated by or pursuant to a contract with the Indian Health Service, a hospital, a cancer center, a rural health clinic, an academic health center, or a nonprofit entity that enters into a partnership or coordinates referrals with such a center, clinic, facility, or hospital to provide patient navigator services.

“(2) The term ‘health disparity population’ means a population that, as determined by the Secretary, has a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates as compared to the health status of the general population.

“(3) The term ‘patient navigator’ means an individual who has completed a training program approved by the Secretary to perform the duties listed in subsection (b).

H. R. 1812—4

“(m) AUTHORIZATION OF APPROPRIATIONS.—

“(1) IN GENERAL.—To carry out this section, there are authorized to be appropriated \$2,000,000 for fiscal year 2006, \$5,000,000 for fiscal year 2007, \$8,000,000 for fiscal year 2008, \$6,500,000 for fiscal year 2009, and \$3,500,000 for fiscal year 2010.

“(2) AVAILABILITY.—The amounts appropriated pursuant to paragraph (1) shall remain available for obligation through the end of fiscal year 2010.”.

*Speaker of the House of Representatives.*

*Vice President of the United States and  
President of the Senate.*

## 2012 Fact Sheet for SCH staff:

# Finding the Way: Patient Navigators

### WHAT IS A PATIENT NAVIGATOR?

Patient navigators are bilingual individuals who are knowledgeable about the health care system and who combine the roles of case manager, patient advocate and guardian angel for the families they serve. Patient Navigators help families better understand their child's health needs and teach them to navigate the health care system.



*Blanca Fields*

### HOW DO PATIENT NAVIGATORS HELP PATIENTS?

Seattle Children's patient navigators work to remove barriers in a variety of ways.



*Ali Adem*

- They establish trust and rapport with families in their own language.
- They instruct families how to interface with SCH and access our many services.
- They assure that families understand their child's diagnosis and medical care and teach them to ask questions and advocate for their children.
- They assure that providers understand the families' cultural needs.
- They teach families how to successfully navigate the health system on their own.

### HOW DO FAMILIES QUALIFY TO BE ASSIGNED A PATIENT NAVIGATOR?

Seattle Children's Patient Navigator Program currently offers services for families who speak Somali, Spanish or an indigenous language of Mexico or Central America. The program offers services to both inpatient and outpatient families who meet at least two of the following criteria:

- Their children have medically complex needs and are being seen in multiple clinics;
- The family's recent immigration status or limited health literacy is making it hard for them to understand their child's diagnosis and treatment and to advocate for their child;
- Their children are being seen in CCMS, HemOnc, Genetics, or Biochemical Genetics;
- Cultural or religious issues are impacting care;
- The family has a history of missed appointments;
- The family is coming from outside of King County.



*Ivonne Poveda*

### HOW DO I GET A PATIENT NAVIGATOR FOR ONE OF MY PATIENTS?

MDs, ARNPs, PAs, nurses, and social workers may order a patient navigator on CIS or check on Epic to see if a navigator has already been assigned. Referring clinics outside SCH may fax a referral form. Please note that referring for patient navigator services **does not** replace referral for care.

To learn more, please contact Cindy Roat, 206-987-6235, [cynthia.roat@seattlechildrens.org](mailto:cynthia.roat@seattlechildrens.org).



**DATE:** September 11, 2013

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

**FROM:** Emma Medicine White Crow, Chair

**SUBJECT: DISCUSSION—FUTURE PRIORITIES**

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## **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 priorities: education, health insurance coverage, healthcare workforce diversity, obesity, diabetes, poverty, environmental exposures and hazards, and behavioral health. The Council also continues work on two priorities—health reform implementation and the state system with a focus on language access to state services.

At our May meeting, we started the conversation about future priorities. Staff reviewed the processes used to select priority health conditions for the 2010 and 2012 action plans and shared a summary of the input provided by communities. At that meeting, Council members voiced a collective desire to learn more about the Governor's priorities so we could ensure alignment. During this agenda, I would like to continue our conversation and hopefully make decisions about new priorities.

## **Recommended Council Action:**

The Council may choose to amend if necessary or adopt the following motion:

***Motion: The Council selects the following priorities for inclusion in future action plan updates: [insert priorities].***

## Health Topics Considered for Prioritization

Presented to the Governor's Interagency Council on Health Disparities

September 11, 2013

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The following list includes health topics that have been formally considered by the Council for possible prioritization. The list includes those specified in statute as well as those added by Council members. Those that have been chosen as priorities are listed in bold font.

Asthma

**Behavioral Health** (Includes Mental Health and Substance Abuse)

Cancer (Includes Breast, Cervical, Colorectal, and Prostate Cancers)

Chronic Kidney Disease

Culturally and Linguistically Appropriate Healthcare

**Diabetes**

**Education**

**Environmental Exposures and Hazards** (Includes Communities/Neighborhoods)

**Healthcare Workforce Diversity**

**Health Insurance**

Health Literacy

**Health Reform**

Heart Disease and Stroke

HIV/AIDS

Immunization Rates

Infant Mortality (Includes SIDS)

Lupus

**Maternal Child Health & Early Development** (Includes Women's Health, Parenting/Childcare Systems, ACES)

**Obesity** (Includes Physical Activity and Nutrition)

Oral Disease

**Poverty** (Includes Income)

Preventive Services Utilization

Smoking

Social Support

**State System** (Focus on Language Access)

**2010 Action Plan Priorities:** Diabetes, Education, Health Care Workforce Diversity, Health Insurance, Obesity

**2012 Action Plan Priorities:** Behavioral Health, Environmental Exposures and Hazards, Poverty

*\*With a focus on the target population of preconception – age 3*

### Ongoing Priorities:

- State System (Focus on Language Access)
- Health Reform (Monitor and Provide Input)
- ACES (Monitor and Provide Input)



# Washington State Department of Early Learning

## DEL Update, August 2013

Washington State Department of Early Learning sent this bulletin at 08/12/2013  
03:00 PM PDT

Can't view this newsletter? [View it as a web page.](#)



# Washington State Department of Early Learning

## DEL Update | August 2013

### Director's Note



**DEL Director Dr. Bette Hyde**

Managed Education and Registry Information Tool (MERIT) is Washington's online tool for early learning professionals to find trainings, access information on career pathways, and track their individual career progress. It's also become an integral part of the portable background

check process and for participating in Early Achievers, Washington's quality rating and improvement system.

Because MERIT has such a big role for child care providers and their employees, it's vitally important that it be user-friendly and that it work well. We've heard from many child care providers and early learning professionals over the years that MERIT needs work. So, over the next several months, we will be working on finding out what works and what doesn't work in MERIT so we can make it a more usable tool for child care providers, their staff and others who use MERIT.

All MERIT users received an email recently asking them to take a survey about MERIT. That's the first step in a MERIT usability project that we are conducting.

### In This Issue

- [Community group raises money to strengthen families](#)
- [Heirloom Birth Certificates celebrate a new life, helps protect children](#)
- [DEL introduces updated Child Care Basics curriculum](#)
- [News you can use for child care providers and families](#)
- [Fire Marshal accepting comment on school-age care](#)

### News you can use for child care providers and families

#### School zone mini grants available

The Washington State Traffic Safety Commission mini-grants (\$500 or less per award) for training, equipment, and supplies for school zone crossing guards. Public, private and tribal schools in Washington state are eligible to apply. [Read more about the mini-grants.](#)

The next step is a usability study, which means that we will ask a sampling of MERIT users to complete a sequence of tasks in MERIT—both in person and remotely – and then collect data about how they complete those tasks. We will select usability study participants from people who indicated in the survey that they are willing to help.

Once we analyze the results of the survey and tests, we will have a plan of action for making significant improvements to MERIT processes and usability to make this a system that works for you.

The process will take some time, so please bear with us. We will post progress reports on the News and Information section on the MERIT portal page and we will send those by email to MERIT users. We appreciate your participation and invaluable feedback, which will result in a system that works better and more easily for you.

## Community group raises money to strengthen families



Tiger Taekwondo Academy in University Place donated \$646 in proceeds from a fundraiser on Aug. 1 to DEL's Strengthening Families Washington program to support our work to strengthen families in communities around the state. Thank you to the students, family and staff at Tiger Taekwondo Academy for your generous donation!

## Heirloom Birth Certificates celebrate a new life, helps protect children



Celebrate a new life with the official Washington State Heirloom Birth Certificate. A lasting memory of a baby's birth, a reminder of a cherished grandchild, the Heirloom Birth Certificate is the perfect gift for baby showers, birthdays,

graduations, anniversaries—even retirements!

Purchasing an Heirloom Birth Certificate helps protect

## Ecology to amend Children's Safe Products Act reporting rule

The Department of Ecology is proposing to amend the Children's Safe Products - Reporting Rule, Chapter 173-334 WAC. Ecology is accepting public comment in person at 6 p.m. on Aug. 27 at its Lacey headquarters, or by email or postal mail. [Read more about the proposed rules and public comment.](#)

## Seasonal influenza webinar for Head Start and child care providers

Join the Head Start National Center on Health, Healthy Child Care America, and the American Academy of Pediatrics' Disaster Preparedness and Response Initiatives at 11 a.m. on Thursday, Aug. 22 for a 90-minute overview of:

- Influenza and why it can be serious in children.
- Seasonal influenza recommendations for 2013-14 and why it's critical for children and their caregivers to get vaccinated every year.
- Strategies to prevent or control the spread of influenza in Head Start and child care settings.

The webinar will be recorded and posted to the [Early Childhood Learning and Knowledge Center \(ECLKC\) website](#) and [Healthy Child Care America website](#).

Participants will receive a certificate upon completion of an online webinar evaluation, which they will receive a link to after the webinar closes. Participants MUST complete the online evaluation in order to receive a certificate. Only participants who view the LIVE webinar will be eligible for a certificate.

[Register here.](#)

## Learn the Signs, Act Early webinar

Child Care Aware of America is hosting a free webinar to help child care providers learn how they can integrate the Centers for Disease Control and Prevention's "Learn the Signs. Act Early" messages and materials into their programs.

The one-hour webinar is at 4 p.m. on Aug. 22. [Register here.](#)

## Fire Marshal

children. More than half of the certificate's \$40 purchase price benefits the Children's Trust Fund of Washington.

To order an Heirloom Birth Certificate:

- Contact the Department of Health Center for Health Statistics at **360.236.4300**
- Follow the ordering instructions at [the Center for Health Statistics website](#).

## DEL introduces updated Child Care Basics curriculum

DEL has released the new Child Care Basics curriculum, a revised version of the existing Basic STARS training. DEL collaborated with a team of early childhood education faculty in Washington to develop the new curriculum, which includes introductory material on child development, learning environments, school readiness topics and Early Achievers in addition to fundamental concepts on health and safety and quality practice. The curriculum focuses on Core Competencies for Early Care and Education Professionals, aligns with the new Washington Administrative Code (WAC) requirements, and meets the needs of professional in child care centers and family child care homes.

DEL is in the process of introducing the curriculum to Washington state-approved trainers via webinars in August and September. Once the trainers attend the webinar, they will be able to offer the training to early learning and child care professionals.

The new curriculum will also be offered at community colleges and Washington Online Learning (WAOL) online starting this fall, and will be worth 3 credits.

At this time, school-age providers should continue taking the 20-hour STARS training. The Child Care Basics curriculum does not include information for school-age providers.

Providers who complete the Child Care Basics curriculum are eligible for cost reimbursement through DEL. You can find more information about this in [MERIT](#) or [contact your licensor](#).

## accepting comment on school-age care

The State Fire Marshal has filed proposed rules regarding before and afterschool care in school buildings as a result of House Bill 1968. The rules will be posted online shortly, and a public hearing is scheduled at 10:30 a.m. on Aug. 27 in Olympia.

[View more information](#) on Washington State Patrol's website.

## ESIT Program Administrator wins national award



DEL's ESIT Program Administrator Karen Walker recently won a national Family Involvement Advocacy Award from the Early Intervention Family Alliance (EIFA). Karen was given the award while attending the Office of Special Education Programs (OSEP) Conference in Washington DC.

Karen was recognized for her leadership and support of family engagement in Washington's Part C Early Intervention System. Karen was presented the award by Kim Travers, EIFA President, at right in the photo.

DEL congratulates Karen on her work on behalf of Washington families.

*Photo: Karen Walker, left, receives an award from EIFA President Kim Travers.*

**Governor's Interagency Council on Health Disparities  
Quarterly Council Meeting Agenda – Selected Agenda Items of Note**

**Updates from DOH**

**Health Care Reform (HCR)** – Secretary Wiesman has appointed a new special assistant on health care reform, Sue Grinnell. Sue is the former director of the Office of Healthy Communities. She will be forming an internal advisory group to work on identifying the role of public health in health care reform, creating fact sheets, and developing Power Point presentations. An IOM report entitled [A Bold New Proposal for Advancing Population Health](#) may be a helpful resource. Sue is available to attend a future Council meeting to provide an update on the Affordable Care Act (ACA).

**Climate Change**

As you know, one of my (Secretary Wiesman) priorities coming into this job was clarifying our public health role in climate change. Jerrod Davis, Office Director for Shellfish and Water Protection, has agreed to take on the role of climate change lead along with his other duties. Jerrod has a real interest in the topic and his office is currently facing climate changes challenges with ocean acidification and increased harmful algae blooms all severely impacting shellfish growers. See the following article on *“framing global warming as a public health issue rather than as an environmental or national security one”*.

<http://link.springer.com/content/pdf/10.1007%2Fs10584-012-0513-6.pdf>

**Language Access**

The Women, Infants and Children (WIC) Program has a project that includes surveying retailers, WIC clinic staff, and WIC clients. To reach even more people, WIC offers the client survey in Spanish.

**Adult Immunizations**

The Immunization program continues to plan and implement adult immunization activities in Washington. We partnered with the Washington Association of Community and Migrant Health Centers to increase adult immunization awareness and rates. One of the focuses of this work is educating Spanish-speaking health promoters and community workers about the importance of adult immunizations. As a result of funding through the Prevention and Public Health Fund Grant, we were able to provide training again this year.

**Excellence in State Public Health Law Program**

Washington has been chosen along with seven other states to take part in the Aspen Institute's Justice and Society Program's very first Excellence in State Public Health Law

Program. The Aspen Institute is an educational and policy studies organization based in Washington, D.C. that works to develop leadership based on strong, long-term, nonpartisan values on crucial issues. This one-year program will deepen our capacity to develop state public health policy. Teams will focus on exploring, identifying, and evaluating how law and policy can advance a health priority identified by the participating states. The WA priority will be the use of public health law tools to implement the “Baby-Friendly Ten Steps to Successful Breastfeeding”. Click on the link below for additional information.

<http://dohweb/News/Newsletters/Sentinel/2013/Sentinel2013-07.pdf>

### **New Employee Orientation (NEO)**

Starting in June 2013, all new health department employees are required to attend a NEO. Health Equity is included as an essential component of the orientation and the foundation of public health. Sessions are offered on the 1<sup>st</sup> and 16<sup>th</sup> of each month. For a copy of the Power Point slides, contact Gail Brandt at [gail.brandt@doh.wa.gov](mailto:gail.brandt@doh.wa.gov).

### **Community Health Worker Training**

Community health workers play an important role in healthcare. They help Washington residents access and navigate the healthcare system. This role must be filled once the Affordable Care Act takes effect in 2014. The Community Health Worker Training Program just completed its third quarter of training for 2013 and the fourth begins August 2013. Since we rolled out the training program in fall 2012, 265 participants have graduated. Graduates are eligible to enroll in one-week health specific online modules. We are excited to offer two new health specific modules; “Understanding Health Insurance” and “Understanding Disparities and Social Determinants.”

### **Results Washington**

<http://dohweb/PaA/docs/gmap/Results%20WA/All%20Goal%20Maps%207-31-13.pdf>

### **2012 BRFSS Adult Obesity State Map**

<http://www.cdc.gov/obesity/data/adult.html>

**Be Active Together:  
Improving Health Disparities through Community Empowerment**

Thursday, September 26, 2013  
4:00 - 6:00 p.m.  
Neighborhood House High Point Center  
6400 Sylvan Way SW  
Seattle, WA 98126

Dear Winona,

From 2008-2013, Neighborhood House's Be Active Together project worked to reduce health disparities among public housing residents. During this time, Be Active Together:

- Helped over 400 residents access new and existing physical fitness opportunities,
- Advocated for culturally appropriate women-only swim and exercise models, currently implemented at multiple sites
- Increased community engagement and neighborhood cohesion among thousands of diverse, low income residents.

Please join Neighborhood House's leadership and our Be Active Together team as we share insights gained from this project and discuss how to build on its successes, and sustain the project's positive impact. As a model ripe for replication in other communities, we would love to have you join us in this discussion!

Kindly RSVP to Molly Franey at [mollyf@nhwa.org](mailto:mollyf@nhwa.org) or 206-760-9330, ext. 10 by Friday, September 20th.

Warm regards,

Mark Okazaki  
Executive Director  
Neighborhood House  
461-8430 x240  
[marko@nhwa.org](mailto:marko@nhwa.org)

**More about Be Active Together**

Over the course of five years, Neighborhood House staff collaborated with local service providers, civic groups and other partners in a campaign emphasizing community engagement in the promotion of healthy living. By identifying and addressing barriers to good health in the High Point and Greenbridge public housing communities, we developed a model that can be applied elsewhere to reduce health disparities in low-income communities.

Through the course of the project, we encouraged members of the community to

advocate for accessible means to improve their community's health and safety. Advocacy training and the resulting Community Action Teams led to real change. The resident-driven programs combated existing barriers by establishing new low-cost and culturally-appropriate options to healthy living within the High Point and Greenbridge neighborhoods.

Food House was proud to have had Seattle Mayor Mike McGinn as our guest at the Society Center and Pool. Staff, volunteers, and participants with our Be Active Together program thanked the mayor for implementing single-gender swim sessions at four Seattle Parks and Rec locations.