

<b>9:45 a.m.</b>	<b>CALL TO ORDER &amp; INTRODUCTIONS</b>	Emma Medicine White Crow, Council Chair
<b>9:50 a.m.</b>	1. Approval of Agenda — <i>Action</i>	Emma Medicine White Crow, Council Chair
<b>9:55 a.m.</b>	2. Approval of September 11, 2013 Minutes — <i>Action</i>	Emma Medicine White Crow, Council Chair
<b>10:00 a.m.</b>	3. Announcements and Council Business	Christy Hoff, Council Staff
<b>10:10 a.m.</b>	4. Proposed 2014 Council Meeting Schedule — <i>Possible Action</i>	Desiree Day Robinson, Council Staff
<b>10:20 a.m.</b>	5. Update—CLAS Project	Yris Lance, Council Staff
<b>10:40 a.m.</b>	6. Briefing—Health Impact Reviews	Christy Hoff, Council Staff Sierra Rotakhina, Council Staff
<b>11:00 a.m.</b>	7. Briefing—Tobacco Prevention and Control in Washington State	Gail Brandt, Council Member Paul Davis, Department of Health Frances Limtiaco, Department of Health Joella Pyatt, Department of Health
<b>11:30 a.m.</b>	8. Briefing—Washington Environmental Biomonitoring Survey	Millie Piazza, Council Member Ann Butler, Department of Health
<b>12:00 p.m.</b>	<b>LUNCH</b>	
<b>1:00 p.m.</b>	9. Update—Food System Roundtable	Gail Brandt, Council Member Amy Ellings, Department of Health
<b>1:30 p.m.</b>	10. Update—Rural Healthcare Strategic Plan	Emma Medicine White Crow, Council Chair Jeff Mero, Association of Washington Public Hospital Districts
<b>2:00 p.m.</b>	11. Public Comment	
<b>2:20 p.m.</b>	<b>BREAK</b>	
<b>2:30 p.m.</b>	12. Review and Discuss Action Plan Update — <i>Possible Action</i>	Emma Medicine White Crow, Council Chair Christy Hoff, Council Staff
<b>3:15 p.m.</b>	13. Review and Discuss Recommendations of the Priority Setting Workgroup — <i>Possible Action</i>	Emma Medicine White Crow, Council Chair Marietta Bobba, Council Member Gail Brandt, Council Member Vazaskia Caldwell, Council Member
<b>4:00 p.m.</b>	14. Council Member Announcements	
<b>4:30 p.m.</b>	<b>ADJOURNMENT</b>	

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 Dec. 6, 2013. This meeting site is barrier free. Emergency contact number during the meeting is (360) 701-2398.



**Draft Minutes of the Governor's Interagency Council on Health Disparities  
September 11, 2013  
Department of Health, Point Plaza East, Rooms 152/153  
310 Israel Road S.E., Tumwater, WA 98501**

**HDC members present:**

Sofia Aragon  
Marietta Bobba  
Gail Brandt  
Vazaskia Caldwell  
Nora Coronado  
Willie Frank

Nova Gattman  
Frankie Manning, Vice Chair  
Emma Medicine White Crow, Chair  
Millie Piazza  
Gwendolyn Shepherd  
Greg Williamson

**HDC members absent:**

Kim Eads  
Jonathan Green  
Winona Hollins-Hauge

Diane Klontz  
Steve Kutz

**HDC Staff present:**

Michelle Davis, Executive Director  
Timothy Grisham, Communications Consultant  
Christy Hoff, Health Policy Analyst

Yris Lance, CLAS Project Manager  
Desiree Robinson, Executive Assistant

**Guests and Other Participants:**

Mary Beth Brunke, Walgreens  
Christine Espina, Washington Center for  
Nursing  
Dawn Hanson, Public Participant  
Adrian Hodos, Cross Cultural Health Care  
Program  
Jackie LeSage, Samoan National Nurses  
Association  
Frances Limtiaco, Washington State  
Department of Health  
Mikaela Louie, Cross Cultural Health Care  
Program

Rebecca Louie, Cross Cultural Health Care  
Program  
Yolanda Lovato, Department of Social and  
Health Services  
Don Martin, Department of Health  
Jason McGill, Governor's Executive Policy  
Office  
Sarah Rafton, Seattle Children's Hospital  
Alison Robbins, Health Care Authority  
Janet St.Clair, Asian Counseling and Referral  
Service  
Evan Stults, Qualis Health

Emma Medicine White Crow, Council Chair called the public meeting to order at 10:07 a.m. She acknowledged that it was September 11, and asked to take a moment to remember those who lost their lives on that date. She thanked everyone for coming and read from a prepared statement (on file). She facilitated introductions of Council members, staff, and members of the public.

**1. APPROVAL OF AGENDA**

Chair Medicine White Crow said there would be a change to the agenda. Jason McGill from the Governor's Office asked to present earlier than originally scheduled. She proposed swapping agenda items 4 and 7.

***Motion:** Approve September 11, 2013 agenda as amended to switch agenda items 4 and 7.*

***Motion/Second:** Frankie Manning/ Marietta Bobba. Approved unanimously.*

**2. ADOPTION OF MAY 8, 2013 MEETING MINUTES**

***Motion:** Approve the May 8, 2013 minutes*

***Motion/Second:** Frankie Manning/ Vazaskia Caldwell. Approved unanimously.*

**3. ANNOUNCEMENTS AND COUNCIL BUSINESS**

Christy Curwick Hoff, Council Staff referred Council members to a letter of support under Tab 3, which was provided to the Group Health Research Institute for a proposal to study asthma care improvement in the Yakima Valley. She said since the last meeting, the Office of the Governor approved the Council's 2013 Update report, which is now available on the Council's web site. She shared that funding for health impact reviews was reinstated in the 2013 biennial budget and the Board was in the process of hiring for the position. She thanked Member Brandt for serving on the interview panel and assisting with recruitment. She introduced Nova Gattman, Council member representing the Workforce Training and Education Coordinating Board.

**4. BRIEFING—GOVERNOR'S HEALTH PRIORITIES**

Chair Medicine White Crow introduced Jason McGill, Health Policy Advisor for Governor Jay Inslee's Legislative Affairs & Policy Office. She said she hoped to develop a stronger relationship with the Governor's Office. Mr. McGill shared information about Results Washington, which was launched by the Governor's Office yesterday. He shared a current draft of measures and indicators for [Goal 4: Healthy and Safe Communities](#). He said they were in a period of taking public comment on the proposed framework. He said he was impressed with the Council's 2013 update to its 2012 action plan and was happy that agencies were in the process of implementing recommendations.

Gail Brandt, Council Member, asked how Governor Inslee would take input and refine the Results Washington process. Mr. McGill said the public could provide comments online via an email form. Greg Williamson, Council Member, thanked Mr. McGill for highlighting the interrelationships between the goals – for instance education and health. He highlighted the collaborative work on childhood obesity prevention between the Department of Early Learning, Department of Health, Office of Superintendent of Public Instruction, and the Governor's office. He asked about the Governor's interest in a health-in-all-policies approach—such as how health would be incorporated into the other goals or within non-health agencies' data systems. Mr. McGill agreed there is an opportunity to look for linkages, highlighting the connections between education, poverty, the environment, and health. Vazaskia Caldwell, Council Member, asked if the Governor's Office worked with community stakeholders in developing the framework. She highlighted the provisions in the Affordable Care Act that were specific to eliminating health disparities and said support for the implementation of those equity provisions would move us in the right direction. Member Brandt said the US Census would soon be releasing 2012 poverty data, including data on income disparities and asked if the Governor's office had plans to respond to it in any way. Mr. McGill agreed that the income gap was a huge indicator of community health but said he did not think a response to a document like that was something the Governor would typically do. Frankie Manning, Council Vice

Chair, reiterated the need to integrate across the different Results Washington goals. She said she was interested in how we can increase graduation rates among youth in prison. Nova Gattman, Council Member, asked if there were strategies within Results Washington related to school lunch programs, e.g., farm to school. Member Williamson said those topics were being addressed under the childhood obesity prevention initiative. Mr. McGill added that Arkansas was a leader in developing and implementing strategies to prevent childhood obesity. Member Williamson said OSPI has been working with the organizations that manage school stores, which provide competition to school lunch programs, to encourage them to offer healthier options. Vice Chair Manning discussed her interest in improving diversity within the health professions.

Chair Medicine White Crow said the Council wants to highlight the good work being done by the agencies and commissions at the table. She said Council meetings serve as a way to learn from others and take good ideas back to our respective agencies. Mr. McGill said that on October 1, we have an historic opportunity to enroll people who have never had insurance and help them to engage in the healthcare system. He said that was an example of what we can do immediately to work together. He added that the Council is doing a great job with its recommendations and implementation and the Governor's office is reviewing them and using its reports.

#### **5. BRIEFING—STATE PARTNERSHIP GRANT, IMPLEMENTING NATIONAL CLAS STANDARDS IN WASHINGTON STATE**

Chair Medicine White Crow invited staff to give their presentation. Ms. Hoff said the Council's grant, which supported outreach and community engagement work ended on August 31. She said they were able to apply for and were successfully awarded a new two-year grant; however, restrictions on what the new grant could be used for prohibited them from submitting a proposal to maintain their community outreach activities. She said the new grant offered an opportunity to promote the National Standards on Culturally and Linguistically Appropriate Services in Health and Healthcare (CLAS Standards). Ms. Hoff introduced Don Martin, Senior Health Educator with the Department of Health and Yris Lance, Council Staff. Mr. Martin gave an overview of the National CLAS Standards and Ms. Lance shared information on the grant project (presentation on file).

Member Caldwell asked for clarification about how staff would track implementation of CLAS standards during the grant. Ms. Hoff said they would track whether the organization has a written policy and would use an assessment tool to determine the degree to which the standards are being implemented. Sofia Aragon, Council Member, thanked Mr. Martin and Ms. Lance – she said the handouts provided (on file) were helpful in providing practical guidance and concrete examples to organizations that want to improve services but don't know how to operationalize the concepts of providing culturally and linguistically appropriate care. Gwendolyn Shepherd, Council Member, and Chair Medicine White Crow spoke about the importance of plain talk and sharing information at a level appropriate for the audience. Chair Medicine White Crow stressed the need to focus on culture and ensuring resources and services are provided in culturally appropriate ways. Vice Chair Manning highlighted the importance of diversity in leadership positions. She said partnerships with the medical and nursing associations were important but emphasized the need to link with the educational system to secure interest in the health professions among students early in life.

*The Council recessed for lunch and reconvened at 1:05 p.m.*

## 6. PUBLIC COMMENT

Chair Medicine White Crow opened the meeting up for public comment and read from a prepared statement (on file).

Michaela Louie, Manager of Cultural Competency Training and Consulting at the Cross Cultural Health Care Program, said she hoped to reconnect with the Council. She said the Cross Cultural Health Care Program provides “Bridging the Gap” medical interpreter training. She their cultural competency training includes new modules on the social determinants of health, the Affordable Care Act, and the CLAS standards. She said her organization consulted on an American Medical Association organizational assessment tool. The tool is designed for hospitals but can be used by public health and social service agencies and is fully aligned with the enhanced CLAS standards. She said they are also developing a new training for patient guides, which will provide medical interpreters with additional training to be patient guides.

Evan Stultz, Communications Director at Qualis Health, said his organization is a nonprofit healthcare organization that provides health care quality improvement services for the state. He said one of their new priorities is to investigate and reduce unnecessary hospitalizations in Medicare. Qualis staff has been providing data on hospital readmissions to health organizations, including disaggregated data by race/ethnicity. They have found in all communities the rate of hospitalizations for non-whites exceeds that of the white population. They have had some exciting dialogue with their stakeholders and will be hosting a meeting to discuss further in November. The focus will be on how to ensure effective care coordination at hospital discharge. He said he will share the meeting invitation when they have more details.

Christine Espina, Diversity Network Director with the Washington Center for Nursing, announced that the Center is about to celebrate its 10<sup>th</sup> anniversary. She said her role is to promote diversity and inclusion in the nursing workforce and she has been working to develop and launch a mentoring program. She said they are actively recruiting mentors and mentees. The program is partnering with health systems across Western Washington and they hope to expand across the state next year. Member Caldwell suggested they partner with Multicare’s nurse camp.

Janet St. Clair, Asian Counseling and Referral Services, said she had three questions about the implementation of CLAS standards. Her first question was about how organizations can assure fidelity to programs while adapting to ensure the programs are culturally and linguistically appropriate. She also asked about how the CLAS standards will align with the State Health Care Improvement Planning work being led by the Health Care Authority in partnership with the Governor’s Office and other state agencies. Her final question was how to measure and enforce that CLAS standards are being followed in provider contracts. Member Aragon said it is important to ensure CLAS standards are considered when implementing evidence-based practices. Ms. St. Clair added that practice-driven research is important in communities of color. She said evidence-based practices can be adapted in appropriate ways so that the practice still has fidelity. She also stressed the importance of having culturally modified materials so they are meaningful for the specific community. She said evidence-based practices are clearly important but that cultural and linguistic adaptations need to be considered at the state level.

Jackie LeSage, Samoan National Nurses Association, said was hoping to have a member of the Marshallese community come to speak to the Council. She said the children attending the school system in Spokane are more likely to speak Marshallese than Spanish. She wanted to share some of

the needs and concerns of this underserved community – they have challenges with accessing health care in Washington State.

Dawn Hanson, public participant, said she lives in the Highlands Neighborhood on the Columbia River in Cowlitz County. She referenced a letter she wrote about an environmental justice issue in her neighborhood (on file under Tab 6). She provided demographic information on the community and mentioned some of the toxic release sites in the neighborhood. She said there are now plans to subject the neighborhood to a coal terminal. This is a community with disproportionately high mortality rates. She thinks this issue deserves the attention of the Council and she invited someone from the Council to come to the hearing. Willie Frank, Council Member, said the Nisqually Tribe and other Tribes have been involved as well. Millie Piazza, Council Member, said she brought a flyer announcing the public meeting. She also referred Council members to the Department of Ecology website where they have information on a public comment period.

## **7. DISCUSSION—FUTURE DIRECTIONS FOR COUNCIL OUTREACH AND ENGAGEMENT**

Chair Medicine White Crow referred Council members to the memo in their packets. Ms. Hoff provided background information on the Council's past grant projects from the Office of Minority Health. She discussed the kinds of outreach and engagement efforts they had been able to support through past grants and reiterated that the new grant project would not be able to support those outreach efforts. She said they would need to develop new strategies to continue outreach and engagement efforts and talked about the continuum of community engagement from information sharing to true collaborative decision-making. Timothy Grisham, Council Staff, gave his presentation, which provided demographic data on social media use (presentation on file). Mr. Grisham shared plans to create some new outreach channels through social media and the Council's web site. He stressed that the new Internet communication strategies would not be able to replace the face-to-face outreach and engagement with community but could be used to supplement efforts and to reach potentially new audiences.

Member Brandt asked about the process for determining what information would be posted to the web site. Ms. Hoff said the process would not change. She said Council members were welcome to share information, meeting notices, resources, and other items with staff for posting to the web or distribution through Facebook or Twitter. Member Brandt asked if we would be able to continue to meet the informational needs of the communities that we have engaged with in the past. Ms. Lance and Mr. Grisham reiterated that we will not be able to reach everyone with social networking. They stressed that without dedicated outreach funding, the Council will need to find creative ways to reach people. Ms. Hoff said she hoped to continue the discussion and asked members to consider how we can all work together—members and staff—to collectively provide outreach and engagement by leveraging resources and opportunities where we might already be providing information to or engaging communities in the work we do. Member Williamson suggested that we also work with students and student groups to share information and resources.

## **8. BRIEFING—RESOURCES FOR NAVIGATING THE HEALTHCARE SYSTEM FOR THE NEWLY INSURED**

Chair Medicine White Crow said Council members initiated a conversation at the last meeting about how individuals who receive insurance for the first time under the Affordable Care Act will be able to effectively navigate the complex health care system. She said this agenda item would allow the Council to continue that conversation. Member Caldwell shared background information on four

patient navigator pilot programs that began in 2008. She said patient navigators are members of the community they serve who are knowledgeable about the health care system. They assist patients by coordinating services, improving communications, and resolving problems. Sarah Rafton, Seattle Children's Hospital, provided information on the patient navigator program at Seattle Children's. She highlighted evaluation data that demonstrated the program's success in reducing missed outpatient appointments, increasing completed specialty referrals, reducing inpatient admissions and length of stays, and increasing the appropriate use of professional interpreters. Alison Robbins, Health Care Authority, provided information on the Washington Apple Health managed care program. She highlighted the care management and care coordination assistance provided through Apple Health as well as informational resources provided to patients. Yolanda Lovato, Department of Social and Health Services, provided a presentation on HealthPath Washington, which is a program aimed at integrating Medicare and Medicaid services. She shared the two strategies being employed (health homes and full integration capitation) and the care coordination and support services provided by each. All presentations are on file under Tab 8. Vice Chair Manning thanked the presenters and said they provided a lot of good information to think about.

## 9. DISCUSSION—FUTURE PRIORITIES

Chair Medicine White Crow referred Council members to the memo under Tab 9 and said the Council started the conversation about selecting new priorities at its last meeting. She said today we had an opportunity to hear about Governor Inslee's priorities and she referred members to a list in their packets of all the health topics that have previously been considered, including those that have been selected in the past. She said that she hoped they would identify some new priorities by the end of the day's discussion.

Member Brandt said a priority for the Department of Health was childhood obesity (healthy weight). She also suggested examining the state's regressive tax structure or identifying a focus on maternal and child health. Nora Coronado, Council Member, suggested a focus on environmental health issues that disproportionately affect Latinos. Marietta Bobba, Council Member, suggested a focus on the health disparities in our foster care system. Member Williamson said OSPI works with students in foster care, students affected by homelessness, and students affected by military deployment. He agreed with a focus on these vulnerable children. He also stressed the importance of academic achievement and reducing dropout rates. He suggested a focus on the "second decade", i.e., the behavioral choices that kids make between 10-20 years of age. He said unhealthy choices that children make are often symptoms of underlying problems. Gwendolyn Shepherd, Council Member, said we are underusing our senior population. She said we should look at retooling and refurbishing seniors who want to be involved in improving the health of their communities. Member Caldwell said obesity and diabetes are still real problems that affect many populations and we need to keep those as priority areas until we have made real strides in reducing disparities. She said she liked the recent approach taken by the Council of focusing on state actions that can be done to reduce disparities and holding agencies accountable for implementing Council recommendations. Chair Medicine White Crow agreed that there are more opportunities to address obesity and diabetes since a greater proportion of our population will have access to health insurance. Member Gatman said it might be interesting for the Council to focus on work-integrated learning (i.e., education and training supported by one's employer). She said this approach could be used to improve the diversity of the healthcare workforce by enabling people with entry-level jobs to move up the career ladder. She said she would brainstorm ways for the Council and the Health Care Personnel Shortage Task Force to work together. Member Brandt said it would be helpful to have guidelines for choosing priorities. She also suggested focusing on a few priorities where we have opportunities to partner with others.

Vice Chair Manning said she hoped we'd be able to align our work with the Governor's priorities and she highlighted some of the indicators in the Results Washington handouts that focused on increasing immunization rates and the percentage of people with healthy weight. She said agencies would be working on the Governor's priorities so there would be plenty of opportunity to collaborate with others. Vice Chair Manning clarified that we wanted to identify some new priorities at this meeting. She said immunizations, infant mortality, and adverse childhood experiences (ACES) were important topics to her, stressing the need to keep kids healthy. Member Bobba said with the military presence in Washington, we have a lot of grandparents raising grandchildren. She also said she hoped we would work toward ensuring cultural competence in state services, including an expectation that contractors would also adopt cultural competence policies and practices. Member Williamson advised that we should focus on a priority area that we are uniquely situated to address. Vice Chair Manning agreed and said we could contribute an equity lens to current priority areas. Member Caldwell said implementing the CLAS Standards as a priority would be a good focus because it is something all agencies can and should be doing. She stressed that providing culturally and linguistically appropriate state services should be the foundation for what the Council does. She said all agencies could report on progress with adopting and implementing the standards. Chair Medicine White Crow said it would offer the opportunity to collaborate, partner, and support each other across agencies. Member Piazza agreed with each representative holding their agencies accountable for implementing the CLAS standards. She emphasized the need to continue to find tangible ways of implementing current priorities as well. Member Williamson suggested appointing a subcommittee to come back to the December meeting with a proposed set of priorities. Chair Medicine White Crow said she thought a consensus was building around tracking progress toward the implementation of CLAS standards. There was general agreement to prioritize the implementation of CLAS standards. In addition, the following members volunteered to meet in the interim to bring back a proposal for future priorities at the December meeting: Members Caldwell, Bobba, Brandt, and Chair Medicine White Crow.

***Motion:** The Council selects the implementation of the National CLAS Standards as a priority and will convene an ad hoc workgroup of members to develop a proposal for additional priorities to bring back to the full Council for its consideration at the December 11, 2013 meeting.*

***Motion/Second:** Vazaskia Caldwell/Frankie Manning. Approved unanimously.*

## 10. COUNCIL MEMBER COMMENTS

No comments taken at this meeting.

## ADJOURNMENT

Chair Medicine White Crow adjourned the meeting at 4:30 p.m.



STATE OF WASHINGTON  
GOVERNOR'S INTERAGENCY COUNCIL ON HEALTH DISPARITIES

Washington State Board of Health

PO Box 47990 • Olympia, Washington 98504-7990

October 9, 2013

Patty Hayes  
Director, Division of Community Health Services  
Public Health – Seattle & King County  
401 Fifth Avenue, Suite 1000  
Seattle, WA 98104

Dear Ms. Hayes:

We are pleased to submit this letter of support for your application to CityMatCH for the Institute for Equity in Birth Outcomes—Cohort 2.

The Governor's Interagency Council on Health Disparities is dedicated to eliminating health inequities by race/ethnicity and gender in Washington state, including disparities in birth outcomes. 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 have enjoyed our collaborative relationship with the Equal Start Community Coalition and look forward to working together to establish an evidence-based practice to address disparities in birth outcomes. We find it unacceptable that American Indian/Alaska Native babies die four times as often, and African American babies at twice the rate as white babies in King County. We are pleased to continue working collaboratively through the Coalition to determine the way forward to eliminating persistent upstream inequities that result in birth outcome disparities in King County and hope to find ways to ensure findings are used to redress such disparities statewide.

We applaud Public Health – Seattle & King County for taking the lead in seeking to address the root causes that lead to these disparities and wish you the best of luck with your application.

Sincerely,

*Emma R. Medicine White Crow*

Emma Medicine White Crow, Chair

## Governor's Interagency Council on Health Disparities Policy & Procedure

<b>Policy Number:</b>	2009-02
<b>Subject:</b>	COMMUNICATING WITH THE LEGISLATURE
<b>Adopted:</b>	February 5, 2009

### Policy Statement:

The Governor's Interagency Council on Health Disparities (Council) was created to help Washington become the healthiest state in the nation by striving to eliminate health disparities by race/ethnicity and gender. Toward this end, the Council is charged with:

- creating a state policy action plan to eliminate health disparities;
- promoting and facilitating communication, coordination, and collaboration among state agencies, the private sector, and communities of color to address health disparities;
- developing recommendations for improving the availability of culturally and linguistically appropriate health literature and interpretive services; and
- gathering information to understand how the actions of state government ameliorate or contribute to health disparities.

In some instances, the Council's responsibilities may be served through identifying, monitoring, and communicating with the Legislature about proposed legislation relevant to the Council. This policy and procedure provides guidance to assist the Council in its decisions whether to provide written or oral testimony or otherwise communicate with the Legislature about proposed legislation.

### Procedure:

Recognizing that decisions about whether to communicate with the Legislature about proposed legislation need to occur in a very short timeframe, the Council authorizes the Chair to make these decisions on behalf of the Council. The Chair may, however, at his or her discretion, consult with individual Council members in making a decision.

During session, Council staff will routinely monitor legislative bill introductions, committee agendas, and other legislative matters to identify bills that may warrant attention by the Council. Council staff shall consider the following guidance when deciding whether to bring a legislative proposal to the attention of the Council Chair:

- The policy or budgetary proposal has a direct impact on the Council's statutory powers and duties or it is directly related to policy recommendations supported by the Council in its state action plan or any interim document approved by the Council, and
- communicating to the Legislature about the policy or budgetary proposal does not run counter to any policy, guidance, or other activity of the Governor or any agency, board, or commission with representation on the Council.

In addition to responding to bills or budget proposals that warrant the Council's attention, the Chair may work with staff and individual Council members to respond to inquiries from members of the Legislature or to provide information about Council priorities and activities to legislators or staff at a legislator's request.

The Council Chair or his or her designee must approve correspondence with legislative staff or members. Such correspondence should routinely be copied and sent to the Department of Health

Office of the Secretary – Policy, Legislative, and Constituent Relations, as consistent with the Board of Health's policy and procedure on communicating with the Legislature (Policy Number 2001-004).

An individual Council member may speak or write to the Legislature on proposed legislation or other matters. In such cases, the speaker should clarify that such communications are from a single Council member and do not necessarily reflect the views of the entire Council.

Any Council member or Council staff member who addresses comments to the Legislature or its staff on proposed legislation relating to the Council must report such activity to the Executive Director of the State Board of Health who must prepare a consolidated quarterly report on such activity as required by the Public Disclosure Commission according to 42.17.190 RCW.

## 2014 Board/Council Meeting Schedule

Approved by the Board 11/13/13

Approved by the Council [date]

	Meeting Date	Location
Board	Wednesday January 8, 2014	Department of Health Point Plaza East, Room 152/153 310 Israel Road SE, Tumwater, WA 98501
Council	Wednesday February 12, 2014	Department of Health Point Plaza East, Room 152/153 310 Israel Road SE, Tumwater, WA 98501
Board	Wednesday March 12, 2014	Location to be determined—possibly Vancouver
Board	Wednesday April 9, 2014	<b>Hold date – meet only if necessary</b>
Council	Thursday May 15, 2014	Location to be determined – possibly SeaTac area
Board	Wednesday June 11, 2014	Eastern Washington – possibly Spokane
Board	Wednesday July 9, 2014	<b>Hold date – meet only if necessary</b>
Board	Wednesday August 13, 2014	Location to be determined
Council	Thursday September 11, 2014	Department of Health Point Plaza East, Room 152/153 310 Israel Road SE, Tumwater, WA 98501
Board	Wednesday October 8, 2014	Location to be determined
Board	Wednesday November 12, 2014	Location to be determined
Council	Thursday December 11, 2014	Location to be determined

Start time is 9:30 a.m. unless otherwise specified. Time and locations subject to change as needed.  
See our website at [www.sboh.wa.gov](http://www.sboh.wa.gov) for the most current information.

Last updated 11/25/2013



# Implementing National CLAS Standards in Washington State

**Yris Lance, MA**

CLAS Standards Project Manager

# Implementing National CLAS Standards in Washington State

## Project Goals

- ▶ Increase development, adoption, and implementation of CLAS policies among government agencies, health and healthcare organizations.
- ▶ Provide education about the importance of cultural competency and language services.

# Implementing National CLAS Standards in Washington State

The Enhanced National CLAS standards can be implemented by any entity wishing to provide services that are responsive to the diverse cultural, language, literacy, and other needs of the populations it serves.

# Implementing National CLAS Standards in Washington State

- ▶ The project *Implementing National CLAS Standards in Washington State* aims to assist government agencies, health, health care and other organizations meet federal requirements established in Title VI of the Civil Rights Act of 1964.
  - Title VI prohibits recipients of federal funding from discriminating on the basis of race, color, or national origin.
  - RCW 49.60.030 establishes freedom from discrimination -- Declaration of civil rights.
  - US Supreme Court decisions include discrimination against people with limited ability to understand English as part of discrimination against national origin.

# Implementing National CLAS Standards in Washington State

## Participating in this project

- ▶ Individual organizations
  - A) Participate in CLAS Collaborative Team to develop culturally and linguistically appropriate policies and practices
  - B) Receive CLAS training, resources, and technical assistance
  
- ▶ Commissions, Associations and Groups
  - Promote CLAS information, training and policy development within their constituencies
  
- ▶ Conferences and Forums
  - Include CLAS sessions/presentations

## Participating in a CLAS Collaborative Team

Organizations will receive increased access to CLAS information, resources, training, and the necessary technical assistance for the development, adoption, and implementation of culturally and linguistically appropriate policies and practices.

Team members must be committed to identifying and evaluating current and future organizational needs and establishing achievable goals to improve, meet and/or exceed National CLAS standards.

# CLAS Collaborative Activities Summary Checklist

- ▶ Complete organizational pre-assessment
- ▶ Select CLAS Collaborative Team members
- ▶ Participate in basic CLAS training
- ▶ Complete organizational self-assessment
- ▶ Select organizational priorities and goals
- ▶ Create a work plan
- ▶ Develop policy and practices
- ▶ Adopt and broadly disseminate CLAS policy
- ▶ Implement CLAS policy and practices
- ▶ Establish a periodic review/update process
- ▶ Participate in state team meetings to share experiences, challenges, successes and lessons learned (Possible)

## Project Timeline

CLAS Project staff estimates that participating organizations can complete their policy and practice guide in a period of 9 months. Nonetheless, each organization will be able to work with Council staff to develop a timeline according to their capacity.

# Implementing National CLAS Standards in Washington State

## EDUCATION

- ▶ Organizations unable to participate in the CLAS Collaborative can schedule CLAS training for their employees.
- ▶ Representatives from Commissions, Associations and other groups can work with Council staff to promote CLAS information and policy development. They can also organize training sessions for their constituencies.
- ▶ Organizations planning and/or sponsoring conferences and forums can work with Council staff to include CLAS sessions/presentations during their events.

► **For more information:**

**Yris Lance, MA**

**CLAS Standards Project Manager**

[Yris.Lance@sboh.wa.gov](mailto:Yris.Lance@sboh.wa.gov)

**Office Phone: 360-236-4109**

**Cell Phone: 360-480-2057**



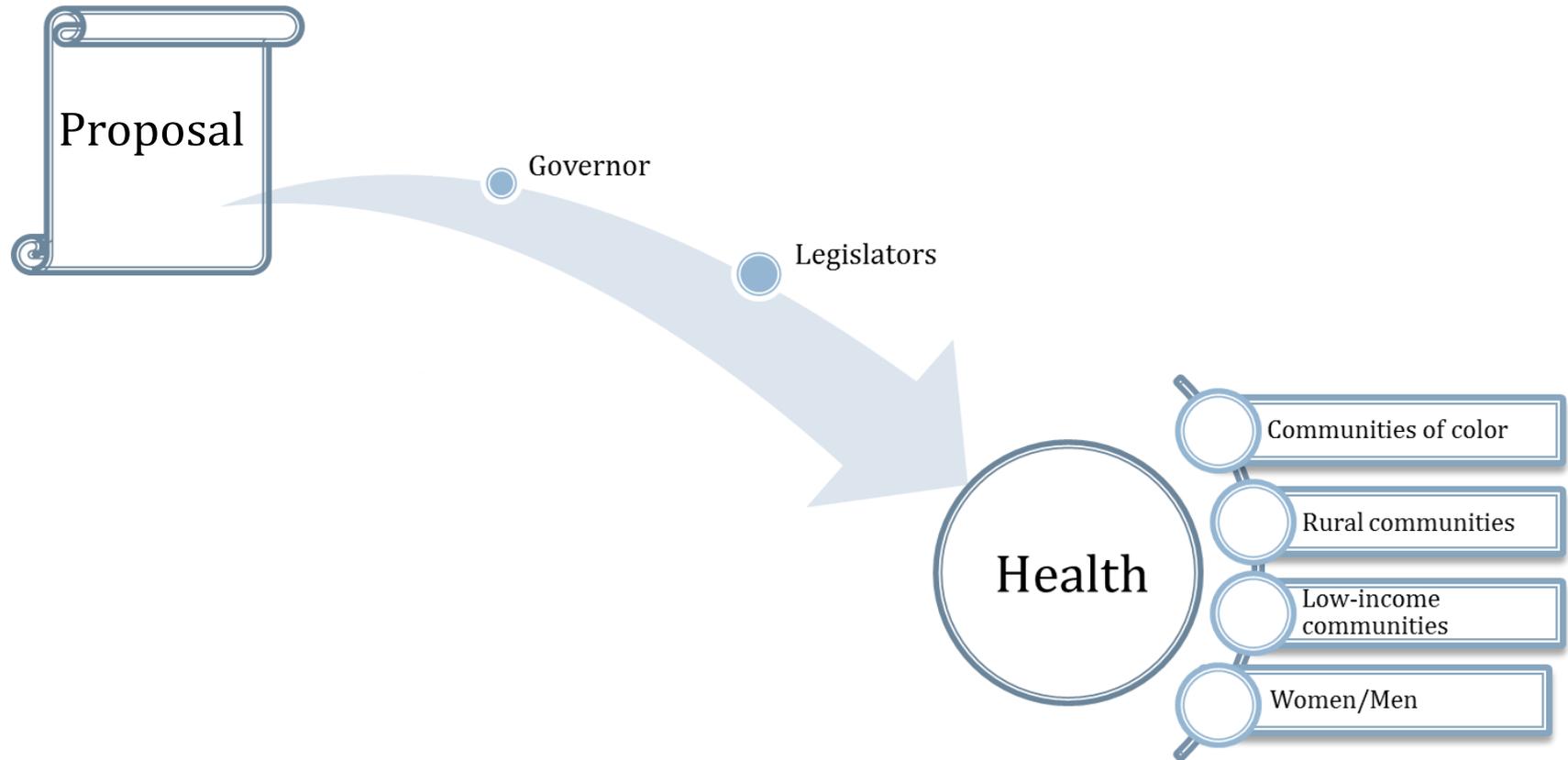
# Health Impact Reviews

December 11, 2013

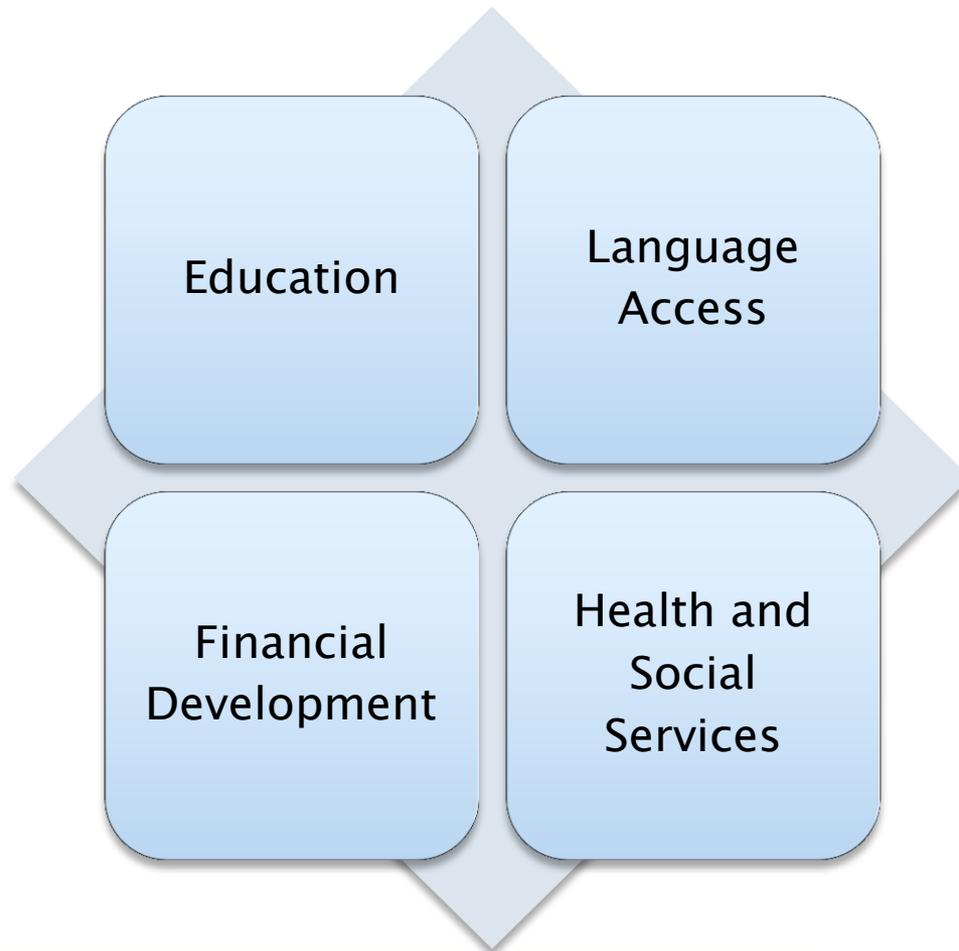
# Overview

- ▶ Health impact reviews overview
- ▶ Past health impact reviews
- ▶ Outreach and education
- ▶ Potential moving forward
- ▶ Past Council member involvement
- ▶ Council member assistance

# Health Impact Reviews



# Past Health Impact Reviews



# Outreach and Education

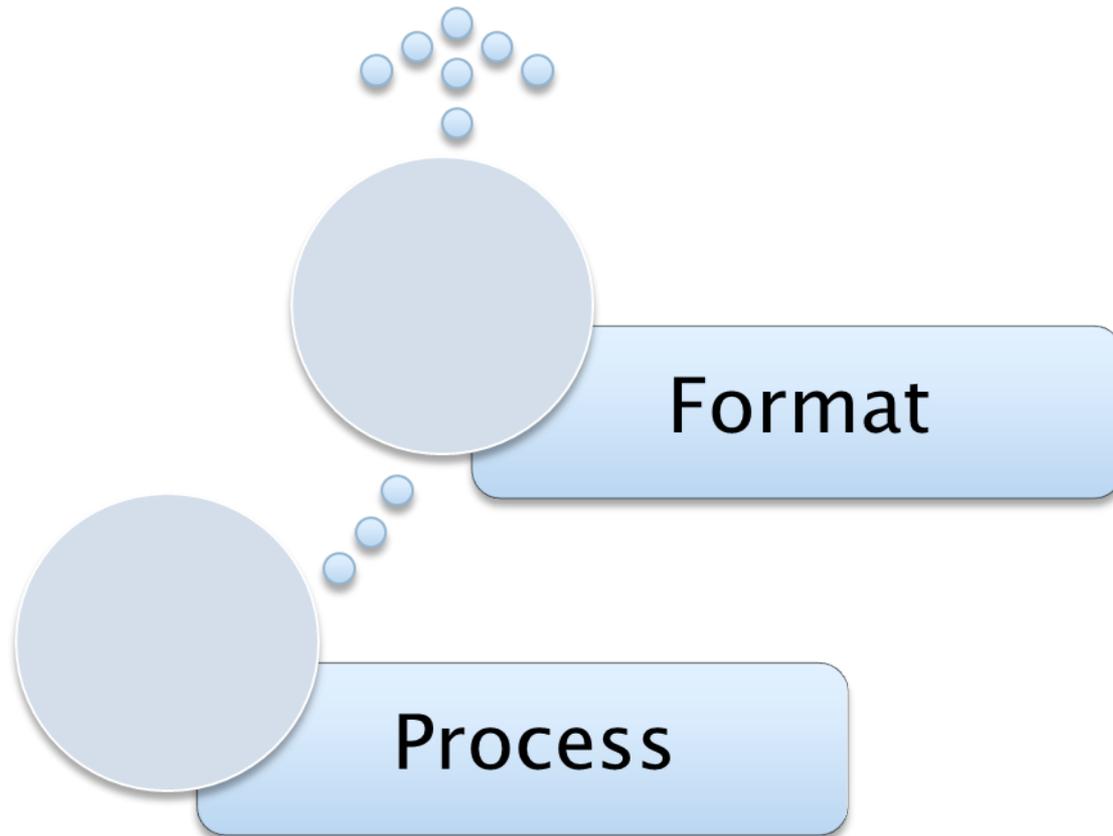
Governor's Office

Legislators

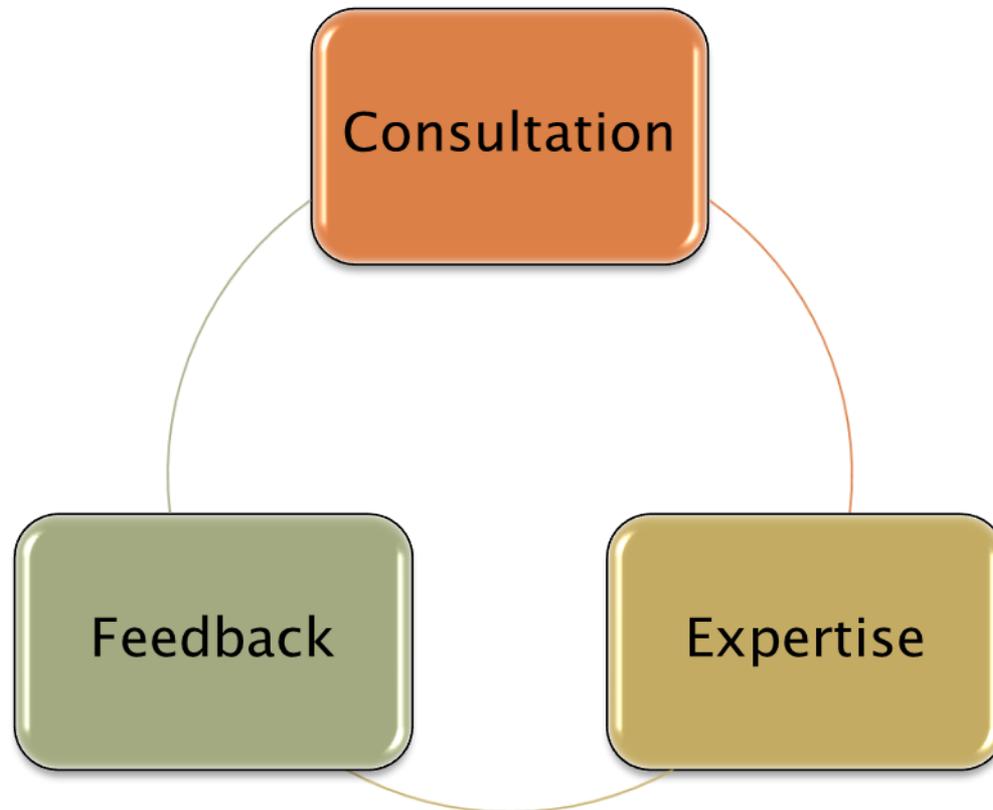
# Potential Moving Forward



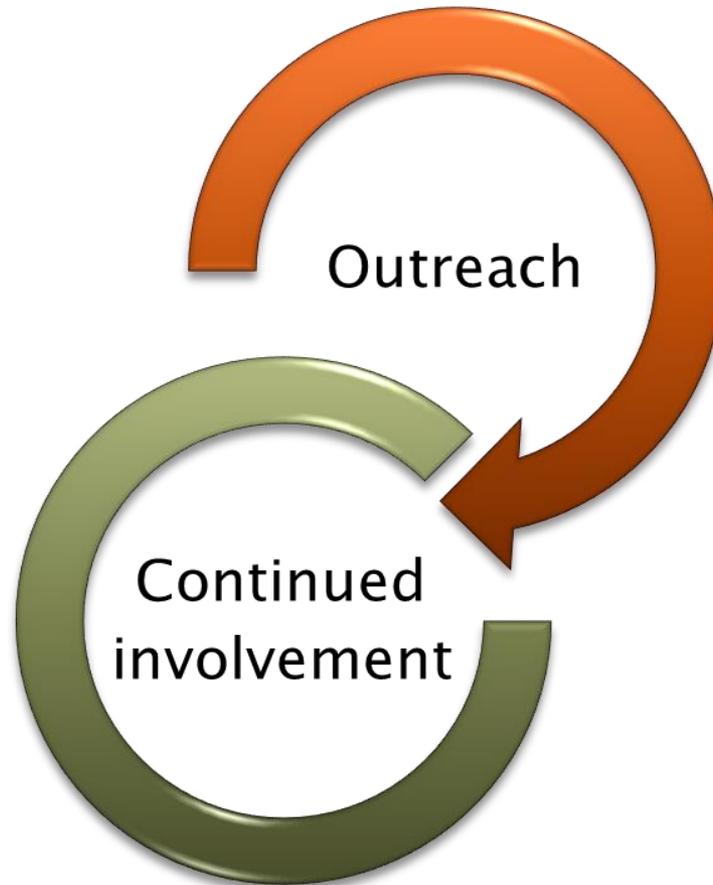
# Potential Moving Forward



# Past Council Member Involvement



# Council Member Assistance



# WASHINGTON STATE HEALTH IMPACT REVIEWS

RCW 43.20.285

## What?

**A health impact review is an analysis of how a proposed legislative or budgetary change will likely impact health and health disparities in Washington.**

**Only the Governor or a state legislator can request a review**

## Why?

- Health impact reviews provide objective information on proposals to help inform policy making
- Reviews provide information quickly—within 10 days of request during session
- Many proposals may directly impact health or the factors that influence health—such as where we live, learn, work, and play
- Health impact reviews can be requested for any topic—including:



Transportation



Housing



Education



Environment



Health Care



Workforce Development

## How?

### ONLINE

[SBOH.WA.GOV](http://SBOH.WA.GOV)

An easy to use online form can be submitted on the Board website

### EMAIL

[HIR@SBOH.WA.GOV](mailto:HIR@SBOH.WA.GOV)

You can also print or download a word document and email it to us

### PHONE

(360) 236-4106

You can also call us and we can take the request over the phone

For more information contact:

Sierra Rotakhina

(360) 236-4106 | [sierra.rotakhina@sboh.wa.gov](mailto:sierra.rotakhina@sboh.wa.gov)

or go to [sboh.wa.gov](http://sboh.wa.gov)



# **PUBLIC HEALTH**

**ALWAYS WORKING FOR A SAFER AND  
HEALTHIER WASHINGTON**

## **Tobacco Prevention and Control in Washington State Governor's Interagency Council on Health Disparities**

*December 11, 2013*

### **Washington State Department of Health**

Paul Davis, Program Manager

Frances Limtiaco, Tobacco Prevention and Chronic Disease Disparities Coordinator

Joella Pyatt, Cessation Coordinator

## Purpose of Presentation:

- Share current overview of tobacco prevention and control in Washington.
- Share data on priority populations and persistent tobacco-related disparities.
- Work towards enhancing our partnership with the Governor's Interagency Council on Health Disparities to:
  - Develop and implement our new strategic plan including the identification and elimination of tobacco-related disparities. (Current strategic plan ends March 2014)
  - Enhance advocacy efforts with insurance plans to cover and promote comprehensive cessation services.

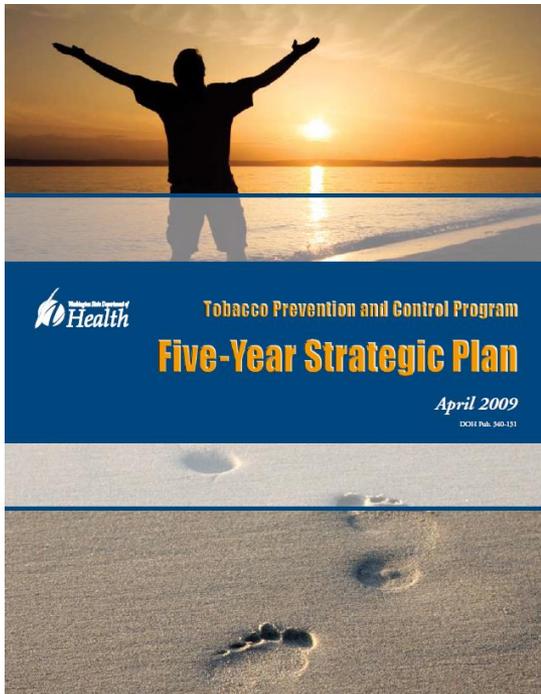
## **Tobacco Use:**

- Remains the single most preventable cause of death and chronic disease in the US and Washington State.
- Is a risk factor for the leading causes of death including heart disease and cancer.
- Is a powerful and pervasive cause of health disparities.

## **In Washington:**

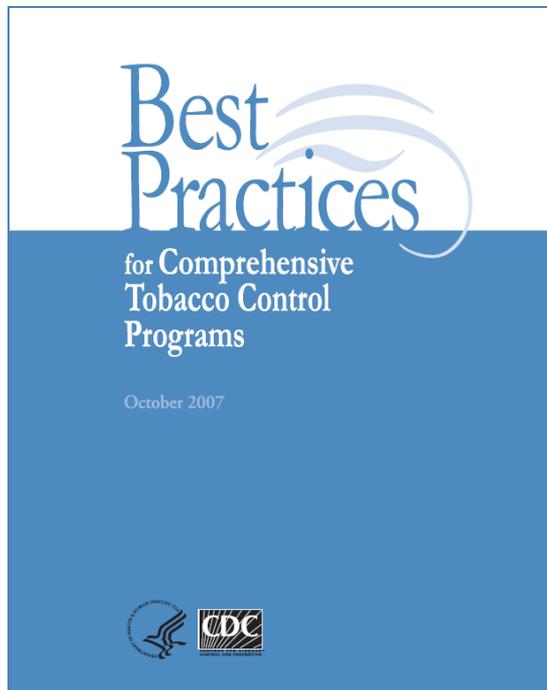
- 880,000 adults and 56,000 youth smoke.

# Four Goals of Tobacco Prevention and Control



1. Identify and eliminate tobacco-related disparities.
2. Prevent youth from starting to use tobacco.
3. Increase quitting among tobacco users.
4. Eliminate exposure to secondhand smoke.

# CDC's Recommendations for Comprehensive Tobacco Control Programs

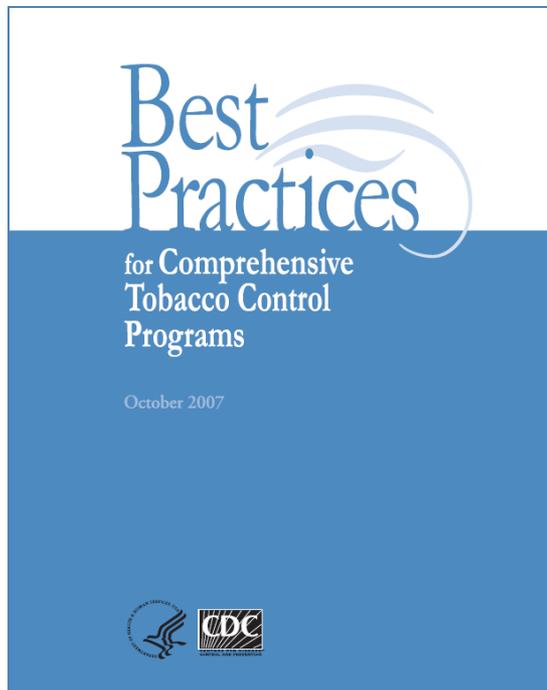


**A coordinated effort combining clinical, regulatory, economic, and social strategies to stimulate public support and social climate changes to:**

- Establish smoke-free policies and norms;
- Decrease affordability of tobacco products;
- Minimize tobacco advertising and promotion;
- Control access to tobacco products; and
- Promote and assist tobacco users to quit.

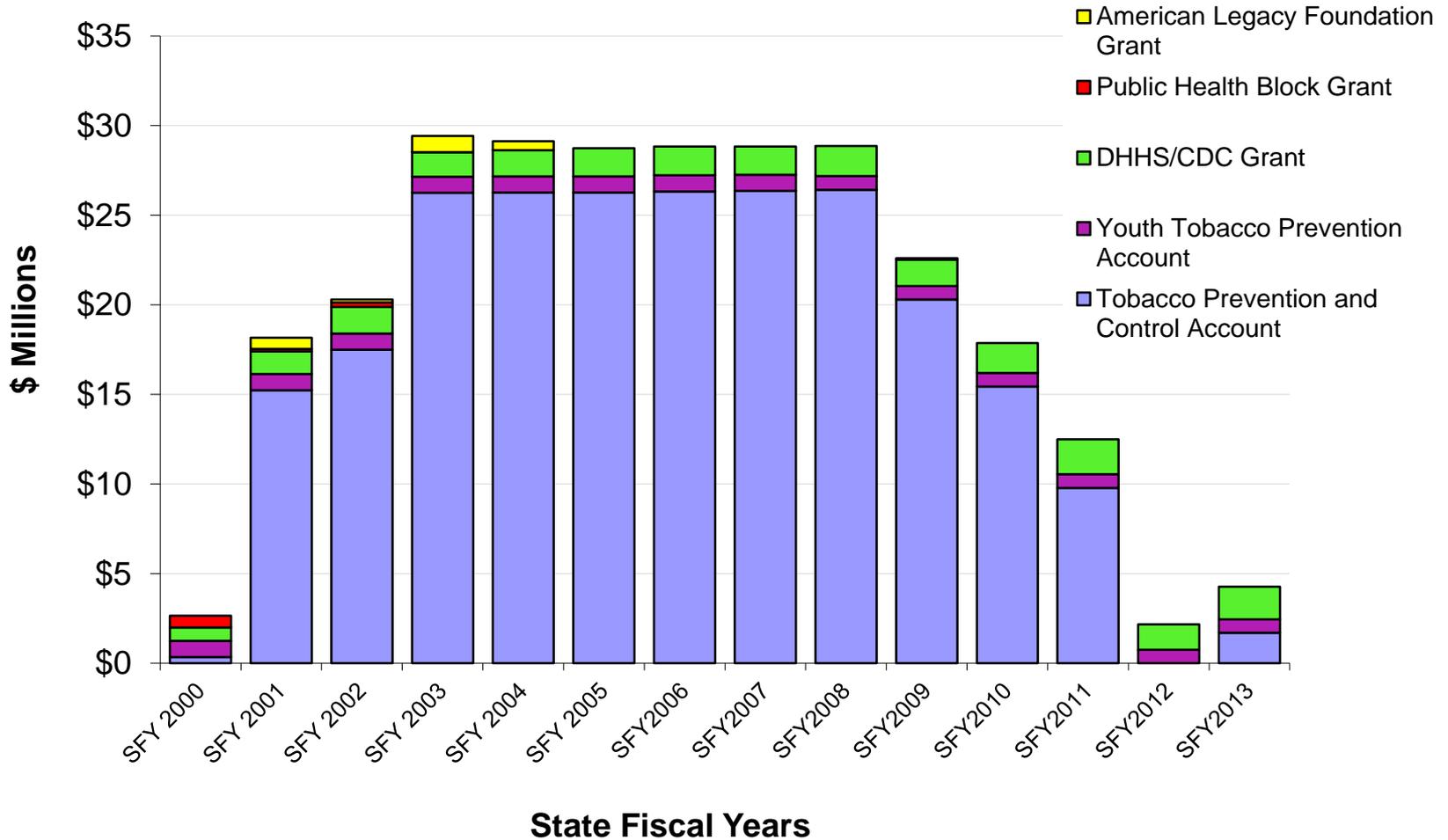
# Comprehensive Tobacco Control Programs

## Best Practices



- State and community interventions
  - Statewide programs
  - Community programs
  - Disparities
  - Youth
  - Chronic disease programs
- Health communications interventions
- Cessation interventions
- Surveillance and evaluation
- Administration and management

# Best Practice Programs Take Money But...



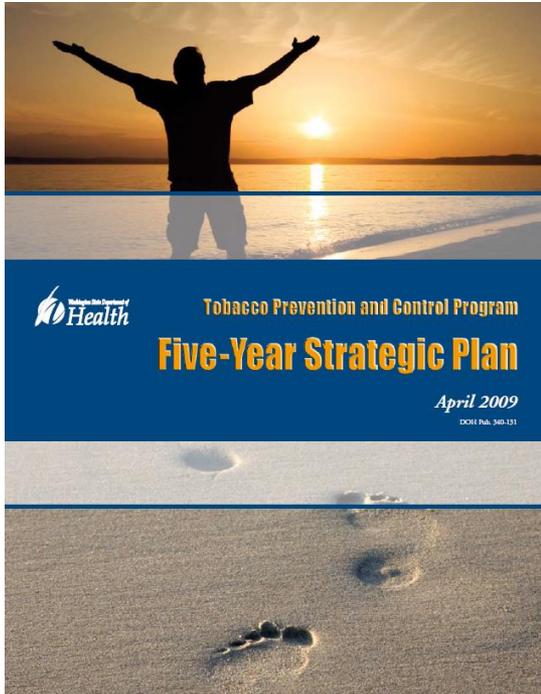
## Federal, State, and Local Funding for Tobacco Prevention and Control

- CDC provides \$1.7 million/yr in core tobacco funds
- Community Transformation Grant (CTG)
  - WA state grant
  - King, Pierce, Spokane grants
  - Chehalis and Makah tribes
- Youth Tobacco Prevention \$750k/yr from licenses and fines
- Some counties receive local funding

## Health Consequences and Return on Investment

- A 2012 study in the *American Journal of Public Health* found that for every dollar spent by WA State's tobacco prevention and control program between 2000 and 2009, more than five dollars were saved by reducing hospitalizations for heart disease, stroke, respiratory disease and cancer caused by tobacco use.
- Over the 10 year period, the program prevented nearly 36,000 hospitalizations, saving \$1.5 billion compared to the \$260 million spent on the program. The 5-1 investment is conservative as cost savings only reflect savings from prevented hospitalizations.

# Goal 1: Identify and Eliminate Tobacco-Related Disparities



## Objective

Reduce the proportion of economically disadvantaged adults who currently smoke to 25 percent or less by 2013 (baseline year 2007=27.9%)

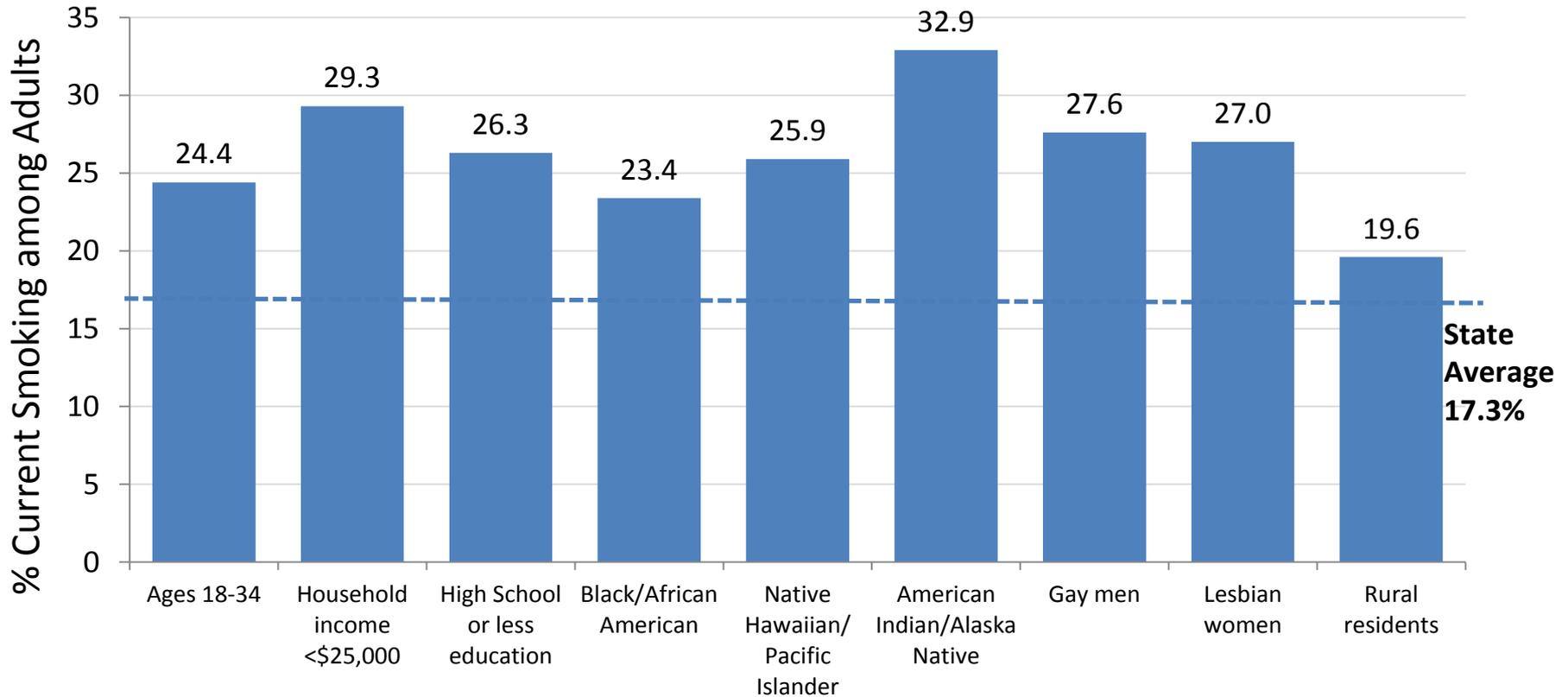
## Strategies

- Enhance data gathering and evaluation methods to guide program planning and practices.
- Mobilize agencies and organizations statewide to adopt policies and practices to eliminate tobacco-related disparities, and promote integration with chronic disease programs.
- Increase community awareness and capabilities to reduce the impact of tobacco use and industry influence on specific populations.

## Tobacco-Related Disparities

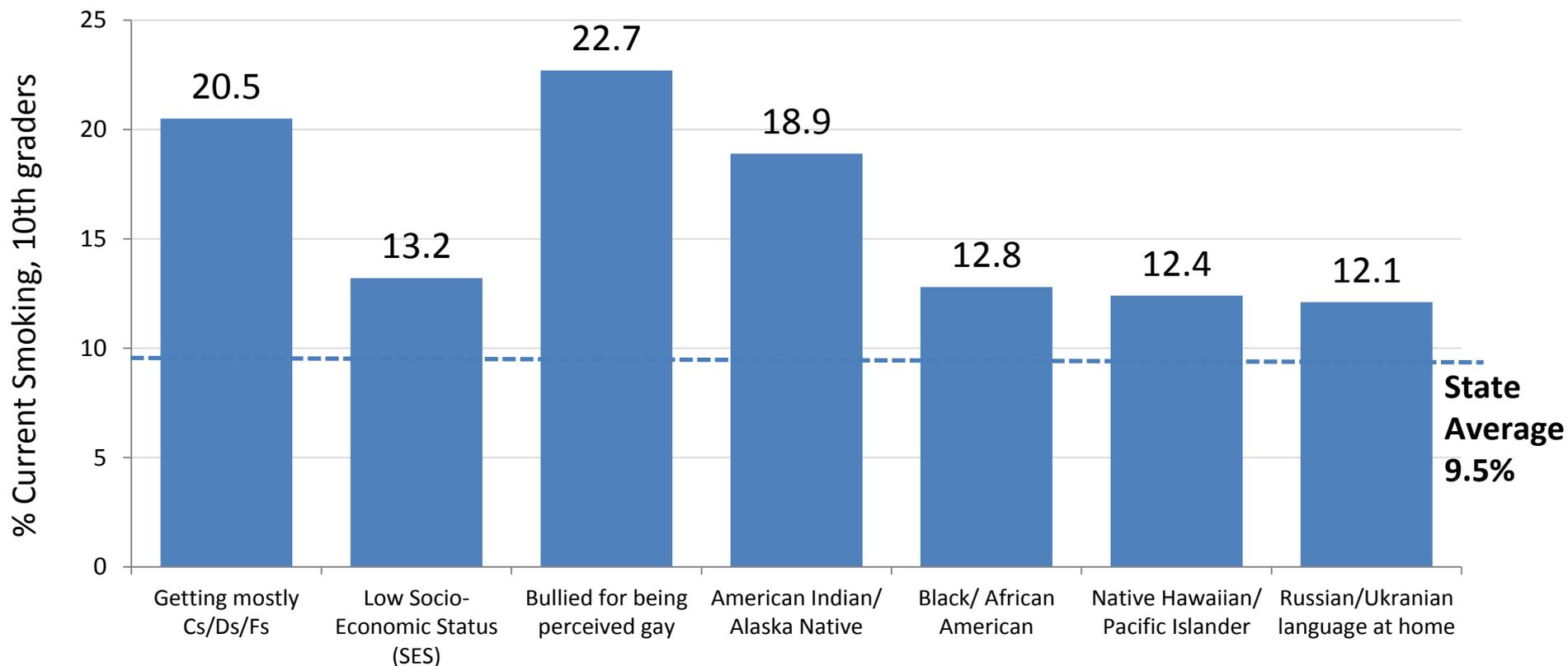
- Smoking rates remain higher among some populations:
  - Race/ethnicity
  - Sexual orientation
  - Income/education
  - Age
- These populations have higher rates of exposure to secondhand smoke, less access to resources, and experience more targeted marketing by tobacco companies.

## Current Prevalence of Smoking and Disparities - Adults



Source: Washington State Behavioral Risk Factor Surveillance System, 2010-2012 combined  
Groups shown have statistically significant differences from relevant comparison groups.

## Current Prevalence of Smoking and Disparities - Youth

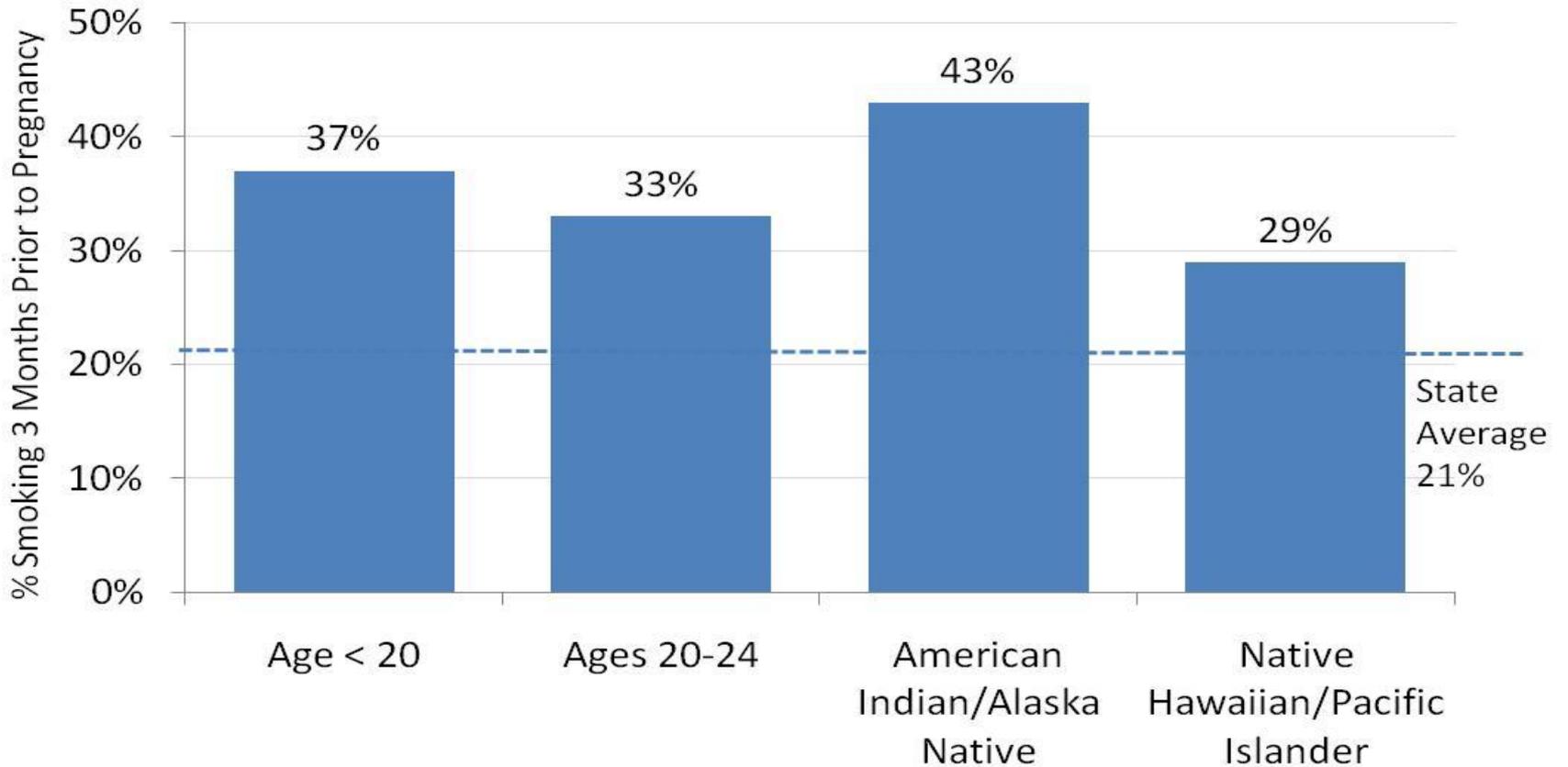


Source: Washington State Healthy Youth Survey, 2012.

All groups shown have statistically significant differences from relevant comparison groups.

Socio-economic status for youth estimated based on mother's highest level of education ("low SES" youth have parents with high school or less as highest completed level of education).

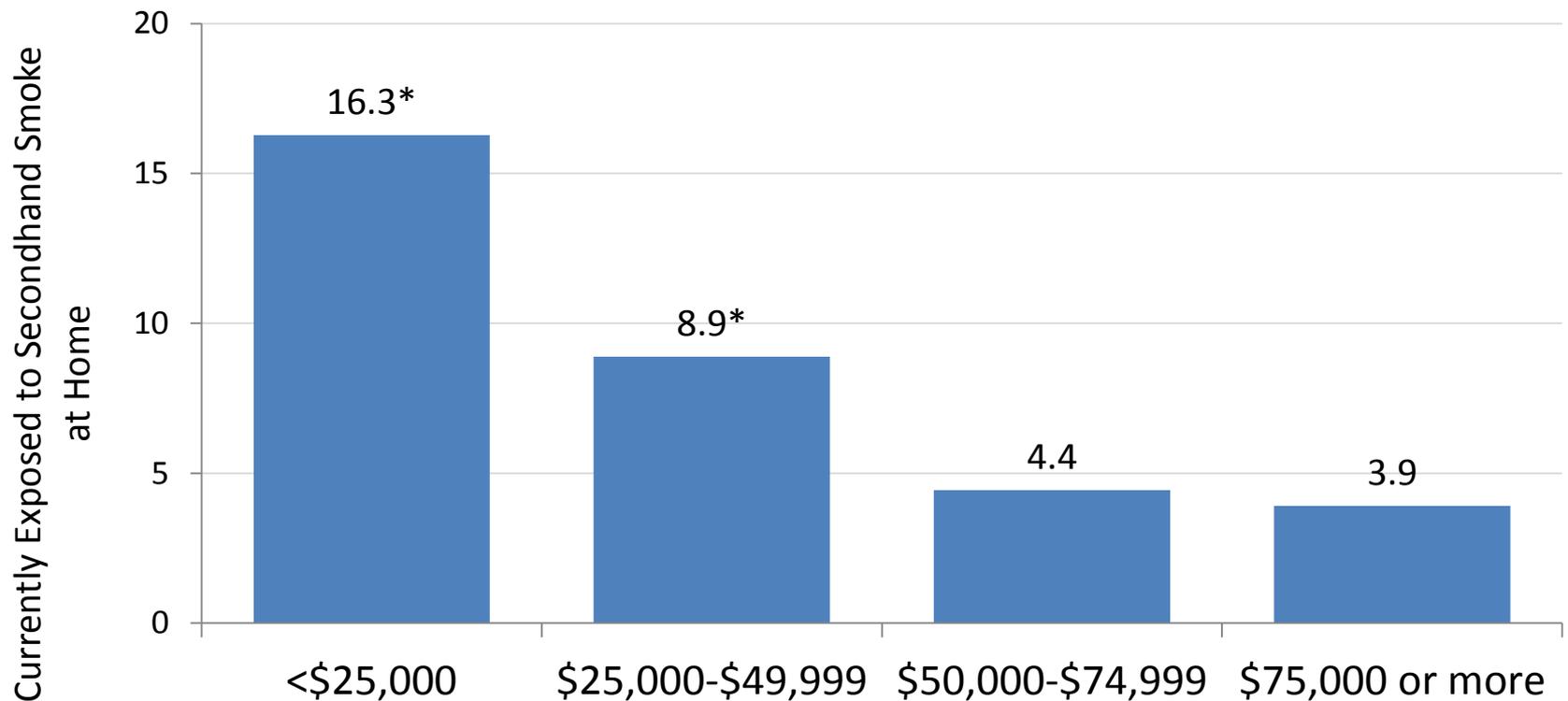
# High Risk Groups for Smoking During Pregnancy



Source: Washington State Pregnancy Risk Assessment Monitoring System (PRAMS), 2007-09 combined.

Younger mothers smoke at significantly higher rates than older mothers; American Indian/Alaska Native mothers smoke at significantly higher rates than white non-Hispanic mothers; Native Hawaiian/Pacific Islander mothers smoke at apparently higher rates than non-Hispanic whites, but margins of error are large and differences are not statistically significant.

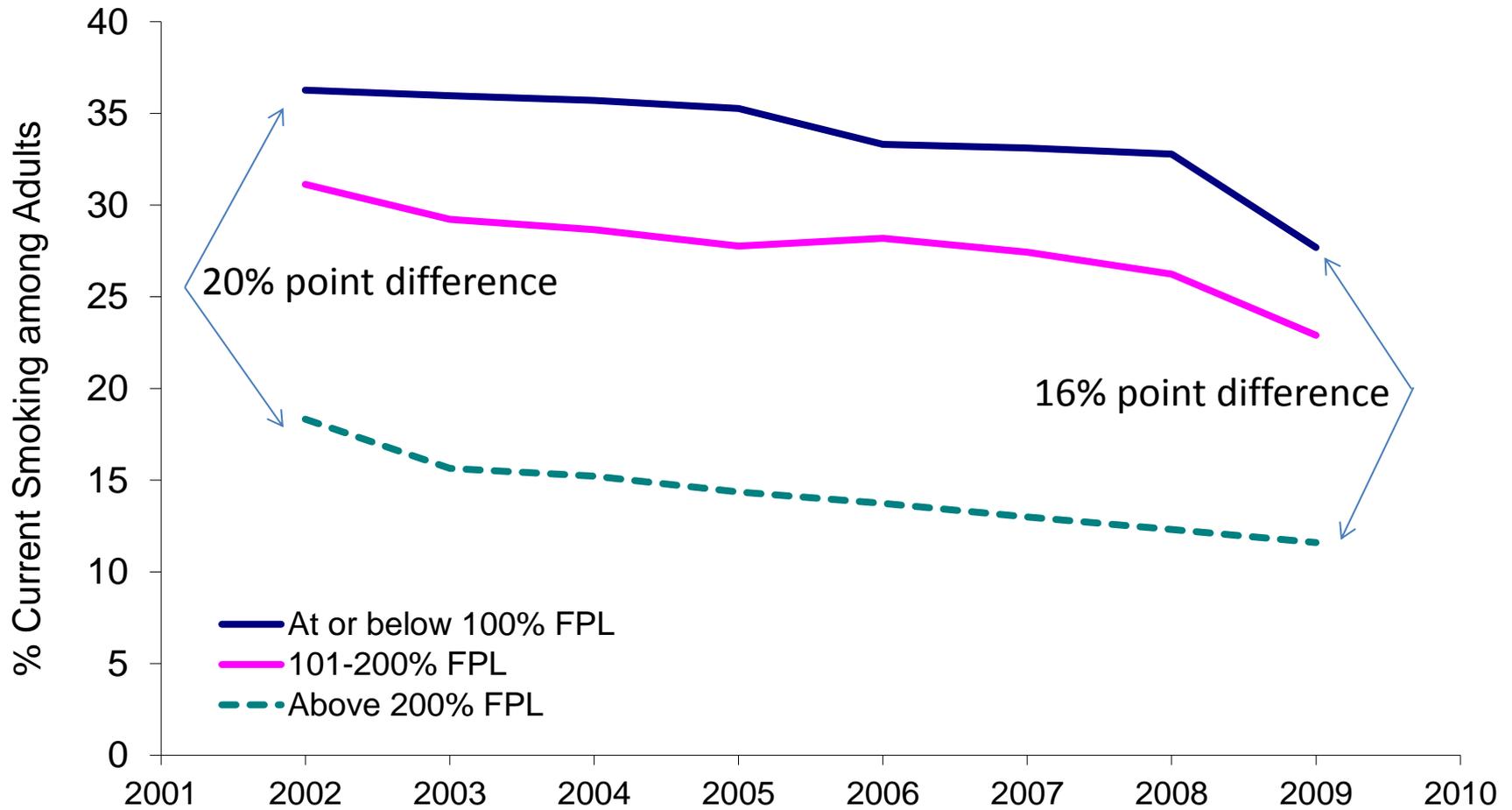
## Secondhand Smoke Exposure Disparities by Income Level



Source: Washington State Behavioral Risk Factor Surveillance System, 2010-2012 combined

\* statistically significant difference from other income groups

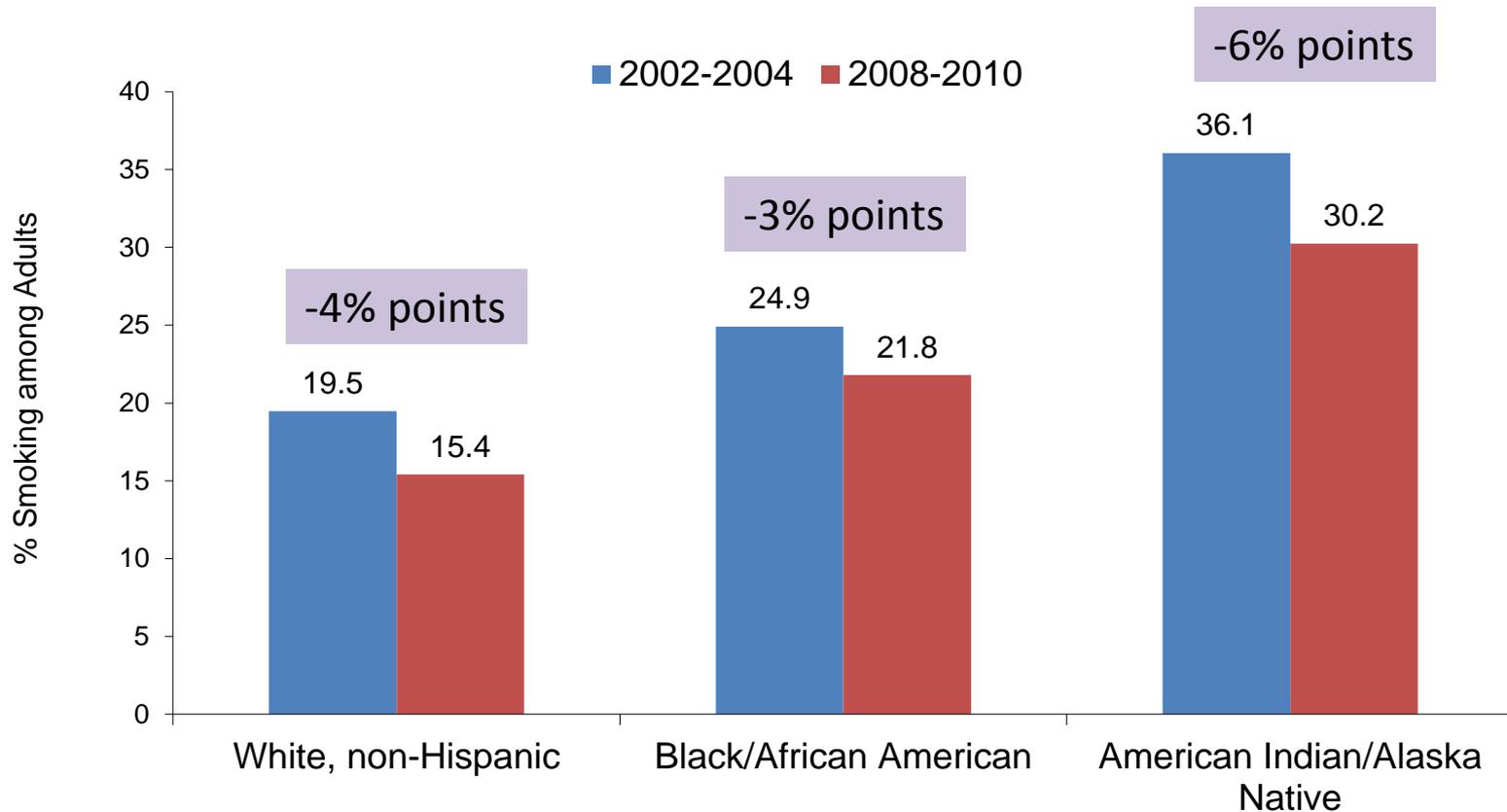
# Adult Smoking Trends by Federal Poverty Level (FPL)



## Other Changes Over Time and Disparities

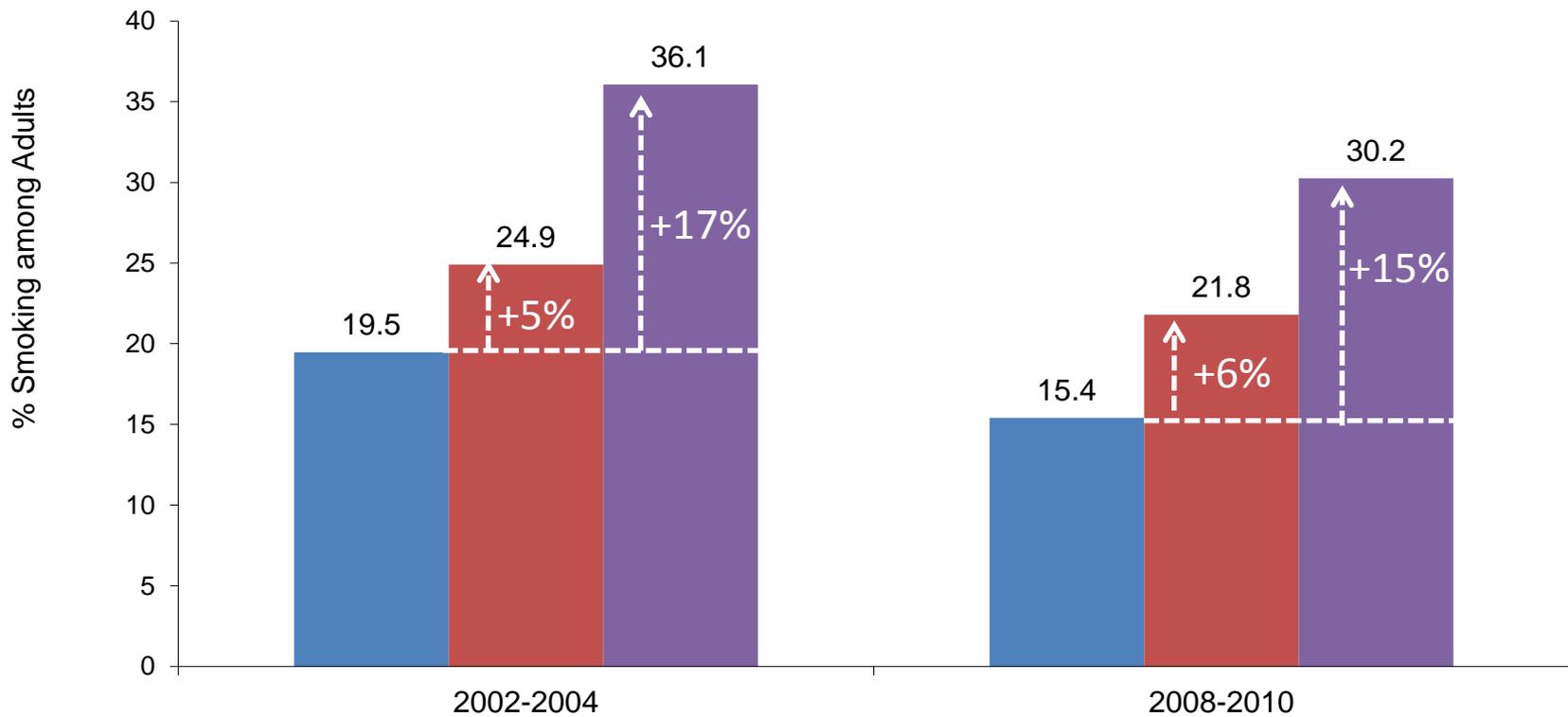
- **Success: smoking has declined**
  - Significant declines among American Indian/Alaska Native (AIAN) adults since 2001 (when Tribal programs began)
  - More modest declines among Black/African American adults
- **Challenges: disparities not reduced**
  - AIAN adult smoking remains about double non-Hispanic white rate, although the gap closed slightly
  - Black/African American adult smoking disparity increased from 1.3 times to 1.4 times the non-Hispanic white rate

# Success: Declining Adult Smoking Trends for Priority Populations



# Challenge: Gaps in Smoking Prevalence Remain

- White, non-Hispanic
- Black/African American
- American Indian/Alaska Native



# Recent National-Level Observations on Smoking Trends and Disparities

Washington is actually doing better in some respects than the nation:

*“Some progress in reducing smoking prevalence among certain racial/ethnic groups was observed; however, disparities among persons with low-SES persisted. For both youth and adults, little to no change in smoking prevalence for those below Federal Poverty Level (FPL) was observed from 2006–2008 to 2009–2010; however, decreases were observed for youth and adults who were above FPL.”*

Source: MMWR Cigarette Smoking — United States, 2006-2008 and 2009-2010, November 22, 2013

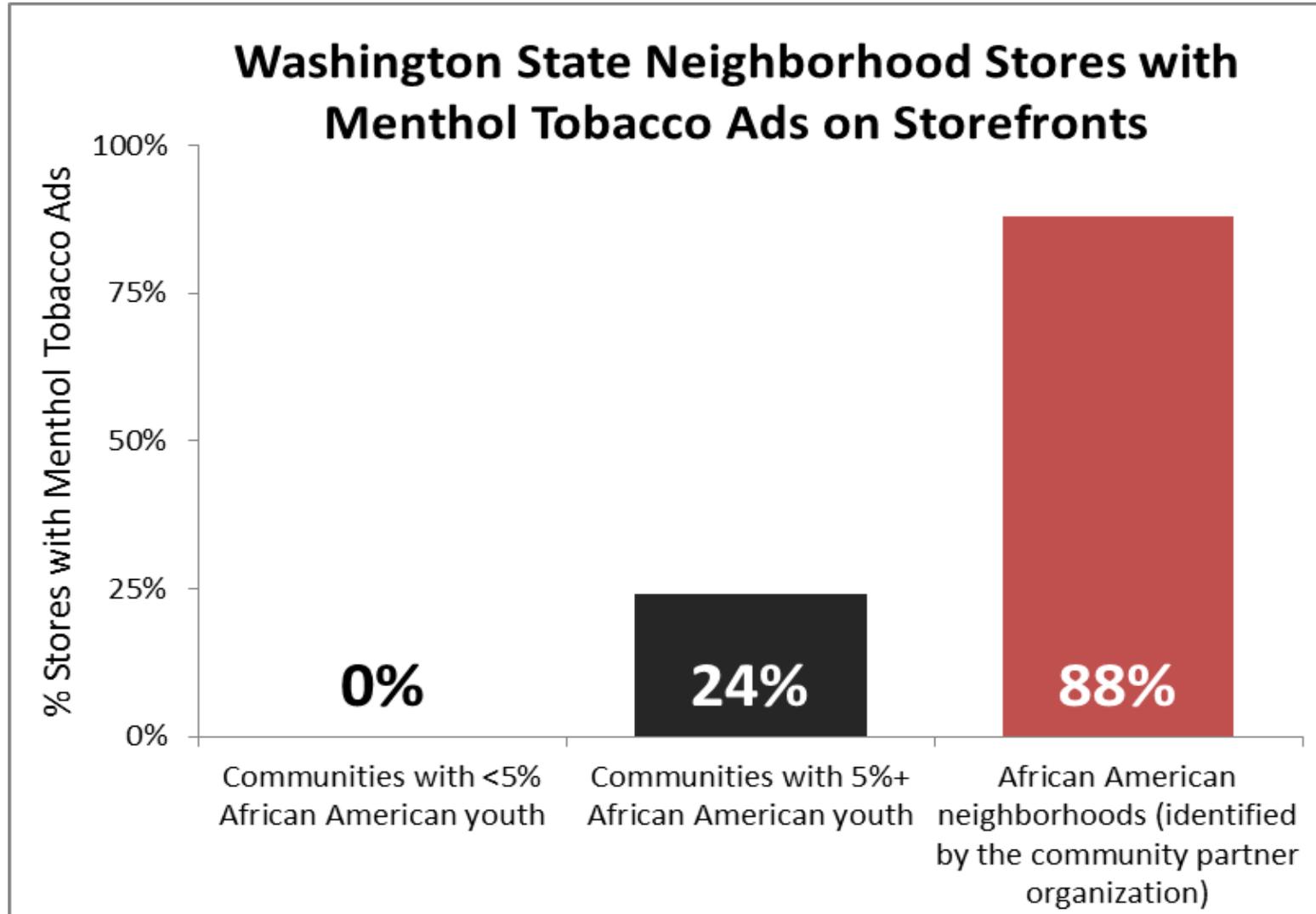
[http://www.cdc.gov/mmwr/preview/mmwrhtml/su6203a14.htm?s\\_cid=su6203a14\\_w](http://www.cdc.gov/mmwr/preview/mmwrhtml/su6203a14.htm?s_cid=su6203a14_w)

# Priority Population Perspectives

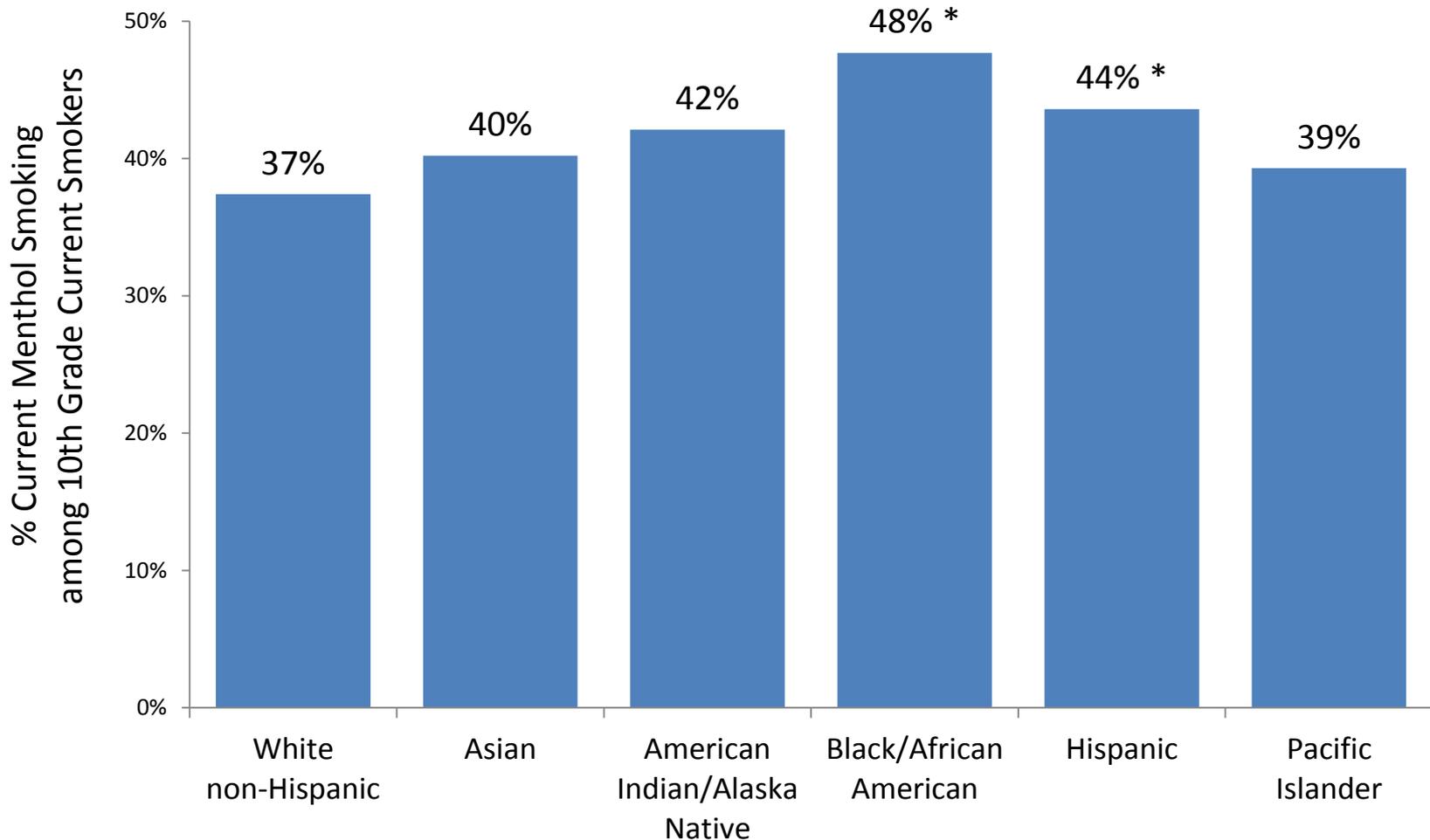
Priority Population	Column A: % of state total population <sup>1</sup>	Column B: Estimated % of “smoker population” <sup>2</sup>	Column D: Estimated # of Adult Smokers <sup>3</sup>
All WA Adults	100%	100%	880,000
HS or less education	35.7%	53.6%	470,000
Black/African American	3.3%	3.8%	33,000
Native Hawaiian/ Pacific Islander	0.8%	1.4%	12,000
American Indian/Alaska Native	1.9%	3.7%	32,000
Lesbian/Gay/Bisexual	4.0%	7.7%	64,000

1. Estimated from preferred race reported in 2012 WA BRFSS
2. 2012 BRFSS
3. Using weighted population estimates from 2012 WA BRFSS, rounded to nearest 10,000 or 1,000

# Targeted Marketing of Menthol



# Menthol Smoking among Youth



Source: 2012 Washington State Healthy Youth Survey.

\* statistically significant difference from White non-Hispanic

# Using Data to Address Disparities

- Systematic reporting of data for priority populations
- Providing communities with data and support to use data
  - Community mobilization and education
  - Planning
  - Evaluation
  - Fundseeking



## Summary Statement

- Progress in reducing smoking has been achieved among many groups, including some racial/ethnic groups with historically high prevalence and low SES populations
- However, disparities have persisted and in some cases may have become greater
- Targeted marketing remains a problem
- Some communities experiencing disparities are working successfully – by using data resources and evidence-based best or promising practices– to make change

# Tobacco Quitline

**1-800-QUIT-NOW**

- A telephone-based counseling center
- Offers individually tailored counseling to quit tobacco.
- Does not ask about documentation of U.S. citizenship (need to have a WA address)
- Special materials for Spanish, American Indian/Alaska Native and pregnant women
- Counselors receive cultural competency training
- For quitline information visit: [www.quitline.com](http://www.quitline.com)

# Languages Available

- English 1-800-QUIT-NOW
- Spanish 1-855-DEJALO-YA or 1-855-335-3569
- Chinese in Cantonese, Mandarin 1-800 939-8917
- Korean 1-800-556-5564
- Vietnamese 1-800 -778-8440
- TTY Line and video relay 1-877-777-6534 (for the hearing impaired)
- Translation in 200 languages

Washington State Department of Health

**Tobacco Quit Line**

**1-800-QUIT-NOW**

toll-free

1-800-784-8669

**QUITLINE.COM**

# Certain populations need specialized counseling

## Limited or low quitline use:

- Spanish speaking Hispanics
- African Americans
- LGBTQ
- American Indian and Alaska Natives
- Natives
- Mentally ill

## Asian Language quitline for:

- Chinese Cantonese and Mandarin
- Korean
- Vietnamese

Quitting Tobacco * Table 6.16	Quit rates
Minimal or no counseling or self-help	8.5%
Quitline telephone counseling	12.7%

Quitting Tobacco * Table 6.17	Quit rates
Medications alone	23.2%
Medications and Counseling	28.1%

Grandfathered group  
plans (small & large)  
Unknown  
(A few use Quit for Life)

Medicaid  
Fee For Service  
Quitline

**The Cessation  
Challenge**

New ACA Health Care  
Plans  
Face to face counseling  
with provider/other

Medicaid Managed  
Care Plans  
Quitlines



## Questions or Comments

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[Paul.Davis@doh.wa.gov](mailto:Paul.Davis@doh.wa.gov), (360) 236-3642

Tobacco Prevention & Chronic Disease Disparities Coordinator:

[Frances.Limtiaco@doh.wa.gov](mailto:Frances.Limtiaco@doh.wa.gov), (360) 236-3771

Cessation Coordinator:

[Joella.Pyatt@doh.wa.gov](mailto:Joella.Pyatt@doh.wa.gov), (360) 236-3518

### Acknowledgement:

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# **PUBLIC HEALTH**

**ALWAYS WORKING FOR A SAFER AND**

**HEALTHIER WASHINGTON**



**Tobacco Prevention and Control Program**

# **Five-Year Strategic Plan**

*April 2009*

DOH Pub. 340-131



## Strategic Planning Partners

University of Washington School of Public and Community Health  
Washington State Department of Health  
Office of Community Wellness and Prevention  
Maternal and Child Health Program  
Washington State Department of Social and Health Services  
Washington State Health Care Authority  
Washington State Office of the Attorney General  
Washington State Office of the Superintendent of Public Instruction

Americans for Nonmokers' Rights  
Campaign for Tobacco-Free Kids  
Centers for Disease Control and Prevention  
National Network on Tobacco Prevention and Poverty

American Cancer Society  
American Heart Association  
American Indian Tribal Health Commission  
American Lung Association of the Northwest  
Fred Hutchinson Cancer Research Center  
Free and Clear, Inc.  
Northwest Communities Education Center/KDNA Radio  
Northwest Portland Area Indian Health Board  
Washington Association of Community and Migrant Health Centers  
Washington Health Foundation  
Washington State Association of Local Public Health Officials  
Washington State Dental Hygienist Association  
Washington State Family Policy Council  
Washington State Medical Association

Educational Service Districts  
Local Health Jurisdictions  
Tobacco Disparities Advisory Committee  
Tobacco Prevention and Control Program Implementation Advisory Committee



Washington State Department of Health  
Division of Community and Family Health  
Office of Community Wellness and Prevention  
Tobacco Prevention and Control Program  
PO Box 47848  
Olympia, WA 98504-7848  
360-236-3730  
[www.doh.wa.gov/tobacco](http://www.doh.wa.gov/tobacco)

For persons with disabilities, this document is available on request in other formats.  
To submit a request, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).

# Overview

Comprehensive tobacco prevention and control efforts in Washington State over the past eight years have significantly reduced tobacco use and exposure to secondhand smoke. Since the Washington State Department of Health Tobacco Prevention and Control Program began in 2000, the number of adult smokers has dropped by 25 percent; youth smoking has decreased by about 50 percent; and secondhand smoke exposure in homes has dropped by more than 50 percent.

Despite these successes, tobacco use continues to harm the health of individuals and impact our state's economy. In 2007, tobacco-related illnesses killed more than 7,600 people in Washington; about \$1.5 billion was spent on tobacco-related health care costs; and state and federal taxpayers spent \$651 million on Medicaid costs.

In addition, some racial/ethnic populations and individuals with less education and income still use tobacco at a higher rate than the overall population. Among young people, there is evidence that the rate of decline among high school students has started to level off – perhaps even creep upwards.

The importance of periodic updating of the state's strategic approach is underscored by the fact that the tobacco industry continues to develop new products and launch new marketing strategies. The industry spends about \$165 million each year in Washington marketing its deadly products, while the state spends \$28.5 million a year helping people quit and keeping kids from starting – countering this financial disadvantage requires dynamic strategic approaches by the state and its partners.

To address these challenges, the Tobacco Prevention and Control Program in 2007 began a yearlong effort to update the strategic direction for the state's tobacco prevention and control efforts.

The resulting *Tobacco Prevention and Control Program Five-year Strategic Plan*:

- Identifies specific and measurable five-year outcomes.
- Identifies key strategies and tactics to achieve outcomes.
- Identifies priority populations.
- Designates eliminating tobacco-related disparities as a top priority.
- Can be implemented within a range of budgets starting at current budget level.

The plan also emphasizes the integration of tobacco prevention with other Department of Health chronic disease prevention efforts (e.g., asthma, diabetes, heart disease, and stroke) and social service outreach (e.g., Medicaid and Head Start) to improve overall efficiency and reduce the prevalence of tobacco-related illnesses and disease.

## Guiding Principles

This plan consolidates and refines the guiding principles of the 1999 *Tobacco Prevention and Control Plan for Washington State*. The principles continue to emphasize the importance of data and evaluation, while maintaining the flexibility to adjust program activities and budgets, adapt approaches, and allocate resources based on changing conditions and the needs of specific populations or communities.

1. The Tobacco Prevention and Control Program takes a comprehensive and integrated approach to achieve the following four goals:
  - A. **Identify and eliminate tobacco-related disparities.**
  - B. **Prevent youth from beginning to use tobacco.**
  - C. **Increase quitting among tobacco users.**
  - D. **Eliminate exposure to secondhand smoke.**
2. Tobacco Prevention and Control Program strategies and activities are guided by research and data, and align with established best practices.
3. The Tobacco Prevention and Control Program prioritizes resources to those strategies that:
  - Help the program achieve expected results.
  - Assure maximum impact.
  - Are the most effective in achieving sustainable results.
4. Tobacco Prevention and Control Program resources shall remain flexible so they can be redirected, based on the following:
  - Program evaluation.
  - Community need.
  - Changes in data, policy, or best practices.
  - Opportunities for cross-program integration with chronic disease.
5. Tobacco Prevention and Control Program policies and practices shall ensure activities and materials are appropriate for priority population audiences.

## Program Objectives

- ▲ Reduce the proportion of economically disadvantaged adults who currently smoke to 25 percent or less by 2013 (baseline year 2007=27.9 percent).
- ▲ Reduce the proportion of 10th grade youth who currently smoke to 10 percent or less by 2013 (baseline year 2006=14.9 percent).
- ▲ Reduce the proportion of adults who currently smoke to 14 percent or less by 2013 (baseline year 2007=16.5 percent).
- ▲ Reduce the proportion of adults exposed to secondhand smoke in the home to 6 percent or less by 2013 (baseline year 2007=8.6 percent).

## Program Priorities

In addition to reaffirming the goals of the original plan, this 2009 plan makes reducing tobacco-related disparities a top priority to help ensure the program can continue reducing the overall rate of tobacco use in Washington State.

The plan designates priority populations that experience higher rates of tobacco use, secondhand smoke exposure, or tobacco industry marketing. Other priority populations experience barriers in service access related to language and cultural issues.

Over the next five years as this plan is implemented, priority populations will receive specifically targeted programs and activities to counter these disparities.

- Adults with low income and/or high school education or less.
- Youth ages 12-18.
- American Indian youth and adults.
- African American adult males.
- Lesbian, gay, bisexual, or transgender adults.
- Latino youth and adults.
- Asian Pacific Islander adults.
- Mental health and chemical dependency treatment populations.

## Reader's Guide

This plan is organized according to the four program goals. For each goal there is a narrative to provide background, and a pyramid chart that identifies the strategies and tactics that will be used to achieve each goal.

*Strategies* are broad-based approaches used to achieve each goal. *Tactics* are the specific methods that will help achieve each strategy. The pyramid shows the relationship between goals, strategies, and tactics.

Each tactic represents a scope of activities that are carried out statewide or within communities. The plan is intended to guide Tobacco Prevention and Control Program resources to activities that achieve the most impact in reducing tobacco use and exposure.





**Goal A**

**▲ Identify and Eliminate Tobacco-related Disparities**

Identifying and eliminating tobacco-related disparities is a top priority in this strategic plan. Smoking rates remain higher among some racial/ethnic and sexual minority populations, and those with less income and education than the general population. These populations also have higher rates of exposure to secondhand smoke, less access to resources, and experience more targeted marketing by tobacco companies. These differences are called tobacco-related disparities.

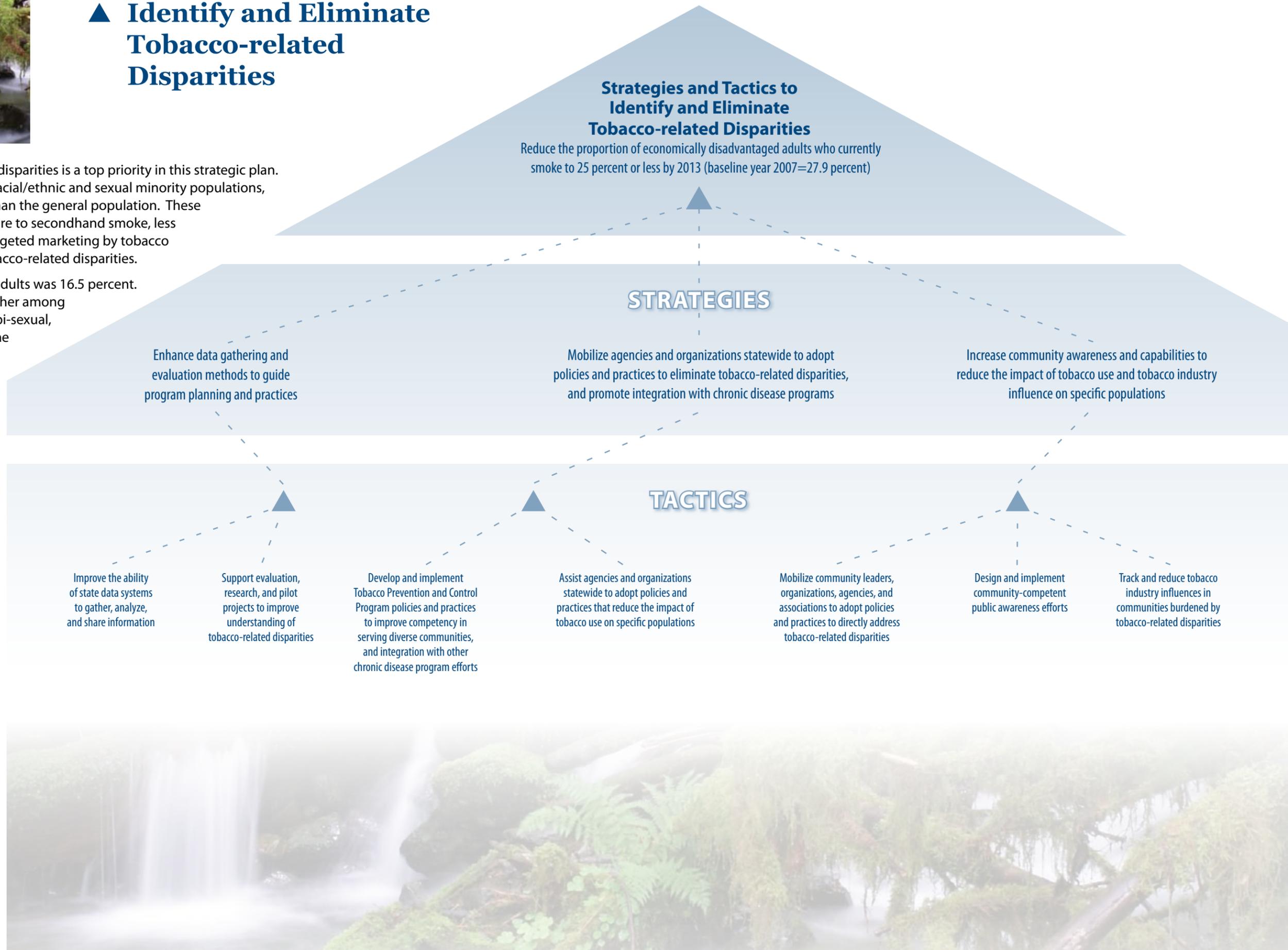
The 2007 smoking rate among Washington adults was 16.5 percent. Average smoking rates (2005-2007) were higher among American Indians (35 percent); lesbian, gay, bi-sexual, and transgender populations (34 percent); the economically disadvantaged (27 percent); and African Americans (22 percent). The rates for many of these groups have not dropped since 2000, while the rate for the general population has dropped by 25 percent.

Since 2000, the Tobacco Prevention and Control Program has gained a better understanding of the tobacco-related disparities that exist in Washington State. It also has enhanced its ability to address these disparities across all program goal areas.

To effectively identify and eliminate tobacco-related disparities, the program will use the tactics detailed for this goal to plan and conduct statewide and community-based activities across all four goal areas.

The plan addresses disparities in the following priority populations:

- Racial/ethnic (African Americans, American Indians, Asian Pacific Islanders, Hispanic/Latinos).
- Sexual minorities.
- Young adults (18- to 29-years-old).
- Those living at or below 200 percent of the federal poverty level or with a high school education or less.





**Goal B**

**▲ Prevent Youth From Beginning to Use Tobacco**

Washington State has seen about a 50 percent reduction in youth tobacco use since the comprehensive Tobacco Prevention and Control Program began. However, 45 young people still start using tobacco every day in Washington. In addition, as this population ages a new generation susceptible to beginning tobacco use emerges.

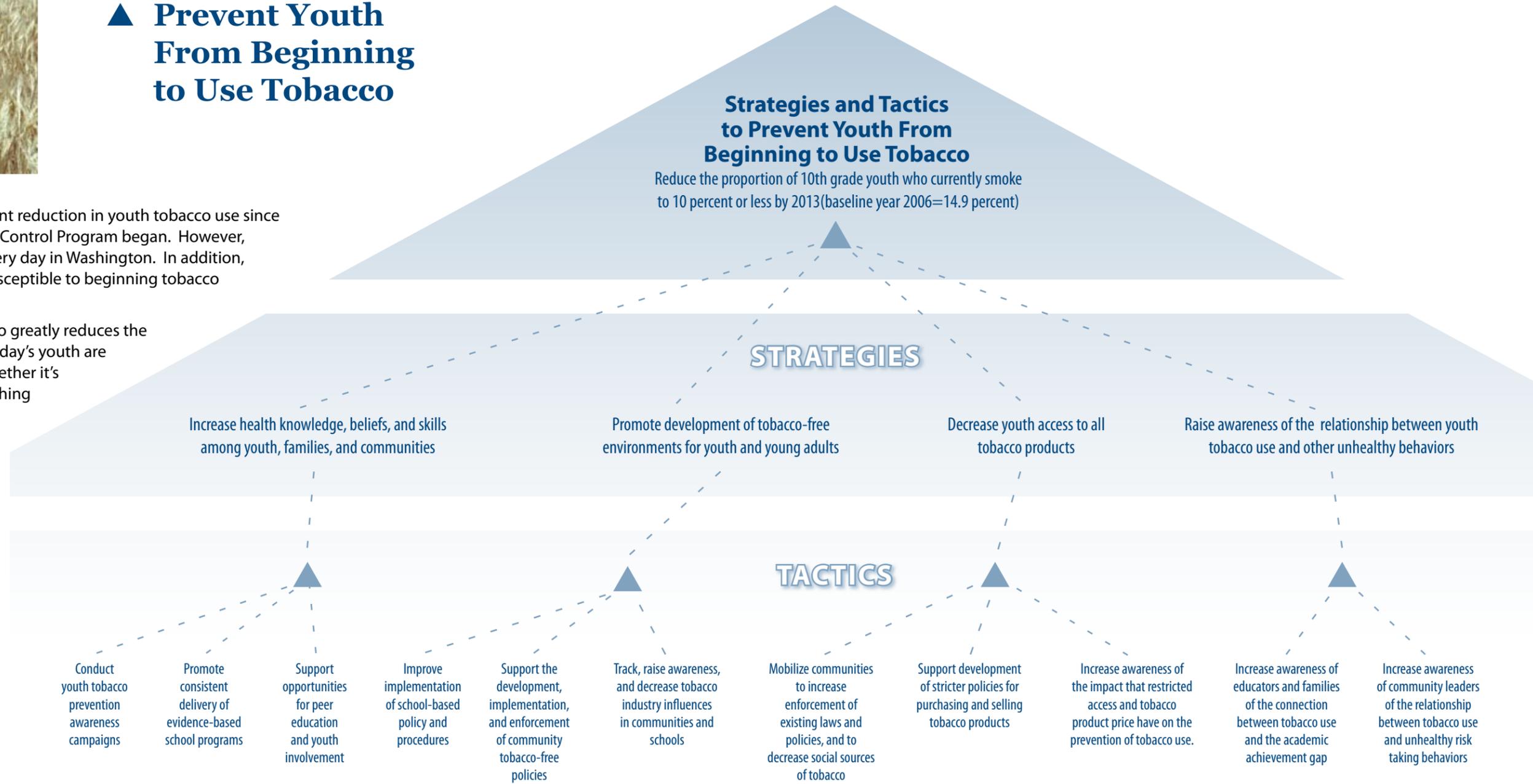
Convincing teenagers to reject using tobacco greatly reduces the likelihood of them becoming adult users. Today's youth are bombarded with pro-tobacco messages, whether it's walking past a local convenience store, watching a movie, or thumbing through a magazine.

One prime strategy is to create a "social norm" where the vast majority of youth do not use tobacco. This can best be achieved by increasing knowledge, beliefs, and skills about the dangers of tobacco use; creating tobacco-free environments; and decreasing the availability of tobacco products to youth.

Tactics in this goal emphasize a comprehensive approach using media, school- and community-based prevention programs and activities, and school and community policies to restrict access to tobacco.

**Strategies and Tactics to Prevent Youth From Beginning to Use Tobacco**

Reduce the proportion of 10th grade youth who currently smoke to 10 percent or less by 2013 (baseline year 2006=14.9 percent)





**Goal C**

**▲ Increase Quitting Among Tobacco Users**

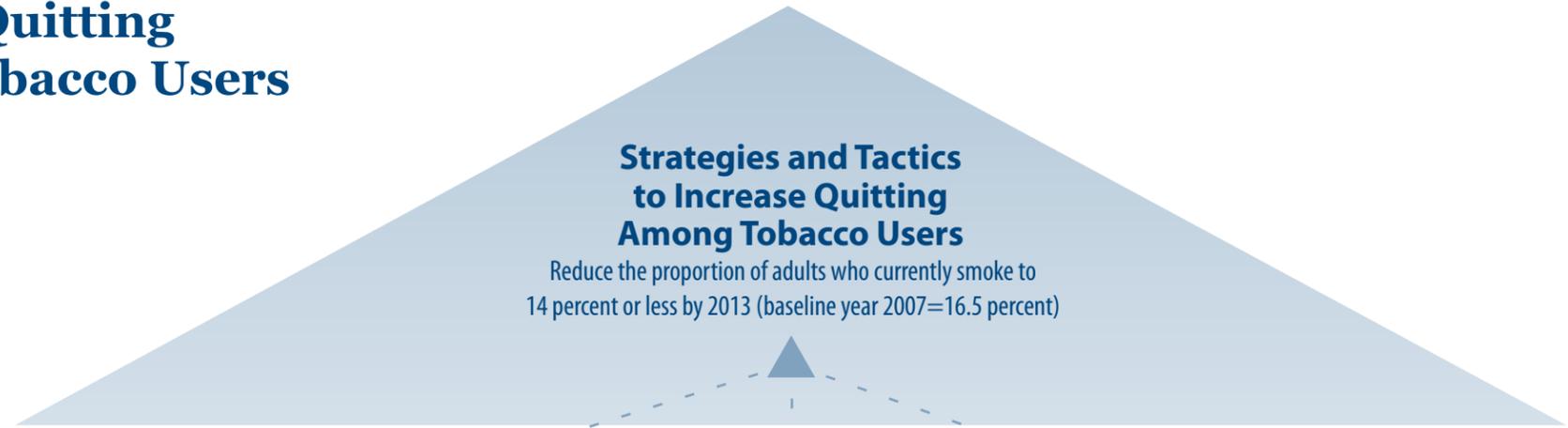
Washington State has the sixth lowest rate of smoking in the nation – the prevalence of tobacco use among adults is 16.5 percent compared to a national rate of 19.8 percent. Still, about 800,000 residents use tobacco—resulting in 7,600 tobacco-related deaths each year—and the medical and financial costs of tobacco use are well documented.

Helping people quit using tobacco can reduce overall health care spending and improve worker productivity. In addition, helping someone quit smoking reduces the exposure of others to secondhand smoke and the availability of tobacco products to kids.

There are many approved evidence-based, clinically proven methods to help tobacco users successfully quit, including:

- Telephone-based cessation services.
- Cessation intervention by health care providers and others.
- More intensive interventions such as:
  - Individual or group counseling that provides social support.
  - Coaching on problem-solving skills.

Lower-income adult tobacco users may understand the dangers of tobacco use and want to quit, but often lack access to affordable and culturally appropriate cessation services. Many tactics in this goal area either increase motivation to quit through education and other means, or increase access to cessation services in clinical settings or in community-based, non-medical settings.





## Goal D

# ▲ Eliminate Exposure to Secondhand Smoke

Secondhand smoke, also known as environmental tobacco smoke, is a complex mixture of gases and particles that includes smoke from the burning cigarette, cigar, or pipe tip (side-stream smoke), and exhaled mainstream smoke. Secondhand smoke contains at least 250 chemicals known to be toxic, including more than 50 that can cause cancer.

Every year in the United States, secondhand smoke kills 38,000 people. Children exposed in their homes and in cars are more likely to develop asthma and upper respiratory infections, and they miss more days of school and require greater medical care.

Creating smoke-free environments is the most effective way to reduce exposure to secondhand smoke. In addition to directly eliminating the negative health impacts of exposure, creating smoke-free environments results in a shift in social acceptability – reducing the likelihood of youth beginning to smoke and encouraging quit attempts by people who currently use tobacco.

Washington State has a comprehensive law prohibiting smoking in work and public places. Ensuring state laws are enforced is one priority of this goal area. Some populations or communities have higher exposure to secondhand smoke. Education and awareness campaigns that promote the benefits of smoke-free homes and cars, and are focused on these populations, are also a priority of Goal D.

### Strategies and Tactics to Eliminate Exposure to Secondhand Smoke

Reduce the proportion of adults exposed to secondhand smoke in the home to 6 percent or less by 2013 (baseline year 2007=8.6 percent)

## STRATEGIES

Support implementation of secondhand smoke public policies

Support the adoption of voluntary smoke-free policies and practices

## TACTICS

Design and implement secondhand smoke public awareness and technical assistance efforts

Mobilize state and community partnerships to support complete implementation of smoke-free policies

Design and implement secondhand smoke public awareness and technical assistance efforts

Mobilize state and community partnerships to promote adoption of smoke-free policies

Ensure that the adoption of smoke-free policies is accompanied by resources to help people quit tobacco use

## Looking Forward

The Tobacco Prevention and Control Program will implement the revised plan on July 1, 2009. The direction taken with statewide efforts like media campaigns, as well as community-based programs, will align with the strategies and tactics in the plan. While the scope and level of activity is always dependent on available funding, the current annual funding of \$28.5 million should allow for accomplishment of the plan's objectives.

The program's evaluation plan will be revised in 2009 to ensure that the impact of the strategic direction and new activities are being well measured. The program remains committed to using its resources to achieve significant reductions in tobacco use and secondhand smoke exposure for adults and youth in Washington State.

***E**ffective tobacco prevention and control is an investment in the health of people in Washington. This Five-Year Strategic Plan uses science and best practices to create a road map for the continued success of this very important work.*

*There are always new challenges. We must make sure every new generation of kids clearly understands the truth about this deadly product. We must find new and better ways to get the message to adults who smoke, and help them quit. With this work we're helping people and encouraging smoke-free environments – making our state a healthier place to live.*

Mary C. Selecky  
Secretary, Washington State Department of Health

## **Tobacco Prevention and Control in Washington State**

*The Tobacco Prevention and Control Plan for Washington State* was completed in 1999 by the Tobacco Prevention and Control Council. The plan established goals, guiding principles, and a framework of key approaches to guide expansion of the state Tobacco Prevention and Control Program. The original plan, based on best-practices recommendations from the federal Centers for Disease Control and Prevention, was fully implemented in 2002 when the state legislature awarded a funding increase.

In 2004, strategic priorities were developed to reflect lessons learned by program staff during the early years of the program; significant improvements in data gathering; changing conditions and emerging issues; and new best practices, research, and federal guidelines.

This 2009 plan refines the guiding principles of the original plan and sets the strategic approaches for tobacco prevention and control efforts in Washington State through 2013.



**PUBLIC HEALTH**  
ALWAYS WORKING FOR A SAFER AND  
HEALTHIER WASHINGTON

Washington State Department of Health  
Division of Community and Family Health  
Office of Community Wellness and Prevention  
Tobacco Prevention and Control Program  
PO Box 47848  
Olympia, WA 98504-7848  
360-236-3730  
[www.doh.wa.gov/tobacco](http://www.doh.wa.gov/tobacco)

For persons with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).

**Tobacco Prevention and Control 2014-2019 Strategic Plan  
Identifying Strategic Priorities**

	Population Impact	Expected Reach	Impact on Health Disparities	Political Feasibility	Community Support	Leveraging opportunity or will it get done anyway?	Sustainability	Ability (and cost) to measure	Evidence	\$2.4 Million* (current level)	\$5 Million	\$15 Million	\$27 Million**
<b>High Level Strategies: Components of a Comprehensive Program</b>													
<b>Office of Healthy Communities, Department of Health</b>													
<i>CDC has identified 4 domains for preventing Washingtonians with equitable opportunities to take charge of their health: 1) Epidemiology and surveillance; 2) Environmental approaches that promote health; 3) Health systems interventions; and 4) Strategies to improve community-clinical linkages. The key elements of the Agenda for Change and the 4 CDC domains inform the Washington State Plan for Healthy Communities. Recommended strategies that support commercial tobacco-free living are listed below.</i>													
Ensure capacity, infrastructure, and leadership of non-governmental community-based organizations serving culturally diverse, low socioeconomic status, and other socially disadvantaged populations (Eg: our work with AIHC, Center for MultiCultural Health, Gay City Health Project etc.)										CDC Core Grant			
Increase the number of providers and clinicians (behavioral and medical) who screen all patients for tobacco, alcohol and drug use and educate providers to refer and provide - or link to - cessation/treatment services and resources (Eg: our Patient-Centered Health Home/Washington Healthcare Improvement Network activities).										Limited CTG \$			
Establish a mechanism for reimbursement of comprehensive tobacco cessation services and substance abuse and mental/behavioral health treatment (Eg: Enhancing partnerships with State HCA and Health Benefit Exchange).										Limited staff time			
Increase the number of places that protect employees, customers, patrons, and others from secondhand smoke (Eg: smoke-free multi-unit housing work, college campuses, worksites etc.)										CDC Core Grant, CTG			
Seek sustainable alcohol, tobacco, and other drugs prevention funding (Eg: comprehensive program funding).										CDC Quitline Grant until 8/31			
Develop and promote messaging about tobacco (including e-cigarettes and unapproved nicotine delivery devices) and substance abuse harms (curriculum and public awareness campaigns), and effective ways to quit.										N/A			

\*CDC Core Tobacco - \$1.4mil/year; Youth Tobacco Prevention Fund - \$750K/year; Quitline Supplemental - \$300K/year

\*\*DOH comprehensive program funding at highest level

**Tobacco Prevention and Control 2014-2019 Strategic Plan  
Identifying Strategic Priorities**

	Population Impact	Expected Reach	Impact on Health Disparities	Political Feasibility	Community Support	Leveraging opportunity or will it get done anyway?	Sustainability	Ability (and cost) to measure	Evidence	\$2.4 Million* (current level)	\$5 Million	\$15 Million	\$27 Million**
Reduce tobacco and alcohol advertising and promotions, product placement, and advertising seen by kids (point of sale, media, etc.).										Limited			
Enforce youth access laws (Eg: our compliance checks/retailer education efforts).										YTP funds			

**TYOLOGY FOR CLASSIFYING EVIDENCE:**

- 1 = Proven (Established through peer review via systematic or narrative review)
- 2 = Likely Effective (Established through peer review)
- 3 = Promising (Established through written program evaluation, evaluation without formal peer review)
- 4 = Emerging (Established through on-going work, practice-based summaries, or evaluation works in progress)
- 5 = Not recommended (Varies)

**RANKING OF PRIORITIZATION CRITERIA**

- 1 = High
- 2 = Medium
- 3 = Low

\*CDC Core Tobacco - \$1.4mil/year; Youth Tobacco Prevention Fund - \$750K/year; Quitline Supplemental - \$300K/year

\*\*DOH comprehensive program funding at highest level

## Washington State Tobacco Prevention And Control Strategic Plan, 2009-2014

**Goals: 1) Identify and eliminate tobacco-related disparities. 2) Prevent youth from beginning to use tobacco. 3) Increase quitting among tobacco users. 4) Eliminate exposure to secondhand smoke.**

Reduce the proportion of economically disadvantaged adults who currently smoke to 25 percent or less by 2013 (baseline year 2007=27.9 percent).

- Enhance data gathering and evaluation methods to guide program planning and practices.
- Mobilize agencies and organizations statewide to adopt policies and practices to eliminate tobacco-related disparities, and promote integration with chronic disease programs.
- Increase community awareness and capabilities to reduce the impact of tobacco use and tobacco industry influence on specific populations.

Reduce the proportion of 10th grade youth who currently smoke to 10 percent or less by 2013 (baseline year 2006=14.9 percent).

- Increase health knowledge, beliefs, and skills among youth, families, and communities.
- Promote development of tobacco-free environments for youth and young adults.
- Decrease youth access to all tobacco products.
- Raise awareness of the relationship between youth tobacco use and other unhealthy behaviors.

Reduce the proportion of adults who currently smoke to 14 percent or less by 2013 (baseline year 2007=16.5 percent).

- Promote quitting among tobacco users.
- Improve access to cessation services in health care systems.
- Increase access to and services for cessation in non-medical settings.

Reduce the proportion of adults exposed to secondhand smoke in the home to 6 percent or less by 2013 (baseline year 2007=8.6 percent).

- Support implementation of secondhand smoke public policies.
- Support the adoption of voluntary smoke-free policies and practices.

### **Funded Tobacco Prevention and Control Program Annual Action Plan, 2013-2014 (\$2.4 Million)\***

By March 2014, increase the membership of a statewide tobacco related coalition to include at least 7 participants representing organizations that have an interest in tobacco prevention and control and represent the needs of populations experiencing tobacco related disparities in Washington State.

By March 2014, the percentage of 10th graders saying it is “sort of hard” and “very hard” to get cigarettes will increase from 43% to 50%.

By March 2014, through the Health Care Provider Outreach Program, increase the number of health care providers, clinics, Federally Qualified rural hospitals who routinely include tobacco identification, advice to quit and referral to the Quit Line into the routine standard of Care or other resources for cessation by 180.

By March 2014, the number of multi unit housing units with no-smoking policies will increase to 335.

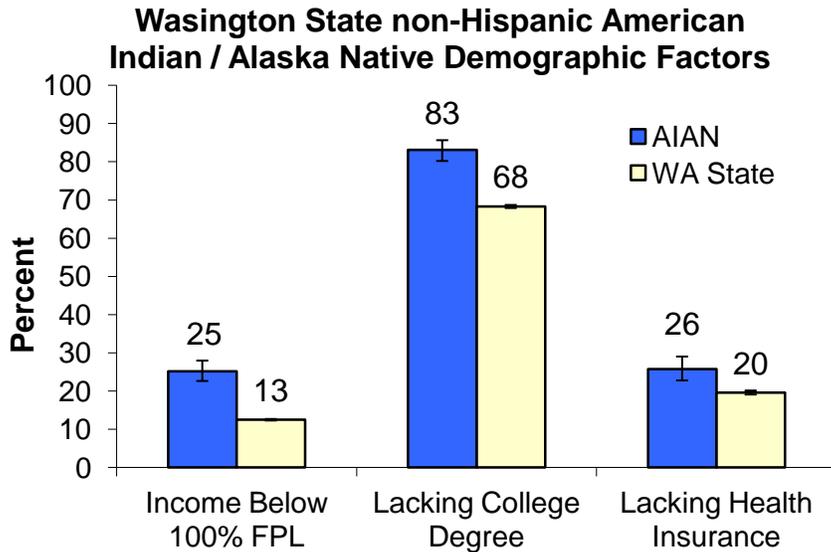
\*CDC Core Tobacco - \$1.4mil/year; Youth Tobacco Prevention Fund - \$750K/year; Quitline Supplemental - \$300K/year

By March 2014, average monthly number of unique visitors to <a href="http://www.smokefreewashington.com">www.smokefreewashington.com</a> website will increase from 1300 to 1500.
By March 2014, the number of local tobacco free private or public policies among healthy communities local grantees will increase by 20.
By March 2014, an evaluation plan for the tobacco prevention and control program will be maintained and accessible to stakeholders.
By March 2014, 3 additional policies will be implemented by state agencies or private organizations with statewide reach that address tobacco use.

\*CDC Core Tobacco - \$1.4mil/year; Youth Tobacco Prevention Fund - \$750K/year; Quitline Supplemental - \$300K/year

# Chronic Disease Profile

## Socio-demographic Risk Factors



In 2011, there were 89,000 non-Hispanic American Indian and Alaska Natives in Washington State, comprising 1.3% of the population.

### Among American Indian / Alaska Natives...

- A fourth of households have income below the federal poverty level.<sup>1</sup>
- Five out of six adults age 25 and older do not have a college degree
- A fourth of adults under age 65 have no medical insurance.

### Compared to Washington State...

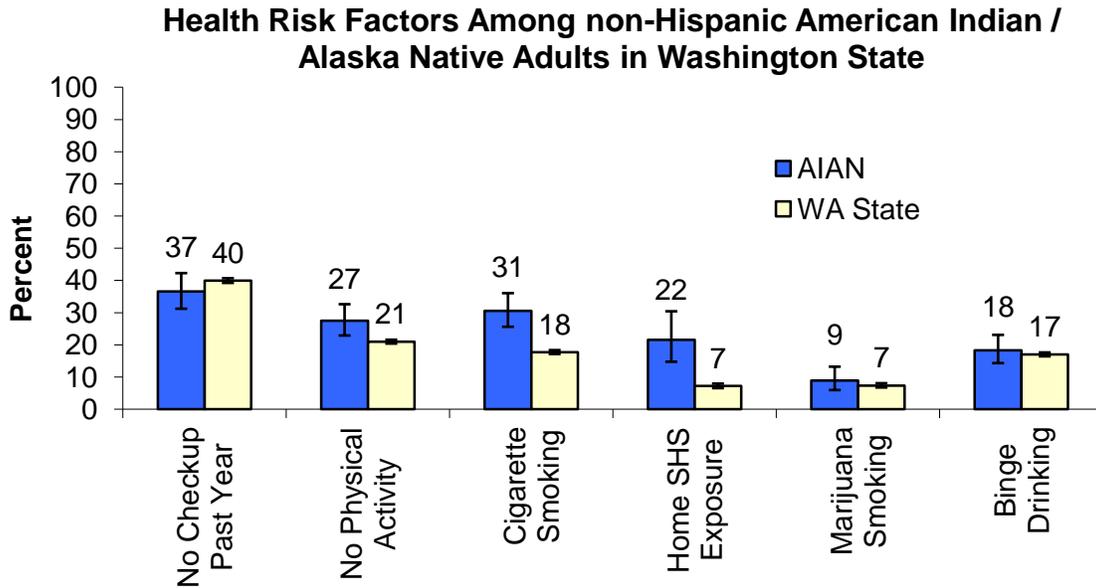
- American Indians and Alaska Natives have more people below poverty, fewer college graduates, and more uninsured than the state average.

1. Federal Poverty Level (FPL) is determined based on household income and household size. In 2012, FPL for a family of four was \$23,050.

Error bars show the 90 percent confidence intervals around the estimate.

Data Sources: US Census Bureau, 2007-2011 American Community Survey (Income, education, insurance)

## Adult Health Risk Factors



### Among American Indian / Alaska Natives ...

- Over a third of adults have not had a checkup in the past year.
- Over a fourth of adults are physically inactive.
- Almost a third of adults currently smoke cigarettes.
- Almost a fourth are exposed to second hand smoke in the home.
- One in 11 smoke marijuana.
- One in six engage in binge drinking.

### Compared to Washington State...

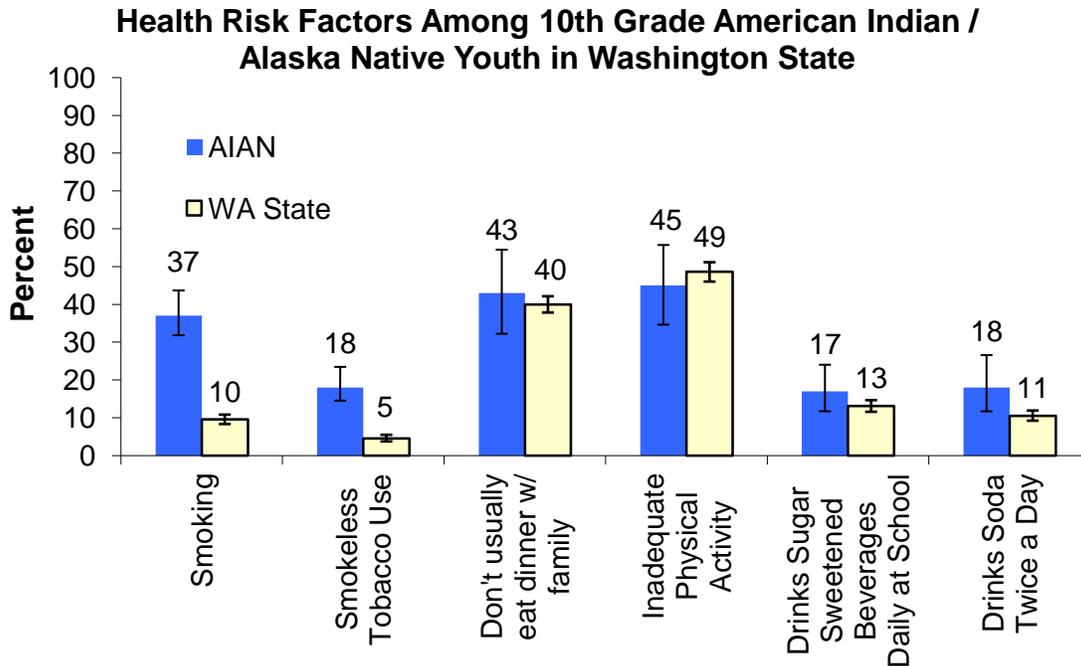
- More American Indians Alaska Native are physically inactive, more smoke cigarettes, more are exposed to secondhand smoke, and more smoke marijuana than the state average.

Error bars show the 95 percent confidence intervals around the estimate.

Data Source: WA Behavioral Risk Factor Surveillance System, 2009-2011 (checkup, smoking, second hand smoke, marijuana, binge drinking) 2009&2011 (physical activity).

For people with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY call 711).

## Youth (10<sup>th</sup> grade) Health Risk Factors



### Among American Indian / Alaska Native 10<sup>th</sup> graders...

- Over a third smoke.
- One in six use smokeless tobacco products.
- Two out of five do not usually eat dinner with their family.
- Almost half do not get enough physical activity.<sup>1</sup>
- One in six drink sugar sweetened beverages daily at school.<sup>2</sup>
- One in six drink soda two or more times a day.

### Compared to Washington State 10<sup>th</sup> graders...

- More American Indian and Alaska Native 10<sup>th</sup> grade students smoke, more use smokeless tobacco, and more drink soda two or more times a day than the state average. .

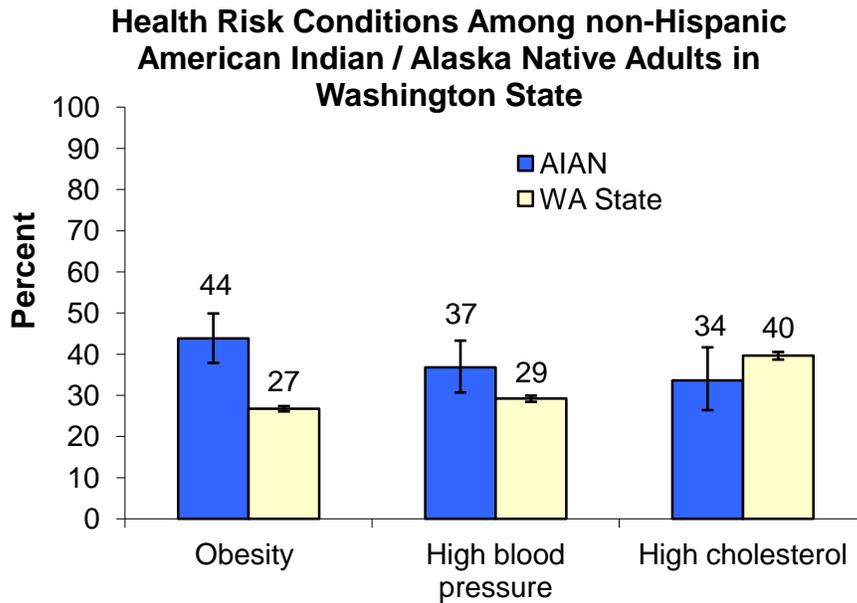
1. CDC recommends 60 minutes moderate or vigorous physical activity every day for youths.

2. Includes soda, fruit juice, sports drinks, kool-aid, etc.

Error bars show the 95percent confidence intervals around the estimate.

Data Source: WA Healthy Youth Survey, 2012.

## Adult Health Risk Conditions



### Among American Indian / Alaska Natives ...

- Almost half of adults are obese.<sup>1</sup>
- Over a third of adults have high blood pressure.<sup>2</sup>
- A third of adults have high cholesterol.<sup>2</sup>

### Compared to Washington State...

- More American Indian and Alaska Native adults are obese and more have high blood pressure than the state average.

Obesity and overweight among youth is available from the Washington State Healthy Youth Survey at <http://www.askhys.net>.

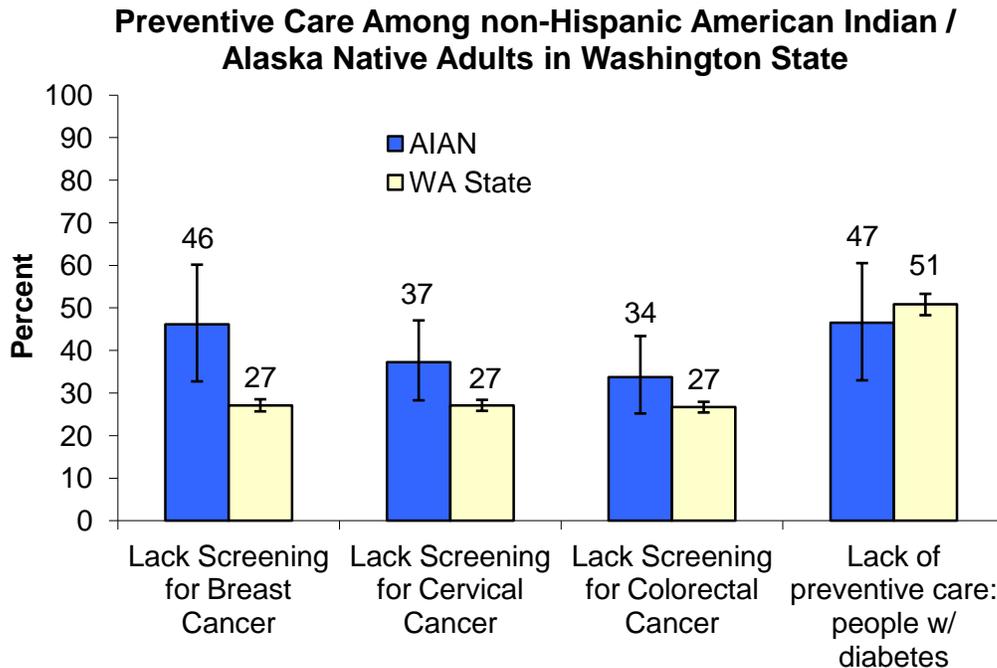
1. Obesity in adults is defined as body mass index  $\geq 30$  kg / m<sup>2</sup>.

2. Self reported lifetime prevalence – Survey respondent answered “yes” to “have you ever been told by a health care professional that you have high blood pressure (or high cholesterol).”

Error bars show the 95percent confidence intervals around the estimate.

Data Source: WA Behavioral Risk Factor Surveillance System, 2009-2011 (Obesity), 2009&2011 (hypertension, cholesterol).

## Adult Preventive Care



### Among American Indian / Alaska Natives ...

- Almost half of women age 40 and over have not been screened for breast cancer.<sup>1</sup>
- Over a third of women age 18 and over have not been screened for cervical cancer.<sup>1</sup>
- A third of men and women age 50 and over have not been screened for colorectal cancer.<sup>1</sup>
- Almost half of adults with diabetes have not received recommended preventive care.<sup>2</sup>

### Compared to Washington State...

- More American Indian and Alaska Native women over age 40 have not been screened for breast cancer and more women have not been screened for cervical cancer than the state average.

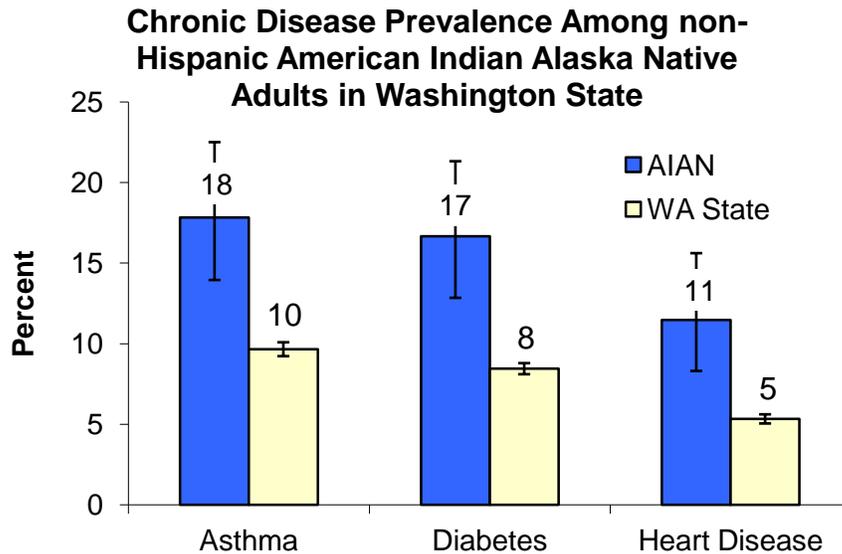
1. DOH recommends women age 40 or older should have a mammogram every two years; women age 18 or older should have a Pap test every three years; and men and women age 50 or older should have had a blood stool test in the past year, sigmoidoscopy in the past 5 years or colonoscopy in the past 10 years.

2. For people with diabetes, recommended preventive care includes annual foot exam, annual eye exam, and bi-annual hemoglobin A1c test.

Error bars show the 95percent confidence intervals around the estimate.

Data Source: WA Behavioral Risk Factor Surveillance System, 2010 (cancer screening) 2009-2011 (diabetes preventive care).

## Adult Chronic Disease Rates



### Among American Indian / Alaska Natives ...

- One in six adults have asthma.<sup>1</sup>
- One in six adults have diabetes.<sup>1</sup>
- One in nine adults have had a heart attack, coronary heart disease, or angina.<sup>1</sup>

### Compared to Washington State...

- More American Indian and Alaska Native adults have asthma, more have diabetes and more have heart disease than the state average.

Cancer incidence rates are available from the Washington State Cancer Registry at <https://fortress.wa.gov/doh/wscr/>.

1. Self reported lifetime prevalence – Survey respondent answered “yes” to “have you ever been told by a health care professional that you have asthma (or diabetes, heart attack, coronary heart disease, or angina).

Error bars show the 95percent confidence intervals around the estimate.

Data Source: WA Behavioral Risk Factor Surveillance System, 2009-2011 (asthma, diabetes, heart disease).

## Appendix: Data Sources & Definitions

The following provides a brief description of each data system and definitions of technical terms used in this report. Data represented in this profile were obtained from a variety of sources. Analyses for this report were completed using Stata/IC 12.0. Some estimates were obtained from previously published reports.

### **DATA SYSTEMS:**

#### **American Community Survey**

Population data were taken from U.S. Census Bureau. The primary constitutional purpose of the census is the apportionment of congressional seats. The Census Bureau also serves as a source of data about the nation's people and economy. The American Community Survey (ACS) is an annual survey of the US population race/ethnicity, education, income, employment, and other socioeconomic factors. Small area estimates at county or census tract level are produced by combining 5 years of ACS data..

- Data related to income and education was obtained from the US Census Bureau American Community Survey (ACS) 2007-2011. For more information on the ACS, go to: <http://www.census.gov>.

#### **Behavioral Risk Factor Surveillance System**

The Behavioral Risk Factor Surveillance System (BRFSS) is an annual telephone survey that provides indicators of health risk behavior, preventive practices, attitudes, health care use and access, and prevalence of selected diseases in Washington. BRFSS was first implemented in Washington State in 1987, and is supported in part by the national Centers for Disease Control and Prevention. The survey includes a sample of English or Spanish (since 2003) speaking adults age 18 years and older. Interviews are conducted in English or Spanish, by a survey firm under contract to the Department of Health (DOH), following survey administration protocols established by Centers for Disease Control and Prevention (CDC).

The data are weighted to represent all adults. The data may underestimate some health behaviors associated with populations speaking neither English nor Spanish, transient populations, institutionalized persons, and military personnel in military housing. Due to the nature of self-reported data, there may be some underestimation of risk factors that are seen as socially unacceptable.

In 2011, CDC began conducting cell phone as well as land-line phones in the BRFSS sample, and implemented new weighting methods to improve survey representativeness. In anticipation of these changes, DOH began collecting cell phone responses in 2009. All BRFSS data in this report are analyzed using the new methodology. Due to changes in methodology, BRFSS estimates given in this report cannot be compared with previous years.

- For more information on Washington State BRFSS, go to: <http://www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/BehavioralRiskFactorSurveillanceSystemBRFSS.aspx>
- For technical notes on the Washington State BRFSS, go to: <http://www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/BehavioralRiskFactorSurveillanceSystemBRFSS.aspx>
- For more information on national BRFSS, go to: <http://www.cdc.gov/brfss>.

#### **Healthy Youth Survey Data**

The Washington State Healthy Youth Survey (HYS) is a school-based survey of students in grades 6<sup>th</sup>, 8<sup>th</sup>, 10<sup>th</sup> and 12<sup>th</sup> in a random sample of public schools in Washington State. It is administered every other year during class time and contains questions about behaviors that result in unintentional and intentional injury (e.g., seat belt use, fighting and weapon carrying); physical activity and dietary behaviors (e.g., fruit and vegetable consumption); alcohol, tobacco, and other drug use; and related risk and protective factors. The survey includes items from the

CDC-sponsored Youth Risk Behavior Survey (YRBS) and Youth Tobacco Survey, the National Institute on Drug Abuse-sponsored Monitoring the Future survey, and the Social Development Research Group's Risk and Protective Factor Assessment instrument. In 2012, 33,270 students participated in the Healthy Youth Survey and contributed to the statewide results. In addition, 170,894 students participated and contributed to local level results for counties, educational service districts, school districts and school buildings.

- For more information on the HYS, go to:  
<http://www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/HealthyYouthSurvey.aspx>
- For technical notes on the HYS, go to:  
<http://www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/HealthyYouthSurvey/TechnicalNotes.aspx>

School-based surveys may underestimate risk behaviors associated with youth who drop out of school or do not attend school. Due to the self-reported nature of the data, certain behaviors may be under-reported.

## DEFINITIONS

**Race and Ethnicity:** Race and ethnicity are defined differently in different data sources:

- **Census Bureau, American Community Survey:** Respondents first identify their ethnicity as Hispanic/Latino or not Hispanic/Latino. Respondents then identify their race by choosing any that apply from a detailed list of racial categories and sub-categories. Identification as multiracial is allowed. In this report, non-Hispanic AIAN refers to those who select non-Hispanic ethnicity, and then select AIAN as their only racial classification. Multi-racial respondents are not included within non-Hispanic AIAN.
- **BRFSS:** Respondents first identify their ethnicity as Hispanic/Latino or not Hispanic/Latino. Respondents then identify their race by choosing one response from a list of racial categories. Respondents who identify themselves as multi-racial are then asked to choose a single preferred racial classification. In this report, non-Hispanic AIAN refers to those who select non-Hispanic ethnicity, and then select AIAN as their preferred race.
- **HYS:** Respondents are asked, "How do you describe yourself? (**Select one or more responses.**)" Response options are: a. American Indian or Alaskan Native; b. Asian or Asian American; c. Black or African-American; d. Hispanic or Latino/Latina; e. Native Hawaiian or other Pacific Islander; f. White or Caucasian; g. Other. Respondents who check more than one option are classified as multiracial. In this report non-Hispanic AIAN refers to those who identify themselves only as AIAN.

For additional Washington State guidelines for using racial and ethnic groups in data analysis, go to: <http://www.doh.wa.gov/Portals/1/Documents/5500/RaceEthnGuidelines.pdf>.

**95 Percent Confidence Intervals:** Sometimes called the "margin of error." Commonly used with survey data to account for the differences in estimates that is due to random factors or chance. Confidence intervals are typically expressed as a range between an upper and lower value. Variation due to random sampling of respondents will place prevalence estimates within the confidence interval 95 percent of the time.

**Statistically Detectable:** Also known as "statistically significant". An observed difference between two populations is determined to be statically detectable (significant) if it is unlikely to have occurred randomly or by chance. If there is more than about a 5% probability that the differences we see are just due to chance, we say that there is no statistically detectable (or significant) difference. In comparing county estimates to Washington State, we only describe

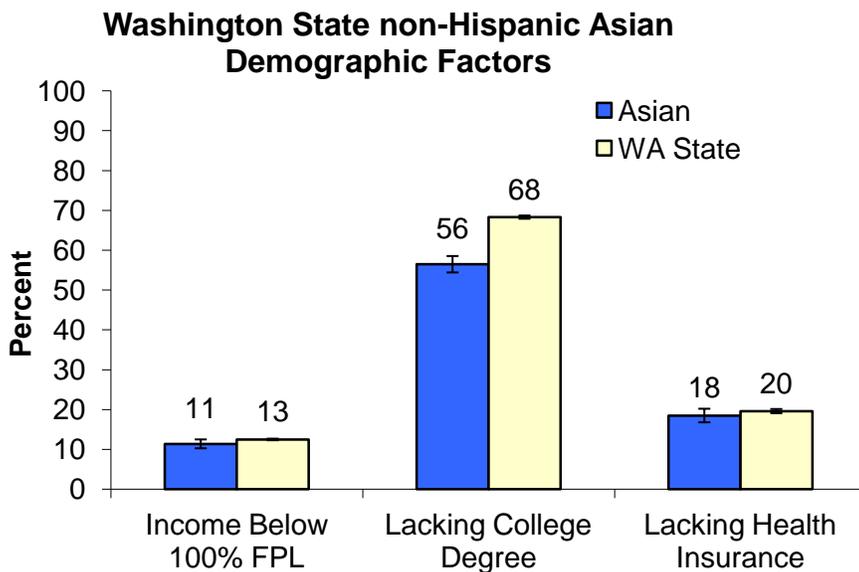
differences that are statistically detectable. Statistically detectable differences may or may not be large enough to be important.

**Crude versus Age-adjusted Rates:** Only crude rates (percentages) are presented in this report. Crude rates represent the absolute burden in a single population at a particular time. Crude rates are recommended when a summary measure is needed and it is not necessary or desirable to adjust for other factors. In other contexts, you may find percentages that are age-adjusted. Age adjustment is used to control for the effects of age differences when making comparisons by sociodemographic factors such as income.

**Insufficient Data:** In our reporting of data we suppressed rates and frequencies that fell below certain criteria to protect confidentiality of individuals, and reduce problems with data reliability. If 10 or fewer respondents reported a condition, or if there were 50 or fewer total respondents, we report “insufficient data.”

# Chronic Disease Profile

## Socio-demographic Risk Factors



In 2011, there were 484,000 Non-Hispanic Asians in Washington State, comprising 7.2% of the population.

### Among Non-Hispanic Asians...

- One in nine households have income below the federal poverty level.<sup>1</sup>
- Over half of adults age 25 and older do not have a college degree.
- One in six adults under age 65 have no medical insurance.

### Compared to Washington State...

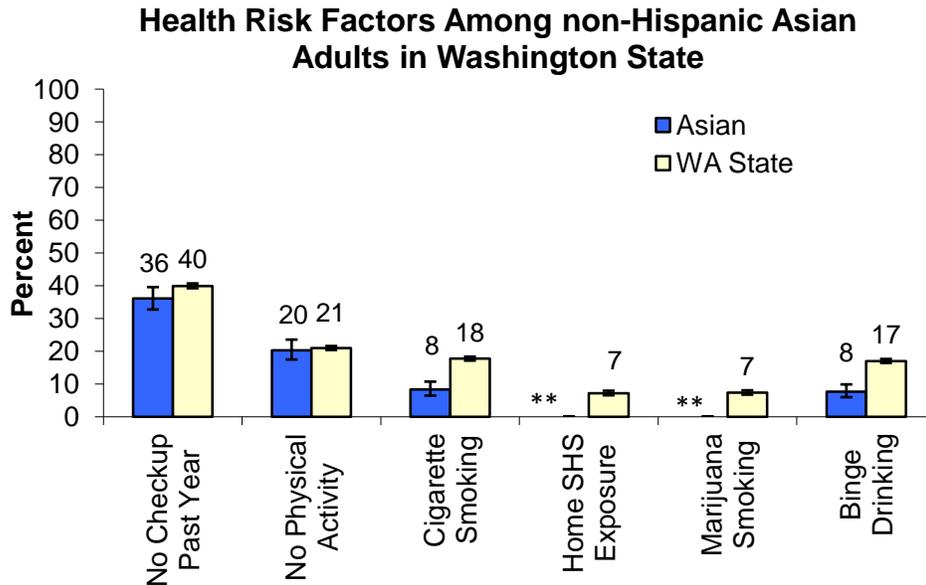
- Among Non-Hispanic Asians, there are fewer households below poverty, and more college graduates than the state average.

1. Federal Poverty Level (FPL) is determined based on household income and household size. In 2012, FPL for a family of four was \$23,050.

Error bars show the 90 percent confidence intervals around the estimate.

Data Sources: US Census Bureau, 2007-2011 American Community Survey (Income, education, insurance);

## Adult Health Risk Factors



### Among Non-Hispanic Asians ...

- Over a third of adults have not had a checkup in the past year.
- One in five adults are physically inactive.
- One in 12 adults currently smoke cigarettes.
- \*\*Insufficient data to estimate secondhand smoke exposure among Asians.
- \*\*Insufficient data to estimate marijuana smoking among Asians.
- One in 12 adults engage in binge drinking.

### Compared to Washington State...

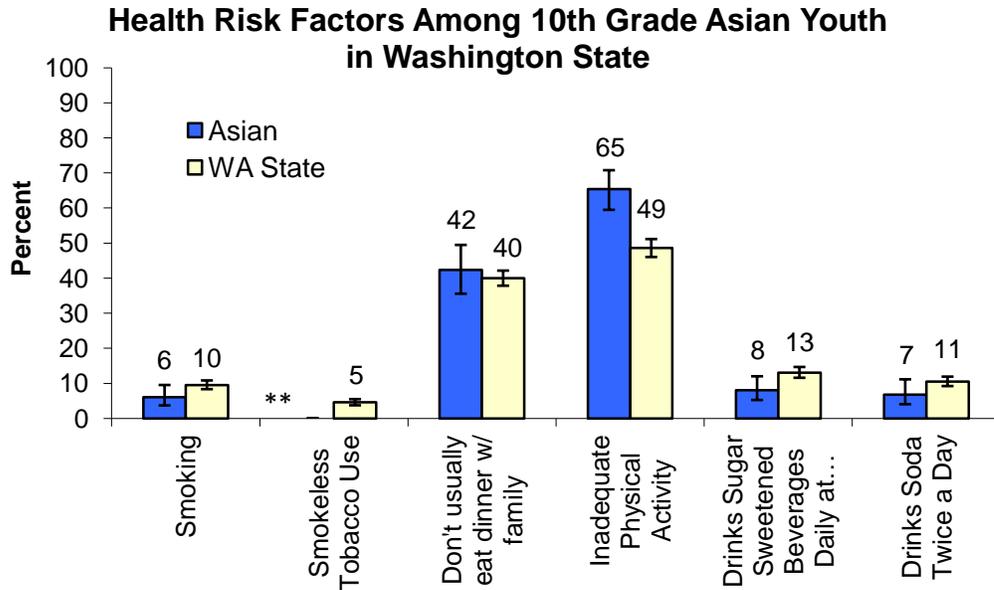
- Fewer non-Hispanic Asians smoke and fewer engage in binge drinking than the state average.

Error bars show the 95 percent confidence intervals around the estimate.

Data Source: WA Behavioral Risk Factor Surveillance System, 2009-2011 (checkup, smoking, second hand smoke, marijuana, binge drinking) 2009&2011 (physical activity).

For people with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY call 711).

## Youth (10<sup>th</sup> grade) Health Risk Factors



### Among Asian 10<sup>th</sup> graders...

- One in 16 smoke.
- \*\* Insufficient data to estimate smokeless tobacco use..
- Two out of five do not usually eat dinner with their family.
- Two thirds do not get enough physical activity.<sup>1</sup>
- One in 12 drink sugar sweetened beverages daily at school.<sup>2</sup>
- One in 14 drink soda two or more times a day.

### Compared to Washington State 10<sup>th</sup> graders...

- Fewer Asian 10<sup>th</sup> grade students smoke than the state average.
- More Asian 10<sup>th</sup> grade students do not get enough physical activity than the state average.

1. CDC recommends 60 minutes moderate or vigorous physical activity every day for youths.

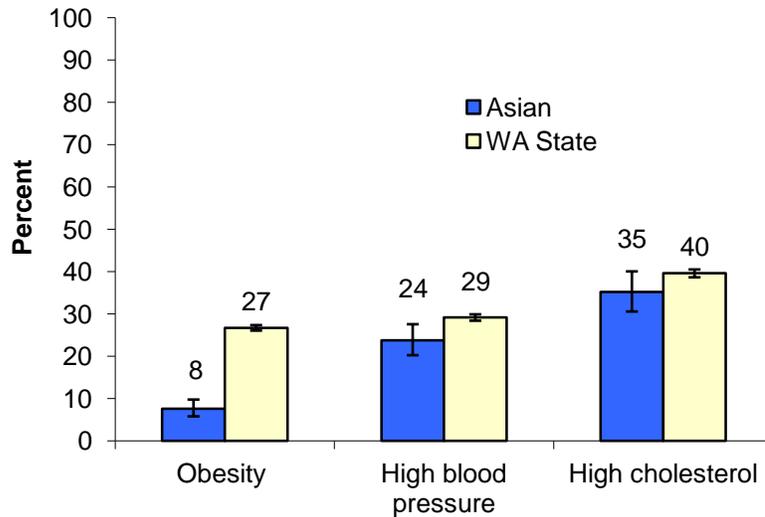
2. Includes soda, fruit juice, sports drinks, kool-aid, etc.

Error bars show the 95percent confidence intervals around the estimate.

Data Source: WA Healthy Youth Survey, 2012.

## Adult Health Risk Conditions

**Health Risk Conditions Among non-Hispanic Asian Adults in Washington State**



### Among Non-Hispanic Asians ...

- One in 12 adults are obese.<sup>1</sup>
- A fourth of adults have high blood pressure.<sup>2</sup>
- A third of adults have high cholesterol.<sup>2</sup>

### Compared to Washington State...

- Fewer non-Hispanic Asians are obese and fewer have high blood pressure than the state average.

Obesity and overweight among youth is available from the Washington State Healthy Youth Survey at <http://www.askhys.net>.

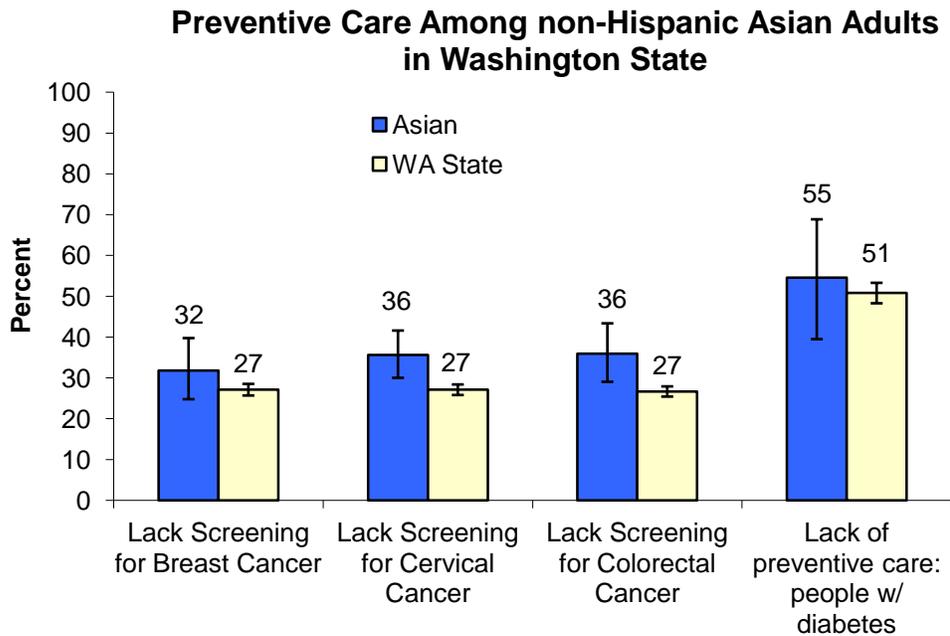
1. Obesity in adults is defined as body mass index  $\geq 30$  kg / m<sup>2</sup>.

2. Self reported lifetime prevalence – Survey respondent answered “yes” to “have you ever been told by a health care professional that you have high blood pressure (or high cholesterol).”

Error bars show the 95percent confidence intervals around the estimate.

Data Source: WA Behavioral Risk Factor Surveillance System, 2009-2011 (Obesity), 2009&2011 (hypertension, cholesterol).

## Adult Preventive Care



### Among Non-Hispanic Asians ...

- A third of women age 40 and over have not been screened for breast cancer.<sup>1</sup>
- Over a third of women age 18 and over have not been screened for cervical cancer.<sup>1</sup>
- Over a third of men and women age 50 and over have not been screened for colorectal cancer.<sup>1</sup>
- Half of adults with diabetes have not received recommended preventive care.<sup>2</sup>

### Compared to Washington State...

- More non-Hispanic Asian adult women have not been screened for cervical cancer, and more adults have not been screened for colorectal cancer.

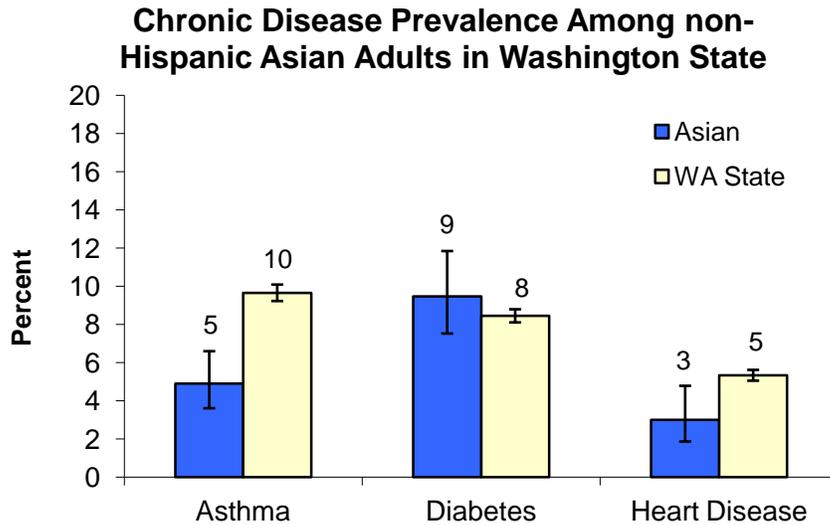
1. DOH recommends women age 40 or older should have a mammogram every two years; women age 18 or older should have a Pap test every three years; and men and women age 50 or older should have had a blood stool test in the past year, sigmoidoscopy in the past 5 years or colonoscopy in the past 10 years.

2. For people with diabetes, recommended preventive care includes annual foot exam, annual eye exam, and bi-annual hemoglobin A1c test.

Error bars show the 95percent confidence intervals around the estimate.

Data Source: WA Behavioral Risk Factor Surveillance System, 2010 (cancer screening) 2009-2011 (diabetes preventive care).

## Adult Chronic Disease Rates



### Among Non-Hispanic Asians ...

- One in 20 adults have asthma.<sup>1</sup>
- One in 11 adults have diabetes.<sup>1</sup>
- One in 30 adults have had a heart attack, coronary heart disease, or angina.<sup>1</sup>

### Compared to Washington State...

- Fewer non-Hispanic Asian adults have asthma and fewer have heart disease than the state average.

Cancer incidence rates are available from the Washington State Cancer Registry at <https://fortress.wa.gov/doh/wscr/>.

1. Self reported lifetime prevalence – Survey respondent answered “yes” to “have you ever been told by a health care professional that you have asthma (or diabetes, heart attack, coronary heart disease, or angina).

Error bars show the 95percent confidence intervals around the estimate.

Data Source: WA Behavioral Risk Factor Surveillance System, 2009-2011 (asthma, diabetes, heart disease).

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The data are weighted to represent all adults. The data may underestimate some health behaviors associated with populations speaking neither English nor Spanish, transient populations, institutionalized persons, and military personnel in military housing. Due to the nature of self-reported data, there may be some underestimation of risk factors that are seen as socially unacceptable.

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The Washington State Healthy Youth Survey (HYS) is a school-based survey of students in grades 6<sup>th</sup>, 8<sup>th</sup>, 10<sup>th</sup> and 12<sup>th</sup> in a random sample of public schools in Washington State. It is administered every other year during class time and contains questions about behaviors that result in unintentional and intentional injury (e.g., seat belt use, fighting and weapon carrying); physical activity and dietary behaviors (e.g., fruit and vegetable consumption); alcohol, tobacco, and other drug use; and related risk and protective factors. The survey includes items from the

CDC-sponsored Youth Risk Behavior Survey (YRBS) and Youth Tobacco Survey, the National Institute on Drug Abuse-sponsored Monitoring the Future survey, and the Social Development Research Group's Risk and Protective Factor Assessment instrument. In 2012, 33,270 students participated in the Healthy Youth Survey and contributed to the statewide results. In addition, 170,894 students participated and contributed to local level results for counties, educational service districts, school districts and school buildings.

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School-based surveys may underestimate risk behaviors associated with youth who drop out of school or do not attend school. Due to the self-reported nature of the data, certain behaviors may be under-reported.

## DEFINITIONS

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- **BRFSS:** Respondents first identify their ethnicity as Hispanic/Latino or not Hispanic/Latino. Respondents then identify their race by choosing one response from a list of racial categories. Respondents who identify themselves as multi-racial are then asked to choose a single preferred racial classification. In this report, non-Hispanic Asian refers to those who select non-Hispanic ethnicity, and then select Asian as their preferred race.
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**95 Percent Confidence Intervals:** Sometimes called the "margin of error." Commonly used with survey data to account for the differences in estimates that is due to random factors or chance. Confidence intervals are typically expressed as a range between an upper and lower value. Variation due to random sampling of respondents will place prevalence estimates within the confidence interval 95 percent of the time.

**Statistically Detectable:** Also known as "statistically significant". An observed difference between two populations is determined to be statically detectable (significant) if it is unlikely to have occurred randomly or by chance. If there is more than about a 5% probability that the differences we see are just due to chance, we say that there is no statistically detectable (or significant) difference. In comparing county estimates to Washington State, we only describe

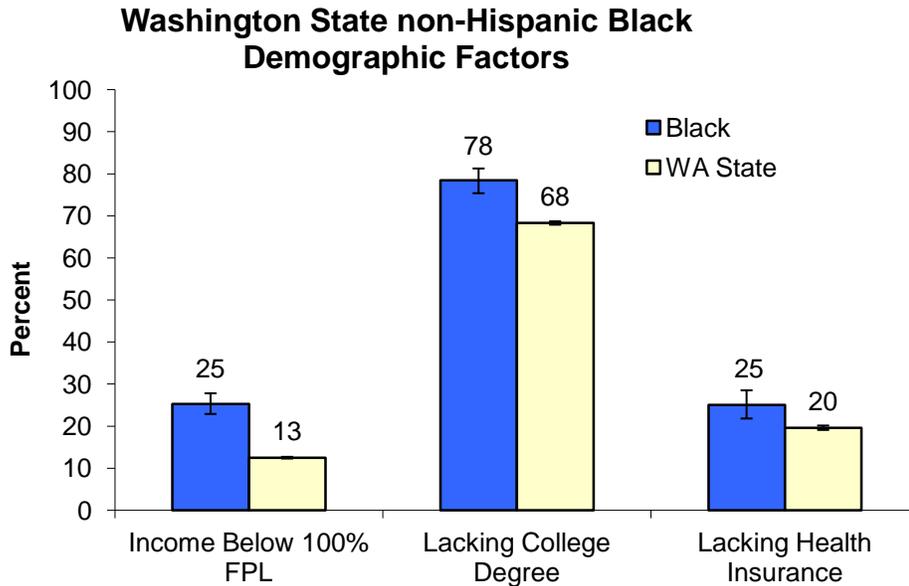
differences that are statistically detectable. Statistically detectable differences may or may not be large enough to be important.

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# Chronic Disease Profile

## Socio-demographic Risk Factors



In 2011, there were 235,000 non-Hispanic blacks in Washington State, comprising 3.5% of the population.

### Among Non-Hispanic Blacks...

- A fourth of households have income below the federal poverty level.<sup>1</sup>
- Over three fourths of adults age 25 and older do not have a college degree.
- Over a fourth of adults under age 65 have no medical insurance.

### Compared to Washington State...

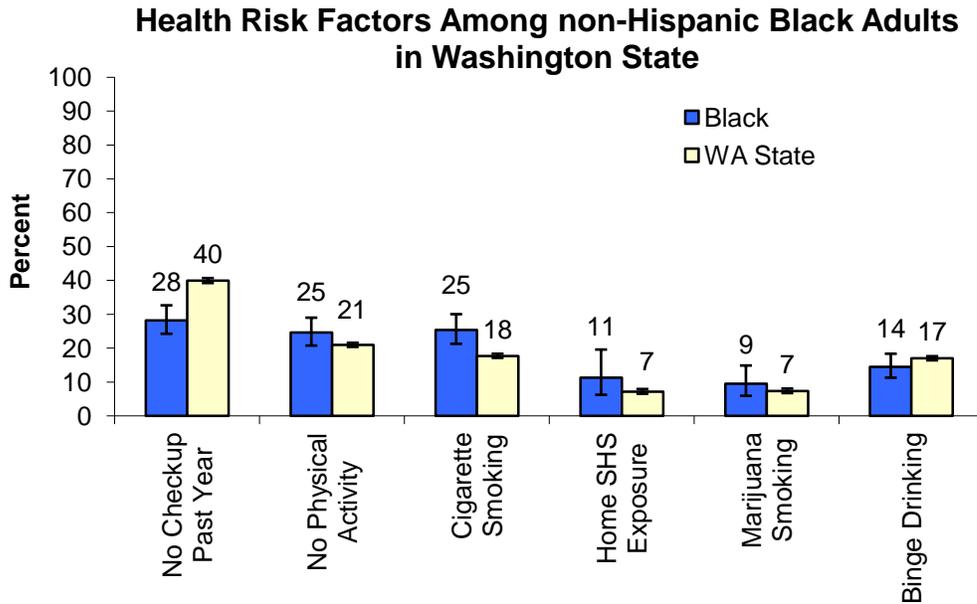
- Among non-Hispanic blacks, more have income below poverty, fewer are college graduates, and more are uninsured than the state average.

1. Federal Poverty Level (FPL) is determined based on household income and household size. In 2012, FPL for a family of four was \$23,050.

Error bars show the 90 percent confidence intervals around the estimate.

Data Sources: US Census Bureau, 2007-2011 American Community Survey (Income, education, insurance);

## Adult Health Risk Factors



### Among Non-Hispanic Blacks ...

- Over a fourth of adults have not had a checkup in the past year.
- A fourth of adults are physically inactive.
- A fourth of adults currently smoke cigarettes.
- One in nine are exposed to second hand smoke in the home.
- One in 11 smoke marijuana.
- One in seven engage in binge drinking.

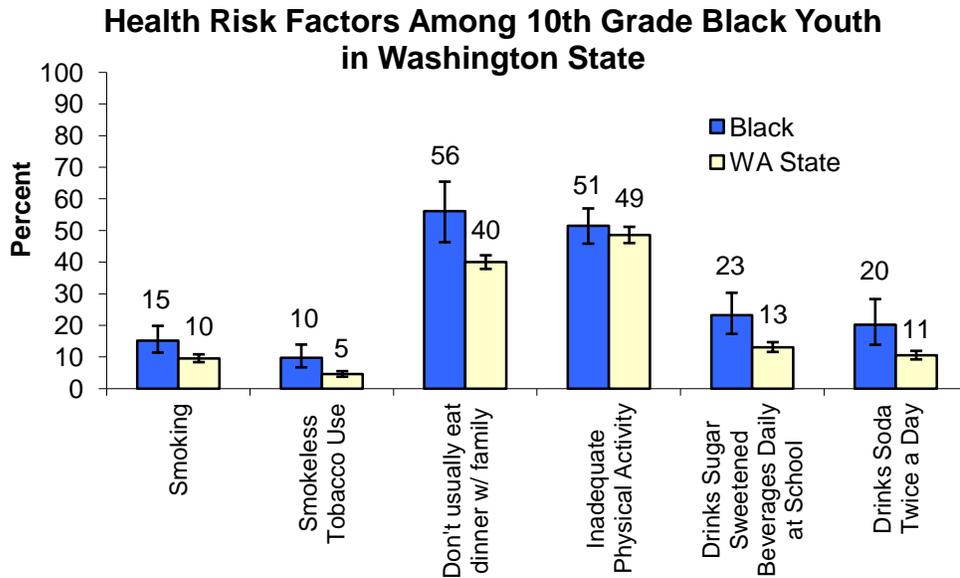
### Compared to Washington State...

- More non-Hispanic blacks smoke cigarettes, more are exposed to second hand smoke, and more smoke marijuana than the state average.
- Fewer non-Hispanic blacks have not had a checkup in the past year than the state average.

Error bars show the 95 percent confidence intervals around the estimate.

Data Source: WA Behavioral Risk Factor Surveillance System, 2009-2011 (checkup, smoking, second hand smoke, marijuana, binge drinking) 2009&2011 (physical activity).

## Youth (10<sup>th</sup> grade) Health Risk Factors



### Among Non-Hispanic Black 10<sup>th</sup> graders...

- One in seven smoke.
- One in ten use smokeless tobacco products.
- Over half do not usually eat dinner with their family.
- Half do not get enough physical activity.<sup>1</sup>
- Almost a fourth drink sugar sweetened beverages daily at school.<sup>2</sup>
- One in five drink soda two or more times a day.

### Compared to Washington State 10<sup>th</sup> graders...

- More non-Hispanic black 10<sup>th</sup> grade students smoke, more are exposed to second hand smoke, more do not eat dinner with family, more drink sugar sweetened beverages at school, and more drink soda two or more times a day than the state average.

1. CDC recommends 60 minutes moderate or vigorous physical activity every day for youths.

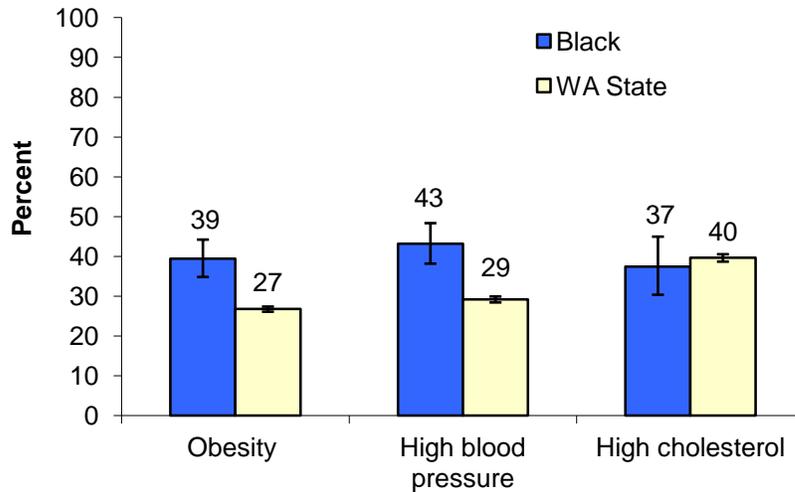
2. Includes soda, fruit juice, sports drinks, kool-aid, etc.

Error bars show the 95percent confidence intervals around the estimate.

Data Source: WA Healthy Youth Survey, 2012.

## Adult Health Risk Conditions

### Health Risk Conditions Among non-Hispanic Black Adults in Washington State



#### Among Non-Hispanic Blacks ...

- Over a third of adults are obese.<sup>1</sup>
- Two out of five adults have high blood pressure.<sup>2</sup>
- Over a third of adults have high cholesterol.<sup>2</sup>

#### Compared to Washington State...

- More non-Hispanic blacks are obese, and more have high blood pressure.

Obesity and overweight among youth is available from the Washington State Healthy Youth Survey at <http://www.askhys.net>.

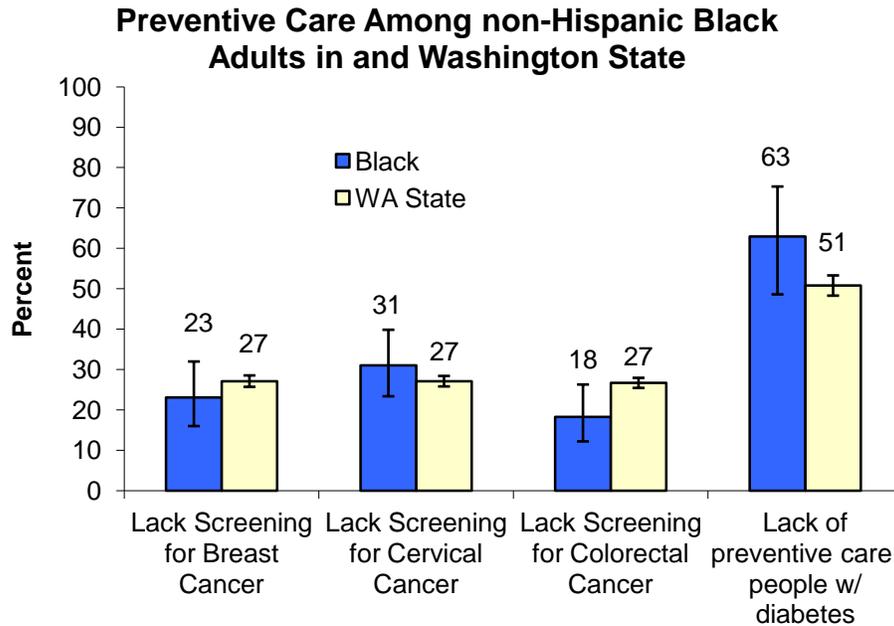
1. Obesity in adults is defined as body mass index  $\geq 30$  kg / m<sup>2</sup>.

2. Self reported lifetime prevalence – Survey respondent answered “yes” to “have you ever been told by a health care professional that you have high blood pressure (or high cholesterol).”

Error bars show the 95percent confidence intervals around the estimate.

Data Source: WA Behavioral Risk Factor Surveillance System, 2009-2011 (Obesity), 2009&2011 (hypertension, cholesterol).

## Adult Preventive Care



### Among Non-Hispanic Blacks ...

- Almost a fourth of women age 40 and over have not been screened for breast cancer.<sup>1</sup>
- Almost a third of women age 18 and over have not been screened for cervical cancer.<sup>1</sup>
- One in six men and women age 50 and over have not been screened for colorectal cancer.<sup>1</sup>
- Almost two thirds of adults with diabetes have not received recommended preventive care.<sup>2</sup>

### Compared to Washington State...

- There are no statistically detectable differences between non-Hispanic Blacks and Washington State..

1. DOH recommends women age 40 or older should have a mammogram every two years; women age 18 or older should have a Pap test every three years; and men and women age 50 or older should have had a blood stool test in the past year, sigmoidoscopy in the past 5 years or colonoscopy in the past 10 years.

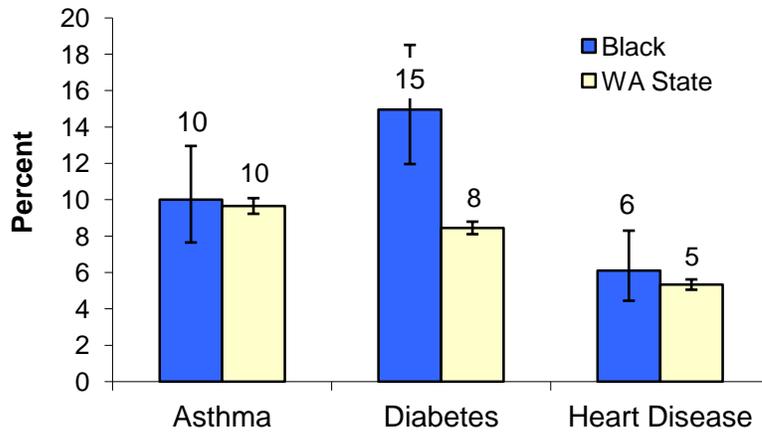
2. For people with diabetes, recommended preventive care includes annual foot exam, annual eye exam, and bi-annual hemoglobin A1c test.

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Data Source: WA Behavioral Risk Factor Surveillance System, 2010 (cancer screening) 2009-2011 (diabetes preventive care).

## Adult Chronic Disease Rates

### Chronic Disease Prevalence Among non-Hispanic Black Adults in Washington State



#### Among Non-Hispanic Blacks ...

- One in ten adults have asthma.<sup>1</sup>
- One in seven adults have diabetes.<sup>1</sup>
- One in 16 adults have had a heart attack, coronary heart disease, or angina.<sup>1</sup>

#### Compared to Washington State...

- More non-Hispanic black adults have diabetes than the state average.

Cancer incidence rates are available from the Washington State Cancer Registry at <https://fortress.wa.gov/doh/wscr/>.

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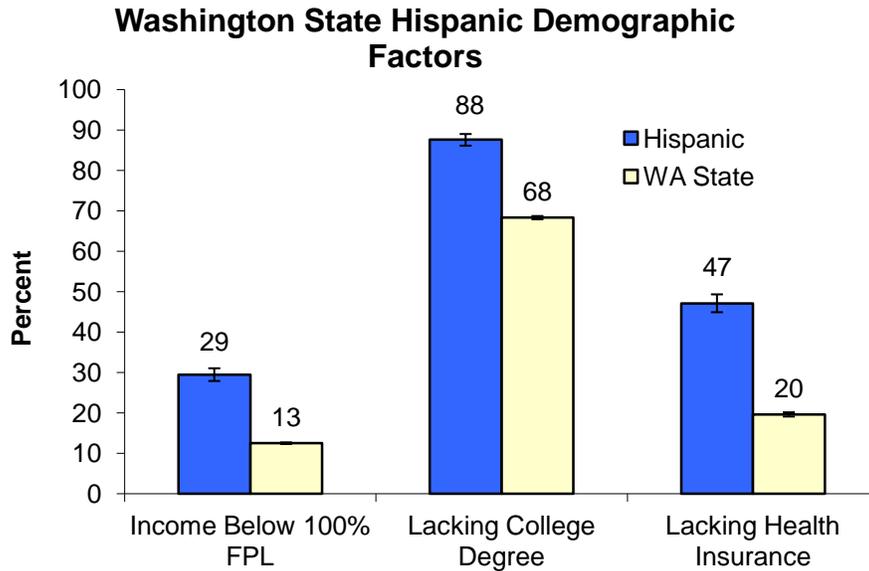
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# Chronic Disease Profile

## Socio-demographic Risk Factors



In 2011, there were 774,000 Hispanics in Washington State, comprising 11.4% of the population.

### Among Hispanics...

- Over a fourth of households have income below the federal poverty level.<sup>1</sup>
- Nearly nine out of ten adults age 25 and older do not have a college degree.
- Almost half of adults under age 65 have no medical insurance.

### Compared to Washington State...

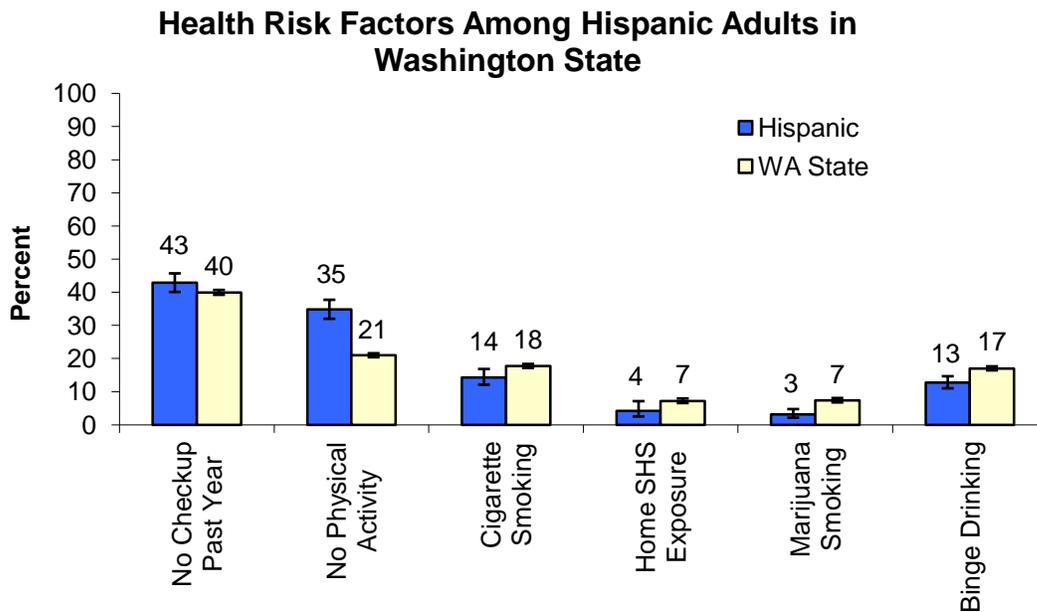
- Among Hispanics, there are more with income below poverty, fewer college graduates, and more uninsured than the state average.

1. Federal Poverty Level (FPL) is determined based on household income and household size. In 2012, FPL for a family of four was \$23,050.

Error bars show the 90 percent confidence intervals around the estimate.

Data Sources: US Census Bureau, 2007-2011 American Community Survey (Income, education, insurance).

## Adult Health Risk Factors



### Among Hispanics ...

- Two out of five adults have not had a checkup in the past year.
- A third of adults are physically inactive.
- One in seven adults currently smoke cigarettes.
- One in 25 are exposed to second hand smoke in the home.
- One in 30 smoke marijuana.
- One in eight engage in binge drinking.

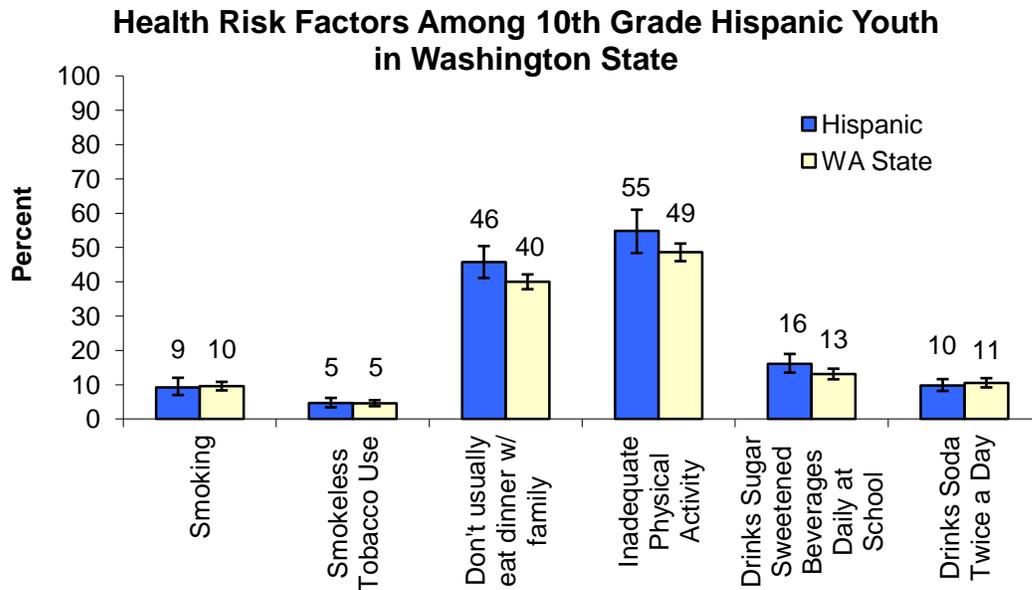
### Compared to Washington State...

- More Hispanic adults are physically inactive than the state average.
- Fewer Hispanic adults smoke, fewer are exposed to secondhand smoke, fewer smoke marijuana, and fewer engage in binge drinking than the state average.

Error bars show the 95 percent confidence intervals around the estimate.

Data Source: WA Behavioral Risk Factor Surveillance System, 2009-2011 (checkup, smoking, second hand smoke, marijuana, binge drinking) 2009&2011 (physical activity).

## Youth (10<sup>th</sup> grade) Health Risk Factors



### Among Hispanic 10<sup>th</sup> graders...

- One in 11 smoke.
- One in 20 use smokeless tobacco products.
- Almost half do not usually eat dinner with their family.
- Over half do not get enough physical activity.<sup>1</sup>
- One in six drink sugar sweetened beverages daily at school.<sup>2</sup>
- One in ten drink soda two or more times a day.

### Compared to Washington State 10<sup>th</sup> graders...

- There are no statistically detectable differences between Hispanics and Washington State.

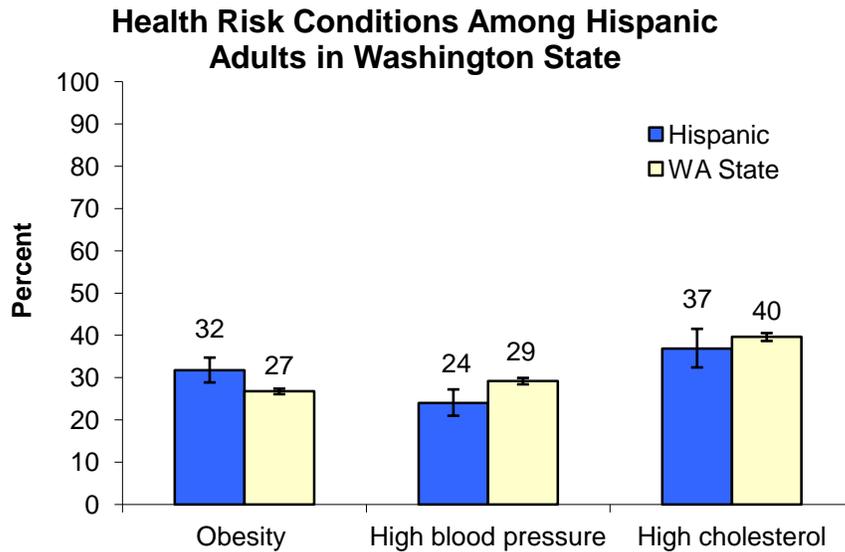
1. CDC recommends 60 minutes moderate or vigorous physical activity every day for youths.

2. Includes soda, fruit juice, sports drinks, kool-aid, etc.

Error bars show the 95percent confidence intervals around the estimate.

Data Source: WA Healthy Youth Survey, 2012.

## Adult Health Risk Conditions



### Among Hispanics ...

- A third of adults are obese.<sup>1</sup>
- A fourth of adults have high blood pressure.<sup>2</sup>
- A third of adults have high cholesterol.<sup>2</sup>

### Compared to Washington State...

- More Hispanic adults are obese than the state average.
- Fewer Hispanic adults have high blood pressure than the state average.

Obesity and overweight among youth is available from the Washington State Healthy Youth Survey at <http://www.askhys.net>.

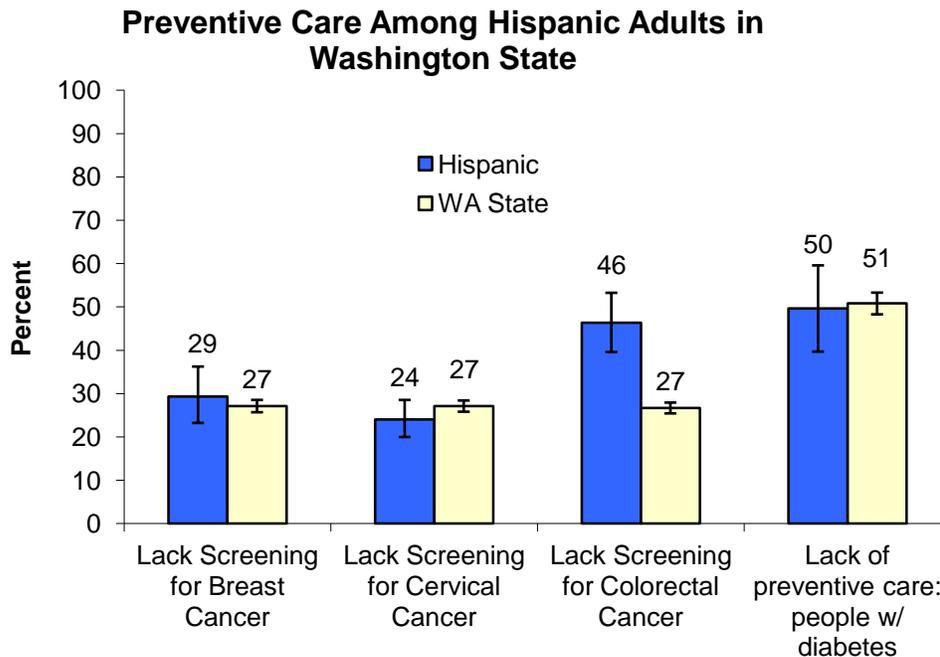
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Error bars show the 95percent confidence intervals around the estimate.

Data Source: WA Behavioral Risk Factor Surveillance System, 2009-2011 (Obesity), 2009&2011 (hypertension, cholesterol).

## Adult Preventive Care



### Among Hispanics ...

- Over a fourth of women age 40 and over have not been screened for breast cancer.<sup>1</sup>
- A fourth of women age 18 and over have not been screened for cervical cancer.<sup>1</sup>
- Almost half of men and women age 50 and over have not been screened for colorectal cancer.<sup>1</sup>
- Half of adults with diabetes have not received recommended preventive care.<sup>2</sup>

### Compared to Washington State...

- More Hispanic adults age 50 and older lack screening for colorectal cancer than the state average.

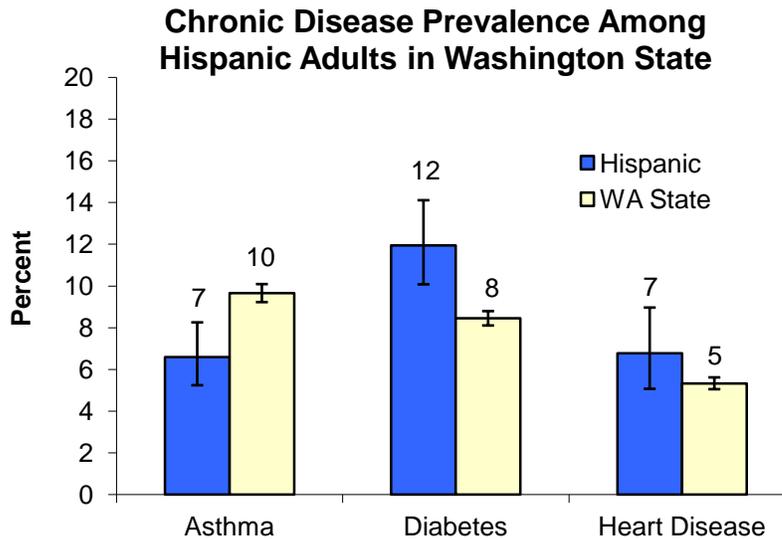
1. DOH recommends women age 40 or older should have a mammogram every two years; women age 18 or older should have a Pap test every three years; and men and women age 50 or older should have had a blood stool test in the past year, sigmoidoscopy in the past 5 years or colonoscopy in the past 10 years.

2. For people with diabetes, recommended preventive care includes annual foot exam, annual eye exam, and bi-annual hemoglobin A1c test.

Error bars show the 95percent confidence intervals around the estimate.

Data Source: WA Behavioral Risk Factor Surveillance System, 2010 (cancer screening) 2009-2011 (diabetes preventive care).

## Adult Chronic Disease Rates



### Among Hispanics ...

- One in 14 adults have asthma.<sup>1</sup>
- One in eight adults have diabetes.<sup>1</sup>
- One in 14 adults have had a heart attack, coronary heart disease, or angina.<sup>1</sup>

### Compared to Washington State...

- More Hispanic adults have diabetes and more have heart disease than the state average.
- Fewer Hispanic adults have asthma than the state average.

Cancer incidence rates are available from the Washington State Cancer Registry at <https://fortress.wa.gov/doh/wscr/>.

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#### **Healthy Youth Survey Data**

The Washington State Healthy Youth Survey (HYS) is a school-based survey of students in grades 6<sup>th</sup>, 8<sup>th</sup>, 10<sup>th</sup> and 12<sup>th</sup> in a random sample of public schools in Washington State. It is administered every other year during class time and contains questions about behaviors that result in unintentional and intentional injury (e.g., seat belt use, fighting and weapon carrying); physical activity and dietary behaviors (e.g., fruit and vegetable consumption); alcohol, tobacco, and other drug use; and related risk and protective factors. The survey includes items from the

CDC-sponsored Youth Risk Behavior Survey (YRBS) and Youth Tobacco Survey, the National Institute on Drug Abuse-sponsored Monitoring the Future survey, and the Social Development Research Group's Risk and Protective Factor Assessment instrument. In 2012, 33,270 students participated in the Healthy Youth Survey and contributed to the statewide results. In addition, 170,894 students participated and contributed to local level results for counties, educational service districts, school districts and school buildings.

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School-based surveys may underestimate risk behaviors associated with youth who drop out of school or do not attend school. Due to the self-reported nature of the data, certain behaviors may be under-reported.

## DEFINITIONS

**Hispanic Origin:** Persons of Hispanic Origin used by the Census Bureau refers to “the ancestry, nationality group, lineage, or country of birth of the person or the person’s parents or ancestors before their arrival in the United States.” Persons of Hispanic Origin have their origins in a Hispanic or Spanish-speaking country such as Mexico, Cuba, Puerto Rico, or the Spanish-speaking countries of Central or South America, regardless of race. The Behavioral Risk Factor Surveillance System (BRFSS) and the Healthy Youth Survey (HYS) treats Hispanic as an ethnic group. For additional Washington State guidelines for using racial and ethnic groups in data analysis, go to: <http://www.doh.wa.gov/Portals/1/Documents/5500/RaceEthnGuidelines.pdf>.

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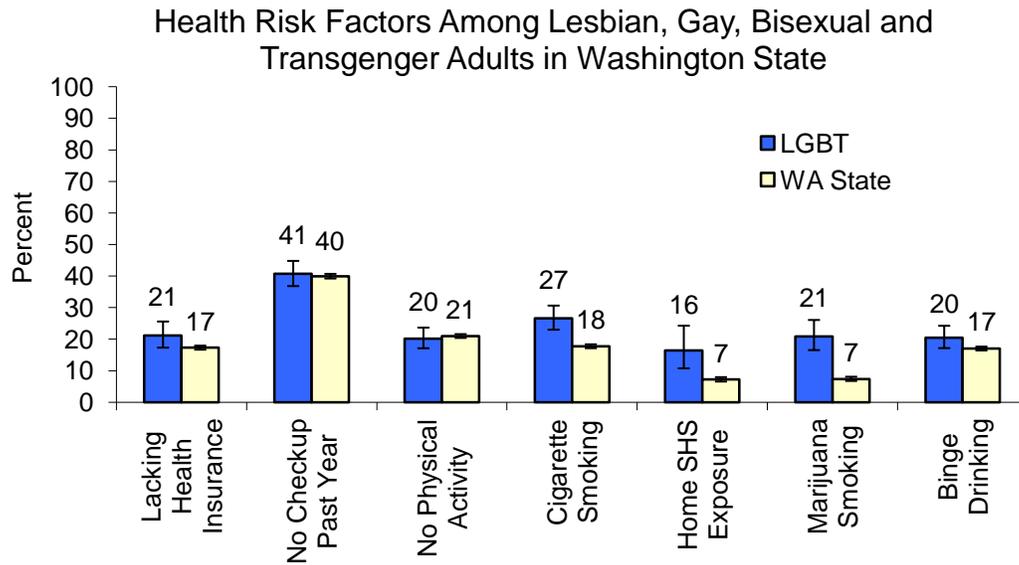
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# Chronic Disease Profile

In Washington State, 3.5% of adults age 18 and older identify themselves as Lesbian, Gay, Bisexual, or Transgender.

## Adult Health Risk Factors



### Among Lesbian Gay Bisexual and Transgender ...

- One in five adults under age 65 have no health insurance.
- Two out of five adults have not had a checkup in the past year.
- One out of five adults are physically inactive.
- Over a fourth of adults currently smoke cigarettes.
- One in six are exposed to second hand smoke in the home.
- One in five smoke marijuana.
- One in five engage in binge drinking.

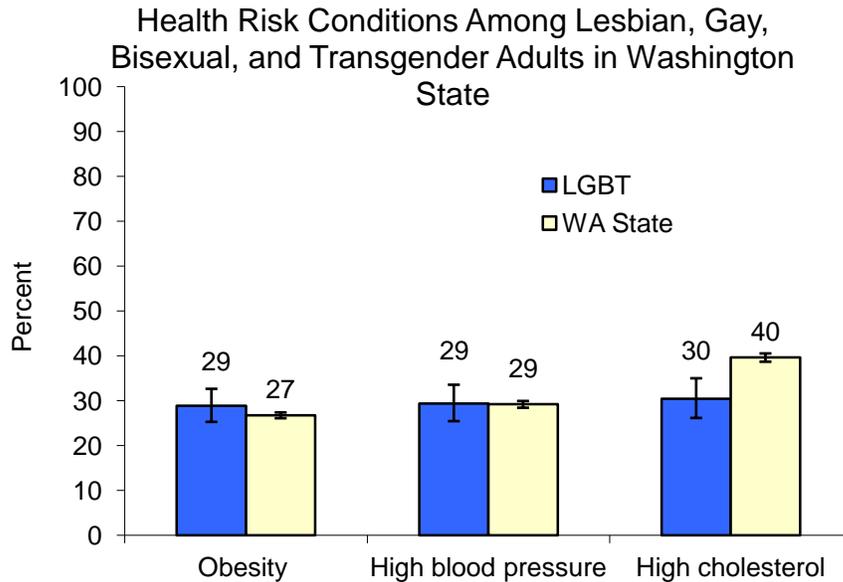
### Compared to Washington State...

- More lesbian, gay, bisexual, and transgender adults are uninsured, more smoke cigarettes, more are exposed to secondhand smoke, and more smoke marijuana than the state average.

Error bars show the 95 percent confidence intervals around the estimate.

Data Source: WA Behavioral Risk Factor Surveillance System, 2009-2011 (Population share, checkup, smoking, second hand smoke, marijuana, binge drinking) 2009&2011 (physical activity).

## Adult Health Risk Conditions



### Among Lesbian Gay Bisexual and Transgender ...

- Over a fourth of adults are obese.<sup>1</sup>
- Over a fourth of adults have high blood pressure.<sup>2</sup>
- Almost a third of adults have high cholesterol.<sup>2</sup>

### Compared to Washington State...

- Fewer lesbian, gay, bisexual, and transgender adults have high cholesterol than the state average.

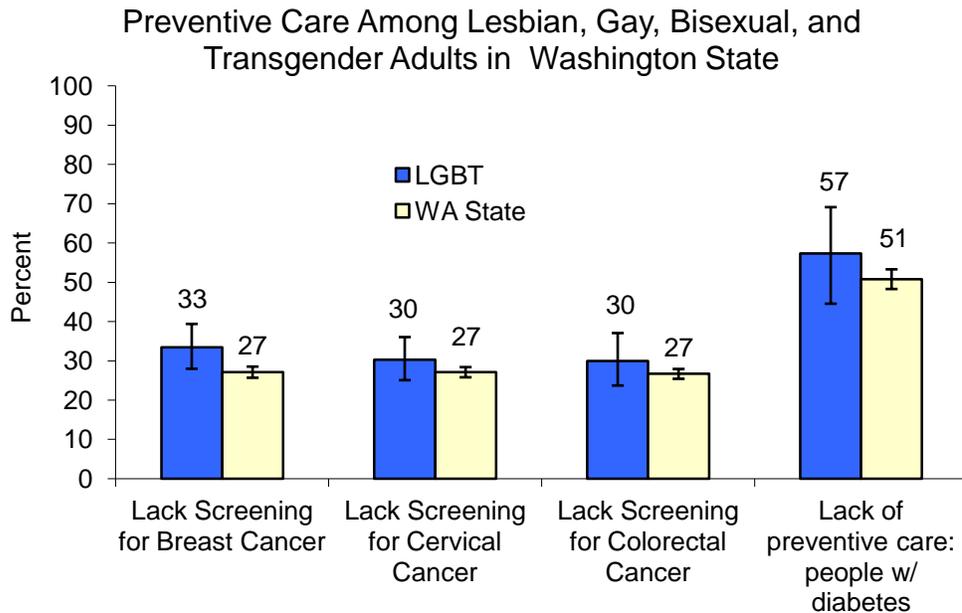
1. Obesity in adults is defined as body mass index  $\geq 30$  kg / m<sup>2</sup>.

2. Self reported lifetime prevalence – Survey respondent answered “yes” to “have you ever been told by a health care professional that you have high blood pressure (or high cholesterol).”

Error bars show the 95 percent confidence intervals around the estimate.

Data Source: WA Behavioral Risk Factor Surveillance System, 2009-2011 (Obesity), 2009&2011 (hypertension, cholesterol).

## Adult Preventive Care



### Among Lesbian Gay Bisexual and Transgender ...

- A third of women age 40 and over have not been screened for breast cancer.<sup>1</sup>
- Almost a third of women age 18 and over have not been screened for cervical cancer.<sup>1</sup>
- Almost a third of men and women age 50 and over have not been screened for colorectal cancer.<sup>1</sup>
- Over half of adults with diabetes have not received recommended preventive care.<sup>2</sup>

### Compared to Washington State...

- There are no statistically detectable differences between lesbian, gay, bisexual, transgender and Washington State.

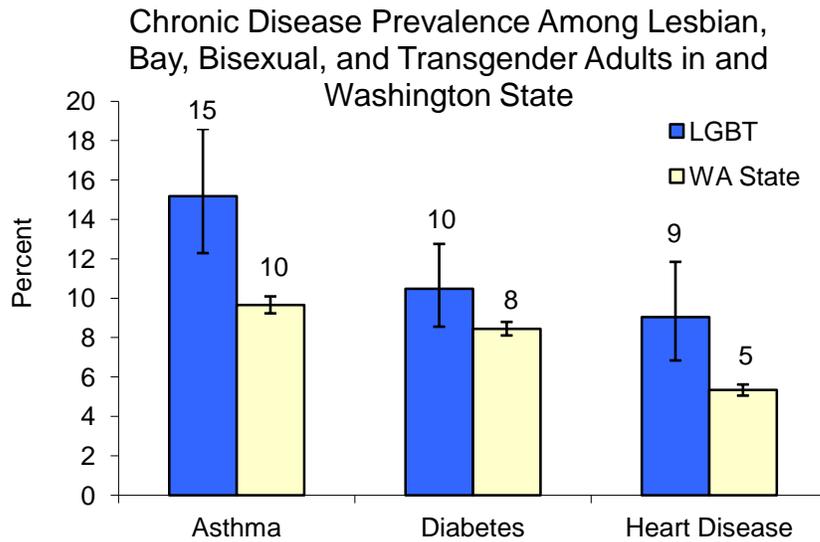
1. DOH recommends women age 40 or older should have a mammogram every two years; women age 18 or older should have a Pap test every three years; and men and women age 50 or older should have had a blood stool test in the past year, sigmoidoscopy in the past 5 years or colonoscopy in the past 10 years.

2. For people with diabetes, recommended preventive care includes annual foot exam, annual eye exam, and bi-annual hemoglobin A1c test.

Error bars show the 95percent confidence intervals around the estimate.

Data Source: WA Behavioral Risk Factor Surveillance System, 2010 (cancer screening) 2009-2011 (diabetes preventive care).

## Adult Chronic Disease Rates



### Among Lesbian Gay Bisexual and Transgender ...

- One in 16 adults have asthma.<sup>1</sup>
- One in seven adults have diabetes.<sup>1</sup>
- One in 12 adults have had a heart attack, coronary heart disease, or angina.<sup>1</sup>

### Compared to Washington State...

- More lesbian, gay, bisexual, and transgender adults have asthma, more have diabetes, and more have heart disease than the state average.

1. Self reported lifetime prevalence – Survey respondent answered “yes” to “have you ever been told by a health care professional that you have asthma (or diabetes, heart attack, coronary heart disease, or angina).

Error bars show the 95percent confidence intervals around the estimate.

Data Source: WA Behavioral Risk Factor Surveillance System, 2009-2011 (asthma, diabetes, heart disease).

## Appendix: Data Sources & Definitions

The following provides a brief description of each data system and definitions of technical terms used in this report. Data represented in this profile were obtained from a variety of sources. Analyses for this report were completed using Stata/IC 12.0. Some estimates were obtained from previously published reports.

### **DATA SYSTEMS:**

#### **Behavioral Risk Factor Surveillance System**

The Behavioral Risk Factor Surveillance System (BRFSS) is an annual telephone survey that provides indicators of health risk behavior, preventive practices, attitudes, health care use and access, and prevalence of selected diseases in Washington. BRFSS was first implemented in Washington State in 1987, and is supported in part by the national Centers for Disease Control and Prevention. The survey includes a sample of English or Spanish (since 2003) speaking adults age 18 years and older. Interviews are conducted in English or Spanish, by a survey firm under contract to the Department of Health (DOH), following survey administration protocols established by Centers for Disease Control and Prevention (CDC).

The data are weighted to represent all adults. The data may underestimate some health behaviors associated with populations speaking neither English nor Spanish, transient populations, institutionalized persons, and military personnel in military housing. Due to the nature of self-reported data, there may be some underestimation of risk factors that are seen as socially unacceptable.

In 2011, CDC began conducting cell phone as well as land-line phones in the BRFSS sample, and implemented new weighting methods to improve survey representativeness. In anticipation of these changes, DOH began collecting cell phone responses in 2009. All BRFSS data in this report are analyzed using the new methodology. Due to changes in methodology, BRFSS estimates given in this report cannot be compared with previous years.

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- For more information on national BRFSS, go to: <http://www.cdc.gov/brfss>.

### **DEFINITIONS**

**Lesbian Gay Bisexual and Transgender:** From 2003-2011, BRFSS respondents have been asked "Now I'm going to ask you a question about sexual orientation. Do you consider yourself to be..." Response options are 1-Heterosexual, that is straight; 2-Homosexual, that is gay or lesbian; 3-Bisexual; 4-Other; 7-Don't know, not sure; 9-Refused. For the purposes of this report Lesbian Gay Bisexual and Transgender (LGBT) is defined as responding 2, 3, or 4. Responses of 7 or 9 are treated as missing information.

**95 Percent Confidence Intervals:** Sometimes called the "margin of error." Commonly used with survey data to account for the differences in estimates that is due to random factors or chance. Confidence intervals are typically expressed as a range between an upper and lower value. Variation due to random sampling of respondents will place prevalence estimates within the confidence interval 95 percent of the time.

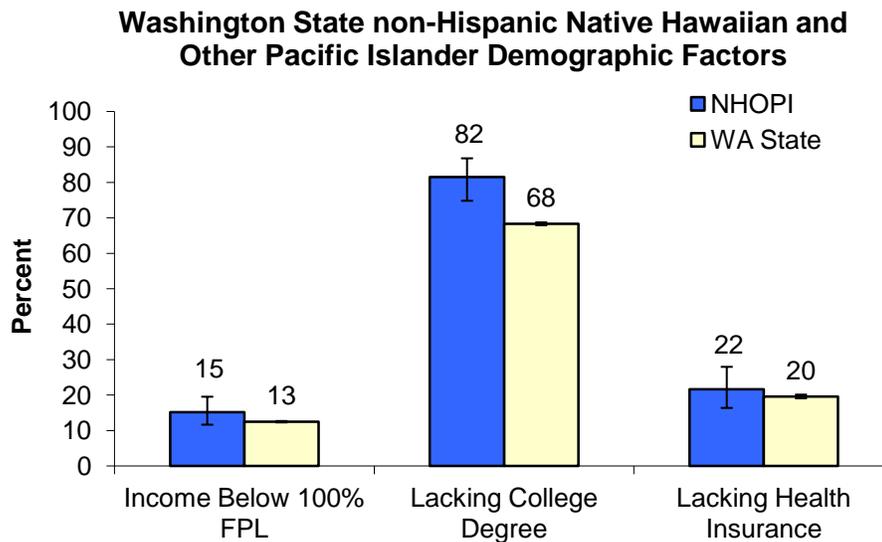
**Statistically Detectable:** Also known as “statistically significant”. An observed difference between two populations is determined to be statically detectable (significant) if it is unlikely to have occurred randomly or by chance. If there is more than about a 5% probability that the differences we see are just due to chance, we say that there is no statistically detectable (or significant) difference. In comparing county estimates to Washington State, we only describe differences that are statistically detectable. Statistically detectable differences may or may not be large enough to be important.

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**Insufficient Data:** In our reporting of data we suppressed rates and frequencies that fell below certain criteria to protect confidentiality of individuals, and reduce problems with data reliability. If 10 or fewer respondents reported a condition, or if there were 50 or fewer total respondents, we report “insufficient data.”

# Chronic Disease Profile

## Socio-demographic Risk Factors



In 2011, there were 40,000 non-Hispanic Native Hawaiian and Other Pacific Islanders in Washington State, comprising 0.6% of the population.

### Among Non-Hispanic Native Hawaiian and Other Pacific Islanders...

- One in seven households have income below the federal poverty level.<sup>1</sup>
- Five out of six adults age 25 and older do not have a college degree.
- Almost a fourth of adults under age 65 have no medical insurance.

### Compared to Washington State...

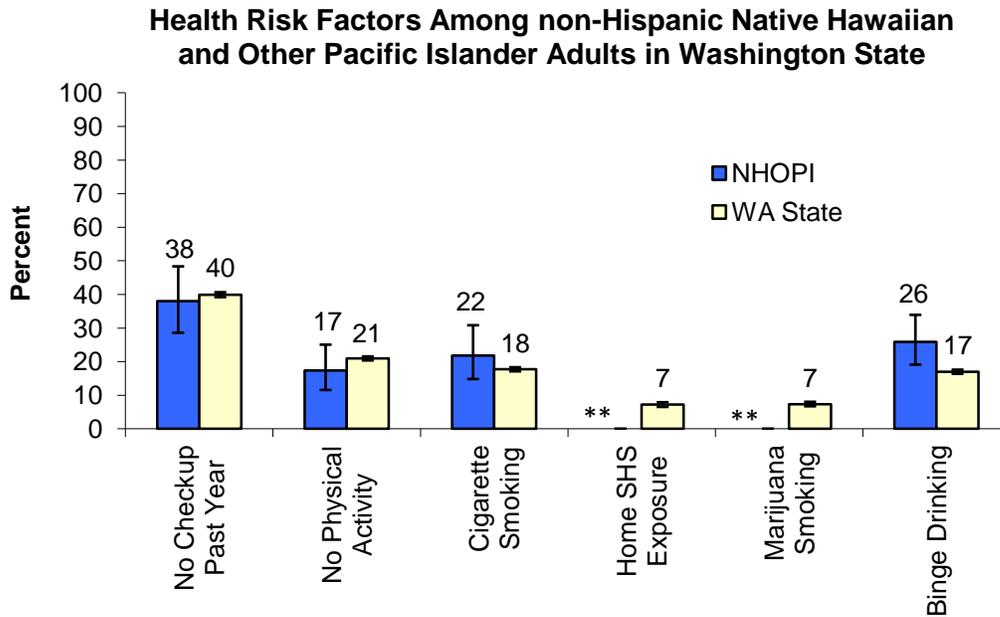
- Among non-Hispanic Native Hawaiian and other Pacific Islanders, there are fewer college graduates than the state average.

1. Federal Poverty Level (FPL) is determined based on household income and household size. In 2012, FPL for a family of four was \$23,050.

Error bars show the 90 percent confidence intervals around the estimate.

Data Sources: US Census Bureau, 2007-2011 American Community Survey (Income, education, insurance);

## Adult Health Risk Factors



### Among Non-Hispanic Native Hawaiian and Other Pacific Islanders ...

- Over a third of adults have not had a checkup in the past year.
- One in six adults are physically inactive.
- Almost a fourth of adults currently smoke cigarettes.
- \*\* Insufficient data to estimate secondhand smoke exposure.
- \*\* Insufficient data to estimate marijuana smoking.
- A fourth engage in binge drinking.

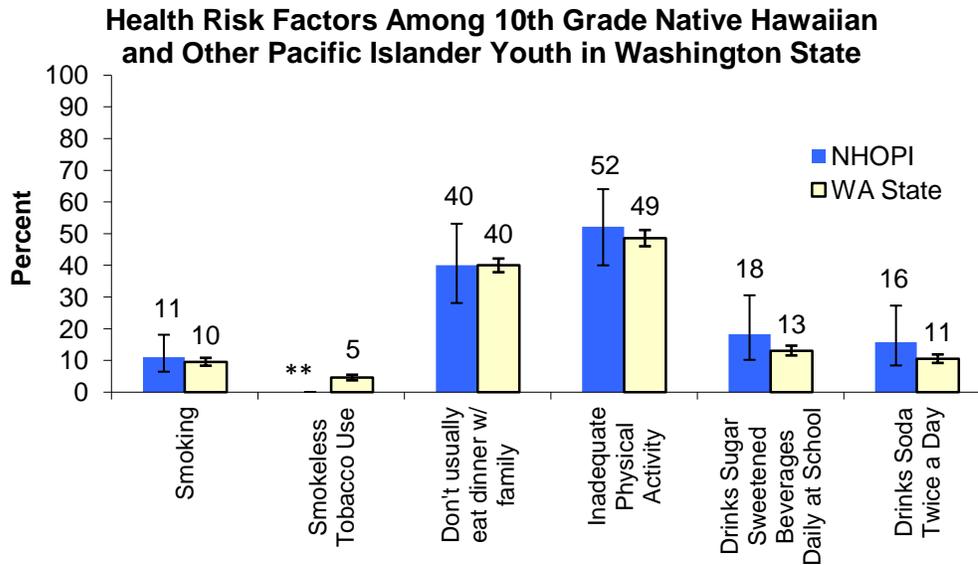
### Compared to Washington State...

- More non-Hispanic Native Hawaiian and other Pacific Islanders engage in binge drinking than the state average.

Error bars show the 95 percent confidence intervals around the estimate.

Data Source: WA Behavioral Risk Factor Surveillance System, 2009-2011 (checkup, smoking, second hand smoke, marijuana, binge drinking) 2009&2011 (physical activity).

## Youth (10<sup>th</sup> grade) Health Risk Factors



### Among Native Hawaiian and Other Pacific Islander 10<sup>th</sup> graders...

- One in nine smoke.
- \*\* Insufficient data to estimate smokeless tobacco use.
- Two out of five do not usually eat dinner with their family.
- Half do not get enough physical activity.<sup>1</sup>
- One in six drink sugar sweetened beverages daily at school.<sup>2</sup>
- One in six drink soda two or more times a day.

### Compared to Washington State 10<sup>th</sup> graders...

- There are no statistically detectable differences between Native Hawaiian and other Pacific Islander 10<sup>th</sup> grade youth and Washington State.

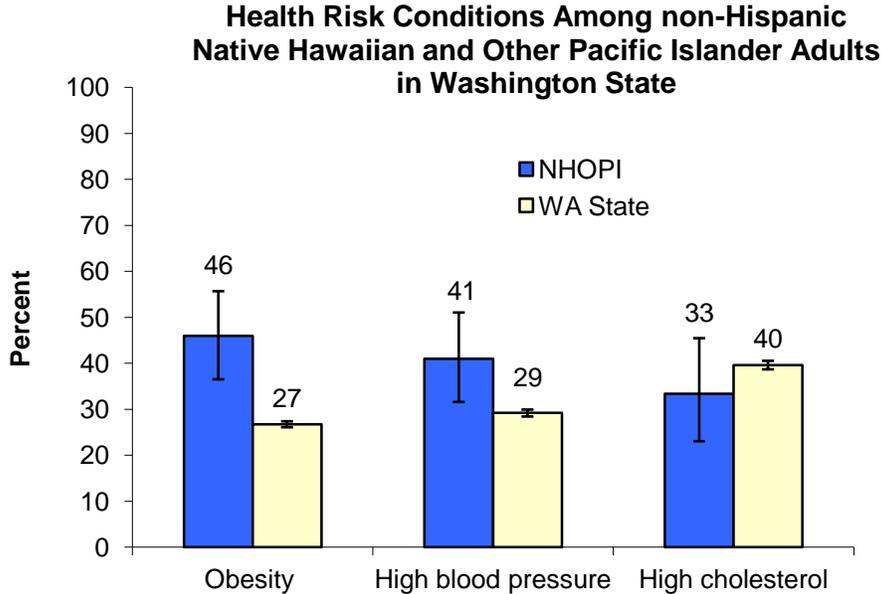
1. CDC recommends 60 minutes moderate or vigorous physical activity every day for youths.

2. Includes soda, fruit juice, sports drinks, kool-aid, etc.

Error bars show the 95percent confidence intervals around the estimate.

Data Source: WA Healthy Youth Survey, 2012.

## Adult Health Risk Conditions



### Among Non-Hispanic Native Hawaiian and Other Pacific Islanders ...

- Almost half of adults are obese.<sup>1</sup>
- Two out of five adults have high blood pressure.<sup>2</sup>
- A third of adults have high cholesterol.<sup>2</sup>

### Compared to Washington State...

- More non-Hispanic Native Hawaiian and other Pacific Islander adults are obese, and more have high blood pressure than the state average.

Obesity and overweight among youth is available from the Washington State Healthy Youth Survey at <http://www.askhys.net>.

1. Obesity in adults is defined as body mass index  $\geq 30$  kg / m<sup>2</sup>.

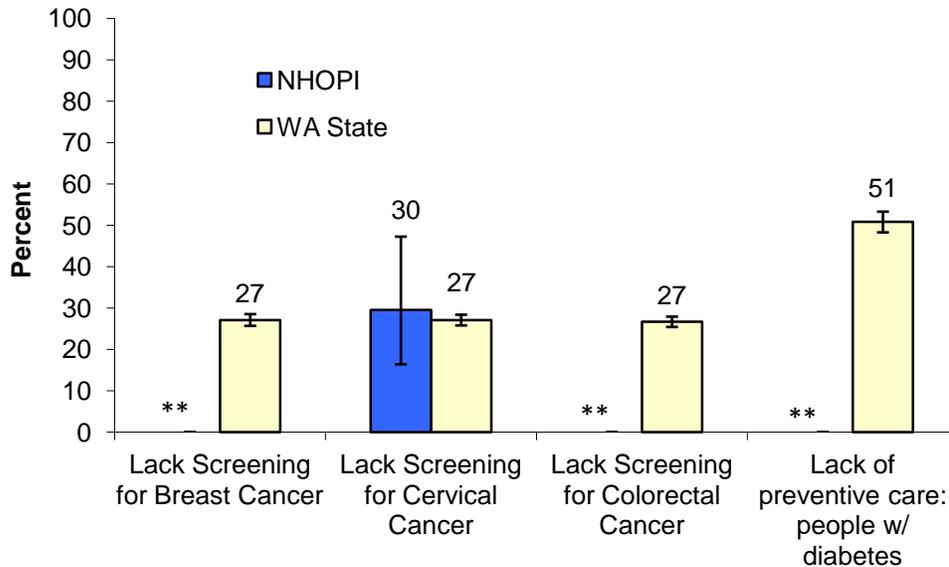
2. Self reported lifetime prevalence – Survey respondent answered “yes” to “have you ever been told by a health care professional that you have high blood pressure (or high cholesterol).”

Error bars show the 95percent confidence intervals around the estimate.

Data Source: WA Behavioral Risk Factor Surveillance System, 2009-2011 (Obesity), 2009&2011 (hypertension, cholesterol).

## Adult Preventive Care

**Preventive Care Among non-Hispanic Native Hawaiian and Other Pacific Islander Adults in Washington State**



### Among Non-Hispanic Native Hawaiian and Other Pacific Islanders ...

- \*\* Insufficient data to estimate breast cancer screening.<sup>1</sup>
- Almost a third of women age 18 and over have not been screened for cervical cancer.<sup>1</sup>
- \*\* Insufficient data to estimate colorectal cancer screening.<sup>1</sup>
- \*\* Insufficient data to estimate preventive care among adults with diabetes.<sup>2</sup>

### Compared to Washington State...

- There are no statistically detectable differences between non-Hispanic Native Hawaiian and other Pacific Islanders and Washington State.

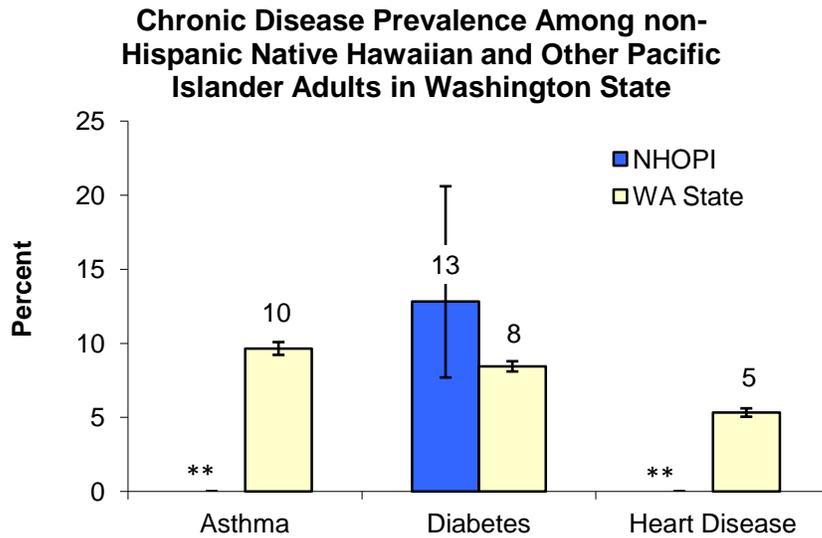
1. DOH recommends women age 40 or older should have a mammogram every two years; women age 18 or older should have a Pap test every three years; and men and women age 50 or older should have had a blood stool test in the past year, sigmoidoscopy in the past 5 years or colonoscopy in the past 10 years.

2. For people with diabetes, recommended preventive care includes annual foot exam, annual eye exam, and bi-annual hemoglobin A1c test.

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Data Source: WA Behavioral Risk Factor Surveillance System, 2010 (cancer screening) 2009-2011 (diabetes preventive care).

## Adult Chronic Disease Rates



\*\* Insufficient data

### Among Non-Hispanic Native Hawaiian and Other Pacific Islanders ...

- \*\* Insufficient data to estimate asthma prevalence.<sup>1</sup>
- One in eight adults have diabetes.<sup>1</sup>
- Insufficient data to estimate prevalence of heart attack, coronary heart disease, or angina.<sup>1</sup>

### Compared to Washington State...

- There are no statistically detectable differences between non-Hispanic Native Hawaiian and other Pacific Islanders and Washington State.

Cancer incidence rates are available from the Washington State Cancer Registry at <https://fortress.wa.gov/doh/wscr/>.

1. Self reported lifetime prevalence – Survey respondent answered “yes” to “have you ever been told by a health care professional that you have asthma (or diabetes, heart attack, coronary heart disease, or angina). Error bars show the 95percent confidence intervals around the estimate.  
Data Source: WA Behavioral Risk Factor Surveillance System, 2009-2011 (asthma, diabetes, heart disease).

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The following provides a brief description of each data system and definitions of technical terms used in this report. Data represented in this profile were obtained from a variety of sources. Analyses for this report were completed using Stata/IC 12.0. Some estimates were obtained from previously published reports.

### **DATA SYSTEMS:**

#### **American Community Survey**

Population data were taken from U.S. Census Bureau. The primary constitutional purpose of the census is the apportionment of congressional seats. The Census Bureau also serves as a source of data about the nation's people and economy. The American Community Survey (ACS) is an annual survey of the US population race/ethnicity, education, income, employment, and other socioeconomic factors. Small area estimates at county or census tract level are produced by combining 5 years of ACS data..

- Data related to income and education was obtained from the US Census Bureau American Community Survey (ACS) 2007-2011. For more information on the ACS, go to: <http://www.census.gov>.

#### **Behavioral Risk Factor Surveillance System**

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#### **Healthy Youth Survey Data**

The Washington State Healthy Youth Survey (HYS) is a school-based survey of students in grades 6<sup>th</sup>, 8<sup>th</sup>, 10<sup>th</sup> and 12<sup>th</sup> in a random sample of public schools in Washington State. It is administered every other year during class time and contains questions about behaviors that result in unintentional and intentional injury (e.g., seat belt use, fighting and weapon carrying); physical activity and dietary behaviors (e.g., fruit and vegetable consumption); alcohol, tobacco, and other drug use; and related risk and protective factors. The survey includes items from the

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School-based surveys may underestimate risk behaviors associated with youth who drop out of school or do not attend school. Due to the self-reported nature of the data, certain behaviors may be under-reported.

## DEFINITIONS

**Race and Ethnicity:** Race and ethnicity are defined differently in different data sources:

- **Census Bureau, American Community Survey:** Respondents first identify their ethnicity as Hispanic/Latino or not Hispanic/Latino. Respondents then identify their race by choosing any that apply from a detailed list of racial categories and sub-categories. Identification as multiracial is allowed. In this report, non-Hispanic NHOPI refers to those who select non-Hispanic ethnicity, and then select NHOPI as their only racial classification. Multi-racial respondents are not included within non-Hispanic NHOPI.
- **BRFSS:** Respondents first identify their ethnicity as Hispanic/Latino or not Hispanic/Latino. Respondents then identify their race by choosing one response from a list of racial categories. Respondents who identify themselves as multi-racial are then asked to choose a single preferred racial classification. In this report, non-Hispanic NHOPI refers to those who select non-Hispanic ethnicity, and then select NHOPI as their preferred race.
- **HYS:** Respondents are asked, "How do you describe yourself? (**Select one or more responses.**)" Response options are: a. American Indian or Alaskan Native; b. Asian or Asian American; c. Black or African-American; d. Hispanic or Latino/Latina; e. Native Hawaiian or other Pacific Islander; f. White or Caucasian; g. Other. Respondents who check more than one option are classified as multiracial. In this report non-Hispanic NHOPI refers to those who identify themselves only as NHOPI.

. For additional Washington State guidelines for using racial and ethnic groups in data analysis, go to: <http://www.doh.wa.gov/Portals/1/Documents/5500/RaceEthnGuidelines.pdf>.

**95 Percent Confidence Intervals:** Sometimes called the "margin of error." Commonly used with survey data to account for the differences in estimates that is due to random factors or chance. Confidence intervals are typically expressed as a range between an upper and lower value. Variation due to random sampling of respondents will place prevalence estimates within the confidence interval 95 percent of the time.

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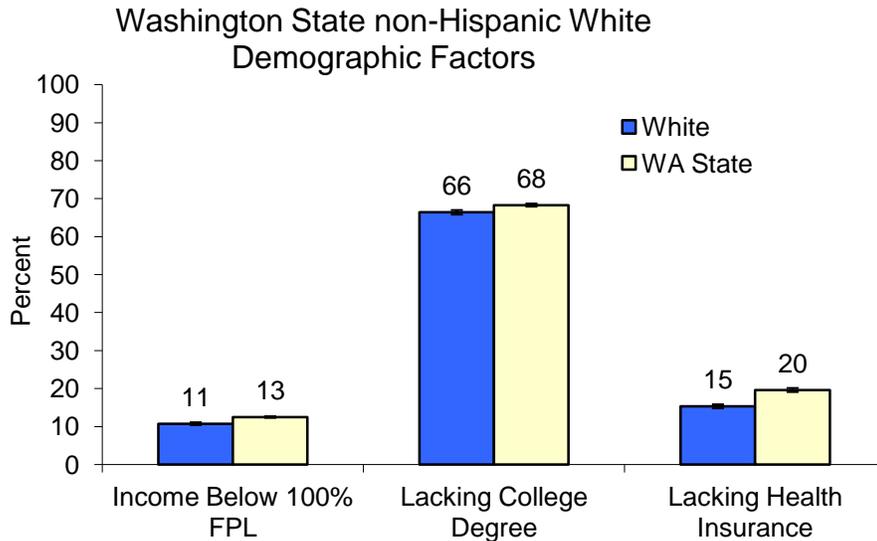
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# Chronic Disease Profile

## Socio-demographic Risk Factors



In 2011, there were 4,897,000 non-Hispanic whites in Washington State, comprising 72% of the population.

### Among Non-Hispanic Whites...

- One in nine households have income below the federal poverty level.<sup>1</sup>
- Two thirds of adults age 25 and older do not have a college degree.
- One in seven of adults under age 65 have no medical insurance.

### Compared to Washington State...

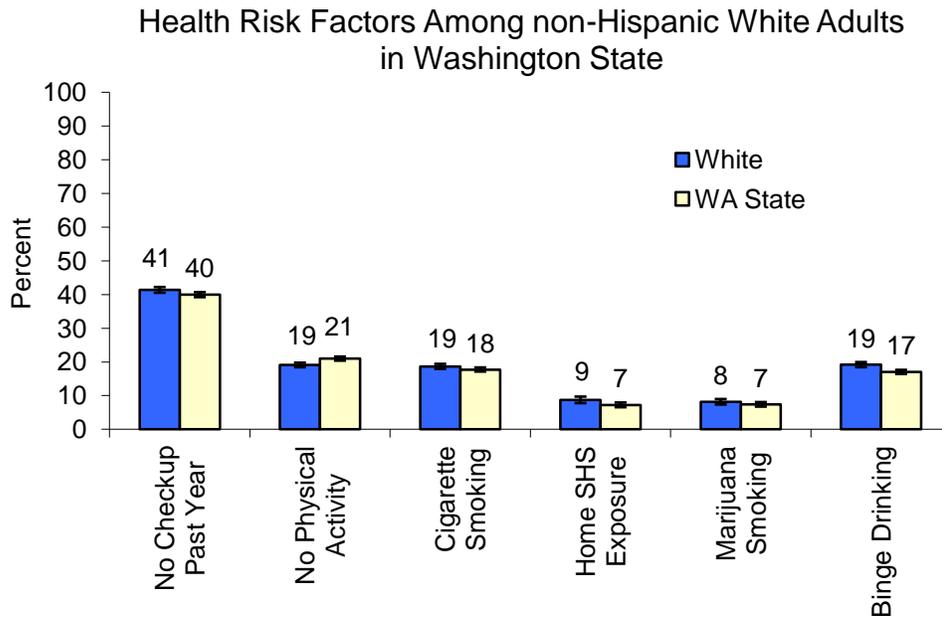
- There are fewer non-Hispanic whites with income below poverty, more college graduates, and fewer uninsured than the state average.

1. Federal Poverty Level (FPL) is determined based on household income and household size. In 2012, FPL for a family of four was \$23,050.

Error bars show the 90 percent confidence intervals around the estimate.

Data Sources: US Census Bureau, 2007-2011 American Community Survey (Income, education, insurance).

## Adult Health Risk Factors



### Among Non-Hispanic Whites ...

- Two out of five adults have not had a checkup in the past year.
- One in five adults are physically inactive.
- One in five adults currently smoke cigarettes.
- One in 11 are exposed to second hand smoke in the home.
- One in 12 smoke marijuana.
- One in five engage in binge drinking.

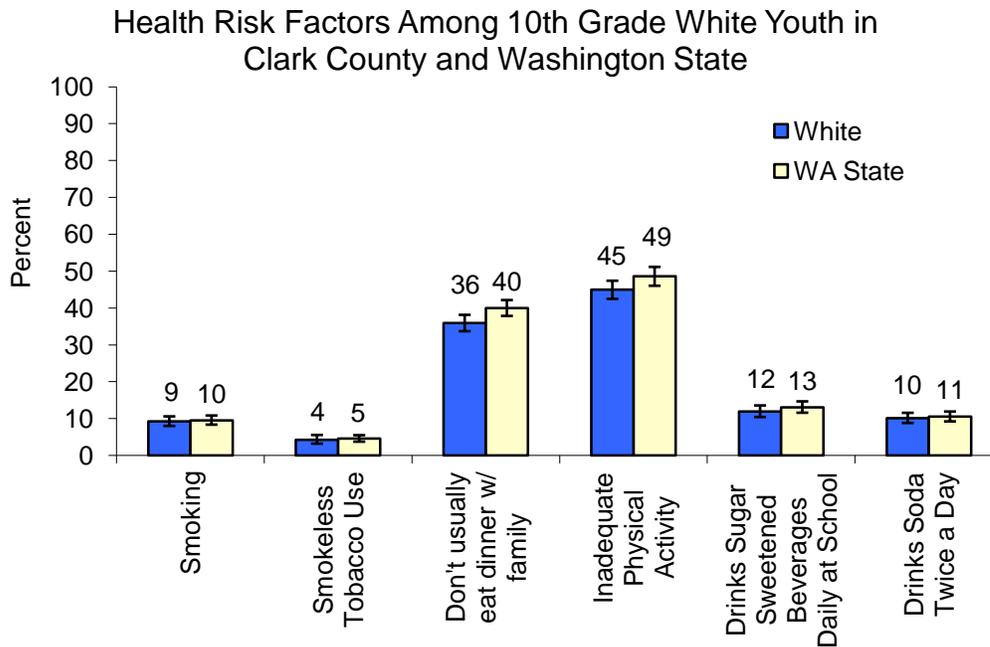
### Compared to Washington State...

- More non-Hispanic white adults engage in binge drinking than the state average.
- Fewer non-Hispanic white adults are physically inactive than the state average.

Error bars show the 95 percent confidence intervals around the estimate.

Data Source: WA Behavioral Risk Factor Surveillance System, 2009-2011 (checkup, smoking, second hand smoke, marijuana, binge drinking) 2009&2011 (physical activity).

## Youth (10<sup>th</sup> grade) Health Risk Factors



### Among White 10<sup>th</sup> graders...

- One in 11 smoke.
- One in 25 use smokeless tobacco products.
- Over a third do not usually eat dinner with their family.
- Almost half do not get enough physical activity.<sup>1</sup>
- One in eight drink sugar sweetened beverages daily at school.<sup>2</sup>
- One in ten drink soda two or more times a day.

### Compared to Washington State 10<sup>th</sup> graders...

- Fewer white 10th graders do not eat dinner with family than the state average.

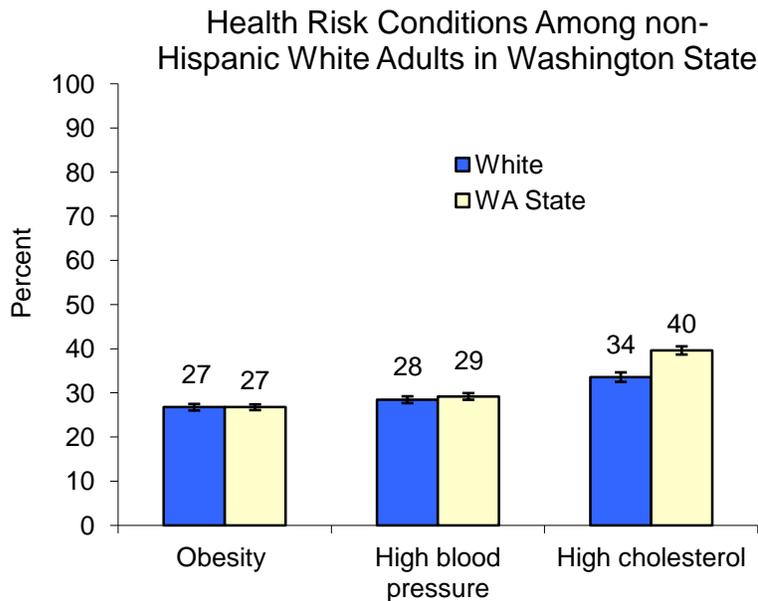
1. CDC recommends 60 minutes moderate or vigorous physical activity every day for youths.

2. Includes soda, fruit juice, sports drinks, kool-aid, etc.

Error bars show the 95percent confidence intervals around the estimate.

Data Source: WA Healthy Youth Survey, 2012.

## Adult Health Risk Conditions



### Among Non-Hispanic Whites ...

- Over a fourth of adults are obese.<sup>1</sup>
- Over a fourth of adults have high blood pressure.<sup>2</sup>
- A third of adults have high cholesterol.<sup>2</sup>

### Compared to Washington State...

- Fewer non-Hispanic white adults have high cholesterol than the state average.

Obesity and overweight among youth is available from the Washington State Healthy Youth Survey at <http://www.askhys.net>.

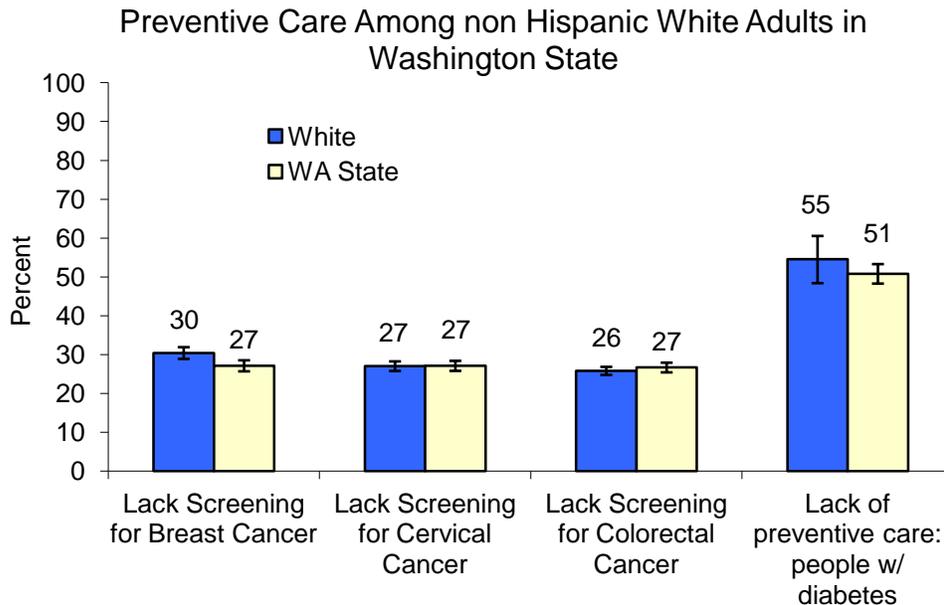
1. Obesity in adults is defined as body mass index  $\geq 30$  kg / m<sup>2</sup>.

2. Self reported lifetime prevalence – Survey respondent answered “yes” to “have you ever been told by a health care professional that you have high blood pressure (or high cholesterol).”

Error bars show the 95percent confidence intervals around the estimate.

Data Source: WA Behavioral Risk Factor Surveillance System, 2009-2011 (Obesity), 2009&2011 (hypertension, cholesterol).

## Adult Preventive Care



### Among Non-Hispanic Whites ...

- Almost a third of women age 40 and over have not been screened for breast cancer.<sup>1</sup>
- Over a fourth of women age 18 and over have not been screened for cervical cancer.<sup>1</sup>
- A fourth of men and women age 50 and over have not been screened for colorectal cancer.<sup>1</sup>
- Over half of adults with diabetes have not received recommended preventive care.<sup>2</sup>

### Compared to Washington State...

- More non-Hispanic white women age 40 and older lack screening for breast cancer than the state average.
- Fewer non-Hispanic white adults age 50 and older lack screening for colorectal cancer than the state average.

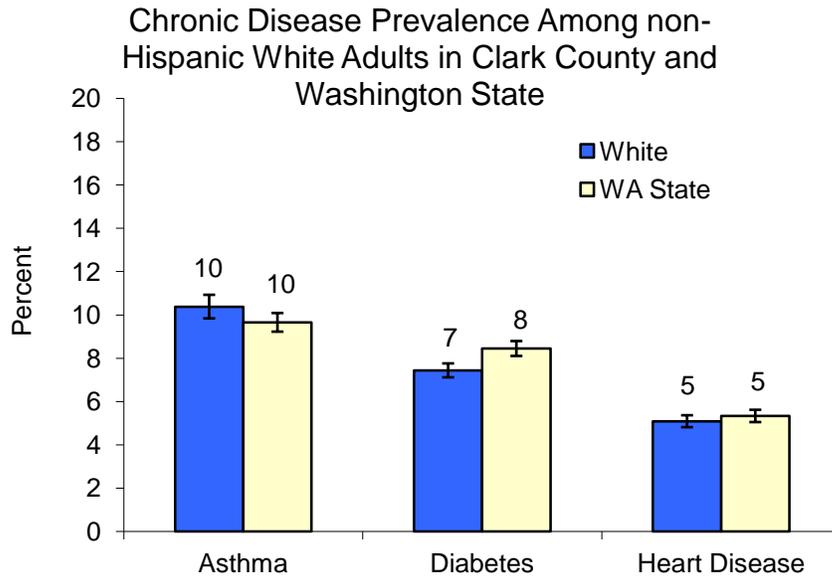
1. DOH recommends women age 40 or older should have a mammogram every two years; women age 18 or older should have a Pap test every three years; and men and women age 50 or older should have had a blood stool test in the past year, sigmoidoscopy in the past 5 years or colonoscopy in the past 10 years.

2. For people with diabetes, recommended preventive care includes annual foot exam, annual eye exam, and bi-annual hemoglobin A1c test.

Error bars show the 95percent confidence intervals around the estimate.

Data Source: WA Behavioral Risk Factor Surveillance System, 2010 (cancer screening) 2009-2011 (diabetes preventive care).

## Adult Chronic Disease Rates



### Among Non-Hispanic Whites ...

- One in ten adults have asthma.<sup>1</sup>
- One in 14 adults have diabetes.<sup>1</sup>
- One in 20 adults have had a heart attack, coronary heart disease, or angina.<sup>1</sup>

### Compared to Washington State...

- More non-Hispanic white adults have asthma than the state average.
- Fewer non-Hispanic white adults have diabetes than the state average.

Cancer incidence rates are available from the Washington State Cancer Registry at <https://fortress.wa.gov/doh/wscr/>.

1. Self reported lifetime prevalence – Survey respondent answered “yes” to “have you ever been told by a health care professional that you have asthma (or diabetes, heart attack, coronary heart disease, or angina).

Error bars show the 95percent confidence intervals around the estimate.

Data Source: WA Behavioral Risk Factor Surveillance System, 2009-2011 (asthma, diabetes, heart disease).

## Appendix: Data Sources & Definitions

The following provides a brief description of each data system and definitions of technical terms used in this report. Data represented in this profile were obtained from a variety of sources. Analyses for this report were completed using Stata/IC 12.0. Some estimates were obtained from previously published reports.

### **DATA SYSTEMS:**

#### **American Community Survey**

Population data were taken from U.S. Census Bureau. The primary constitutional purpose of the census is the apportionment of congressional seats. The Census Bureau also serves as a source of data about the nation's people and economy. The American Community Survey (ACS) is an annual survey of the US population race/ethnicity, education, income, employment, and other socioeconomic factors. Small area estimates at county or census tract level are produced by combining 5 years of ACS data..

- Data related to income and education was obtained from the US Census Bureau American Community Survey (ACS) 2007-2011. For more information on the ACS, go to: <http://www.census.gov>.

#### **Behavioral Risk Factor Surveillance System**

The Behavioral Risk Factor Surveillance System (BRFSS) is an annual telephone survey that provides indicators of health risk behavior, preventive practices, attitudes, health care use and access, and prevalence of selected diseases in Washington. BRFSS was first implemented in Washington State in 1987, and is supported in part by the national Centers for Disease Control and Prevention. The survey includes a sample of English or Spanish (since 2003) speaking adults age 18 years and older. Interviews are conducted in English or Spanish, by a survey firm under contract to the Department of Health (DOH), following survey administration protocols established by Centers for Disease Control and Prevention (CDC).

The data are weighted to represent all adults. The data may underestimate some health behaviors associated with populations speaking neither English nor Spanish, transient populations, institutionalized persons, and military personnel in military housing. Due to the nature of self-reported data, there may be some underestimation of risk factors that are seen as socially unacceptable.

In 2011, CDC began conducting cell phone as well as land-line phones in the BRFSS sample, and implemented new weighting methods to improve survey representativeness. In anticipation of these changes, DOH began collecting cell phone responses in 2009. All BRFSS data in this report are analyzed using the new methodology. Due to changes in methodology, BRFSS estimates given in this report cannot be compared with previous years.

- For more information on Washington State BRFSS, go to: <http://www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/BehavioralRiskFactorSurveillanceSystemBRFSS.aspx>
- For technical notes on the Washington State BRFSS, go to: <http://www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/BehavioralRiskFactorSurveillanceSystemBRFSS.aspx>
- For more information on national BRFSS, go to: <http://www.cdc.gov/brfss>.

#### **Healthy Youth Survey Data**

The Washington State Healthy Youth Survey (HYS) is a school-based survey of students in grades 6<sup>th</sup>, 8<sup>th</sup>, 10<sup>th</sup> and 12<sup>th</sup> in a random sample of public schools in Washington State. It is administered every other year during class time and contains questions about behaviors that result in unintentional and intentional injury (e.g., seat belt use, fighting and weapon carrying); physical activity and dietary behaviors (e.g., fruit and vegetable consumption); alcohol, tobacco, and other drug use; and related risk and protective factors. The survey includes items from the

CDC-sponsored Youth Risk Behavior Survey (YRBS) and Youth Tobacco Survey, the National Institute on Drug Abuse-sponsored Monitoring the Future survey, and the Social Development Research Group's Risk and Protective Factor Assessment instrument. In 2012, 33,270 students participated in the Healthy Youth Survey and contributed to the statewide results. In addition, 170,894 students participated and contributed to local level results for counties, educational service districts, school districts and school buildings.

- For more information on the HYS, go to:  
<http://www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/HealthyYouthSurvey.aspx>
- For technical notes on the HYS, go to:  
<http://www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/HealthyYouthSurvey/TechnicalNotes.aspx>

School-based surveys may underestimate risk behaviors associated with youth who drop out of school or do not attend school. Due to the self-reported nature of the data, certain behaviors may be under-reported.

## DEFINITIONS

**Race and Ethnicity:** Race and ethnicity are defined differently in different data sources:

- **Census Bureau, American Community Survey:** Respondents first identify their ethnicity as Hispanic/Latino or not Hispanic/Latino. Respondents then identify their race by choosing any that apply from a detailed list of racial categories and sub-categories. Identification as multiracial is allowed. In this report, non-Hispanic white refers to those who select non-Hispanic ethnicity, and then select white as their only racial classification. Multi-racial respondents are not included within non-Hispanic whites.
- **BRFSS:** Respondents first identify their ethnicity as Hispanic/Latino or not Hispanic/Latino. Respondents then identify their race by choosing one response from a list of racial categories. Respondents who identify themselves as multi-racial are then asked to choose a single preferred racial classification. In this report, non-Hispanic white refers to those who select non-Hispanic ethnicity, and then select white as their preferred race.
- **HYS:** Respondents are asked, "How do you describe yourself? (**Select one or more responses.**)" Response options are: a. American Indian or Alaskan Native; b. Asian or Asian American; c. Black or African-American; d. Hispanic or Latino/Latina; e. Native Hawaiian or other Pacific Islander; f. White or Caucasian; g. Other. Respondents who check more than one option are classified as multiracial. In this report non-Hispanic white refers to those who identify themselves only as white.

For additional Washington State guidelines for using racial and ethnic groups in data analysis, go to: <http://www.doh.wa.gov/Portals/1/Documents/5500/RaceEthnGuidelines.pdf>.

**95 Percent Confidence Intervals:** Sometimes called the "margin of error." Commonly used with survey data to account for the differences in estimates that is due to random factors or chance. Confidence intervals are typically expressed as a range between an upper and lower value. Variation due to random sampling of respondents will place prevalence estimates within the confidence interval 95 percent of the time.

**Statistically Detectable:** Also known as "statistically significant". An observed difference between two populations is determined to be statically detectable (significant) if it is unlikely to have occurred randomly or by chance. If there is more than about a 5% probability that the differences we see are just due to chance, we say that there is no statistically detectable (or significant) difference. In comparing county estimates to Washington State, we only describe

differences that are statistically detectable. Statistically detectable differences may or may not be large enough to be important.

**Crude versus Age-adjusted Rates:** Only crude rates (percentages) are presented in this report. Crude rates represent the absolute burden in a single population at a particular time. Crude rates are recommended when a summary measure is needed and it is not necessary or desirable to adjust for other factors. In other contexts, you may find percentages that are age-adjusted. Age adjustment is used to control for the effects of age differences when making comparisons by sociodemographic factors such as income.

**Insufficient Data:** In our reporting of data we suppressed rates and frequencies that fell below certain criteria to protect confidentiality of individuals, and reduce problems with data reliability. If 10 or fewer respondents reported a condition, or if there were 50 or fewer total respondents, we report “insufficient data.”



# Washington Environmental Biomonitoring Survey (WEBS)

Ann Butler

NICE/DCHS

WA Department of Health

# CDC Grant

- Increase PHL capacity for biomonitoring
  - CDC methods
  - CDC analytes
- Assess general population exposures
- Assess exposures in high risk groups
- Use information for prevention efforts
- Grant awarded Sept. 1, 2009 for 5 years
  - Year 5: Sept. 1, 2013 – August 31, 2014

# Biomonitoring Studies

- WEBS General Population
- WEBS High Arsenic Area
- Licensed Pesticide Applicators
  - Pyrethroid Exposure Survey & Test (PEST)
- UW Dairy Workers Study
- Residents of Subsidized Housing
  - Low-income Survey & Testing (LIST)

# Urine Analytes

Analyte	General Population*	High As Area	Pyrethroid Exposure Survey & Testing (PEST)	Low Income Survey & Testing (LIST)*
1. Total arsenic + 12 metals	X	X		
2. Speciated arsenic	X	X		
3. Creatinine	X	X	X	X
4. Pesticides				
pyrethroid metabolites (3-PBA, DCCA, 4F-3PBA, DBCA)	X		X	X
OP metabolite (TCPy)	X			X
bifenthrin metabolites	X		X	
5. BPA and Phthalates	X			X

\* Indicates 5 year storage of samples

Green indicates non-CDC funding for lab analysis

# WEBS General Population

- Participants  $\geq 6$  years
- May 2010 -June 2011
- Data collection
  - Urine sample (1<sup>st</sup> morning void)
  - Household & individual questionnaires
  - Household drinking water sample
- Analytes
  - ✓ Total & speciated arsenic
  - ✓ Metals (Ba, Be, Cd, Cs, Co, Pb, Mo, Pt, Sb, Tl, W, U)
  - ✓ Pesticide metabolites (1 OP (TCPy) & 4 pyrethroids)
  - ✓ Subsample of 240 for bifenthrin metabolites (Germany)
  - Subsample of 425 for BPA & phthalates (women & teens)
- Water samples: As, Cd, Pb, Mn, Tl, U
- 1422 participants from 666 households

# Low Income Survey & Testing (LIST)

- Residents of subsidized housing in King County
  - Women & children
- May 2013 – April 2014
- Data Collection
  - 2 urine samples; Household & participant questionnaires
  - Pesticide use & building materials from housing authority
- Analytes
  - Pesticides: OP & Pyrethroid metabolites
  - BPA & phthalates
- Results for Education/Prevention Activities

# Low Income Survey & Testing (LIST)

- Bisphenol A - used in some hard plastics such as water bottles and in the lining of food cans
- Phthalates – used to make soft plastics, vinyl products, and food packaging materials. Found in some beauty & skin care products: shampoos, lotions, makeup
- Higher levels in low income population
- Potential for endocrine disruption

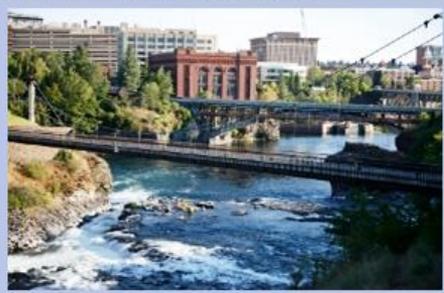


# Washington Tracking Network

[WTNhome](#)

Welcome to the Washington Tracking Network (WTN). We are working to improve public health by delivering science-based information on health and the environment where we live, work, and play. We are currently improving our website to better serve the public and our partners, please check back often for new topics, data, and content.

## Environmental Exposure



- Air Quality
- Biomonitoring
- Drinking Water
- Lead Risk and Exposure

## Health Outcomes



- Asthma
- Birth Defects
- Birth Outcomes
- Cancer
- Carbon Monoxide
- Heart Attack (MI)

## Community



- Population Characteristics



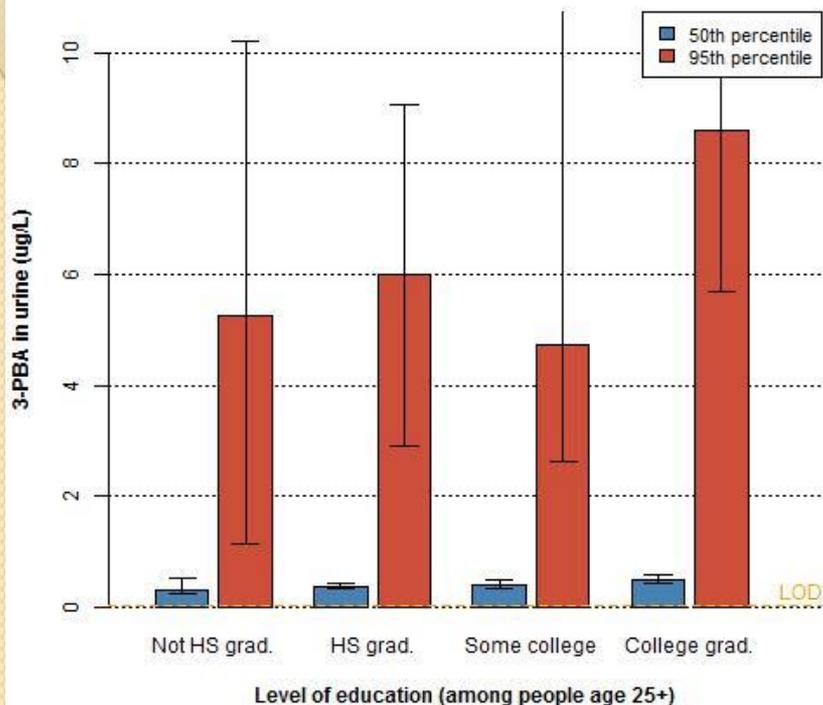
# Pesticide background

- Organophosphates (Ops)
  - Generally being phased out
  - Health effects relatively well understood
    - Chemical weapon (e.g. sarin gas)
    - Neurotoxicity and neurodevelopmental issues
  - Metabolite: TCPy (specific to chlorpyrifos)
- Pyrethroids
  - Common replacement for OPs
  - Health effects not as well understood
    - Potential for endocrine disruption
  - Metabolite: 3-PBA

# Pesticide results: Education

**Urinary pyrethroid metabolite (3-PBA) by level of education**

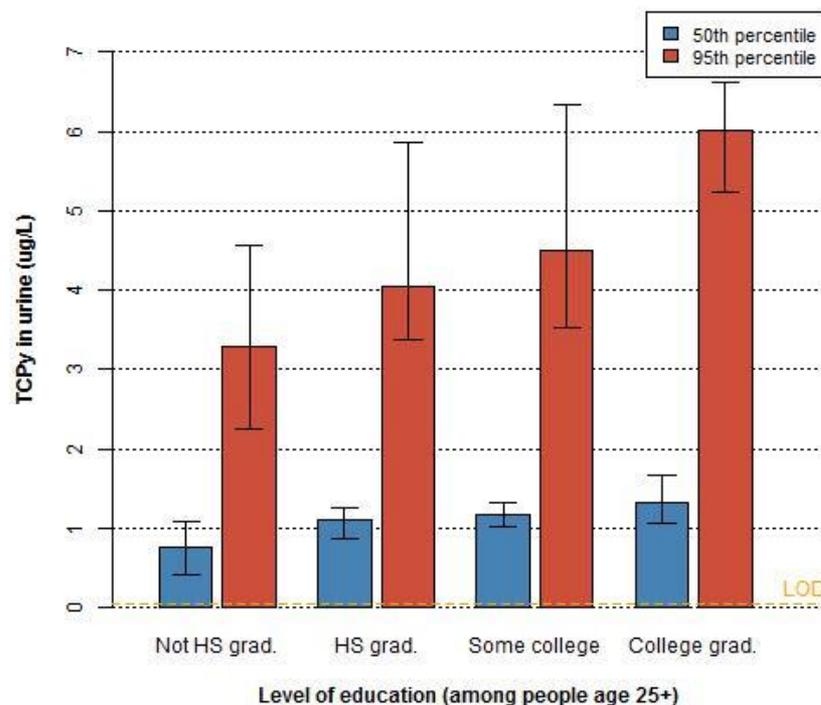
Washington Environmental Biomonitoring Survey, 2010-2011



Group	n	50th percentile	95th percentile
Did not graduate from HS	69	0.317 (0.24-0.52)	5.25 (1.15-10.2)
Graduated HS or GED	238	0.372 (0.328-0.437)	5.99 (2.92-9.08)
Some college or technical school	329	0.399 (0.33-0.499)	4.73 (2.62-10.9)
Graduated from 4-year college	368	0.491 (0.421-0.583)	8.6 (5.68-13.2)

**Urinary chlorpyrifos metabolite (TCPy) by level of education**

Washington Environmental Biomonitoring Survey, 2010-2011

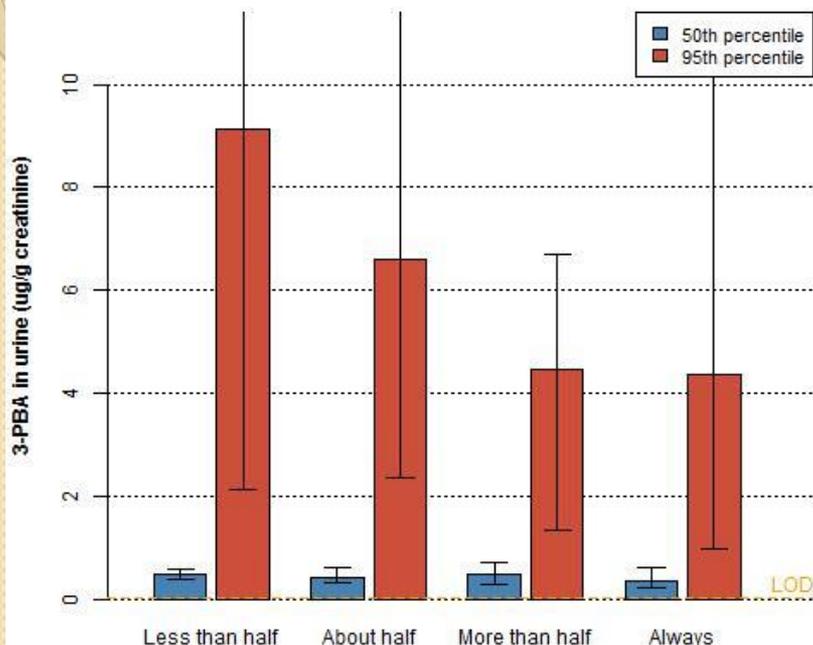


Group	n	50th percentile	95th percentile
Did not graduate from HS	69	0.748 (0.417-1.08)	3.28 (2.26-4.56)
Graduated HS or GED	238	1.1 (0.863-1.26)	4.05 (3.38-5.85)
Some college or technical school	329	1.17 (1.01-1.33)	4.49 (3.53-6.33)
Graduated from 4-year college	368	1.33 (1.06-1.67)	6.01 (5.24-6.62)

# Pesticide results: Eating organic foods

## Urinary pyrethroid metabolite (3-PBA) and eating organic foods

Washington Environmental Biomonitoring Survey, 2010-2011

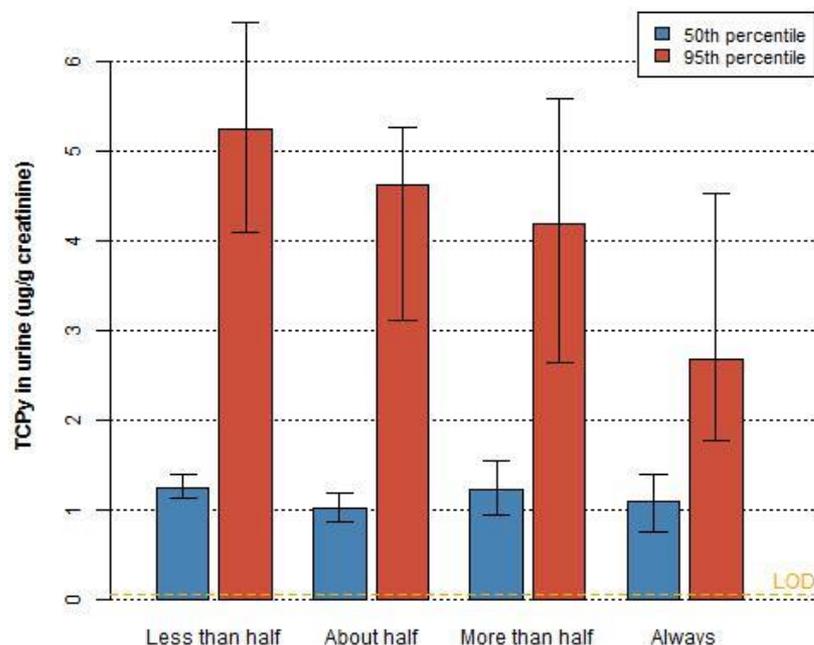


How much of the time eating organic fruits/vegetables in past 2 days

Group	n	50th percentile	95th percentile
Less than half the time	356	0.499 (0.406-0.583)	9.13 (2.13-55.4)
About half the time	155	0.434 (0.329-0.621)	6.61 (2.36-14.8)
More than half the time	80	0.484 (0.295-0.74)	4.47 (1.35-6.69)
Always	42	0.374 (0.222-0.626)	4.36 (0.997-57.9)

## Urinary chlorpyrifos metabolite (TCPy) and eating organic foods

Washington Environmental Biomonitoring Survey, 2010-2011



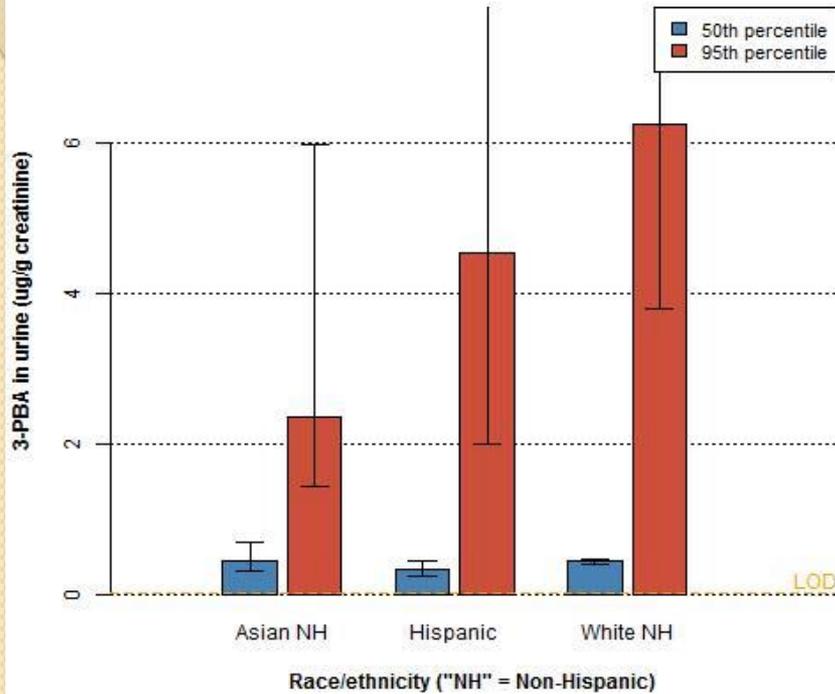
How much of the time eating organic fruits/vegetables in past 2 days

Group	n	50th percentile	95th percentile
Less than half the time	356	1.24 (1.14-1.39)	5.25 (4.09-6.44)
About half the time	155	1.03 (0.876-1.19)	4.62 (3.12-5.27)
More than half the time	80	1.22 (0.944-1.55)	4.2 (2.65-5.6)
Always	42	1.09 (0.758-1.39)	2.68 (1.78-4.54)

# Pesticide results : Race/Ethnicity

Urinary pyrethroid metabolite (3-PBA) by race/ethnicity

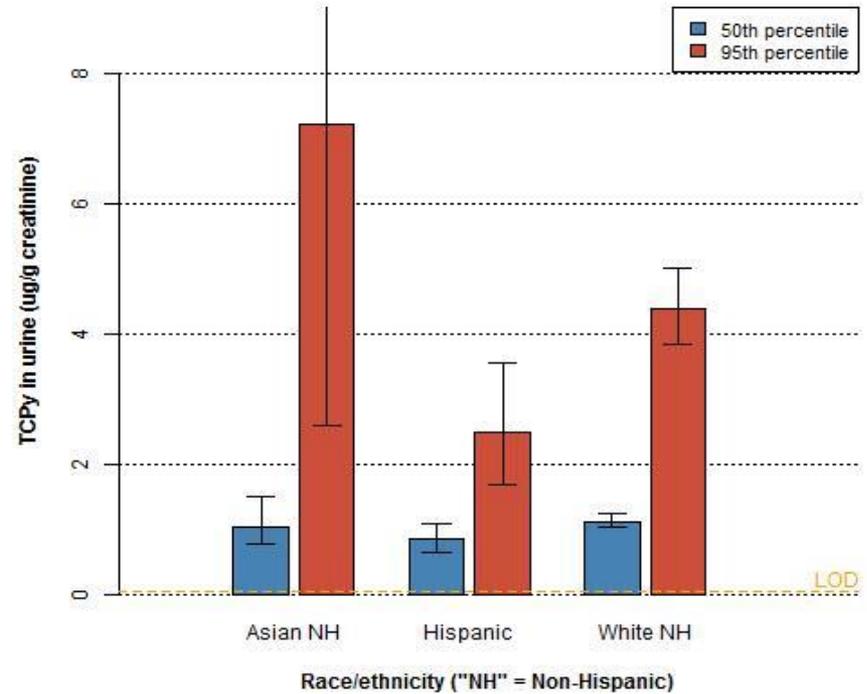
Washington Environmental Biomonitoring Survey, 2010-2011



Group	n	50th percentile	95th percentile
Asian only, NH	94	0.447 (0.311-0.69)	2.36 (1.44-5.99)
Hispanic	174	0.348 (0.257-0.444)	4.55 (2-12.2)
White only, NH	1003	0.44 (0.399-0.484)	6.25 (3.81-9.79)

Urinary chlorpyrifos metabolite (TCPy) by race/ethnicity

Washington Environmental Biomonitoring Survey, 2010-2011



Group	n	50th percentile	95th percentile
Asian only, NH	94	1.05 (0.77-1.51)	7.21 (2.6-44)
Hispanic	174	0.847 (0.658-1.09)	2.5 (1.7-3.55)
White only, NH	1003	1.12 (1.03-1.24)	4.38 (3.85-5.01)

# Speciated and Total Arsenic

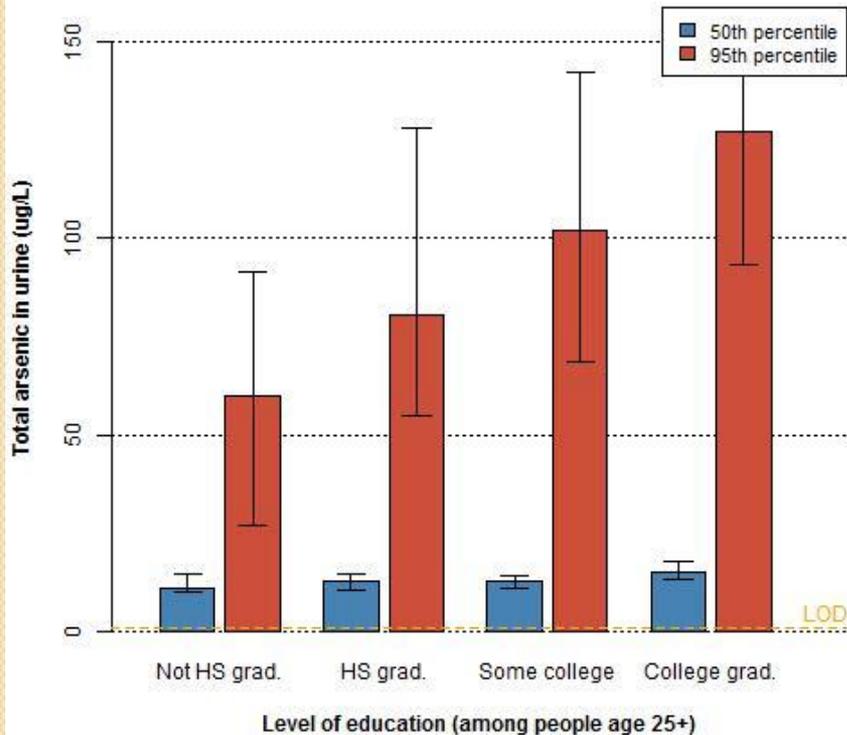
- Inorganic: Toxic
  - Arsenous (III) acid
  - Arsenic (V) acid
- Organic: Low toxicity
  - Monomethylarsonic acid (MMA)
  - Dimethylarsinic acid (DMA)
  - Arsenobetaine (AsB)
  - Arsenocholine
- Total arsenic



# Arsenic findings: Education/Income

**Urinary total arsenic by level of education**

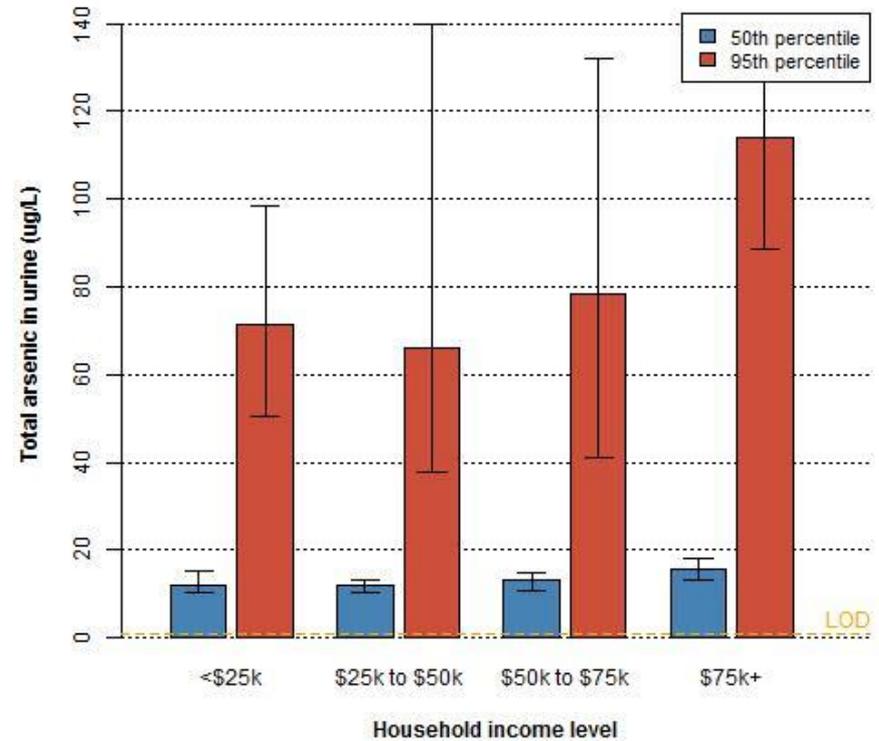
Washington Environmental Biomonitoring Survey, 2010-2011



Group	n	50th percentile	95th percentile
Did not graduate from HS	69	10.9 (10.1-14.5)	59.7 (26.9-91.6)
Graduated HS or GED	238	12.7 (10.6-14.5)	80.3 (54.9-128)
Some college or technical school	329	12.6 (11-14.2)	102 (68.7-142)
Graduated from 4-year college	368	15.1 (13.3-17.7)	127 (93.3-159)

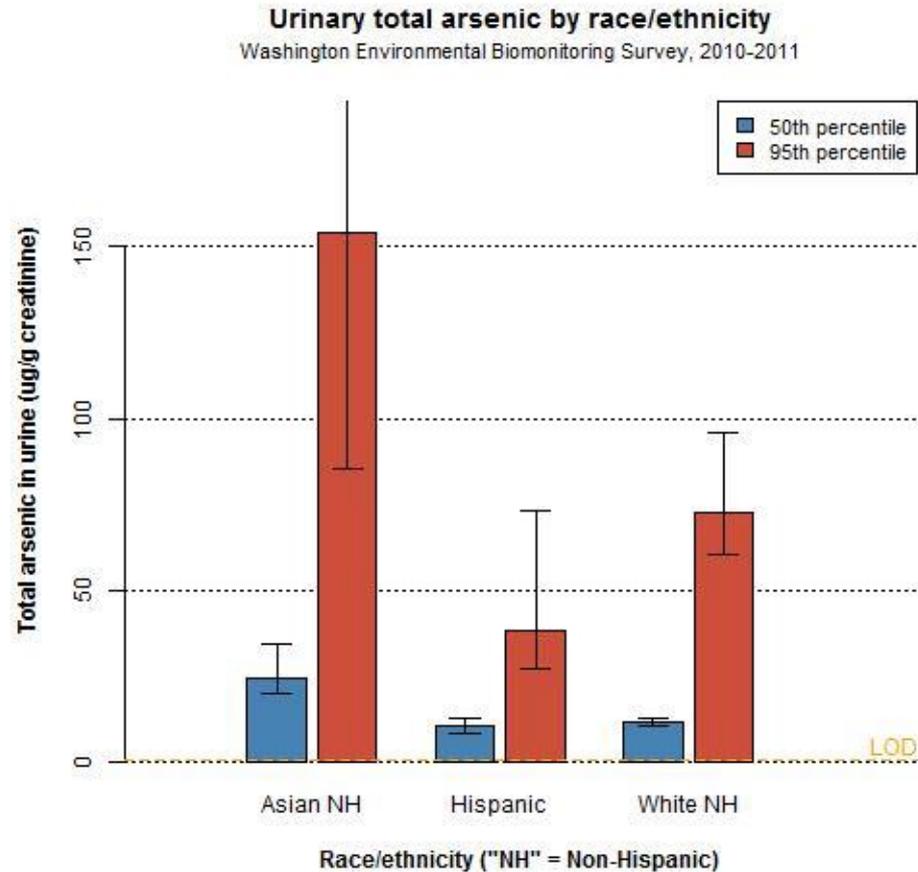
**Urinary total arsenic by household income**

Washington Environmental Biomonitoring Survey, 2010-2011



Group	n	50th percentile	95th percentile
Less than \$25,000	189	11.8 (10.2-15.3)	71.4 (50.4-98.6)
\$25k to less than \$50k	342	11.8 (10.4-13.3)	66 (37.9-140)
\$50k to less than \$75k	249	13.3 (10.8-14.6)	78.2 (41-132)
\$75k or more	434	15.5 (13.3-17.9)	114 (88.6-144)

# Other arsenic findings: Race/ethnicity



Group	n	50th percentile	95th percentile
Asian only, NH	94	24.3 (19.9-34.6)	154 (85.4-473)
Hispanic	174	10.4 (8.3-13)	38.4 (27-73.2)
White only, NH	1003	11.4 (10.3-12.8)	72.4 (60.4-95.9)

# Low Income Survey & Testing

- Final samples collected April 2014
- Summer 2014
  - Analysis
  - Results: survey group as a whole
  - Education/prevention activities
  - Partners: SHA, RHA, DOH, SKC-PH, UW

# Washington Environmental Biomonitoring Survey

## Summary of Activities and Findings

In 2009, the Centers for Disease Control and Prevention (CDC) awarded the Washington State Department of Health a 5-year biomonitoring grant.

This funding improves the capability of our Public Health Laboratories to test biomonitoring samples and assess exposure to chemicals.

The goals of the Washington Environmental Biomonitoring Survey (WEBS) are to:

- Understand amounts of environmental chemicals in our bodies—for the general population and those at high risk of exposure in Washington.
- Compare our levels to U.S. levels.
- Use this information to help reduce exposures.

## Activities: 2009–2012

### Statewide General Population Study

From May 2010 to June 2011, WEBS staff collected urine samples from 1,422 people living in Washington State. This was a random sample of residents age six and older. Our laboratory tested urine samples for total and speciated arsenic, and 12 metals (antimony, barium, beryllium, cadmium, cesium, cobalt, lead, molybdenum, platinum, thallium, tungsten and uranium). Participants received their arsenic and metals results by mail after about eight weeks. Our laboratory also tested urine samples for metabolites of the pesticide chlorpyrifos as well as a group of commonly used pyrethroid insecticides. We mailed pesticide results to participants at the end of 2012.

WEBS staff also collected drinking water samples from 498 households participating in the statewide study starting in July 2010. Our laboratory tested water samples for arsenic, cadmium, lead, thallium, uranium and manganese. The Washington Tracking Network funded the drinking water testing.

### Major findings:

- Urine levels of total arsenic were higher in Washington (median 11.9 µg/g creatinine) compared to U.S. levels reported by CDC (7.9 µg/g creatinine). About 11 percent of WEBS participants had urine levels above CDC's reporting level of 50 µg/L.
- Arsenic from seafood contributed to the higher levels. People who ate shellfish, fish, kelp or sushi in the previous three days had higher urine levels of arsenic—arsenic compounds in food occur naturally and have low toxicity.
- In Washington, median urine levels were higher for cadmium and cobalt, and lower for cesium, lead and thallium compared to the entire U.S.
- Almost all drinking water samples met Environmental Protection Agency (EPA) standards. Most water samples (76 percent) came from large public water systems.
- In Washington, median urine levels were higher for pyrethroids and lower for chlorpyrifos compared to the most recent U.S. levels from 2001–2002. We expected these differences because chlorpyrifos was banned for home use in 2001 and home use of pyrethroids has increased since that time.
- Pyrethroid levels were higher in people who reported recent use of home insecticides and were lower in people who reported eating organic fruits and vegetables.

### *Biomonitoring*

*measures the amount of environmental chemicals or their breakdown products (called metabolites) in human blood, urine, hair or other body tissues.*

### *For more information*

Denise Laflamme  
WEBS Field Study Manager  
denise.laflamme@doh.wa.gov  
360-236-4345  
www.doh.wa.gov/biomonitoring  
WEBS biomonitoring data:  
www.wtn.doh.wa.gov

*Arsenic is found naturally in seafood and some groundwater. Arsenic is also found in soils because of industrial activities or the use of certain pesticides.*

*Pyrethroid pesticides are used in agriculture and are popular residential insecticides. They are found in products that kill ants, fleas, spiders, cockroaches and other pests.*

*Chlorpyrifos is a pesticide that is widely used in agriculture to kill insects. It was banned for home use in the U.S. in 2001.*

*Bisphenol A (BPA) is a chemical compound used to make hard plastics and epoxy resin. BPA is commonly found in the lining of food and drink cans.*

*Phthalates are chemicals added to plastics to make them more flexible and durable. They are used in many consumer products, including toys, food packaging, building materials and perfumes.*

## High Arsenic Area Study: South Whidbey Island

Arsenic is normally found in water, soil and air. In some areas of the state, natural underground deposits of arsenic cause contamination in drinking water wells. South Whidbey Island is one area of the state known to have high, naturally-occurring arsenic in groundwater.

From July to September 2011, WEBS staff collected urine and drinking water samples from residents on private wells or small water systems (less than 15 connections). We pre-screened tap water with a test kit. Then we invited households with arsenic at or above EPA's drinking water standard to participate. A total of 172 residents from 82 households participated in this study.

### Major findings:

- Urine levels of total arsenic were higher for South Whidbey (28.4 µg/g creatinine) compared to statewide and national levels.
- 28 percent of participants had urine arsenic levels above CDC's reporting level.
- 54 percent of water samples retested at the laboratory were above the EPA's standard.
- Arsenic from seafood and tap water contributed to higher arsenic levels in urine.

## The Pyrethroid Exposure Survey and Testing (PEST) Study

From May to October 2012, WEBS staff invited pest management professionals in western Washington to participate in the PEST study. The purpose was to learn how work practices affect their exposures. Licensed pesticide applicators from King, Pierce, Snohomish, Clark or Thurston counties who used pyrethroid products at work were eligible. 56 participants each completed a questionnaire and gave urine samples after a work day of applying pesticides. Results, expected by the end of 2013, will be used to improve continuing education for these professionals.

## Activities Planned for 2013 and 2014

### Planned activities include:

- Developing laboratory methods, and measuring bisphenol A and phthalates in urine samples already collected from the general statewide population.
- Measuring pyrethroid and chlorpyrifos pesticides, bisphenol A, and phthalates in urine samples of people living in subsidized housing in King County to compare with statewide and U.S. levels.
- Measuring pyrethroid pesticides in urine samples collected from PEST participants, conducting data analysis, and preparing a report of findings.

**We hope that you will agree to help with this survey.**

### **How was I selected?**

We selected housing authority properties in Renton and Seattle that served families. We are asking girls and women ages 6–44 and boys and men ages 6–19 living in subsidized units to take part.

### **Why should I help?**

You can help us learn:

- How diet, cooking food in plastic, and the use of beauty and skin care products and pesticides affect the amount of chemicals that get into the body.
- If people living in subsidized units have more of these chemicals in their bodies compared to other people in our state or around the country.
- How to reduce these chemicals in people.

### **Will I receive anything if I take part?**

- Adults will get a \$25 VISA card.
- Youth ages 12–17 will get a \$15 VISA card.
- Each household will get information to help lower exposure to pesticides.
- Everyone will get a stainless steel water bottle.



### **If you take part in the survey:**

Adults and teens receive VISA gift cards. Everyone gets a stainless steel water bottle.

### **For more information:**

Call 1-877-494-3137 or visit <http://www.doh.wa.gov/biomonitoring>

This brochure is available in Spanish, Russian, Somali, Vietnamese, Cambodian, Amharic/Tigrinya, and traditional Chinese.

For persons with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY call 711).

WASHINGTON  
**Environmental  
Biomonitoring**  
SURVEY

## **Women, Children, and Teenagers:**

**You can help us learn about exposures to pesticides and chemicals in plastics.**

**Washington State Department of Health invites you to take part in an important survey about chemicals in your home.**

 Washington State Department of  
**Health**  
DOH 210-089 March 2013

## The survey will ask you about your use of these kinds of products



Makeup



Plastic containers



Plastic water bottles



Canned food



Pesticides

## What happens next?

Soon, field staff who work for the Washington State Department of Health will visit your home to explain the survey and ask if you want to take part. They will have photo IDs and will wear a vest that says Washington State Department of Health. If you want to take part this visit could take up to 45 minutes depending on how many people in your home want to take part. Staff will provide or call for interpreters if needed.

## What will I be asked to do if I take part?

- Give us two urine samples to test for pesticides and chemicals in plastics.
- Freeze the urine until we pick it up.
- Answer questions about you and your home, such as foods you ate, plastic products you used, and use of bug sprays.
- All of this will take about 30 minutes.

## Who will know my results?

Only the Department of Health survey team will know who is taking part in the survey. We will keep all information confidential. Names will not appear on any of the information we collect. We will report only on the results of the survey group as a whole.

## What are the chemicals you want to learn about?

Pesticides, BPA, and phthalates.

- **Pesticides** are used to control insects in and around buildings and in farming.
- **Bisphenol A (BPA)** is used in some hard plastics, such as older baby bottles and water bottles, and in the lining of food cans.
- **Phthalates** are used to make soft, flexible plastics, vinyl products, and food packaging materials. They are found in some beauty and skin care products such as shampoos, lotions and makeup.

## Why does the Department of Health want to know about these chemicals?

- Department of Health works to protect health through prevention and education.
- Research shows that these chemicals can be harmful to animals in early life. Scientists want to learn more about how much of these chemicals are in children, teenagers and women ages 20–44.

## What if I don't want to take part?

Taking part is your choice. You can drop out at any time. You can call the Washington State Department of Health toll-free at 1-877-494-3137 for more information or if no one in your home wants to take part. You can also call if you are not living in a subsidized unit, or if there are no girls or women ages 6–44 or boys or men ages 6–19 living in your home. If you decide later that you want to take part, call us.



**DATE:** December 11, 2013

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

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

**SUBJECT: UPDATE—FOOD SYSTEM ROUNDTABLE**

---

**Background and Summary:**

The Council's *2012 State Policy Action Plan to Eliminate Health Disparities* focused on recommendations that state agencies and their partners could immediately start implementing with existing resources. The Council agreed to track progress on the plan's implementation at its meetings and to document that progress in its biannual update reports to the Governor and Legislature.

As you may recall, the Department of Social and Health Services and the Department of Health were charged with convening a Food System Roundtable, as recommended in the *Report on Washington's Food System—Response to Executive Order 10-02*. One of the Council's 2012 action plan recommendations was for the Food System Roundtable to consider and include in its 25 year vision the needs of diverse communities in accessing healthy foods, including communities of color, immigrant, refugee, low-income, and rural communities. In addition, the Council recommended that diverse communities should serve on the Food System Roundtable to directly provide input into the 25 year vision.

During this agenda item, we will hear from Council Member Gail Brandt and Ms. Amy Ellings, Healthy Eating Active Living Program Manager for the Washington State Department of Health. Ms. Ellings will provide an update to the Council on the Food System Roundtable, which is currently in the process of choosing members, and will seek the input of the Council on membership and other Roundtable activities.

**Recommended Council Action:**

No recommended action at this time.

CHRISTINE O. GREGOIRE  
Governor



STATE OF WASHINGTON  
**OFFICE OF THE GOVERNOR**

*P.O. Box 40002 · Olympia, Washington 98504- 0002 · (360) 753- 6780 · [www.governor.wa.gov](http://www.governor.wa.gov)*

**EXECUTIVE ORDER 10-02**

**STRENGTHENING WASHINGTON'S FOOD SYSTEMS  
THROUGH POLICY AND COLLABORATION**

**WHEREAS**, a number of governmental agencies and programs of the state share goals and missions relating to food, nutrition, agriculture, health, and economic development through sustained agricultural production and improved access to nutritious foods;

**WHEREAS**, the current food system in Washington state is complex and directly affected by the activities and policies of multiple nongovernmental organizations, state agencies, and local governments, and a coordinated, systemic approach is necessary to improve the food security, nutrition and health of Washington's citizens;

**WHEREAS**, the percentage of young people who are overweight has tripled since 1980, and in Washington twenty-five percent of high school students and nearly sixty-one percent of Washington adults are either obese or overweight, and obesity contributes substantially to the burden of preventable illnesses and premature death;

**WHEREAS**, the Federal government has several initiatives focused on improving the nation's food security, nutrition, and health, including First Lady Michelle Obama's Let's Move campaign and the USDA's "Know Your Farmer, Know Your Food" initiative;

**WHEREAS**, our current economic climate and budget challenges require us to constantly evaluate state agency functions and structures and take steps to coordinate and streamline their operations; and

**NOW THEREFORE, I**, Christine O. Gregoire, Governor of the state of Washington, declare my commitment to improve coordination of efforts relating to our state food policy and hereby declare and direct the following:

1. The Departments of Health, Agriculture, and Social and Health Services shall work collaboratively with other agencies and non-governmental organizations to examine state food policy, food-related programs, and food-related issues. In addition, I request the Conservation Commission and the Office of Superintendent of Public Instruction join as full partners in this effort.

2. These agencies shall produce a report to the Governor and Legislature which provides an assessment of existing data and identifies remaining gaps and opportunities in Washington State food policy to help address food security, nutrition, and health challenges faced by Washington citizens and to support realistic solutions to these issues. The report will be delivered by December 31, 2011.
3. The report is intended to help agencies, stakeholders and legislators:
  - a. Explore ways to promote nutrition, especially for those who are most in need.
  - b. Identify ways to educate the public and policy makers on the status of hunger in Washington State and the role they play in addressing the issue of food security, nutrition, and health.
  - c. Educate the public and policy makers on the importance of farmland preservation and the importance of promoting Washington-grown products to farmer's markets, food banks, and institutions.
4. It is the intent of this executive order to place the state in a favorable position to qualify for available federal funds, moneys from foundations, and other sources to address issues of food security, nutrition and health of Washington citizens.

This executive order will take effect immediately.

Signed and sealed with the official seal of the state of Washington on this 22<sup>nd</sup> day of June 2010 at Seattle, Washington.

By:

/s/

---

Christine O. Gregoire  
Governor

BY THE GOVERNOR:

/s/

---

Secretary of State

## Washington State Food System Roundtable Charter

### History

Governor Christine Gregoire enacted Executive Order 10-02, directing state agencies to examine state food policy, food-related programs, and food-related issues. This analysis was completed January 2012 and concluded with a recommendation to establish a Washington State Food System Roundtable to develop a 25 year vision for our state's food system. In July 2012, Governor Gregoire approved the recommendation to establish the Food System Roundtable.

The Executive Order was a result of years of work by many stakeholders. A broad coalition worked with legislators to propose Senate Bill 6343 during the 2010 session of the Washington legislature. The bill called for the creation of a Washington Food Policy Council. Although the bill passed, Governor Gregoire vetoed the bill, citing overlap of the bill's goals with the activities of state agencies. Due to her commitment to "a more focused examination of state food policy, food-related programs, and food-related issues," Governor Gregoire issued the Executive Order to create this collaborative initiative in 2010.

### Our Dual Purpose

1. Developing and stewarding the 25 year vision. The vision will identify strategies, measures and accountability based on the Roundtable's Guiding Values and Principles.
2. Providing a forum for effective and true collaboration among Washington food system sectors. The Roundtable invites and encourages discussions between nongovernmental organizations and state agencies that will help inform actions impacting Washington's food system. As all partners work through their networks to support and steward a shared vision for a stronger, more coordinated food system in Washington, the Roundtable will be a forum for sharing ideas, experiences, and will provide a platform for strengthening our food system thru policy and collaboration.

### Structure & Leadership

*Roundtable Membership* (2 year renewable terms): The members are individuals committed to improving the Washington State food system through active participation in the Roundtable. 25-30 representatives from varied food system sectors will be chosen/elected to provide direction for the Roundtable. Members will be ultimately responsible for decision making.

*Leadership -Elected Co-chairs* (staggered 2 year term): Begin with one Co-chair for one year term and one Co-chair for two year term. The dyad will consist of one public sector partner and one private sector partner. Co-chairs will be chosen from and by the Roundtable Members.

*Workgroups*: Workgroups will be agreed upon and established by the Roundtable when a need for further work on a specific topic or issue is identified. Standing workgroups can be established. A Workgroup can be ad hoc and will end once it is no longer needed. Each workgroup can vary in size and longevity depending on its purpose. Workgroups will consist of volunteers from the membership and can include non-members with expertise on issues.

*Staffing:* Until there is a permanent staffing option, the Roundtable will choose one to two members to support the logistics of managing an effective Roundtable.

*Decision Making Process:* Roundtable members will strive to achieve consensus of members attending meetings. If consensus is not achieved, electronic voting can occur with one vote per member.

### **Roles and Responsibilities**

*Roundtable Membership:* The members are responsible for stewarding the Roundtable's vision by:

- Representing element(s)/sector(s) of the WA food system and ensuring that those in their sector networks are informed and engaged.
- Providing diverse perspectives on relevant issues.
- Actively participating (e.g. attend meetings, provide feedback, etc.).
- Sharing responsibility for resources needed to sustain the Roundtable (e.g. meeting location, logistics, supplies, fund development as needed, etc.).
- Providing direction and expertise to the Roundtable.
- Communicating with the Roundtable Membership.
- Recommend meeting agendas for the Roundtable meetings.
- Establishing the processes for identifying the priorities and related measures.
- Finalizing the Roundtable's priorities and related measures.
- Tracking progress and adjusting approaches as needed.
- Reviewing and, if needed, revising the charter annually.

*Co-chairs:* The Co-chairs are responsible for moving the Roundtable's Vision forward by:

- Develop and approve agendas.
- Facilitating meetings.
- Providing coordination of the Roundtable and workgroups.
- Ensuring fair participation and shared leadership.
- Representing the Roundtable (e.g. conferences, meetings, etc.), as needed.

*Workgroups:* Workgroup members are responsible for:

- Developing work plan on assigned topic and following through on agreed upon activities.
- Drawing from outside resources if expertise is needed.
- Coordinating workgroup meeting logistics such as agenda, location, and frequency.
- Reporting workgroup outcomes to Roundtable Members.

**Guiding Values and Principles:** The Roundtable's work is guided by:

- Creating a healthy food system through collaboration and broad engagement of the food system community.
- Believing that the food system should be as regenerative and sustainable as possible.
- Protecting and improving the environment (land use, water, transportation, energy, aquatic resources, waste management, etc.) through agricultural best practices, protection and wise use of natural resources.
- Promoting social justice and health equity.

- Maximizing local and state economic development.
- Sharing responsibility across the sectors.
- Eliminating food insecurity.
- Assuring access to nutritious food for all Washington residents, particularly low income residents.
- Assuring the food supply is safe, healthy, secure, affordable and culturally reflective for all Washingtonians.
- Continuing to support and promote a robust agricultural community.
- Increasing demand and supply for Washington grown food.
- Preserving and protecting farmland for food production.
- Promoting food production as a viable economic activity, and ensuring that farmers have access to the necessary resources including land, soil, water, and labor.
- Enabling connections among small-scale producers and consumers to support a sustainable farming network.

**Group Expectations:** Each member is expected to:

- To attend and actively participate in all meetings.
- Represent your food system sector by providing that perspective and sector relevant information
- Update your sector colleagues regularly on roundtable decisions, news, issues and other information.
- Honor previously made decisions unless there is significant new information regarding the past decisions.
- Be respectful of all viewpoints.
- Be courteous (minimize interruptions or side conversations while someone else is speaking, and unrelated laptop and cell phone use).
- Respond timely to meetings and requests for information.



**DATE:** December 11, 2013

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

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

**SUBJECT: UPDATE—RURAL HEALTHCARE STRATEGIC PLAN**

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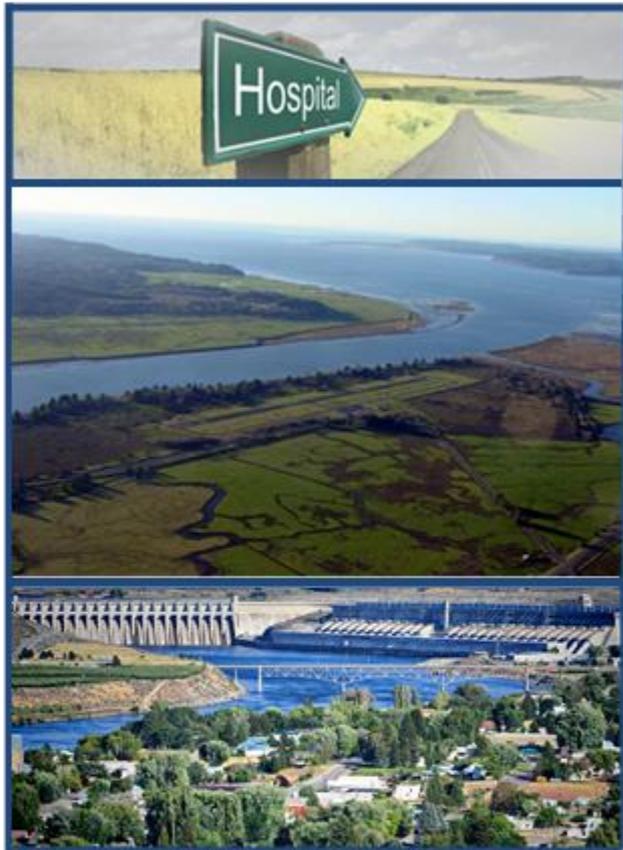
**Background and Summary:**

The Council's *2012 State Policy Action Plan to Eliminate Health Disparities* focused on recommendations that state agencies and their partners could immediately start implementing with existing resources. The Council agreed to track progress on the plan's implementation at its meetings and to document that progress in its biannual update reports to the Governor and Legislature. As you may recall, one of the recommendations from the 2012 action plan was for the Legislature to support the strategies in the 2012 Rural Health Care Strategic Plan for Washington State in an effort to sustain and improve the health of rural communities.

During this agenda item, we will hear from Mr. Jeff Mero, Executive Director of the Association of Washington Public Hospital Districts, who will brief the Council on the Rural Cluster's Essential Care, Everywhere campaign. The campaign is an effort to protect access to health care across Washington State. In addition, Mr. Mero will provide an update on the Rural Health Care Strategic Plan's implementation to date.

**Recommended Council Action:**

No recommended action at this time.



# Addressing Health Disparities and Risks to Access in Rural Washington State

November 2013

Jeff Mero

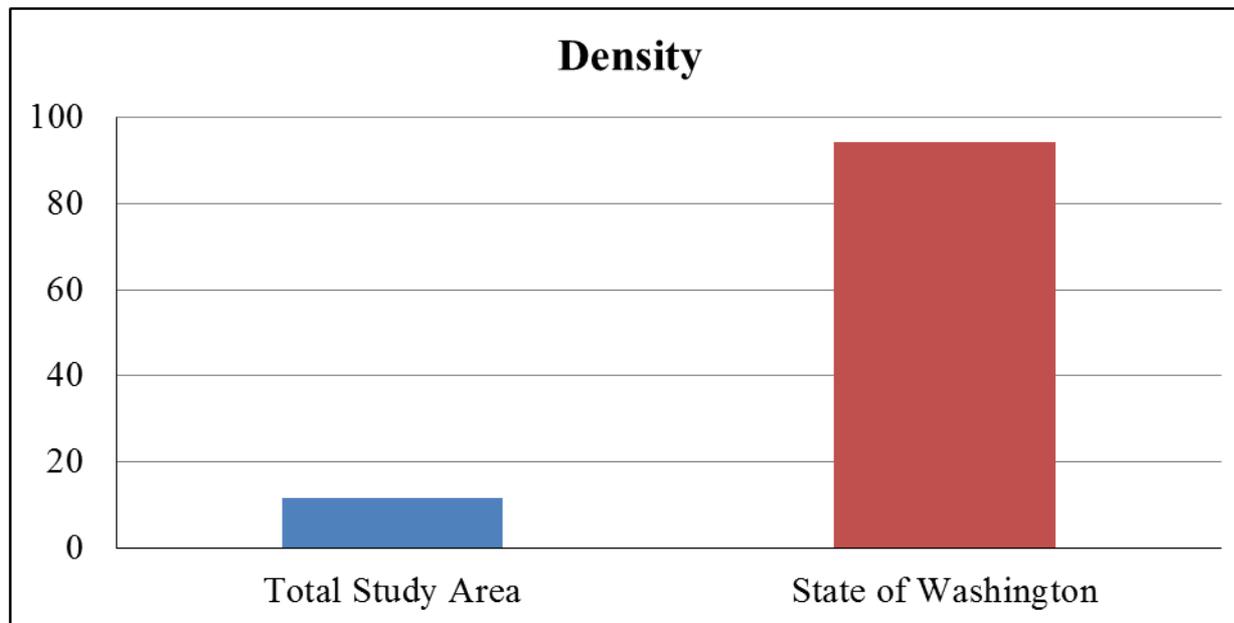
[jeffm@awphd.org](mailto:jeffm@awphd.org)

206.216.2519



The Study service area is much more sparsely populated than the State. Density per square mile is 87% lower than State average.

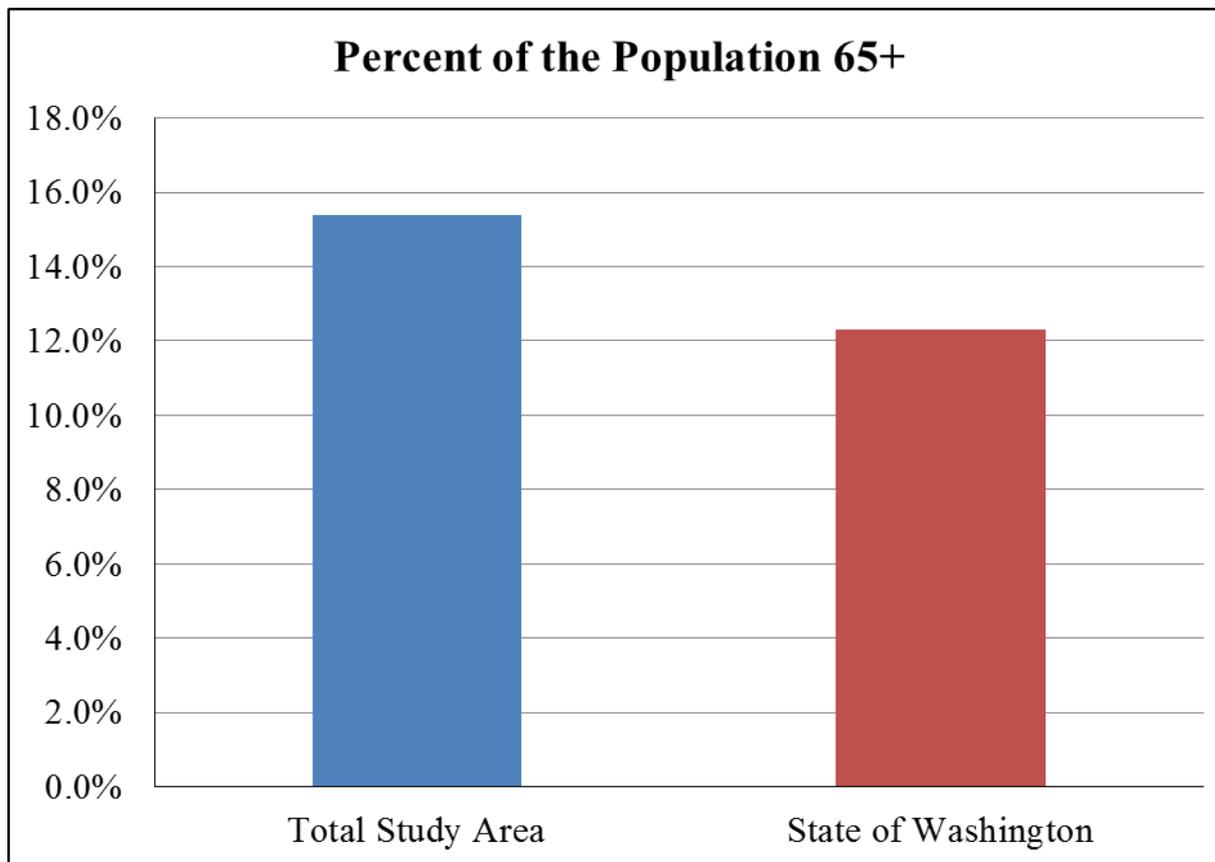
- ❑ Washington State has over 6,724,000 residents; the study area has just over 1,000,000 residents.
- ❑ Nearly 15% of the State's population resides in the study area.



Source: 2010 US Census

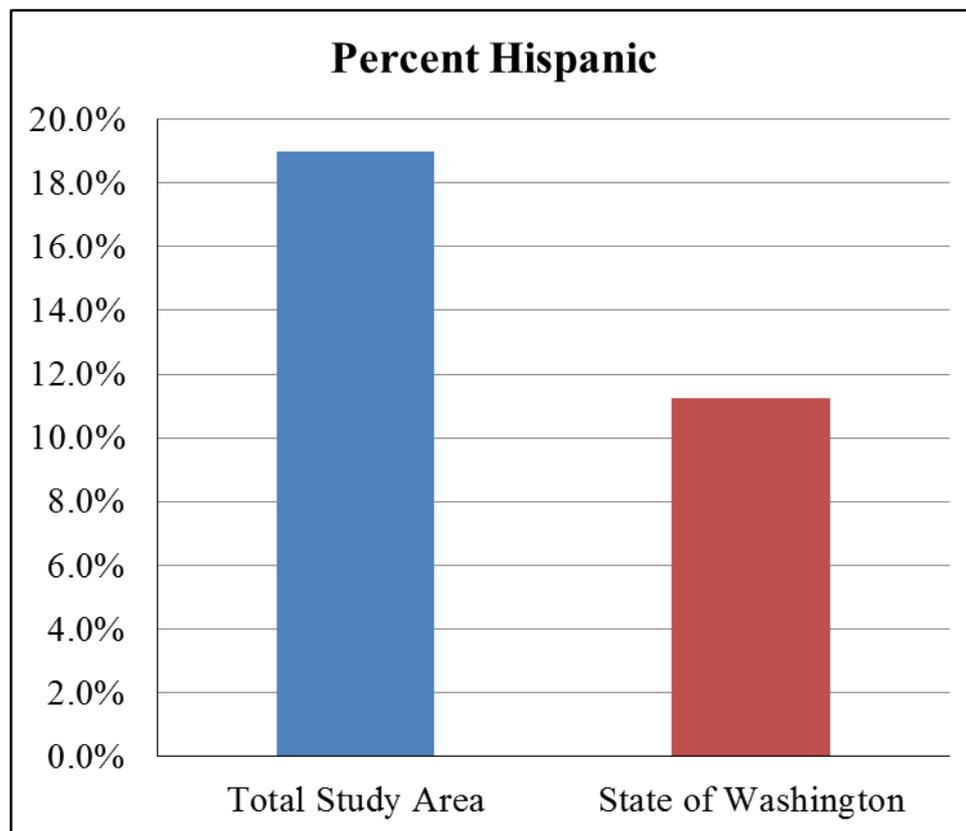
The communities studied are, on average significantly older – with almost 25% more 65+ residents than the State average.

(Range = 6%-28%+).



Source: 2010 US Census

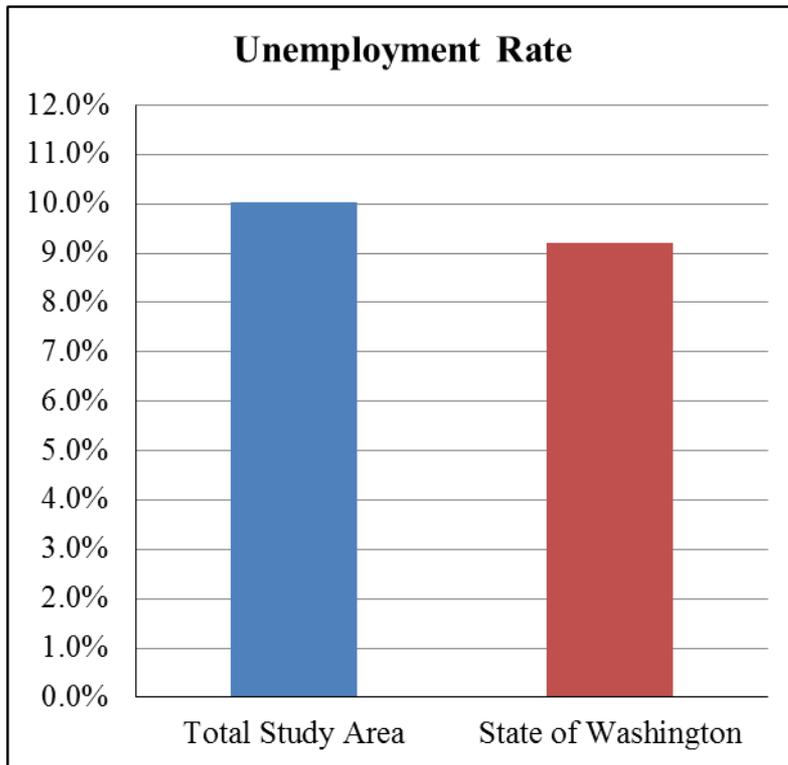
The communities are also much more ethnically diverse. For example, the percent of the population that is Hispanic is almost 70% higher than the State average.



Source: 2010 US Census

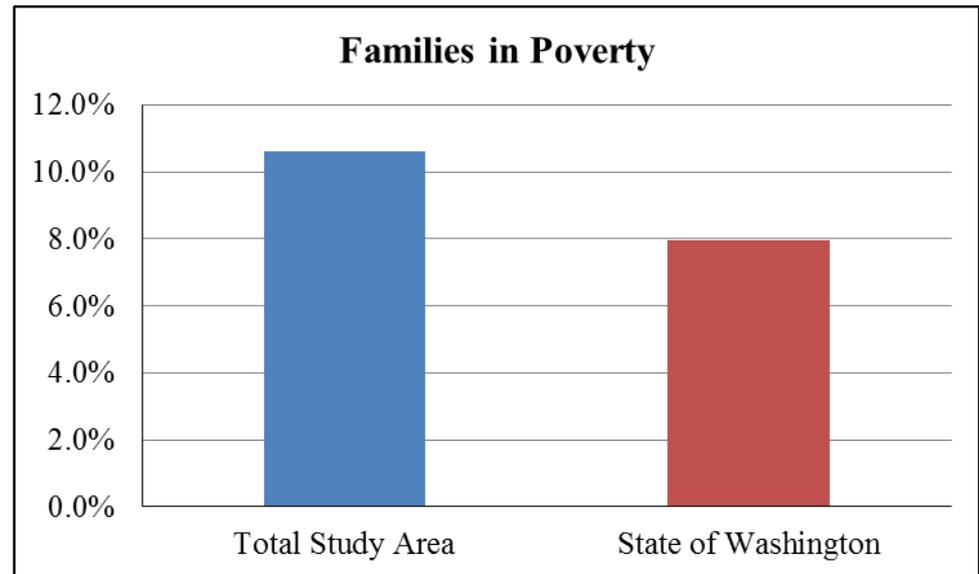
- ❑ The percent of the total population that is Hispanic ranges from 2.4% – 74.9% in the 42 service areas.
- ❑ Residents in the Study area are also more likely to speak a language other than English at home.
- ❑ Not just Hispanic

Residents of Study area are more likely to have lower income and higher rates of unemployment than the State at large.



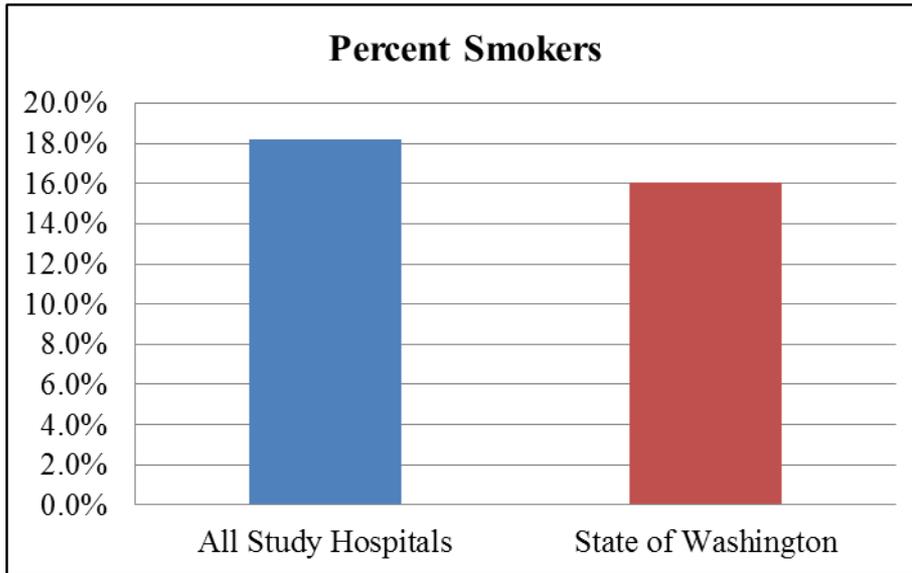
Source: 2010 US Census

- ❑ The unemployment rate is 9% above the State rate. (Range = 6%-16%)
- ❑ The percent of families in poverty is one third higher than the State.
- ❑ Per Capita Income is nearly 28% lower than the State.



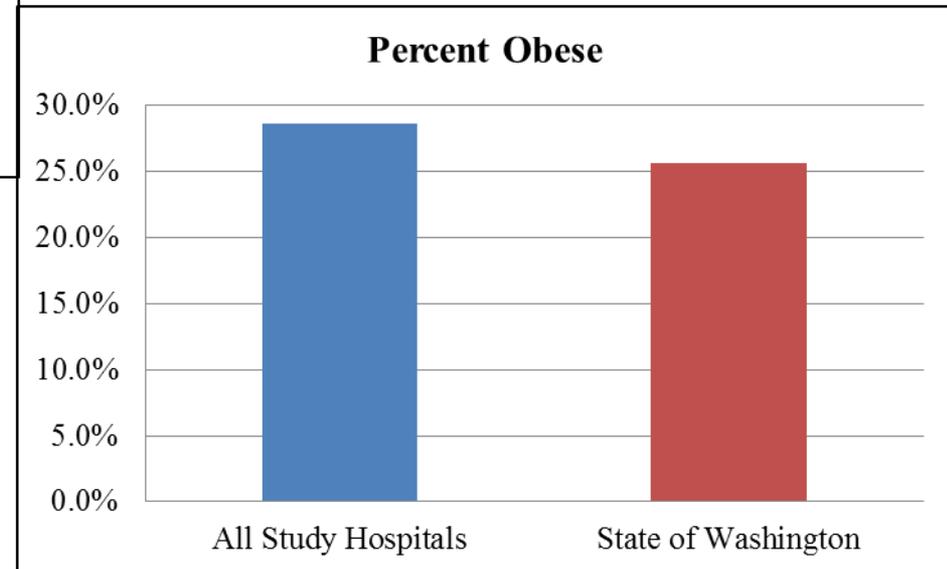
Source: Nielsen Claritas

And, the communities overall have higher rates of risk factor behaviors than the State at large.



Source: BRFSS 2007-2012

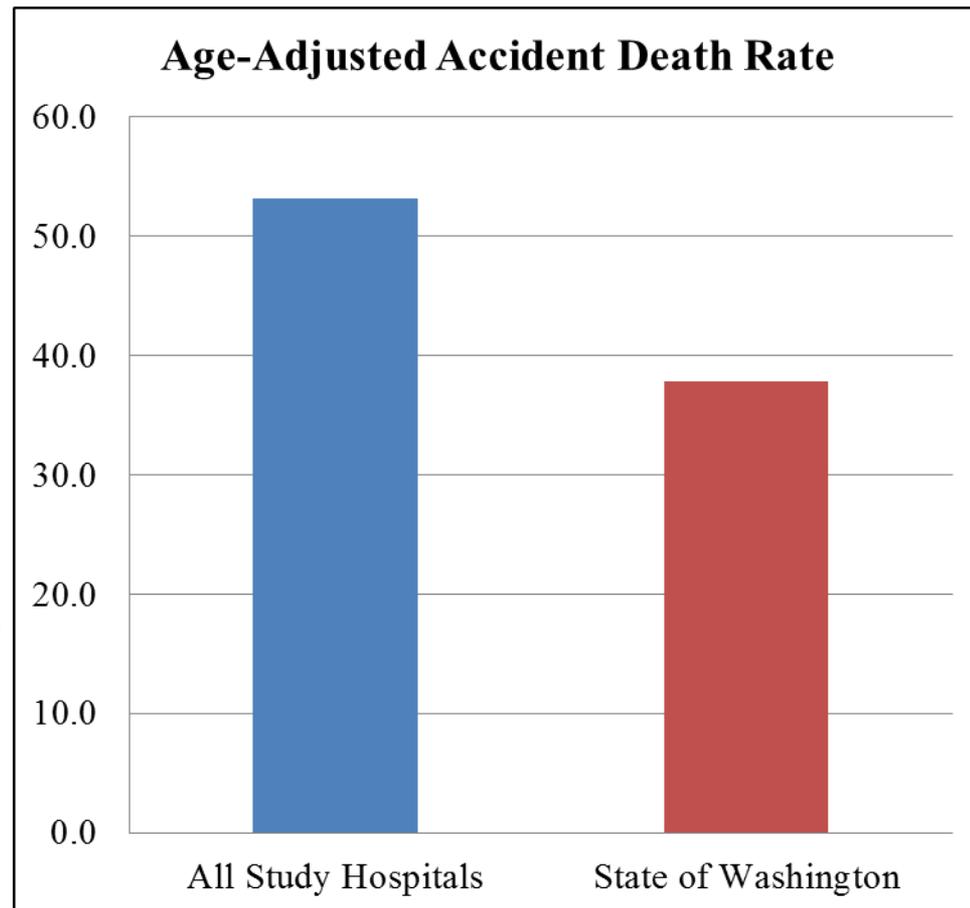
- ❑ Obesity is almost 12% higher than the State rate, with some communities at 40%+.
- ❑ Smoking is 13% higher than the State rate, ranging from 8.3% to 28.2%.



Source: BRFSS 2007-2012

The mortality rate due to accidents is over 40% higher than the State rate.

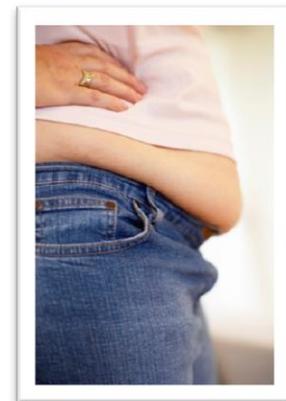
- ❑ In the Study area, the top two causes of mortality are cancer and heart disease and the death rates due to these causes are slightly higher than the State rate.
- ❑ The Chronic Lower Respiratory Disease (tobacco use is a major risk factor) death rate is about 10% higher than the State rate



Rate per 100,000 population years 2000-2009  
Source: Washington State Department of Health

# Summary: Vulnerable Populations

- ❑ Older
- ❑ More diverse
- ❑ Poorer:
  - ❑ Unemployment rate is 9% higher
  - ❑ Percent of families in poverty is 33% higher
  - ❑ Income is nearly 28% lower
- ❑ Obesity is almost 12% higher
- ❑ Smoking is 13% higher



# Where We're Going



# Policy Opportunities

## Current Grant Work

Community Paramedicine Initiatives

Cambia Behavioral Health Integration

Telemedicine

## Current Work within DOH

Adjust licensing requirements to reflect “the New Community Hospital”

Create New Facility Type (DOH’s New Blue H Group)’

Encourage Population Health Status Improvement as a goal: Incentives?

HCA SIM Proposals

Medical Homes/ Focus on Primary Care and Family Support



# Questions and Comments



Association of  
Washington Public Hospital Districts



**DATE:** December 11, 2013

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

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

**SUBJECT:** **REVIEW AND DISCUSS ACTION PLAN UPDATE**

---

**Background and Summary:**

At a recent meeting, the Council had a discussion about our statutory reporting requirements and agreed to submit biannual action plan updates. The updates will focus on implementation of our current recommendations and will incorporate new recommendations as they become available.

Today, I have asked to staff to review the draft text for our *December 2013 Biannual Update Report*. As was done with our June 2013 report, I am recommending the Council approve the draft text, incorporate any suggestions from today's discussion that the whole Council determines should be moved forward, and authorize the Council chair to approve the final report on the Council's behalf.

**Recommended Council Action:**

After reviewing draft text for the *December 2013 Biannual Update Report*, the Council may choose to consider, amend if necessary, and adopt the following motion:

*Motion: The Council approves in concept the draft text of the December 2013 Biannual Update Report as submitted on December 11, 2013, directs staff to incorporate changes from today's discussion as necessary, and authorizes the chair to approve the final report for submission to the Governor and Legislature.*



## December 2013 Update

### State Action Plan to Eliminate Health Disparities

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<b>National CLAS Standards</b>	2
<b>Health Impact Reviews</b>	4
<b>Implementation of 2012 Action Plan Recommendations</b>	5
<b>Council Membership</b>	8

December 2013

Governor's Interagency Council on Health Disparities

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## INTRODUCTION

In accordance with RCW 43.20.280 the Governor’s Interagency Council on Health Disparities (Council) is required to create an action plan to eliminate health disparities by race/ethnicity and gender and to update the plan biannually.

The Council submitted its first action plan in June 2010—that plan focused on education, health insurance coverage, healthcare workforce diversity, obesity, and diabetes. With that plan, the Council delivered broad policy recommendations, most of which would have required executive or legislative action to implement.

In December 2012, the Council submitted a second action plan, which focused on behavioral health, environmental exposures and hazards, and poverty. The Council’s aim with its 2012 action plan was to deliver recommendations that state agencies and their partners could take steps toward implementing immediately with existing resources. It then submitted a June 2013 Update, which shared progress toward implementing all of the recommendations in the 2012 action plan.

All reports are available on the Council’s Web site:

[HealthEquity.wa.gov](http://HealthEquity.wa.gov)

The purpose of this December 2013 Update is to provide information on the Council’s newest priority—the implementation of the National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare. This report also highlights Health Impact Review work and provides status updates on selected recommendations from the 2012 action plan where substantial progress has been made.

## NATIONAL CLAS STANDARDS

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards) are a comprehensive set of guidelines that inform and facilitate the provision of culturally and linguistically appropriate services. The goals of the standards are to advance health equity, improve quality of services, and work toward the elimination of health disparities. While the target audiences for the standards are organizations providing health or healthcare services, the standards can be implemented by any entity wishing to provide services that are responsive to the diverse cultural, language, literacy, and other needs of the populations it serves.

The CLAS standards were first developed by the U.S. Department of Health and Human Services Office of Minority Health in 2000. In April 2013, the agency released the newly enhanced CLAS standards, which apply to a broader audience and which include expanded conceptualizations of culture and health. Box 1 provides a list of the 15 standards.

## Box 1: Enhanced National CLAS Standards

### 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.

### 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.

### 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.

Over the years, the Council has recognized the need for language assistance and culturally competent services to improve the health of Washington’s diverse communities and to work toward the elimination of health disparities. The Council has adopted the state system and its potential impacts on health disparities as a priority health issue and has focused on language access to state government services. Issues around workforce diversity, cultural competence, and language access have been reoccurring themes in the Council’s recommendations since it submitted its first action plan in 2010. Moreover, the Council has direct authority as described in RCW 43.20.275 to “...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.”

Most recently, the Council has initiated the following two actions in an effort to obtain dedicated resources to work toward the adoption of the CLAS standards in Washington state:

- The Council applied for and successfully received a grant from the U.S. Department of Health and Human Services Office of Minority Health. The funding, which began on September 1, 2013, is for a two year project from the Office of Minority Health’s State Partnership Program to Improve Minority Health. Through the grant project, the Council will provide resources, information, training, and technical assistance on the CLAS standards to state agencies and health and healthcare organizations interested in developing and implementing organizational CLAS policies and practices.
- At its September 11, 2013 meeting, the Council approved a motion to adopt the implementation of the CLAS standards as a new priority. The agencies participating on the Council agreed to implement the standards in their agencies and report back on progress over time.

## HEALTH IMPACT REVIEWS

According to RCW 43.20.285, the State Board of Health must conduct health impact reviews in collaboration with the Council. A health impact review is an analysis of how a proposed legislative or budgetary change will likely impact health and health disparities in Washington. It provides objective information that policy makers can use when deciding whether to proceed with a proposal, or to make changes to the proposal to mitigate the harms, maximize the health benefits, and potentially reduce costs.

Many proposals may directly impact health or the factors that influence health such as where we live, learn, work, and play. Therefore, health impact reviews can be requested for

any proposal, even those that may not seem to directly relate to health, such as proposals that impact education, transportation, the environment, housing, and income.

More information on Health Impact Reviews, including how to request a review and copies of completed reviews, is available on the State Board of Health’s Web site:

<http://sboh.wa.gov/OurWork/HealthImpactReviews.aspx>

Staff complete reviews within 10 days of request during legislative session and during the interim, staff will work with the requester to determine a timely and feasible completion date. Only the Governor or a member of the Legislature can request a health impact review.

To date, the State Board of Health has completed health impact reviews of both policy and budget proposals and covered topics ranging from education, language access, financial development, and cuts to health and social services. Due to budget constraints health impact review funds were suspended from 2009-2013. Funding was restored in the 2013-2015 biennial operating budget. The State Board of Health has recently hired a health policy analyst to complete health impact reviews and at the time of this writing, the Board has received one request to review 2SHB 1680 –Relating to implementing strategies to close the educational opportunity gap.

## **IMPLEMENTATION OF 2012 ACTION PLAN RECOMMENDATIONS**

Health disparities faced by communities of color were first documented in 1985 when the U.S. Department of Health and Human Services released its *“Report of the Secretary’s Task Force on Black and Minority Health.”* Nearly three decades later, disparities still persist nationally and in Washington state. The Council recognizes that the elimination of health disparities is a huge challenge that requires broad collaboration across multiple sectors, both public and private. No one entity or intervention can take on the challenge alone. The interagency structure of the Council, which includes state agencies and boards in addition to the racial/ethnic commissions and consumer representatives, allows for the kind of collective action that is needed if health equity is to be achieved.

In developing the recommendations in its 2012 action plan, the Council focused on tangible activities that could be implemented by state agencies and its partners using existing resources. Collectively, actions being taken to implement the recommendations move the state in the right direction toward reducing health disparities. Much more work remains, but the Council is pleased to be able to document current steps that are being taken.

This section provides updates on the implementation of the 2012 recommendations. The Council created a list of measures to systematically track adoption and implementation of its environmental exposures and hazards recommendations. Table 1 provides the status of those measures for each of the agencies participating on the Council. Table 2 provides selected highlights of current and planned work toward implementing the behavioral health and poverty recommendations.

**Table 1: Measures for Tracking Environmental Exposures and Hazards Recommendations**

Measures	Board of Health	Dept. of Agriculture	Dept. of Commerce	Dept. of Early Learning	Dept. of Ecology	Dept. of Health	Dept. of Social and Health Services	Health Care Authority	Office of Superintendent of Public Instruction	Workforce Training and Education Coord. Board
<b>Institutional Awareness and Diversity</b>										
Requires cultural competency and/or diversity training for all staff.	●	●	●		●	●	●			
Requires government-to-government training for all staff.	●	●	●		●	●	●			
Includes objectives, strategies, and performance measures in its strategic plan to increase staff and management diversity.	●	●	●		●	●	●			
<b>Service Equity, Accountability, and Metrics</b>										
Collects and analyzes demographic data such as race/ethnicity, gender, language, disability status, etc. of individuals receiving agency services or who are impacted by agency actions.	●	●	●		●	●	●			
Includes objectives, strategies, and performance measures in its strategic plan to promote equity and/or reduce disparities in service delivery and outcomes.	●	●	●		●	●	●			
<b>Community Capacity Building and Involvement</b>										
Employs a dedicated community ombudsperson – an agency point of contact who works to ensure affected communities are informed and engaged in agency decision-making.	●	●	●		●	●	●			
Provides comprehensive language assistance services, including having a written agency language access policy and plan/guidance.	●	●	●		●	●	●			
Employs a designated Tribal Liaison and has a written tribal consultation policy and plan/guidance.	●	●	●		●	●	●			
<b>Reducing/Eliminating Harmful Environmental Exposures</b>										
Has a policy and plan/guidance for Environmentally Preferably Purchasing (EPP) that includes green products and services (e.g., cleaning products, construction materials, electronics, landscaping practices, office supplies).	●	●	●		●	●	●			
Prioritizes reducing, reusing, and recycling at the office to help conserve energy and reduce pollution and greenhouse gas emissions.	●	●	●		●	●	●			
<p><b>Scale:</b></p> <p>● = No—my agency does not do this</p> <p>● = Somewhat—my agency is taking steps to implement this or is implementing this in some offices/divisions</p> <p>● = Yes—my agency is doing this</p>										

**Table 2: Implementation Status of Select 2012 Recommendations**

Recommendation	Status
<p><b>Behavioral Health - Credentialing</b> The Department of Health should consult with agencies, facilities, federally recognized Indian Tribes within the state, or counties that can employ agency affiliated counselors before any changes to agency affiliated counselor scope of practice and/or credentialing requirements are made in rule.</p>	<p>The Department of Health has not engaged in rulemaking related to agency affiliated counselor scope or practice or credentialing requirements. The Department values input from stakeholders and will invite agencies, facilities and Indian Tribes to participate in any future rule making activities.</p>
<p><b>Behavioral Health - Provider Training</b> The disciplinary authorities for behavioral health professions should: (1) consider cultural competency training as acceptable to meet part of the total required continuing education hours and (2) include providers of acceptable cultural competency training among those approved to provide continuing education.</p>	<p>The Health Services Quality Assurance Division at the Department of Health reviewed behavioral health professional program rules. The review shows cultural competency is accepted continuing education for behavioral health professionals. Due to the rules moratorium, the Department has not been able to amend rules to promote cultural competency training or recognize training providers. The Department will consider amending continuing education rules during future rule reviews to specifically promote cultural competency.</p>
<p><b>Behavioral Health – Qualified Health Homes</b> Health Care Authority and Department of Social and Health Services should ensure the definition of qualified health homes allows for the inclusion of Tribes, urban Indian health organizations, community-based organizations, and school-based health centers to be a part of qualified health homes.</p>	<p>The Department of Social and Health Services has implemented health homes in all areas of the state with the exception of King and Snohomish Counties for both Medicaid and Medicare/Medicaid (duals) beneficiaries who meet the high risk/cost eligibility. Duals in those two counties will participate in a fully capitated managed care demonstration instead of the health home model. Tribes, urban Indian and community based organizations have been provided information on how to participate in Health Homes. Individual meetings to provide more detailed information are ongoing.</p>
<p><b>Behavioral Health - Culturally Competent Care</b> Health Care Authority and Department of Social and Health Services should ensure payment models incentivize culturally competent care coordination and other supports and services that promote engagement and positive health outcomes.</p>	<p>The Department of Social and Health Services has updated Health Plan contract language to incentivize high quality service delivery and care coordination including cultural and linguistic competence in Health Action Planning. Additional emphasis has been placed on coordinating routine preventive care, community services and networks, and promoting healthy life choices.</p>
<p><b>Behavioral Health - Access and Engagement</b> Health Care Authority and the Health Benefit Exchange Board should ensure that culturally and linguistically competent community-based organizations, Tribes, and urban Indian health organizations are eligible to serve as navigators and be compensated for providing outreach to and increase enrollment of diverse communities into Medicaid Expansion and plans offered under the Health Benefit Exchange.</p>	<p>In March 2013, the Washington Health Benefit Exchange solicited proposals from organizations around the state to serve as In-Person Assister Lead Organizations. On June 5, the Exchange announced that ten organizations, including public health agencies, coalitions, regional health networks, and other community organizations, were chosen statewide. Additional in-person assister organizations have been chosen to help serve tribes, coalitions of tribes, and/or tribal/tribe-affiliated organizations to provide in-person assistance for tribal members who need help comparing and enrolling in Qualified Health Plans. These include: Colville Confederated Tribes on the Colville Reservation, Lummi Nation, Suquamish Tribe, South Puget Intertribal Planning Agency, and The NATIVE Project in Spokane.</p>

## COUNCIL MEMBERSHIP

The Council has 17 members: a chair appointed by the Governor; representatives of 14 state agencies, boards, and commissions; and two members of the public who represent the interests of health care consumers. A list of current Council members is provided in Box 2. The interagency structure of the Council allows it to have a statewide and broad approach to addressing health disparities. The Council considers not only health and healthcare issues, but also the social factors that influence health, such as education, poverty, employment, and the environment.

<b>Box 2: Governor’s Interagency Council on Health Disparities Membership</b>	
Governor’s Representative and Council Chair:	Emma Medicine White Crow
Consumer Representative and Council Vice Chair:	Frankie T. Manning
Consumer Representative:	Gwendolyn Shepherd
Commission on African American Affairs:	Kameka Brown
Commission on Asian Pacific American Affairs:	Sofia Aragon
Commission on Hispanic Affairs:	Nora Coronado Diana Lindner (alternate)
Department of Agriculture:	Kim Eads
Department of Commerce:	Diane Klontz
Department of Early Learning:	Jonathan Green
Department of Ecology:	Millie Piazza John Ridgway (alternate)
Department of Health:	Gail Brandt
Department of Social and Health Services:	Marietta Bobba
American Indian Health Commission <sup>1</sup> :	Willie Frank Jan Olmstead (alternate)
Health Care Authority:	Vazaskia Caldwell
Office of Superintendent of Public Instruction:	Dan Newell Greg Williamson (alternate)
State Board of Health:	Stephen Kutz
Workforce Training and Education Coordinating Board:	Nova Gattman

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



**DATE:** December 11, 2013

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

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

**SUBJECT:** **REVIEW AND DISCUSS RECOMMENDATIONS OF THE PRIORITY SETTING WORKGROUP**

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**Background and Summary:**

At our May and September meetings, we discussed future priorities for the Council. At the September meeting, the Council approved a motion to work on the implementation of the CLAS standards as a new priority. In addition, we created an ad hoc priority setting workgroup consisting of Council members Marietta Bobba, Gail Brandt, Vazaskia Caldwell, and myself.

The workgroup met on November 26 to begin the discussions. In preparation, we reviewed a number of materials that we've included in your packets under Tab 13. These materials included the following:

- *Council 2010, 2012, and 2014 Prioritization Processes:*
  - Outline of past processes as well as considered and selected priorities
  - List of potential future priorities, criteria, and populations of interest that have been mentioned by Council members during recent Council meetings
  - Recent community input
- *Governor, State Agency, and Commission Health Priorities:*
  - Health issues of interest to the Governor and select state agencies and commissions
  - Summary of issues commonly identified across several groups
- *Washington State Data: Disparities by Race/Ethnicity and Sex:*
  - List of issues that have disparate impacts in Washington state
  - 'Summary of Findings' highlighting issues addressed in multiple reports
- *National Health Disparities:*
  - List of nationwide disparities in health and health care
- *Racial/Ethnic Disparity Work in Washington: Select Organizations and Committees:*
  - Examples of organizations in Washington that are doing racial equity work and lists of each organization's current priorities
  - Summary list of issues that a number of these organizations are working on

Today, we will provide a summary of our workgroup conversations and will bring three items for discussion among the full Council.

**Recommended Council Action:**

No recommended action at this time.

## **RCW 43.20.270**

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

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

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

## **RCW 43.20.275**

### **Council created — Membership — Duties — Advisory committees.**

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

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

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

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

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

[2006 c 239 § 3.]

#### **Notes:**

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

## **RCW 43.20.280**

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

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

## **RCW 43.20.285**

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

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

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

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

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

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

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

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

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

**RCW 43.20.290****Obtaining and allocating federal or private funding.**

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

# Council Prioritization

## 2010 Prioritization Process Overview

### PHASE I:

- In addition to the 16 priorities specified in statute, the Council expanded the list to include 16 additional health topics. These additional topics were added after the Council solicited public input on which additional priorities they should cover. They received over 50 suggestions.
- Members were provided with factsheets for each issue (including magnitude of the problem, severity of the problem, and extent of the disparity)
- Members scored each issue
- Some issues were combined after scoring (e.g. infant mortality and SIDS)
- Twelve issues moved onto Phase II

### PHASE II:

- Members further scored the twelve issues using the following:
  - criterion #1: opportunities for council support (i.e., readiness)
  - criterion #2: identified community need as identified in community surveys (2X weight)
  - criterion #3: prioritization of need (as identified by data)
- This scoring resulted in the selection of five priorities

2010 Prioritization			
Priorities taken into consideration		Priorities that made it to Phase II	Selected priorities
<p style="text-align: center;"><i>Topics Listed in RCW 43.20.280</i></p> <ul style="list-style-type: none"> <li>• asthma</li> <li>• breast cancer</li> <li>• cervical cancer</li> <li>• chronic kidney disease</li> <li>• diabetes</li> <li>• heart disease</li> <li>• HIV/AIDS</li> <li>• immunization rates</li> <li>• infant mortality</li> <li>• mental health</li> <li>• oral disease</li> <li>• prostate cancer</li> <li>• SIDS</li> <li>• smoking rates</li> <li>• stroke</li> <li>• women’s health</li> </ul>	<p style="text-align: center;"><i>Topics Added by the Council</i></p> <ul style="list-style-type: none"> <li>• access to nutritious food</li> <li>• colorectal cancer</li> <li>• culturally &amp; linguistically appropriate healthcare</li> <li>• education</li> <li>• environmental exposures</li> <li>• health insurance coverage</li> <li>• health literacy</li> <li>• healthcare workforce diversity</li> <li>• income</li> <li>• language access</li> <li>• lupus</li> <li>• opportunities for physical activity</li> <li>• overweight &amp; obesity</li> <li>• preventive services utilization</li> <li>• promoting equity within state agencies</li> <li>• social support</li> <li>• substance abuse</li> <li>• supportive parenting &amp; childcare systems</li> </ul>	<p style="text-align: center;"><i>Social Determinants</i></p> <ul style="list-style-type: none"> <li>• education</li> <li>• environmental exposures</li> <li>• health insurance coverage</li> <li>• health literacy</li> <li>• healthcare workforce diversity</li> <li>• smoking rates</li> <li>• substance abuse</li> </ul> <p style="text-align: center;"><i>Health Conditions</i></p> <ul style="list-style-type: none"> <li>• chronic kidney disease</li> <li>• diabetes</li> <li>• heart disease and stroke</li> <li>• HIV/AIDS</li> <li>• obesity</li> </ul>	<p style="text-align: center;"><i>Social Determinants</i></p> <ul style="list-style-type: none"> <li>• education</li> <li>• health insurance coverage</li> <li>• health workforce diversity</li> </ul> <p style="text-align: center;"><i>Health Conditions</i></p> <ul style="list-style-type: none"> <li>• diabetes</li> <li>• overweight and obesity</li> </ul> <p style="text-align: center;"><i>Council responsibility set out separately in statute</i></p> <ul style="list-style-type: none"> <li>• language access</li> <li>• promoting equity within state agencies</li> </ul>

## 2012 Prioritization Process Overview

- Council members agreed they did not want to start from the beginning again. Instead, they agreed to start with the remaining topics from the list of twelve issues from Phase II of the 2010 prioritization process that were not selected.
- Members submitted additional health topics to staff over the interim
- Council members were given time during the following meeting to advocate for health topics they would like to see addressed in the next action plan
- These topics (along with those submitted to staff in the interim) were added to the priority list for consideration
- Through open discussion the Council members selected 3 broad topics to be briefed on:
  - environmental exposures, community, neighborhoods
  - early life development and maternal infant health indicators
  - poverty/income
- After briefings, members participated in World Café small group discussions to prioritize issues and then each small group stated the priorities that they had selected
- Chair Medicine White Crow facilitated a discussion to arrive at consensus among Council members of the new set of priorities

2012 Prioritization		
Priorities considered in 2010 prioritization process that were not selected	Additional priorities suggested by Council members	Selected priorities
<ul style="list-style-type: none"> <li>• behavioral health (substance abuse and mental health)</li> <li>• chronic kidney disease</li> <li>• environmental exposures</li> <li>• health literacy</li> <li>• heart disease and stroke</li> <li>• HIV/AIDS</li> <li>• smoking rates</li> </ul>	<ul style="list-style-type: none"> <li>• adverse childhood events (ACEs)</li> <li>• community/neighborhoods</li> <li>• early life experience</li> <li>• environmental exposures and hazards</li> <li>• health reform implementation</li> <li>• housing</li> <li>• income/poverty</li> <li>• maternal and child health</li> <li>• maternal and paternal leave policies (to improve early child development)</li> <li>• state system/advocacy</li> <li>• transportation</li> </ul>	<ul style="list-style-type: none"> <li>• adverse childhood events (ACEs)</li> <li>• behavioral health (substance abuse and mental health)*</li> <li>• environmental exposures and hazards*</li> <li>• health reform implementation</li> <li>• income/poverty*</li> <li>• state system/advocacy</li> </ul>
*Advisory Committees were convened for these priorities		

## 2014 Prioritization

### Priorities mentioned by Council members for consideration for 2014 priorities during Council meetings (bolded priorities were addressed in 2010 or 2012 Action Plan)

- active living
- **adverse childhood experiences (ACE's)**
- asthma
- CLAS Standards\*
- childhood **obesity**
- cultural competence in state services (including an expectation that contractors would also adopt cultural competence policies and practices)
- **diabetes**
- **education** (e.g. the Dream Act, early learning, the education pipeline, academic achievement, drop-out rates)
- **environmental health**
- **health reform**
- **health workforce diversity**
  - work-integrated learning (i.e., education and training supported by one's employer)
- healthy eating
- immunizations
- "second decade" (i.e. the behavioral choices that youth make between 10-20 years of age)
- smoking cessation
- state's regressive tax structure
- women and children/maternal and child health
  - infant mortality rates and home visiting strategies as they pertain to maternal-infant health

### Potential criteria suggested by Council members for selecting 2014 priorities

- Focus on topics that have been prioritized in the past that are still relevant today because more work is needed
- Topics that are priorities for the new Governor and other agencies (increases chances to collaborate)
- Focus on state actions that can be done to reduce disparities and hold agencies accountable for implementing Council recommendations
- Focus on priorities where the Council has opportunities to partner with others
- Focus on a priority area that we are uniquely situated to address

### Populations mentioned by Council members for consideration for 2014 priorities

- Latinos (specifically considering environmental health issues that disproportionately affect Latinos)
- Children in foster care
- Children affected by homelessness
- Children affected by military deployment
- Older adults
  - seniors who want to be involved in improving the health of their communities
  - consider high number of grandparents raising their grandchildren in Washington

\* At the September 11, 2013 Council meeting the Council selected the implementation of the National CLAS Standards as a priority

<b>2013 Community Input</b>	
<b>What do you think the Council should focus on next to eliminate health disparities by race/ethnicity and gender in Washington State?</b> (numbers in parenthesis indicate frequency of mention)	
<b>Email input</b>	<ul style="list-style-type: none"> <li>• American Indian youth (behavioral &amp; physical health)</li> <li>• asthma (2)</li> <li>• health literacy</li> <li>• K-12 education/STEM</li> <li>• oral health</li> <li>• physician cultural competence</li> <li>• sexual and intimate partner violence</li> <li>• treatment of addictive disorders</li> </ul>
<b>Central Area Senior Center Annual Health &amp; Wellness Fair/Forum</b>	<ul style="list-style-type: none"> <li>• community outreach/education</li> <li>• cultural and linguistic competency</li> <li>• elder health (cultural, language, literacy) (3)</li> <li>• healthcare workforce diversity</li> <li>• individual responsibility and patient advocacy</li> <li>• maternal and child health</li> <li>• natural remedies</li> <li>• nutrition</li> <li>• oral health</li> </ul>
<b>Bothell Health &amp; Safety Fair</b>	<ul style="list-style-type: none"> <li>• community health fairs</li> <li>• cultural competence of health care providers</li> <li>• early childhood development</li> <li>• equal pay and treatment</li> <li>• health care access (2)</li> <li>• health care provider/patient rights and obligations</li> <li>• health information (literacy) (3)</li> <li>• language access to state services</li> <li>• poverty, education, health insurance (continue)</li> <li>• promote health equity and racial justice</li> </ul>
<b>Community Outreach Roundtable</b>	<ul style="list-style-type: none"> <li>• community outreach and information primary language of audience</li> <li>• state agency diversity and cultural competency</li> <li>• community engagement and input into state agency decision-making</li> </ul>
Note: Community members were given this open ended question about what the Council should focus on in written survey form.	

# Governor, State Agency, and Commission Health Priorities



*This word cloud represents how many of the state agencies and commissions mentioned in this paper are prioritizing or doing work around each health issue. The largest words represent issues that are highlighted by the most agencies/commissions. This word cloud does **not** provide information such as which health issues have greater prevalence, impacts, or disparities.*

# Governor, State Agency, and Commission Health Priorities

## *Summary of Findings*

This document outlines health and social determinant of health priorities (or issues to be addressed or measured) that have been outlined by the Governor's Office and other Washington state agencies and commissions. Information is summarized from the following sources:

- I. The Governor's health care priorities and Executive Order 13-06
- II. Results Washington indicators
- III. The Washington State Board of Health's 2012 biennial report on health priorities, including essays from a number of state agencies included in the BOH report
- IV. Washington State Commissions on African American Affairs; Asian Pacific American Affairs; and Hispanic Affairs; and the American Indian Health Commission
- V. Washington's Public Health Improvement Partnership's *Agenda for Change* report

Highlights for each document as well as a more detailed exploration of each source are available below. When considering all of these resources together, a number of issues are being commonly cited by several of these agencies:

- Access to care
- Child and maternal health
- Education
- Health homes
- Immunizations
- Mental health
- Nutrition
- Physical activity
- Prevention services
- Tobacco

## *Findings*

### **I. Governor Inslee has outlined four health care priorities<sup>1</sup>:**

- Extend coverage to hundreds of thousands more Washingtonians by expanding Medicaid.
- Pay for quality instead of quantity.
- Curb state employee costs by improving health and focusing on primary and preventive care.
  - Executive Order 13-06 issued in October 2013 explicitly mentions the following in relation to state employee wellness<sup>2</sup>:
    - Diabetes
    - Lactation support programs
    - Nutrition

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<sup>1</sup> Washington Governor Jay Inslee's website. Accessed November 12, 2013. Available from <http://www.governor.wa.gov/issues/health/>.

<sup>2</sup> State of Washington Office of the Governor. Executive Order 13-06. 2013. Available from <http://www.governor.wa.gov/office/execorders/documents/13-06.pdf>.

- Physical activity
  - Tobacco
- Stabilize rural emergency services and primary care funding.

## II. Results Washington<sup>3</sup> highlights some indicators, that may impact health

### *Highlights*

These selected indicators are not necessarily indicative of Governor priorities as they may have been selected based on measurability and data availability. A number of indicators have been selected. Select examples from the ‘Education,’ ‘Economy,’ and ‘Sustainable Energy and a Clean Environment’ categories have been outlined below. In addition, a more detailed list of indicators from the ‘Healthy and Safe Communities’ category has also been provided below. A number of indicators explicitly set goals related to mitigating disparities or addressing high rates in specific racial/ethnic subgroups. These include:

- Education related indicators (e.g. addressing the opportunity gap and percentage of Board certified teachers who teach in high-poverty schools)
- Low birth weight (among infants born to African American and American Indian/Alaska Native mothers)
- Healthy weight (among Native Hawaiians/Other Pacific Islanders and American Indian/Alaskan Natives)
- Smoking (among low income populations and pregnant women)
- Uninsured rates (among those eligible for Medicaid)
- Youth of color in detention
- Poverty/income

### *Details*

Results Washington outlines five major categories, each which includes several specific indicators.

- 1.) World Class Education
  - a. Early learning: e.g. enrollment in high-quality early learning programs and percentage of children entering kindergarten who are ready
  - b. K-12: e.g. percentage of schools rated ‘exemplary’ or ‘very good’\* and percentage of K-12 students who score proficient or better on statewide exams\*
  - c. Postsecondary: e.g. percentage of population enrolled in certificate, credential, apprenticeship and degree programs and attainment of certificates, credentials, apprenticeships, and degrees
- 2.) Prosperous Economy: e.g. number of jobs and average earnings in Washington
- 3.) Sustainable Energy and a Clean Environment: e.g. clean energy, air, and water; healthy fish and wildlife; and responsible land use
- 4.) Healthy and Safe Communities
  - a. Healthy babies
    - i. Preterm birthrates
    - ii. Prenatal care in the first trimester
    - iii. Low birth weight\*

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\*These indicators explicitly address inequities

<sup>3</sup> Results Washington website. Accessed November 12, 2013. Available from <http://www.results.wa.gov/>.

- iv. Cesarean section rates
- b. Healthy youth and adults
  - i. Vaccination rates
  - ii. Healthy weight (youth and adults)\*
  - iii. Cigarette smoking (youth and adults)\*
  - iv. Youth outpatient chemical dependency treatment retention
  - v. Percentage of mental health consumers receiving service quickly after discharge
- c. Access/pay for quality
  - i. Uninsured rates\*
  - ii. State-purchased health care cost growth
  - iii. Medical expansion
  - iv. Medical homelessness (not having a health care provider or personal doctor)
- d. Public
  - i. Rates of return to institution for offenders
  - ii. Case plan/conditions of supervision compliance
  - iii. Juvenile re-arrest rates
  - iv. Percentage of youth of color in detention\*
  - v. Employment rates for offenders
  - vi. Rates of violent infractions in prison
- e. Traffic
  - i. Traffic related fatalities
  - ii. Drug and/or alcohol related driver-involved fatalities
  - iii. Speed-involved fatalities
  - iv. Traffic fatalities for young drivers
- f. Worker safety
  - i. Workplace injury rates that cause 3+ missed days of work
  - ii. Work related deaths resulting from injury
  - iii. Work related hospitalization from injury
  - iv. Workplace injury for leading causes of injury
- g. Protection and prevention
  - i. Child abuse/neglect
  - ii. Percentage of children in out-of-home placement for 5+ years
  - iii. Social worker involvement within 24 hours
- h. Stability and self sufficiency
  - i. Percentage of residents living below the poverty level\*
  - ii. Percentage who leave TANF due to increased income\*
  - iii. Employment rates for adults with developmental disabilities
  - iv. Homelessness
  - v. Veteran homelessness
- i. Quality of life
  - i. Percentage of supported seniors and individuals with developmental disabilities who are served in home and community based settings
  - ii. Percentage of long-term care clients served in home and community-based settings

- iii. Vulnerable adult abuse and neglect investigations open longer than 90 days

5.) Efficient, Effective, and Accountable Government

**III. The Washington State Board of Health is required to produce a biennial report outlining suggestions for public health priorities for the following biennium and such legislative action as it deems necessary (RCW 43.20.100)**

*Highlights*

The last report was released in 2012. In this *Washington State Health Report*,<sup>4</sup> the Board compiled essays from a number of state agencies which highlighted each agency's past work, current work, strategic goals, or future priorities. The following issues were mentioned by at least two of the state agencies who submitted essays for the Washington State Health Report as important priorities/issues moving forward (issue mentioned by):

- Access to healthy food/food security/nutrition (BOH, DOH, DEL, WSDA, DSHS/ESA, OSPI)
- Health homes (BOH, HCA, DSHS/ADSA)
- Mental health/(DEL, DOC, OSPI)
- Physical activity (BOH, DSHS/ESA, OSPI)
- Communicable disease (DOH, DOC)
- Food safety (BOH, WSDA)
- Immunizations (DOH, HCA)
- Obesity (DSHS/ESA, OSPI)
- Tobacco/Smoking (DOH, OSPI)

*Details*

The following is a brief outline of the issues presented in each agency's essay:

**Board of Health**

The Board outlined five priorities and recommendations based on its strategic plan (*potential state partners mentioned in the report are indicated in italics for each topic*):

1. Strengthen the public health system (*Public Health Improvement Partnership*)
2. Increase access to preventative services (*DEL, DOH, OSPI, HCA, DSHS; L&I, WDVA, DOC*)
  - Access to care
  - Health homes
3. Reduce health disparities (*Governor's Interagency Council on Health Disparities*)
  - Support recommendations outlined by the Council
4. Encourage healthy behavior (*WSDA, DSHS*)
  - Nutrition

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<sup>4</sup>Washington State Board of Health. Washington State Health Report: 2012. Accessed November 14, 2013. Available from [http://sboh.wa.gov/Portals/7/Doc/StateHealthReports/SHR\\_2012.pdf](http://sboh.wa.gov/Portals/7/Doc/StateHealthReports/SHR_2012.pdf).

- Physical activity
- 5. Promote healthy and safe environments (*Department of Ecology, DOH, QEC*)
  - Food safety
  - On-site sewage
  - School environmental health and safety

**Department of Health:** (references Washington’s Public Health Improvement Partnership’s *Agenda for Change Action Plan* which is outlined in further detail below)

- Communicable disease surveillance and response
- Financing public health
- Healthy food
- Immunizations across the lifespan
- Integrated data collection system for communicable disease
- Physical activity
- Prevention
- Tobacco

**Department of Early Learning:** (references Washington’s *Early Learning Plan*)

- Access to healthy food
- Development and social-emotional/mental health screening
- Early childhood oral health
- Food security
- Health insurance
- Increase breastfeeding
- Medical homes
- Mental health services for children and families
- Screening for postpartum mood disorders

**Office of Superintendent of Public Instruction:**

OSPI’s essay focuses on current and past achievements rather than future priorities. The essay does reference a document titled *Research Review: School Based Health Interventions and Academic Achievement* which outlines 13 health risks that impact student achievement that schools should focus on<sup>5</sup>:

- Alcohol use
- Cigarette smoking
- Depressed for at least 2 weeks in past year
- Drinking 2 or more soda pops per day
- Feeling unsafe at school
- Fewer than 8 hours of sleep at night

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<sup>5</sup> Dilley, Julia. Research Review: School-based Health Interventions and Academic Achievement. 2009. Available from [http://here.doh.wa.gov/materials/research-review-school-based-health-interventions-and-academic-achievement/12\\_HealthAcademic\\_E09L.pdf](http://here.doh.wa.gov/materials/research-review-school-based-health-interventions-and-academic-achievement/12_HealthAcademic_E09L.pdf).

- Insufficient exercise
- Insufficient fruit and vegetable consumption
- Marijuana use
- Not eating breakfast
- Obesity
- Severe asthma
- Watching TV 3 or more hours on an average school day

**Health Care Authority:**

- Health homes
- Immunizations (particularly among children of Russian-speaking parents)
- Increasing purchasing power by partnering with department of corrections
- Prescription monitoring
- State employee wellness

**Department of Social and Health Services (Aging and Disability Services Administration):**

- Health homes for all high-cost-high-risk dual beneficiaries
- Improving and coordinating care for Medicaid/Medicare dual beneficiaries

**Department of Labor and Industries:**

- Worksite injuries

**Washington State Department of Veterans Affairs:**

- Post-Traumatic Stress Disorder among veterans
- Skill building for veterans (to increase employment)
- Traumatic Brain Injury among veterans

**Department of Corrections:**

- Chemical dependency
- Communicable diseases disproportionately affecting offender population (e.g. hepatitis C and B, HIV, other sexually transmitted infections, and tuberculosis)
- Continuity of care upon release for individuals with mental health illness
- Mental health

**Washington State Department of Agriculture:**

- Access to healthy foods
- Food safety

**Department of Social and Health Services (Economic Services Administration):**

- Food security
- Nutrition
- Obesity
- Physical activity

**State Department of Ecology:**

- Children's safe products

- Decrease air pollution (e.g. wood stoves, diesel exhaust)
- Promoting alternatives to toxic materials in products
- Reducing toxic threats through prevention

#### **IV. Washington State Commissions on African American Affairs; Asian Pacific American Affairs; and Hispanic Affairs; and the American Indian Health Commission—current work, strategic goals, and/or priorities**

##### *Highlights*

Three of the commissions are prioritizing or conducting work around the following issues:

- Economic development
- Education
- Parent/guardian involvement

The following issues were cited by two of the commissions:

- Civil rights
- Drop-out rates
- Health care access
- Interpretation and translation
- Linking small business owners with resources
- Nutrition
- Opportunity gap
- Physical activity
- Prevention services
- Tobacco
- Voting-rights
- Washington Assessment of Student Learning (WASL) scores

##### *Details*

Each Commission presents their priorities and current projects in a unique format. For this reason, a number of sources (i.e. commission health or legislative priorities, strategic plans, and current projects) were used to identify the priorities outlined below. This methodology suggests that the following outline may not be a comprehensive list of each commission's priorities.

##### **Commission on African American Affairs (from Priorities webpage<sup>6</sup>):**

- Civil Rights
- Economic Development
- Education
  - Drop-out rates
  - Early learning
  - Opportunity gap
  - Parent/guardian involvement
  - Washington Assessment of Student Learning (WASL) scores

<sup>6</sup> Washington State Commission on African American Affairs website. Priorities. Accessed November 19, 2013. Available from <http://www.caa.wa.gov/priorities/civil/civilRights.shtml>.

- Health Care
  - Diabetes
  - Education
  - Heart disease
  - High blood pressure
  - HIV/AIDS
  - Nutrition
  - Physical activity
  - Stroke
- Youth and Families

**Commission on Asian Pacific American Affairs (from 2009-2015 Strategic Plan<sup>7</sup> and 2013 Legislative Priorities<sup>8</sup>):**

- Education
  - Closing the opportunity gap
  - Cultural competence in schools
  - Engaging bilingual parents
  - High school graduation rates
  - Language access in schools
  - Training education interpreters/translators
  - Washington State Dream Act
- Health care and human services
  - Access to care
  - Children’s health care (including mental health)
  - Collection of disaggregated healthcare data for Asian Americans and Pacific Islanders
  - Culturally competent care
  - Health insurance
  - Prevention measures
  - Promotion of healthy lifestyles
  - Translation services
- Economic development
  - Affordable commercial space for Asian American and Pacific Islander small businesses
  - Affordable housing
  - Increasing export initiatives with Asian countries
  - Job creation
  - Linking small business owners with resources
- Immigration
  - Citizenship
  - Economic self-sufficiency for refugees and immigrants
  - Job availability

<sup>7</sup> Washington State Commission on Asian Pacific American Affairs. *Strategic Plan: 2009-2015*. Available from <http://www.capaa.wa.gov/documents/0915StrategicPlan.pdf>.

<sup>8</sup> Washington State Commission on Asian Pacific American Affairs website. *2013 Legislative Priorities*. Accessed November 19, 2013. Available from <http://www.capaa.wa.gov/legislation/legislativePriorities.shtml>.

- Civil Rights
  - Voting rights

**Commission on Hispanic Affairs (from 2009-2015 Strategic Plan<sup>9</sup> goals):**

- Justice and equity
  - Explore benefits of community municipal advisory groups, community interaction councils, and local human rights commissions
  - Gang prevention
  - Interpretation and translation
- Education
  - Drop-out rates
  - Opportunity gap
  - Parental involvement
  - Washington Assessment of Student Learning (WASL)
- Economic development
  - Financial literacy
  - Linking small business owners with resources
- Legislative Affairs/Advocacy
  - Improve participation as voters and stakeholders in state government

**American Indian Health Commission (from current projects outlined on website<sup>10</sup>):**

- Emergency preparedness
- Healthy communities
  - Emotional wellness
  - Nutrition
  - Physical activity
  - Prevention services
  - Tobacco
- Immunizations
- Maternal child health
- Tobacco
- Home visiting

**V. Washington’s Public Health Improvement Partnership’s Agenda for Change<sup>11</sup>**  
*Highlights*

This partnership brings together many local and state public health leaders. The most recent action plan produced by this partnership outlines three main priorities. Within these priorities are more specific goals. The goals outlined in this action plan which mirror issues highlighted by other state agencies in the BOH *Washington State Health Report* include:

<sup>9</sup> Washington State Commission on Hispanic Affairs. *2009-2015 Strategic Plan*. Available from <http://www.cha.wa.gov/sites/default/files/StrategicPlanFinal.pdf>

<sup>10</sup> American Indian Health Commission for Washington State website. Accessed November 19, 2013. Available from <http://www.aihc-wa.com/aihc-health-projects/home-visiting/>.

<sup>11</sup> Public Health Improvement Partnership. *Agenda for Change Action Plan for Washington’s Public Health Network*. Accessed November 14, 2013. Available from <http://www.doh.wa.gov/Portals/1/Documents/1200/A4C-APsummary.pdf>. Accessed November 14, 2013.

- Communicable disease
- Health homes
- Immunizations
- Physical activity
- Safe and healthy food
- Tobacco use and exposure

In addition, the action plan outlines goals around issues that have recently been mentioned in Council meetings during discussions on priority setting. These include:

- Access to care
- Adverse Childhood Experiences (ACEs)
- Child and maternal health (e.g. preconception, prenatal, and postnatal care; breastfeeding)
- Immunizations
- Physical activity
- Safe and healthy food
- Tobacco use and exposure

#### *Details*

This partnership was created under [RCW 43.70.520](#) and [580](#) and includes local and state public health leaders, local boards of health, public health agencies, and tribal nations, the state Board of Health, the State Department of Health, the American Indian Health Commission, the Washington State Association of Local Public Health Officials, and the federal Department of Health and Human Services. These partners collaborated to create the *Agenda for Change Action Plan* in 2012 which outlines three health priorities:

#### **Priority 1: Preventing communicable disease and other health threats**

- Communicable disease surveillance and response
- Immunizations
- Integrated data collection system for communicable disease

#### **Priority 2: Fostering Healthy Communities and Environments**

- Adverse Childhood Experiences (ACEs)
- Physical activity
- Preconception, prenatal, postnatal and care for uninsured women
- Safe and healthy food
- Support breastfeeding
- Tobacco use and exposure

#### **Priority 3: Public Health Partnering with the Health Care System**

- Access to care
- Availability in rural and urban communities
- Evidence based clinical prevention services (e.g. screening and immunizations)
- Health homes
- Preventative services

**Washington State Data  
Disparities by Race, Ethnicity, and/or Sex**



*This word cloud represents how frequently each health issue appears in the reports cited in this paper. The largest words represent issues that were most frequently included in the reports. This gives an idea of how many organizations are reporting data on each issue. This word cloud does **not** provide information such as which health issues have greater prevalence, impacts, or disparities.*

# Washington State Data

## Disparities by Race, Ethnicity, and/or Sex

### *Summary of Findings*

A number of reports in Washington have highlighted state-level disparity data. The majority of these reports do not rank or prioritize the disparities, but rather provide data and discussion around each disparity presented. This paper highlights disparities in Washington as presented by the DOH, the Kaiser Family Foundation, HHS, and Region X RHEC. It should be noted that inclusion within a report does not indicate that the issue is or should be a priority—it may just be a topic where data were available. The disparities most commonly highlighted in these reports include (frequency of mention):

- Child Maternal Health (7)
  - Infant mortality
  - Low birthweight
  - Prenatal care
  - Reported child abuse/neglect
- Sexual health (4)
  - Adolescent pregnancy
  - Condom use
  - Rates of Sexually Transmitted Infections
  - Unplanned pregnancy
- Diabetes (3)
- Education (3)
- Obesity (3)
- Oral health (3)
- Cardiovascular disease (2)
- Colorectal cancer (2)
- Coronary heart disease (2)
- Having a personal provider (2)
- Health insurance (2)
- HIV/AIDS (2)
- Lung cancer (2)
- Medical access (2)
- Nutrition (2)
- Physical activity (2)
- Poverty (2)
- Stroke (2)
- Suicide (2)

The Kaiser Family Foundation report specifically analyzes racial/ethnic disparities among women. The authors created a disparity index by comparing the ratio between rates for non-Hispanic white women and rates for women of all other racial/ethnic groups combined. The six indicators with the greatest disparity indexes are:

- New AIDS cases
- Women with no high school diploma
- Poverty
- Fair or poor health status
- No health insurance
- Late initiation of or no prenatal care

### *Findings*

#### **I. Washington Department of Health’s *Health of Washington Report*<sup>1</sup>**

The Washington DOH most recent *Health of Washington Report* highlights state data for a number of health issues. Although each chapter discusses the disparate impacts of that health issue, these topics are not chosen using health disparity indexes as a criterion. The following criteria are used to select the health topics:

- The issue impacts many people in Washington
- The issue may impact relatively few people but might result in serious outcomes, such as death or disability
- The issue may impact relatively few people but might affect larger numbers if not well controlled (such as infectious diseases and environmental pollution)
- The issue has evidence-based public health interventions
- DOH staff availability to write each chapter

Of the most recent chapters available, the following health issues have disproportionate impacts on people of color and women (more detailed information available in Appendix A):

- Alcohol use (binge drinking)
- Asthma
- Child abuse/neglect reported
- Colorectal cancer
- Coronary heart disease
- Domestic violence
- Drowning
- Female Breast Cancer
- HIV
- Infant mortality
- Sexual Health (condom use)
- Sexually Transmitted Infections
- Suicide
- Tobacco
- Tuberculosis
- Unintended pregnancy

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<sup>1</sup> Washington State Department of Health website. Health of Washington State Report. Accessed November 18, 2013. Available from <http://www.doh.wa.gov/DataandStatisticalReports/HealthofWashingtonStateReport.aspx>.

In 2007 a number of additional chapters were released by the DOH. This data is not updated, but the following health issues were indicating disproportionate impacts on people of color and women prior to 2007:

- Adolescent pregnancy (by race/ethnicity)
- Dental caries and adult tooth loss (by race/ethnicity)
- Diabetes (by race/ethnicity)
- Drug induced deaths (by race/ethnicity)
- Falls among older adults (by sex)
- Fatal occupation injuries (by race/ethnicity)
- First trimester prenatal care (by race/ethnicity)
- Have a personal healthcare provider (by race/ethnicity)
- Homicide deaths (by race/ethnicity)
- Lead poisoning (by race/ethnicity)
- Low birth weight (by race/ethnicity)
- Lung cancer mortality (by race/ethnicity)
- Mental health (by race/ethnicity and sex)
- Motor vehicle deaths (by race/ethnicity)
- Nutrition (by race/ethnicity)
- Obesity (by race/ethnicity)
- Pesticide related illness and injury (by ethnicity)
- Physical activity (by sex for some age groups)
- Poisoning and drug overdose (by race/ethnicity)
- Skin cancer (by sex and by race/ethnicity [highest among whites])
- Stroke (by race/ethnicity and sex for some age groups)
- Traumatic brain injury (by race/ethnicity)
- Youth serious violent crime **arrest** rates (by race)

## **II. Kaiser Family Foundation *Putting Women's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level*<sup>2</sup>**

The Kaiser Family Foundation has calculated disparity indexes for women for a number of health conditions as well as social determinants of health. Researchers calculated the disparity index by comparing the ratio between non-Hispanic white women and women of all other racial/ethnic groups combined. A score of '1' indicates no disparity while a score greater than one indicates worse outcomes for women of color and a score less than one indicates worse outcomes for non-Hispanic white women. Note that because all women of color have been aggregated to calculate this disparity index potential disparities between these racial/ethnic groups may be hidden. For example, this table indicates a disparity index close to one for obesity, but black, AIAN, and Hispanic women have

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<sup>2</sup> Kaiser Family Foundation. *Putting Women's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level*. 2009. Available from <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7886.pdf>.

higher rates of obesity than non-Hispanic white women, but Asian American, and NHOPI women have lower rates thereby decreasing the disparity index.

<b>Table 1. Health Disparities among Women in Washington State</b>	
<b>Indicator</b>	<b>Disparity Index</b>
New AIDS cases	7.12
Women with no high school diploma	2.93
Poverty	1.70
Fair or poor health status	1.66
No health insurance	1.64
Late initiation of or no prenatal care	1.64
No pap in past three years	1.53
Median household income	1.52
Diabetes	1.51
No personal doctor/provider	1.47
Cardiovascular disease	1.42
Low birth weight	1.41
No doctor visit in past year due to cost	1.39
Gender wage gap for women who are full-time year-round workers (compared to non-Hispanic white men*)	1.25
No dental check-up in past two years	1.23
No mammogram in past two years (ages 40-64 years)	1.14
Women in female-headed households with children	1.09
Obesity	1.04
Physical or mental health not good	0.98
Serious psychiatric distress in past year	0.95
No routine check-up in past two years	0.95
Cancer death rate	0.72
Smoking	0.69
*Nationally adult women who worked full time, year round earned 69.2 cents for every dollar earned by a non-Hispanic white man. For every dollar a white man earned, Hispanic and American Indian and Alaska Native female full-time workers earned 50.9 and 56.5 cents, respectively, compared to 73.3 cents for White and 77.4 cents for Asian American, Native Hawaiian, and Other Pacific Islander women.	
Source: Kaiser Family Foundation. <i>Putting Women's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level.</i> 2009. Available from <a href="http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7886.pdf">http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7886.pdf</a> .	

### III. Health and Human Services' Office on Women's Health—Health Disparities Profiles<sup>3</sup>

The Department of Health and Human Services' Office on Women's Health has created health disparities profiles for each state. Washington's profile can be found in Appendix B. They are using 22 health indicators to highlight some of the key areas related to racial/ethnic health disparities (data from year):

#### Major causes of death:

- Chronic obstructive pulmonary disease related deaths (age 45 and over) (2009)
- Colorectal cancer related deaths (2009)
- Coronary heart disease related deaths (2009)
- Diabetes related death (2009)
- Heart disease related deaths (2009)
- Influenza and pneumonia related deaths (2009)
- Lung cancer (related deaths 2009)
- Stroke related deaths (2009)
- Suicide (2009)
- Unintentional injuries related deaths (2009)

#### Health risk factors:

- Diagnosed high blood pressure (2011)
- Eats 5+ fruits and vegetables per day (2009)
- No leisure-time physical activity (2011)
- Obesity (age 20 and over) (2011)

#### Preventative care:

- Cholesterol screening in past 5 years (2011)
- Dental visit within the past year (2010)
- Health insurance coverage (ages 18-64) (2011)
- Routine check-up in past 2 years (2011)

### IV. Region X RHEC<sup>4</sup> Draft Blueprint

Region X RHEC has developed a draft blueprint for addressing health disparities. The draft report does not highlight all health disparities, and one of Region X RHEC's future goals is to conduct an environmental scan of health issues and disparities in the region. The following issues are highlighted in this draft report as having racial/ethnic disparities:

- Education
- Infant mortality rates
- Poverty
- Residential segregation
- Unemployment
- Workforce diversity

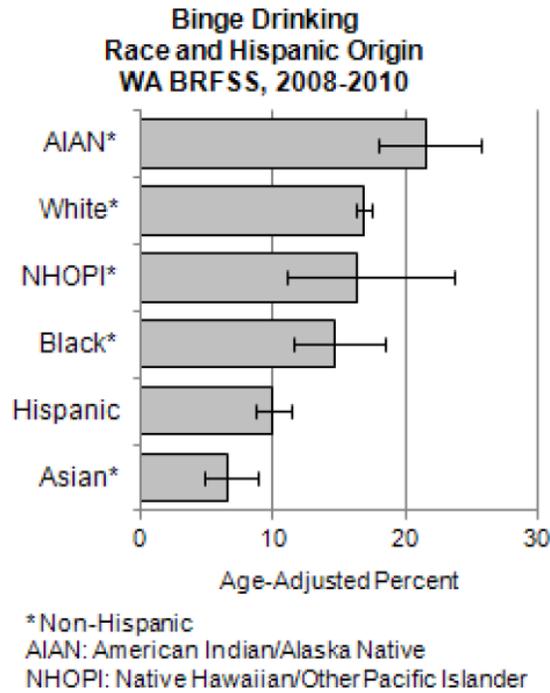
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<sup>3</sup>Health and Human Services' Office on Women's Health website. Health Disparities Profiles. Accessed November 18, 2013. Available from [http://www.healthstatus2020.com/disparities/ChartBookData\\_search.asp](http://www.healthstatus2020.com/disparities/ChartBookData_search.asp).

<sup>4</sup>National Partnership for Action to End Health Disparities. *DRAFT: Region X RHEC Blueprint*. 2013.

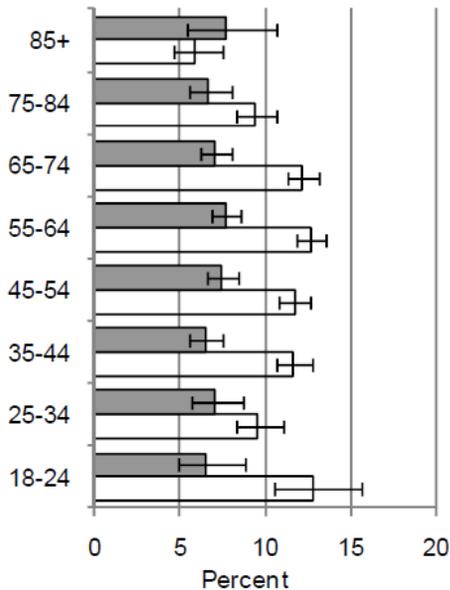
## Appendix A. Health of Washington Report Graphs Depicting Disparities

### Alcohol

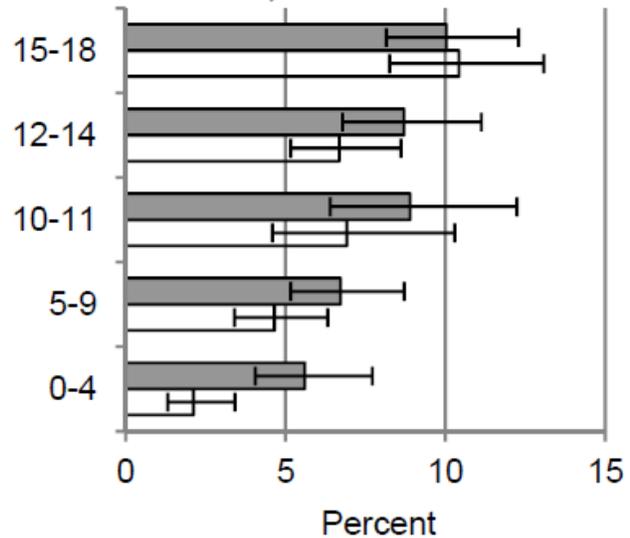


### Asthma

**Adult Asthma  
Age and Gender  
BRFSS, 2008-2010**



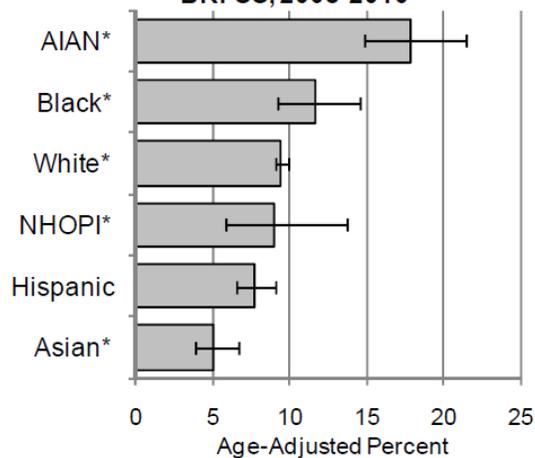
**Child Asthma  
Age and Gender  
BRFSS, 2009-2010**



■ Male □ Female

■ Male □ Female

**Adult Asthma  
Race and Hispanic Origin  
BRFSS, 2008-2010**

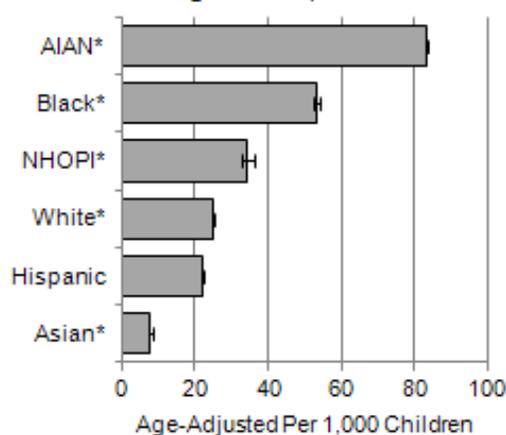


\* Non-Hispanic  
AIAN: American Indian/Alaska Native  
NHOPI: Native Hawaiian/Other Pacific Islander

***Child abuse/neglect***

Note: It is unknown to what extent these differences in CPS referrals are due to variations in income and education, amount of contact with social service agencies, or reporting or screening bias.

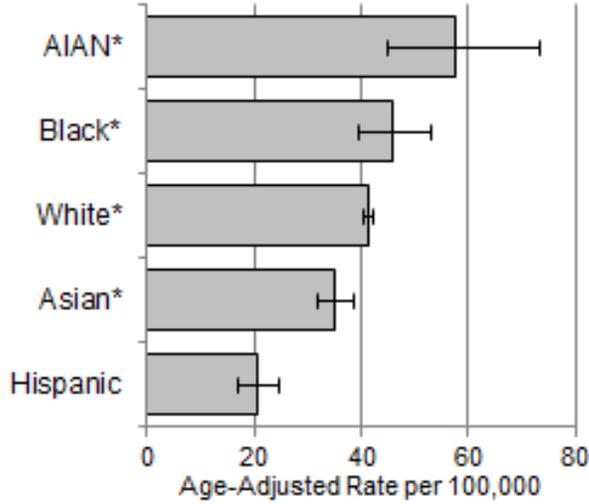
**Children in CPS Accepted Referrals  
Race and Hispanic Origin  
Washington State, 2009-2011**



\* Non-Hispanic  
AIAN: American Indian/Alaska Native  
NHOPI: Native Hawaiian/Other Pacific Islander  
CPS: Child Protective Services

**Colorectal cancer**

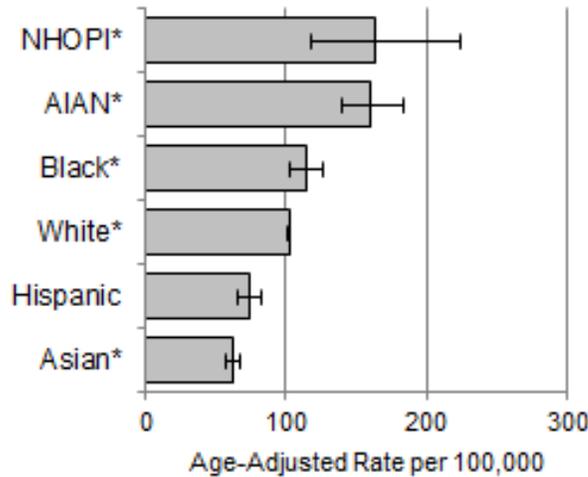
**Colorectal Cancer Incidence  
Race and Hispanic Origin  
Washington State  
Cancer Registry, 2008–2010**



\* Non-Hispanic, single race only  
AIAN: American Indian/Alaska Native  
Native Hawaiian/Other Pacific Islander not shown due to small numbers.

**Coronary heart disease**

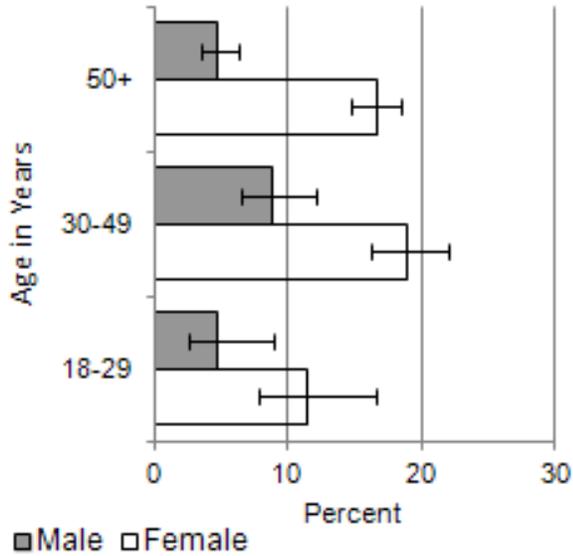
**Coronary Heart Disease Deaths  
Race and Hispanic Origin  
Death Certificates, 2009–2011**



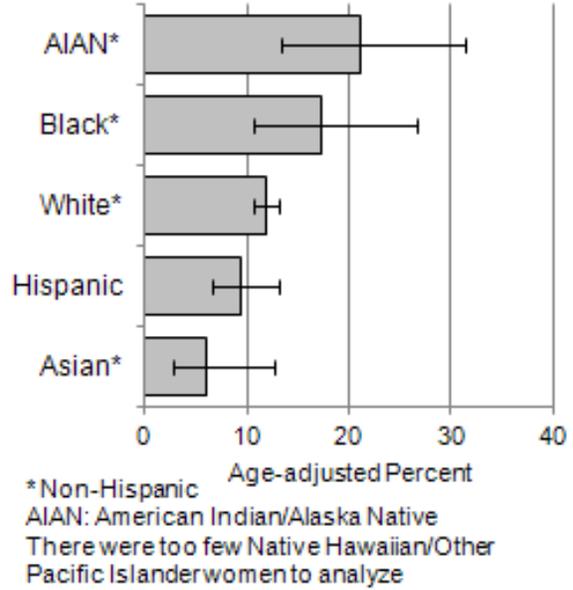
\* Non-Hispanic, single race only  
AIAN: American Indian/Alaska Native  
NHOPi: Native Hawaiian/Other Pacific Islander

**Domestic violence**

**Injured by Partner During Lifetime  
Age and Gender  
Washington State BRFSS, 2011**

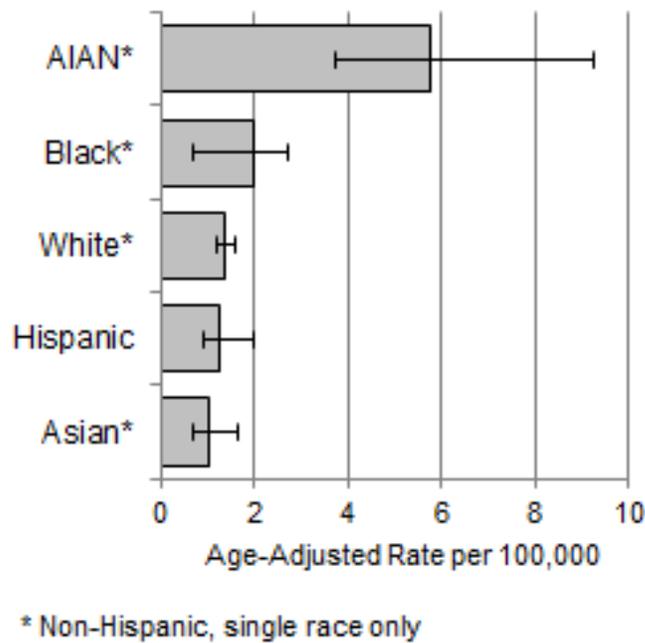


**Injured by Partner During Lifetime  
Race and Hispanic Origin  
Washington State BRFSS, 2011**



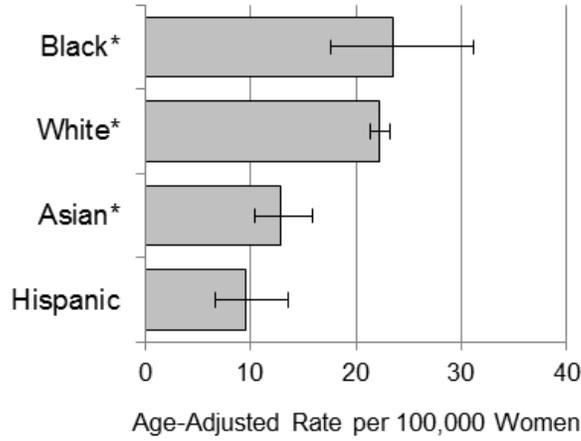
**Drowning**

**Drowning Death Rates by  
Race and Hispanic Origin  
Washington State  
Death Certificates, 2007–2011**



**Female breast cancer**

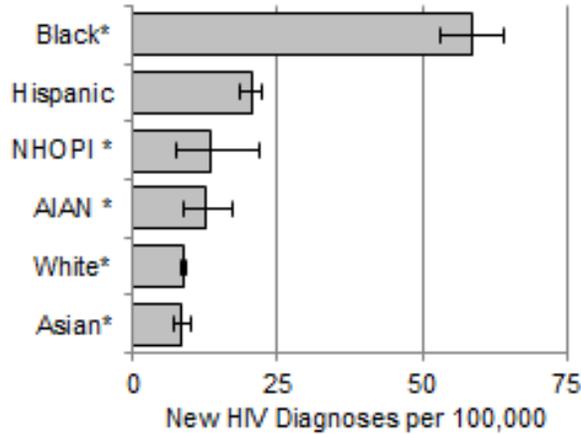
**Female Breast Cancer Mortality  
Race and Hispanic Origin  
Washington State  
Death Certificates, 2009–2011**



\* Non-Hispanic, single race only

**HIV**

**Rates of New HIV Diagnoses  
Race and Hispanic Origin  
eHARS, 2008–2012**

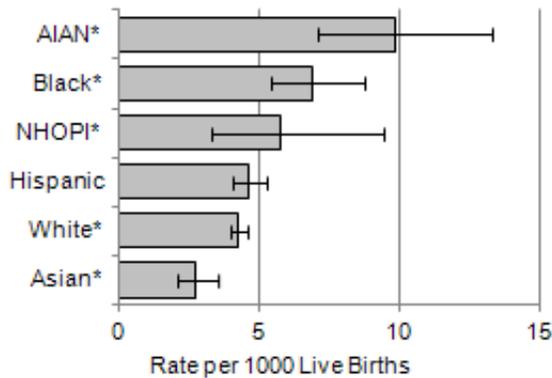


\* Non-Hispanic, single race only  
AIAN: American Indian/Alaska Native  
NHOPI: Native Hawaiian/Other Pacific Islander

### Infant mortality

Note: Washington is seeing an increase in infant mortality rates for babies born to American Indian and Alaska Native mothers. In addition, breastfed infants are less likely to die from any cause in the post-neonatal period. In Washington, the percent of women who breastfeed varies by race and ethnicity.

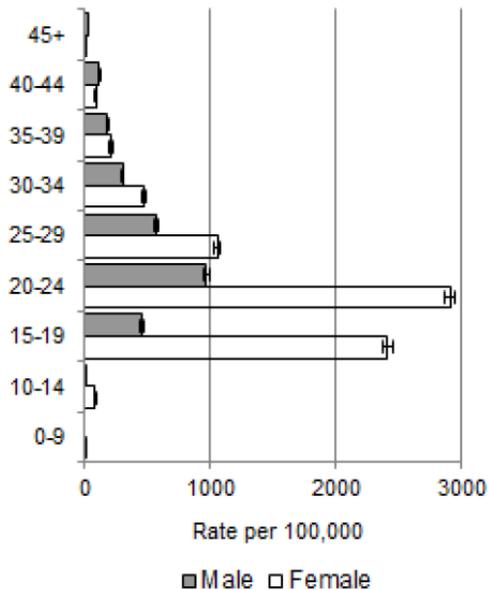
**Infant Mortality  
Race and Hispanic Origin  
Linked Birth Infant Death File, 2009–2011**



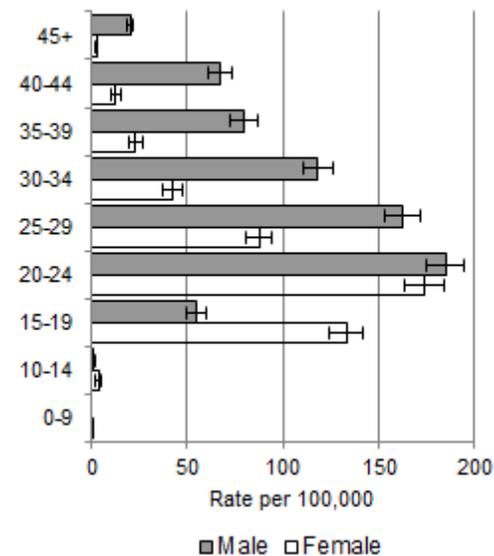
\* Non-Hispanic  
AIAN: American Indian/Alaska Native  
NHOPI: Native Hawaiian/Other Pacific Islander

### Sexually transmitted infections

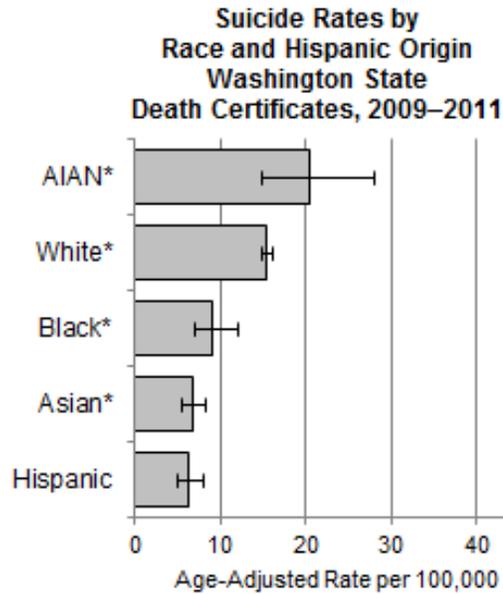
**Chlamydia Incidence  
Age and Gender  
STI Surveillance, 2010–2012**



**Gonorrhea Incidence  
Age and Gender  
STI Surveillance, 2010–2012**

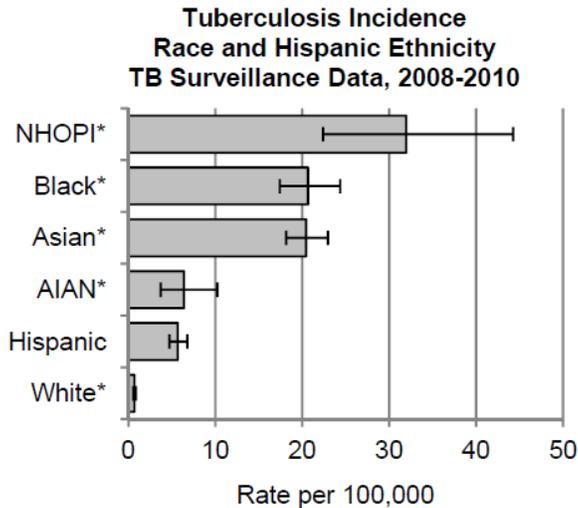


## Suicide



\* Non-Hispanic, single race only  
AIAN: American Indian/Alaska Native  
Native Hawaiian/Other Pacific Islander not included due to unreliable rates due to small numbers.

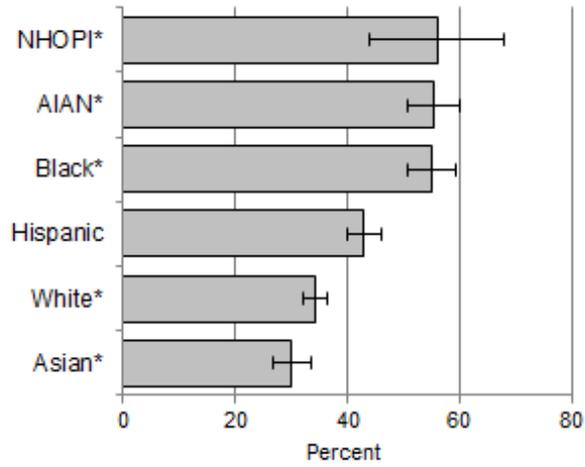
## Tuberculosis



\* Non-Hispanic  
AIAN: American Indian/Alaska Native  
NHOPI: Native Hawaiian/Other Pacific Islander

*Unintended pregnancy*

**Births from Unintended Pregnancy  
Race and Hispanic Origin  
PRAM<sup>†</sup>, 2008–2010**



† Pregnancy Risk Assessment Monitoring Program

\* Non-Hispanic

AIAN: American Indian/Alaska Native

NHOPI: Native Hawaiian/Other Pacific Islander

Source: Washington State Department of Health website. *Health of Washington State Report*. Accessed November 18, 2013. Available from <http://www.doh.wa.gov/DataandStatisticalReports/HealthofWashingtonStateReport.aspx>.

## Appendix B. HHS Office on Women's Health—Washington State Health Disparities

	Non-Hispanic White	Non-Hispanic Black	Hispanic	American Indian/Alaskan Native	Asian/Pacific Islander	State Total	Healthy People 2020 National Target	State Rank
Population (2010) (all ages)	74.6	4.2	11.2	2.2	8.7	<b>6,724,540</b>		
<b>Major causes of death (rate per 100,000)¶</b>								
All cause	728.5	810.4	428.7	849.9	448.7	<b>709.7</b>	+	18
Heart disease	158.3	189.0	93.8	182.5	86.9	<b>154.5</b>	+	13
Coronary heart disease	119.7	135.6	69.0	142.0	67.0	<b>116.6</b>	100.8	26
Total cancer	181.4	192.8	93.4	154.8	115.5	<b>174.9</b>	160.6	29
Colorectal cancer	14.9	12.8	7.2	20.1	9.0	<b>14.4</b>	14.5	13
Lung cancer	49.9	47.0	13.2	36.8	27.0	<b>47.3</b>	45.5	23
Stroke	38.6	49.9	21.7	31.8	38.2	<b>38.7</b>	33.8	21
Chronic obstructive pulmonary diseases (age 45 & over)	131.4	103.3	40.2	116.3	35.1	<b>122.8</b>	98.5	24
Diabetes-related	76.0	140.7	79.9	131.0	72.8	<b>77.8</b>	65.8	36
Influenza and pneumonia	10.9	6.7	11.1	18.1	5.7	<b>10.7</b>	+	4
Unintentional injuries	41.2	35.7	27.8	89.8	18.3	<b>39.5</b>	36	26
Suicide	14.3	9.7	8.2	17.0	8.2	<b>13.4</b>	10.2	31
<b>Health risk factors (percent) §</b>								
Diagnosed high blood pressure (2011)	30.3	42.8	25.0	32.5	29.4	<b>30.2</b>	26.9	25
Obesity (2011) (age 20 & over)	27.3	42.8	32.2	38.0	10.1	<b>27.0</b>	30.6	20
No leisure-time physical activity (2011)	20.2	23.3	36.3	27.4	21.6	<b>21.8</b>	32.6	10
Smoking currently (2011)	18.2	24.8	12.0	32.2	7.4	<b>17.5</b>	12	7
Eats 5+ fruits and vegetables a day	24.9	26.0	20.4	24.7	31.7	<b>25.0</b>	+	18
<b>Preventive care (percent) §</b>								
Cholesterol screening in past 5 yrs. (2011)	71.5	71.2	54.4	65.8	68.2	<b>69.4</b>	82.1	45
Routine check-up in past 2 yrs. (2011)	76.3	80.3	67.6	73.1	79.8	<b>76.0</b>	+	37
Dental visit within the past year (2010)	72.7	66.8	61.1	64.6	71.3	<b>70.7</b>	+	18
<b>Health insurance coverage (percent)</b>								
Health insurance coverage (2011) (ages 18–64)	83.0	70.5	48.1	73.2	81.6	<b>78.7</b>	100	27

¶ Estimate age-adjusted and for all ages unless noted.  
 § Estimate age-adjusted and for 18 years of age and over unless noted.  
 \* Figure does not meet standard of reliability or precision.  
 + No Healthy People 2020 target associated with this health indicator.

NOTE: All data are from 2009 unless noted.  
 NOTE: Low numerical rankings indicate better relative health status.  
 NOTE: State rank includes the 50 states, District of Columbia, Guam, Puerto Rico and Virgin Islands, where data are available and reliable.  
 NOTE: Healthy People targets correspond with the Healthy People 2020 Objectives.

Source: Health and Human Services' Office on Women's Health website. Health Disparities Profiles. Accessed November 18, 2013. Available from [http://www.healthstatus2020.com/disparities/ChartBookData\\_search.asp](http://www.healthstatus2020.com/disparities/ChartBookData_search.asp).

# National Health Disparities

In recent years three main reports proving national level data on health disparities have been released. These have been provided by the CDC, HHS, and AHRQ (an agency within HHS). The health issues highlighted in each report which disparately impact communities of color are outlined below.

## I. CDC *Morbidity and Mortality Weekly Report*

The CDC released a *Health Disparities and Inequalities Report* in 2011<sup>1</sup> and then an updated report in 2013<sup>2</sup> which highlight a number of nation-wide health disparities. The criteria used to select the indicators for both the 2011 and 2013 report are:

- 1.) High-quality national data is available for the indicator.
- 2.) The indicator is a leading cause of premature death, higher disease burden, or lower life expectancy at birth for certain segments of the U.S. population as defined by sex, race/ethnicity, income or education, geography, sexual orientation, and disability status.
- 3.) The indicator is a known determinant of health where disparities have been identified.
- 4.) Effective and feasible interventions exist for the indicator.

The health issues indicated in the reports that disparately impact communities of color include:

- Access to healthier food retailers
- Adolescent births
- Adolescent pregnancy
- Air pollution
- Asthma
- Bring drinking
- Colorectal cancer screening
- Diabetes
- Drug induced deaths
- Education
- Flue vaccination
- Health insurance coverage
- Health-related quality of life
- Heart disease deaths (accounts for the largest proportion of inequality in life expectancy between black and white populations)
- HIV
- Homicide deaths
- Housing
- Hypertension
- Income
- Infant mortality rates

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<sup>1</sup> Centers for Disease Control and Prevention. MMWR: CDC Health Disparities and Inequalities Report—United States, 2011. 2011. Available from <http://www.cdc.gov/mmwr/pdf/other/su6001.pdf>.

<sup>2</sup> Centers for Disease Control and Prevention. MMWR: CDC Health Disparities and Inequalities Report — United States, 2013. 2013. Available from <http://www.cdc.gov/mmwr/pdf/other/su6203.pdf>.

- Motor vehicle crash fatalities
- Obesity
- Overrepresentation in high-risk occupations
- Periodontitis/gum disease
- Pre term births
- Preventable hospitalization
- Reported asthma attacks (among those with asthma)
- Residential proximity to major highways
- Stroke death
- Suicide
- Tobacco
- Tuberculosis
- Unemployment
- Work-related fatal injuries
- Years of life free of activity limitations (YFAL) as a result of chronic condition

## **II. HHS Action Plan to Reduce Racial and Ethnic Health Disparities<sup>3</sup>**

HHS recently released an *Action Plan to Reduce Racial and Ethnic Health Disparities* report. The report focuses primarily on broad goals, but it does highlight a few more specific indicators as well:

- Health care access
- Strength of health and human services infrastructure
- Low birthweight newborns
- Seasonal influenza vaccination rate
- Cigarette use
- Healthy weight

## **III. AHRQ 2012 National Healthcare Disparities Report<sup>4</sup>**

AHRQ's disparity report highlights nationwide racial and socioeconomic disparities in health care delivery. This report concludes that health care quality is suboptimal (particularly for low-income and communities of color) and, although overall quality is improving, disparities are not improving and access is declining. The researchers highlighted cancer care as one disparity that warrants urgent attention. Other indicators with marked differences in quality or access which are statistically significant and negatively impact people of color include:

- Colorectal cancer screening
- Colorectal cancer deaths
- Blood pressure screening
- High blood pressure
- Inpatient mortality rates from heart attack
- Hospitalization rate for congestive heart failure

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<sup>3</sup> Health and Human Services. HHS Action Plan to Reduce Racial and Ethnic Health Disparities. Available from [http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS\\_Plan\\_complete.pdf](http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf).

<sup>4</sup> U.S. Department of Health and Human Services Agency for Healthcare Research and Quality. 2012 National Healthcare Disparities Report. Available from <http://www.ahrq.gov/research/findings/nhqrdr/nhdr12/2012nhdr.pdf>.

- Rates of nephrology care more than 12 months before start of dialysis
- Rates of Arteriovenous Fistula at first dialysis
- Registered on a waiting lists for kidney transplants
- Receive recommended care for diabetes
- Management of diabetes
- Rate of hospital admissions for uncontrolled diabetes
- End stage renal disease due to diabetes
- New AIDS cases
- HIV infection death rates
- Vaccination rates
- Early and adequate prenatal care
- Vision screening
- Well-child visits
- Treatment for depression
- Treatment for drug or alcohol abuse
- Completion of substance abuse treatment
- Patients with pneumonia who received recommended hospital care
- Completion of tuberculosis treatment
- Take daily preventive asthma medicine
- Provider advice to quit smoking
- Provider advice to exercise for obese patients
- Provider advice about healthy eating for obese patients
- Inpatient rehabilitation progress
- Shortness of breath among home health care patients
- Pressure sores in nursing home residents
- Emotional support among hospice patients
- Enough information about what to expect among hospice family caregivers
- End-of-life care consistent with their wishes
- Postoperative sepsis
- Catheter-associated UTIs
- Obstetric trauma
- Adult timeliness of care for injury or illness
- Emergency department wait times
- Hospital patients with heart attack who received timely percutaneous coronary intervention
- Hospital patients with heart attack who received timely fibrinolytic medication
- Poor communication with health providers
- Have usual source of care
- Involvement in making treatment decision
- Hospitalized adult patients with heart failure who were given complete written discharge instructions
- Effective care coordination among children with special health care needs
- Potentially avoidable hospitalizations
- Rates of physicians and surgeons per 100,000 population



# **Racial/Ethnic Disparity Work in Washington**

## **Select Advocacy Organizations, Community Based Organizations, and State Committees**

### ***Summary of Findings***

Below is a list of state organizations doing equity work and the issues that they are working on. This is not a comprehensive list of state organizations but rather a list of organizations identified through the Google search engine using search terms associated with disparities and equity (e.g. 'racial disparities,' 'opportunity gap,' 'inequity'). In addition, SEIU Healthcare 775NW was included as a result of personal communication between a union representative and Council staff. The issues most commonly addressed by the organizations identified through this search method are (frequency):

- Education (7)
- Criminal justice system (6)
- Economic justice (4)
- Healthcare (4)
- Housing (3)
- Immigration (3)
- Structural/institutional racism (3)
- Child welfare system (2)
- Civil rights (2)
- Health equity (2)
- Justice (2)
- Tribal sovereignty (2)

### ***Findings***

- I. Alliance for a Just Society** (formerly the Northwest Federation of Community Organizations)<sup>1</sup>
  - Economic justice
  - Health care
  - Immigration
- II. Casey Family Programs**<sup>2</sup>
  - Racial/ethnic disproportionality in the child-welfare system
- III. Community Organizations in Action** (highlighted the following issues in the *2010 Legislative Report Card on Racial Equity*)<sup>3</sup>:
  - Budget equity

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<sup>1</sup> Alliance for a Just Society website. *Issues*. Accessed November 18, 2013. Available from <http://allianceforajustsociety.org/issues/>.

<sup>2</sup> Casey Family Programs. *An Analysis of Racial/Ethnic Disproportionality and Disparity at the National, State, and Country Levels*. Available from <http://www.cssp.org/publications/child-welfare/alliance/an-analysis-of-racial-ethnic-disproportionality-and-disparity-at-the-national-state-and-county-levels.pdf>.

<sup>3</sup> Community Organizations in Action. *2010 Legislative Report Card on Racial Equity*. Available from [http://nwfco.org/wp-content/uploads/2010/12/2010-1208\\_WA-2010-Leg-Report-Card-Racial-Equity.pdf](http://nwfco.org/wp-content/uploads/2010/12/2010-1208_WA-2010-Leg-Report-Card-Racial-Equity.pdf).

- Civil rights
- Criminal justice
- Economic justice
- Education and youth
- Health equity
- Housing
- Institutional racism
- Tribal sovereignty

#### **IV. Educational Opportunity Gap Oversight and Accountability Committee<sup>4</sup>**

- Opportunity gap (education)

#### **V. Public Defender Association (Racial Disparity Project)<sup>5</sup>**

- Racial inequities in the criminal justice system

#### **VI. Puget Sound Health Alliance<sup>6</sup>**

- Health care

Note: The Puget Sound Health Alliance *Disparities in Care: 2013 Report* outlines inequities in health care in five Washington counties.<sup>7</sup>

#### **VII. Schools out Washington<sup>8</sup>**

- Structural racism among afterschool, youth development, and education programs

#### **VIII. SEIU Healthcare 775NW<sup>9</sup>**

- Criminal justice
- Dream Act
- Voting Rights Act
- Worker protection (for long-term health care workers)

#### **IX. Task Force on Race and the Criminal Justice System<sup>10</sup>**

- Racial inequities in the criminal justice system

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<sup>4</sup> Washington Superintendent of Public Instruction website. Educational Opportunity Gap Oversight and Accountability Committee. Accessed November 18, 2013. Available from <http://www.k12.wa.us/AchievementGap/>.

<sup>5</sup> Public Defender Association. *Racial Disparity Project*. Accessed November 18, 2013. Available from <http://rdp.defender.org/>.

<sup>6</sup> Puget Sound Health Alliance website. Accessed November 18, 2013. Available from <http://www.pugetsoundhealthalliance.org/>.

<sup>7</sup> Puget Sound Health Alliance. *Disparities in Care: 2013 Report*.

<sup>8</sup> School's Out Washington website. Accessed November 18, 2013. Available from <http://www.schoolsoutwashington.org/index.htm>.

<sup>9</sup> Heather Villanueva. Personal communication, November 14, 2013.

<sup>10</sup> University of Washington School of Law website. Task Force on Race and the Criminal Justice System. Accessed November 18, 2013. Available from <http://www.law.washington.edu/about/racetaskforce/default.aspx>.

## **X. Washington CAN<sup>11</sup>**

- Economic justice
- Health care
- Immigrant Rights
- Racial justice
  - Education
  - Health care
  - Housing
  - Income
  - Justice
  - Taxes
- Small business

**In addition, WA CAN compiled the 2012 Legislative Report Card on Racial Equity and addressed the following<sup>12</sup>:**

- Budget and revenue
- Civil rights
- Criminal justice
- Education and youth equity
- Families and workers
- Health equity
- Housing equity
- Immigrant rights
- Institutional racism
- Tribal sovereignty

## **XI. Washington State PTA<sup>13</sup>**

- Opportunity gap (education)

## **XII. Washington State Racial Disproportionality Advisory Committee<sup>14</sup>**

- Racial/ethnic disproportionality in the child-welfare system

## **XIII. Washington Supreme Court's Minority and Justice Commission<sup>15</sup>**

- Racial inequities in the criminal justice system

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<sup>11</sup> Washington Community Action Network website. *Our Issues*. Accessed November 18, 2013. Available from <http://washingtoncan.org/wordpress/our-issues/>.

<sup>12</sup> Washington Community Action Network. Washington: Facing Race 2012 Legislative Report Card on Racial Equity. Available from [http://washingtoncan.org/reports/Facing\\_Race.pdf](http://washingtoncan.org/reports/Facing_Race.pdf).

<sup>13</sup> Washington State PTA. 2013-2014 Legislative Platform. Accessed November 18, 2013. Available from [http://www.wastatepta.org/outreach/translated/Leg/2013\\_legislative\\_issues\\_pamphlet.pdf](http://www.wastatepta.org/outreach/translated/Leg/2013_legislative_issues_pamphlet.pdf).

<sup>14</sup> Department of Social and Health Services website. Children's Administration. Accessed November 18, 2013. Available from <http://www.dshs.wa.gov/ca/about/disproportion.asp>.

<sup>15</sup> Washington State Minority and Justice Commission website. Accessed November 18, 2013. Available from <https://www.courts.wa.gov/index.cfm?fa=home.sub&org=mjc&layout=2>.

## **Acronym Key**

ADSA: Aging and Disability Services Administration

AHRQ: Agency for Healthcare Research and Quality

AIAN: American Indian/Alaska Native

AIDS: Acquired Immune Deficiency Syndrome

BOH: Board of Health

CDC: Centers for Disease Control and Prevention

DEL: Department of Early Learning

DOC: Department of Corrections

DOH: Department of Health

DSHS: Department of Social and Health Services

ESA: Economic Services Administration

HCA: Health Care Authority

HHS: United States Department of Health and Human Services

HIV: Human Immunodeficiency Virus

L&I: Department of Labor and Industries

NHOPI: Native Hawaiian or Other Pacific Islanders

OSPI: Office of Superintendent of Public Instruction

QEC: Quality Education Council

RHEC: Regional Health Equity Council

SEIU: Service Employees International Union

WA CAN: Washington Community Action Network

WDVA: Washington State Department of Veterans Affairs

WSDA: Washington State Department of Agriculture

[0](#)Receive Updates 

## DEL Update - November 2013

Washington State Department of Early Learning sent this bulletin at 11/14/2013 08:35 AM PST

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



### DEL Update | November 2013

#### Director's Note



By DEL Director Dr. Bette Hyde

Gov. Jay Inslee has proclaimed the week of Nov. 18-22 as Parent Education Week. Parents are children's first and most important teachers, so we've built parent engagement into ECEAP, our state-funded preschool program, and Early Achievers, our child care quality rating and improvement system.

DEL's Strengthening Families Washington has a key role in parent engagement in Washington. Strong families are key to creating healthy, resilient environments for children. Strengthening Families Washington focuses on helping families strengthen family bonds, understand childhood development, cope with parenting challenges and develop positive discipline skills.

Strengthening Families Washington connects with community groups that help with parent outreach and engagement efforts. Sometimes, that means awarding grants to local organizations that work to strengthen and support families. In other cases, means helping spread the word about parent education classes

#### In This Issue

- [DEL reports on outcomes for children who attend state's preschool program in 2012-13](#)
- [Early Achievers in nearly every Washington county](#)
- [Verify your education in MERIT, earn some cash!](#)
- [Nominate an Unsung Hero](#)
- [UW P-3 Executive Leadership Institute: Applications open!](#)
- [How does the Affordable Care Act help women, kids?](#)
- [DEL, scientists partner on early education professional development](#)
- [DEL partners with Tribal commission to expand home visiting](#)
- [Tips for managing children's health](#)

in Washington communities. We also work directly with families through our parent advisory group, which tells us how we can better serve parents and caregivers. In February, we will honor parents and other primary caregivers who make a difference for their families and communities with our Unsung Heroes awards. We are [accepting nominations](#) for those awards until Jan. 4, 2014.

Parents and caregivers can find parent education at 20 of the state's 34 community and technical colleges, at churches and community centers, [Head Start and ECEAP centers](#), housing developments, as well as public, private and tribal schools.

Here are some resources to help parents and caregivers find information:

- [Find a list of Washington Community and Technical Colleges.](#)
- Find information about [Strengthening Families Washington.](#)
- [Follow DEL on Facebook.](#)
- [View the press release about Parenting Education Week.](#)

## DEL reports on outcomes for children who attend state's preschool program in 2012-13

The Department of Early Learning (DEL) reported gains in student achievement and the lowest-ever turnover rate for children who attend Early Childhood Education and Assistance Program (ECEAP), Washington's state-funded preschool program.

During the 2012-13 school year, DEL administered ECEAP through 40 contracts with educational service districts, school districts, community colleges, local governments and nonprofits. ECEAP served children in 37 of 39 Washington counties at 269 sites.

In the 2012-13 school year:

- ECEAP had space for 8,391 children. ECEAP served 9,328 children. The ECEAP turnover rate has decreased each year to 11 percent in 2012-13, the lowest in ECEAP's recorded history.
- At its peak in May 2013, the ECEAP waiting list had 1,186 4-year-olds and 1,281 3-year-olds, totaling 2,467 children.
- Approximately 32,322 children in Washington were eligible for ECEAP and were not served by ECEAP or the federal Head Start program. Head Start and ECEAP serve 37 percent of Washington children who are eligible for ECEAP.
- [ECEAP received 9 out of 10 quality points from the National Institute for Early Education Research \(NIEER\)](#) for our state early learning guidelines, comprehensive family and health services, staff professional development requirements, class sizes, staff-to-child ratios, meals and DEL's monitoring of program quality. The 10th quality point would require ECEAP lead teachers to have a bachelor's degree. DEL currently requires an associate or higher degree with 30 quarter credits of early childhood education.

During the 2012-13 school year, ECEAP children progressed from below age level to at or above age level during their time in ECEAP:

## DEL, scientists partner on early education professional development

Starting in late October, the Washington Department of Early Learning (DEL) is piloting a program in partnership with Frontiers of Innovation (FOI), an initiative of the Center on the Developing Child at Harvard University, that will provide professional development about executive function in adults and young children to approximately 70 teachers, child care professionals and practitioners who support children and families.

Since 2011, DEL has been working with FOI to explore how training about executive function for early learning professionals can help young children's development. Executive function is the brain's "air traffic control system" that allows us to manage multiple streams of information at the same time, control impulses and revise tasks as necessary. Acquiring the early building blocks of these skills is critical to school readiness and social development through middle childhood, adolescence, and into early adult life.

"This partnership is very exciting for Washington early learning," said DEL Director Dr. Bette Hyde. "Executive function is the biological foundation for school readiness. Children are not born with these skills, but they are born with the capacity to develop them. It's crucial that we prepare the adults who care for and work with young children to be able to help children develop the skills they need to make good decisions, participate in school, and adapt flexibly to new situations."

Facilitators who lead each training group were selected based on their expertise with adult learners, interest in early brain development and ability to reach their local communities. They are:

- Amber Havens, Educational Training Partners, Thurston/Pierce County
- Kerry Beymer, Encompass Northwest, East King County
- Renee Rinderknecht, GRE Consulting, Spokane
- Maggie Mendoza, ESD 105, Yakima
- Corina McEntire, ESD 112, Vancouver
- Darcie Donegan, Whatcom Community College, Bellingham

<b>Social-emotional development</b>	<b>42%</b>
<b>Physical development</b>	<b>34%</b>
<b>Language development</b>	<b>38%</b>
<b>Cognitive development</b>	<b>40%</b>
<b>Literacy development</b>	<b>44%</b>
<b>Mathematics</b>	<b>56%</b>

[Read the 2012-13 ECEAP Outcomes report.](#)

Starting this school year, ECEAP is expanding thanks to the 2013 state operating budget, which increased the number of slots and the per-slot funding for ECEAP children. This school year, ECEAP added 350 slots; next year ECEAP will add 1,350 slots and increase the per slot-funding for ECEAP. Each subsequent year after 2014, ECEAP will add up to 2,400 slots until 2018-19, when it becomes an entitlement for all Washington children who qualify.

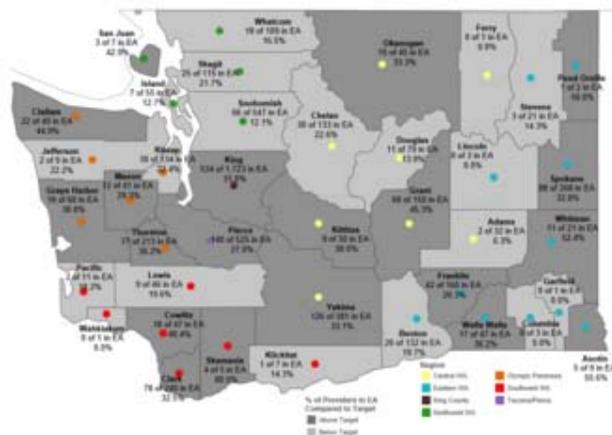
[Read the ECEAP expansion plan.](#)

## Early Achievers in nearly every Washington county

Early Achievers was only launched just over a year ago, but already the reach of this system-wide initiative has been phenomenal. Thanks to the hard work and dedication of the [Child Care Aware](#) teams around the state, and the enthusiasm and commitment to children of Washington's early learning providers, more than 1,700 participants have now enrolled in Early Achievers, serving more than 53,000 children! (See performance tracker below.)

One of the most exciting parts of the strong enrollment data is that Early Achievers is reaching nearly every county in the state. This map shows participation by county as of August 31, 2013.

Read more in the [October Race to the Top-Early Learning Challenge Update](#).



Find out if your child care provider is participating in Early Achievers by searching for them in [Child Care Check](#), DEL's child care licensing information system. The Early Achievers icon is in the upper right corner with the provider's participation status listed, as shown below.

Groups will meet for 15 weeks following a framework designed in partnership with leading executive function researchers from across the nation. Group facilitators will help participants build awareness and knowledge of executive function, and deeply explore how to support executive function in early learning settings. Participants will receive early learning continuing education credit and a certificate of completion from DEL and FOI.

Early learning advocate and Washington Rep. Ruth Kagi said, "Science and research provide the foundation of early learning policy in Washington. Our partnership with the Center on the Developing Child at Harvard is helping Washington find new ways to use the science at the practice and program levels, using innovative strategies to serve children and families more effectively."

Some examples of activities that support the development of executive function in young children include:

- Back-and-forth, "serve-and-return" interaction between young children and adults, in which adults notice and respond to children's efforts to vocalize and engage in playful activities.
- Play in which children are able to take on roles and "play out" a developed scenario that is supported by teachers.
- Structuring a daily schedule that allows time for children to use their developing skills, and allowing children to practice these skills with adult supervision but without adult intrusion.
- Ensuring that early learning settings are arranged so that children have time to work individually with adults who have carefully observed their potential and capacities.
- Creating a safe emotional climate in early learning settings that creates opportunities for children to practice their social skills with each other and with adult support to reduce conflict and promote problem-solving.
- Meditative or mindfulness-based practices for both adults and children.
- Ensuring that children and adults have enough sleep and exercise to support healthy brain development.
- Playing games that allow children to learn rules and then switch them, called cognitive flexibility. A good example is Simon Says.

DEL is partnering with The University of Washington to evaluate the impact of the learning communities and with researchers



## Verify your education in MERIT, earn some cash!

Did you know you can be awarded money for your education? Amounts vary between \$100-\$600 for having your education verified and being placed on the [Washington State Career Lattice](#).

To get started:

- Log into your [MERIT](#) account.
- Complete an Education Application in MERIT (found under the Applications Tab).
- Follow these [Four Easy Steps](#) to complete your education verification.
- Once your education is verified and you are placed on the Career Lattice, complete the Career Lattice/Education Award Application in MERIT (found under the Applications Tab).

Your verified education will become a part of your MERIT professional record.

Once your Career Lattice/Education Award application has been approved, please allow 2-4 weeks for delivery of your award.

Monetary awards have been made available through the [Race to the Top – Early Learning Challenge](#) Grant.

Questions? Contact [merit@del.wa.gov](mailto:merit@del.wa.gov).

## Nominate an Unsung Hero

DEL's Strengthening Families Washington is accepting nominations for its 2014 Unsung Heroes awards. Each February, we honor 28 primary caregivers -- parents, foster parents, adoptive parents, grandparents, guardians -- who are an Unsung Hero to their families or their communities. We will honor each hero with a short bio that will be posted on Seattle's Child website and at a recognition event in late February.

Nominations are due Jan. 4, 2014. Fill out the [nomination form](#) and submit it to us by email, fax or mail.

## UW P-3 Executive Leadership Institute: Applications open!

The University of Washington College of Education is accepting applications for the Washington Certificate in P-3 Executive Leadership. This first-in-the-nation program is designed for PreK-8 principals and early learning directors/program administrators who are working to close achievement gaps by the end of third grade.

The Certificate is intended to build and support a cadre of administrators – in both early learning and elementary education – who are well-equipped to ensure Washington's young children have a high-quality continuum of learning that begins at birth and extends through elementary school.

at the University of Minnesota to collect data about the development of the children who participate in the trainees' early learning environments.

- [View more information about FOI.](#)
- [View more information about executive function.](#)

## DEL partners with Tribal commission to expand home visiting

Early learning partnerships help ensure all Washington children have what they need for school and life success. Through thoughtful partnerships with parents, private organizations, the public sector and others, DEL is setting up a lasting, comprehensive and interconnected early learning system that supports children and parents. Partnerships that connect expertise and goals are particularly powerful.

In 2010, the Washington State Department of Health's (DOH) home visiting statewide needs assessment showed higher health and social risks factors for American Indian/Alaska Native pregnant women than any other racial group in our state. Also in 2010, the American Indian Health Commission's (AIHC) Healthy Communities: A Tribal Maternal-Infant Health Strategic Plan identified maternal and infant health disparities and culturally appropriate strategies to addressing these concerns. Washington's [Early Learning Plan](#), published in 2010, discussed increasing home visiting accessibility for at-risk families, and cited Tribal-state efforts in meeting the objectives laid out in the plan.

DEL is partnering AIHC through the federally funded Maternal, Infant Early Childhood Home Visiting program. AIHC has been working for the past 18 months to engage the 29 federally recognized Indian Tribes and two Urban Indian Health Organizations (UIHOs) in Washington to identify:

- Home visiting services currently provided in Tribal communities.
- Home visiting effectiveness and areas of improvement.
- Gaps and barriers experienced by Tribal families participating in home visiting and early learning services.
- Culturally appropriate strategies to develop the quality and the capacity of Tribal home visiting interventions.
- Funding and leveraging opportunities to support Tribal

The certificate is gained through a year-long, executive style course of study designed for working professionals all across Washington.

There are 25 spaces available for principals and 25 spaces available for early learning administrators. Priority consideration will be given to applications submitted by November 30, 2013. For additional information, please visit the [UW COE website](#).

Questions? Contact Kimberly Kinzer, Program Director, at [kinzek@uw.edu](mailto:kinzek@uw.edu).

## How does the Affordable Care Act help women, kids?

Secretary of Health and Human Services Kathleen Sebelius spent some time explaining how the Affordable Care Act protects women's access to quality health care.

Under the Affordable Care Act, no one can be denied health insurance coverage because of a preexisting health condition, such as breast cancer, pregnancy, or being a victim of domestic violence -- and preventive services including mammograms are now available to women at no additional cost.

[Learn more about the ways the Affordable Care Act helps women get covered.](#)

WITH OBAMACARE, <b>WOMEN STAY HEALTHY &amp; SAVE MONEY</b>	
Insurance companies are now required to cover preventive care with no additional costs or co-pays.	
	OUT OF POCKET COSTS
WELL-WOMAN VISIT	\$0
PAP TEST FOR CERVICAL CANCER	\$0
FDA-APPROVED BIRTH CONTROL	\$0
MAMMOGRAM	\$0

HEALTHCARE.GOV #GETCOVERED

The Affordable Care Act requires many privately run health insurance companies to offer benefits to parents and kids, including:

- 26 free preventive services, such as immunizations; screening tests for conditions like autism, obesity, depression, and hearing problems; iron and other vitamin supplements for kids with deficiencies; drug counseling; and more. Certain uninsured pregnant women also may benefit from preventive services, although this benefit may not fully be in effect until 2014.
- "Essential health benefits" include ambulatory and ER care, hospital stays, maternity and newborn care, mental health and substance abuse services, prescription drug plans, rehabilitative care, and lab work. Dental and vision care is covered until a child reaches age 19.

home visiting infrastructure and services.

Last month, AIHC presented its phase 1 project report [Healthy Communities: Tribal and Urban Indian Maternal Infant Early Childhood Home Visiting](#), a comprehensive exploration of Tribal home visiting services, gaps and barriers, and culturally appropriate next steps.

Recommendations include:

- Engaging in intentional outreach and education with Tribal communities to deepen the understanding of home visiting services and how home visiting connects to healthy, resilient parents and children.
- Continuing to support building culturally appropriate practices in current home visiting programs.
- Exploring home visiting models shown to be effective with Tribal families.
- Identifying opportunities to continue linking Tribal and State driven initiatives.
- What can happen when dedicated partnerships focus on encouraging and supporting parents as their child's first and most important teacher in culturally relevant and accessible ways? Watch for:
- Community development that reflects the wisdom of individual community members.
- Voluntary, family-focused services based on the parent and child's interests and needs.
- Our state's youngest learners entering kindergarten with a solid foundation for school and life success.

DEL looks forward to learning and growing with AIHC and other state partners in this important work.

## Tips for managing children's health

From [USA.gov](#)

Keeping your kids healthy is one of your top priorities as a parent, but it's not always an easy task. Between staying on top of their normal checkups and trying to get them to wash their hands before dinner, there are a lot of things that could slip through the cracks. Use these tips from [USA.gov](#) to make managing your kids' health a little easier.

- Stay up-to-date with your children's immunizations and developmental milestones with an [easy tracking chart you can download for free from Publications.USA.gov](#). It

- Medical, dental, and vision coverage for a child under age 19, even if he or she has a disability or pre-existing medical condition like diabetes or asthma.
- Coverage under a parent's plan until an adult child is 26. Adult children under age 30 who outgrow this service and are uninsured may qualify for what's called "catastrophic insurance" — insurance that helps minimize the cost of medical care for those on limited incomes.

Read more from [kidshealth.org](http://kidshealth.org).

Sources: [whitehouse.gov](http://whitehouse.gov), [kidshealth.org](http://kidshealth.org).

- reminds you of all the necessary immunizations from infancy through age six. It also highlights developmental milestones—like recognizing a caregiver's voice and learning to talk—that you can monitor as your children grow up.
- If you're struggling to pay for health insurance for your kids, they may be eligible for the Children's Health Insurance Program (CHIP). CHIP offers free or low-cost medical coverage for kids up to 19 years old. Coverage for eligible children includes checkups, hospital visits, dental coverage, immunizations and more. Find out if they're eligible at [InsureKidsNow.gov/chip](http://InsureKidsNow.gov/chip).
- Sometimes your kids don't want to listen to mom or dad, but you want them to get information from a trusted source. Point them to the [health resources on Kids.gov](http://healthresourcesonkids.gov), where they can learn about everything from keeping their eyes safe to understanding germs and where they can play fun games that drive home the importance of brushing their teeth or getting their shots.
- Find more [free guides on managing your children's health](http://freeguidesonmanagingyourchildrenshealth) from infant to teen at [Publications.U.S.A.gov](http://Publications.U.S.A.gov).



Questions?  
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This service is provided to you at no charge by [Washington State Department of Early Learning](#).



## 2014 Agency Request Legislation

The Department of Health is considering several agency request bills for the 2014 legislative session. The following three bills would have fiscal impact.

### **Healthiest Next Generation**

The prevention of childhood obesity is a cross-agency and multi-sector issue. The Department of Health, along with the Department of Early Learning and Office of Superintendent of Public Instruction recommend coordination of a comprehensive statewide obesity prevention plan. Areas to be addressed would be impacts of childhood obesity (short and long term health outcomes); healthcare costs; academic achievement in early learning and school settings; and disparities in childhood obesity.

### **Chemical Dependency Professionals Title or Description of Services**

By statute and the Medicaid State Plan, chemical dependency professionals (CDP) and chemical dependency professional trainees (CDPT) are the only credentialed professionals allowed to provide chemical dependency services to individuals presenting in a Department of Social and Health Services (DSHS), Division of Behavioral Health and Recovery (DBHR) certified chemical dependency (CD) treatment agency with concerns regarding their substance use. Since the credential was created, the number of CDPs has remained fairly static.

DSHS has estimated that with the implementation of the Affordable Care Act, 16 percent, or 40,000 of the newly Medicaid eligible individuals, will need some type of chemical dependency service. This will overwhelm the current system. It is anticipated that the state will need over 700 new CDPs, or the equivalent, to provide the needed CD treatment services to these newly eligible individuals.

Legislation would amend RCW 18.205.040 which prohibits the use of the title “certified chemical dependency professional” or “certified chemical dependency professional trainee” when treating patients in settings other than programs approved under chapter 70.96A RCW. The practice limitation would be removed for those who can already provide CD services within their current scope of practice. This would increase the number of providers who can provide services and decrease access to care concerns while maintaining the integrity of the profession.

The intent is that if a provider has only a CDP, CDPT, certified adviser, or certified counselor credential, they would not be able to represent themselves as a CDP outside of an approved agency, under 70.96A.

### **Expanded Function Dental Auxiliary Continuing Education**

RCW 18.23.002 requires the Dental Quality Assurance Commission to regulate the competency and quality of professional health care providers under its jurisdiction. The commission believes continuing education is necessary to assist in patient safety. Currently chapter 18.260 RCW lacks authority to require continuing education for licensed expanded function dental auxiliaries. This bill would add authority to require continuing education for license renewal.



The bills being considered without fiscal impact are:

### **CHARS Patient Data Privacy**

State law direct the department to collect records of hospital patient discharges in Washington through the Comprehensive Hospital Abstract Reporting System (CHARS). The non-confidential CHARS data file does not contain direct patient identifiers. However, the file contains indirect identifiers (e.g. age, sex, race, and zip code) that make it possible to re-identify one or more of the records with additional information from outside sources. Although direct patient identifiers, described as information that is “readily associated” with a person’s identity in RCW 70.02, are exempt from disclosure under the Public Records Act, indirect patient identifiers are not.

The proposed legislation would amend RCW 43.70.052 to seek a Public Records Act exemption for CHARS, with exceptions and appropriate restrictions under which the data may be released. It would also prohibit using CHARS data to identify patients, define direct and indirect patient identifiers, provide the department rule making authority, and define conditions under which the department will release CHARS data. This bill will have no fiscal impact.

### **Demographic Census Response**

RCW 18.71.080 1(b) allows the Medical Quality Assurance Commission to collect demographic information during license renewal on medical doctors and physician assistants for the purposes of facilitating workforce planning. A low response rate of below 50 percent has been received, due to the response being voluntary, therefore making the information inadequate for the purposes of workforce planning and analysis. Current law would be amended to require response from the licensee during renewal. This bill would have no fiscal impact.

### **Flexibility to use the Public Health Supplemental Account (319)**

Currently, receipts deposited into Account 319 cannot be used to pay for permanent FTE. Use of these funds is restricted to project, non-permanent staff. When private funds are limited to non-salary expenses, it adds complication to our budgeting and creates limitations. For example, the Medical Home collaborative had 319 funds that were under spent while scraping together federal funds from multiple sources in small amounts to keep a single project manager FTE to run the program. Since the 319 funds were not used for salaries and benefits, multiple small contributions from federal sources created complicated budget scenarios, which take more time and resources to manage.

### **For More Information**

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## Governor's Interagency Council on Health Disparities 12/11/13 Updates

1. **Health Care Reform** – see attached.
2. **Legislation** – see attached.
3. **[The Raising of America Project](#)** – will reframe how we view early childhood health and development. This documentary series and multimedia initiative by the producers of ***UNNATURAL CAUSES: Is Inequality Making Us Sick?*** explores how a strong start for all our kids leads not only to better individual life course outcomes (learning, earning and physical and mental health) but also to a healthier, safer, better educated and more prosperous and equitable America.
4. **Immunizations** - It is flu season and time for your vaccinations. The flu is unpredictable and can be serious even for healthy people. Click [here](#) to connect with the DOH website for more information on flu vaccines. The more people in our community who are vaccinated, the better chance we all have of avoiding this nasty illness. Yet, our state's annual flu vaccination rate is usually not even 50 percent.

Since 2011, DOH has received two immunization grants. to strengthen delivery systems for childhood and adult immunizations. Current work on both grants has resulted in progress on a variety of immunization policies, such as:

- Increased the number of pharmacy locations using our state Immunization Information System (IIS) to order and track vaccines from 159 to 438.
- Provided training to 574 child care providers on the importance of adult immunization against flu and whooping cough. This course is available for free online beginning in January 2014.
- Distributed information on adult immunization at 63 outreach events in Spanish speaking communities.
- Partnered with the Hep B Coalition of Washington to provide Hepatitis B testing and vaccination for employees at 203 nail salons.
- Developed new immunization brochures (in English and Spanish) regarding adult vaccination to be included in future Child Profile Health Promotion mailings.
- Surveys were conducted with the American Indian Health Commission to determine the knowledge, attitudes and practices of healthcare workers at tribal clinics. Eighty-nine surveys were completed. We will distribute results and analysis to all tribes in the next several months and present at tribal leadership conferences.
- Conducted a cost-benefit analysis with all local health jurisdictions to determine their ability and the feasibility of billing private insurance for the cost of immunization services, followed by a four-part training. As of October 2013, 17 LHJs (34%) now bill private health plans for services they provide.

- Improved healthcare provider vaccine management by enhancing the IIS to support online reporting of monthly immunization inventory. This also includes updating business rules, guidelines, and multiple vaccine storage and handling materials to match new requirements.
5. The Public Employee Benefits Board (PEBB) has added the diabetes prevention program (DPP) as a benefit to all active employees, their adult family members and early retirees. DPP provides support for people with pre-diabetes who are looking to make healthy changes.
  6. The Puget Sound Health Alliance has just released the [Disparities in Care 2013 Report](#).
  7. Centers for Disease Control and Prevention: [Health Disparities and Inequalities Report](#) – United States, 2013.
  8. **DOH change in leadership** – New Chief of Health Equity and new medical director (TBA) and other CHIEF roles (See below)

#### **Department of Health “Chief” Role**

The purpose of the chief role is to appoint a senior leader to address an issue that is critical to improving public health and the organizational health of the Department of Health. Each issue influences the entire agency and our staff.

These agency-wide issues include health equity, climate change, organizational culture and health, succession planning, establishing an academic health department, workplace health and wellness, and return on investment for public health programs. For each issue, the chief has authority, accountability, and responsibility to take actions, such as:

- Developing an action plan with performance measures and benchmarks
- Identifying relevant work already going on in the agency
- Assessing and identifying best practices and tools
- Securing resources
- Serving as an executive sponsor for an agency-wide workgroup or other venue
- Appointing champions from each area to implement agreed upon strategies and actions
- Considering workforce development needs, such as training, staff expectations, recruitment, and retention

- Identifying communication strategies
- Identifying relevant partners and processes for engagement
- Taking into consideration the role of health care reform
- Integrating and aligning this work with other agency-wide efforts

### **Health Equity (New Deputy Secretary for Public Health Operations – Dennis Worsham)**

Health equity is achieved when every person has the opportunity to “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances.” Health disparities or inequities are unfair health differences closely linked with social, economic, or environmental disadvantages that adversely affect groups of people. To successfully address health equity, we must address the root causes, leverage public/private partners, leverage funding, and strengthen our organizational effectiveness in support of health equity.

### **Climate Change (Maryanne Guichard)**

Climate change poses numerous public health risks from allergies and asthma, to harmful algae blooms, to increasing animal-borne diseases. Increasing temperatures can cause injuries and fatalities related to severe weather events and heat waves. Warmer temperatures can increase the risk of foodborne, waterborne, and vectorborne diseases. Increasing droughts and floods pose threats to food and water supplies. We are already seeing some impacts from climate change in Washington like the emergence of new shellfish toxins and West Nile virus as well as increases in forest fires impacting air quality.

### **Organizational Culture and Health (Allene Mares)**

Organizational culture is an agency’s values, vision, norms, working language, systems, beliefs, and habits. It affects the way people and groups interact with each other, with partners, and with stakeholders.<sup>2</sup> An organization is healthy when its management, operations, strategy, and culture fit together and make sense.

### **Succession Planning (Martin Mueller)**

Workforce and succession planning is “a deliberate and systematic effort by an organization to ensure leadership continuity in key positions, retain and develop intellectual and knowledge capital for the future, and encourage individual advancement.”<sup>4</sup> Having such a systematic effort is a smart business move anytime. It’s imperative in today’s climate with large percentages of the workforce nearing retirement (or having already passed retirement but delayed retiring given the Great Recession) with housing and employment numbers improving, and the likely increased mobility of employees wanting new job experiences.

**Academic Health Department (Jennifer Tebaldi)**

An academic health department, or teaching health department, represents a formal affiliation between an academic institution, like the University of Washington, and a public health practice agency, like the Department of Health. It exists to strengthen the link between public health practice and its broad academic base, and is designed to enhance public health education and training, research, and service for both partners.

**Workplace Health and Wellness (Jessica Todorovich)**

A workplace health and wellness program is an agency-wide initiative designed to support healthy behavior and improve health. Wellness programs also include policies intended to facilitate employee health, including providing smoke-free environments, offering healthy food options in vending machines, and holding “walk and talk” meetings. Effective workplace programs, policies, and environments that are health-focused and worker-centered can significantly benefit employers, employees, their families, and communities.

**Return on Investment (Karen Jensen)**

By keeping people healthy, public health investments produce dividends. When we invest in health programs, employers, taxpayers, and communities benefit. We need the ability and tools to clearly demonstrate return on investment for the public health programs we provide.

**Prevention and Community Health Division, Office of Healthy Communities**

**Adult Quality Metrics**

- **One of the goals of the ACA is to improve the quality and efficiency of health care. To support that goal, DOH has a dedicated metrics coach to work with providers through the Washington Healthcare Improvement Network (WHIN) to provide training and technical assistance on using data and measurement to improve the quality of care in their practices.**
  - During this period the metrics coach has provided Technical Assistance and Patient Centered Medical Home Assessment data analysis reports to 18 clinics in our WHIN regional patient-centered medical home collaboratives and to 4 clinics participating in our WHIN Initiative “self-paced” collaborative. The information in the reports helps the clinics understand where they are on the medical home continuum and gives them some ideas of where they may want to focus their quality improvement efforts.
- **DOH encourages providers to select and track measures that align with national initiatives and goals, such as Million Hearts, the US Preventive Service Task Force (USPSTF), CDC, and the American Diabetes Association.**
  - During this period clinics enrolled in the Whatcom regional collaborative have selected 16 measures that align with national initiatives and priorities. Thurston, Mason, Lewis, and Eastern Grays Harbor are just getting started selecting and reporting their measures but already it is looking promising. Of those who have selected their measures there are 18 that align with national initiatives and goals.
  - DOH has created a matrix of quality measures that are being used across the state to measure quality improvement in healthcare.
  - DOH also created a matrix of cross office, as well as cross department metrics work to identify alignment of measures in use across the state. This matrix has been shared with DOH managers and other agencies for input.
- **DOH works with subject matter experts from around the state to create a recommended list of measures for providers to consider, and looks at statewide and local population data to assist providers in selecting measures that best reflect the needs of their patient population.**
  - DOH continues to work with the WHIN coaches to help the clinics choose the measures that best reflect the goals of the practice and meet the needs of the patients.
  - The list of recommended measures now includes breast cancer screening with the recent update by the US Preventive Service Task Force guidelines, as well as recommendations from the American Cancer Society.
  - We were also asked by the CDC Million Hearts program to update the measures section of the Blood Pressure Manual, previously developed by DOH, to reflect the format currently used in our recommended list of measures, which is located in our provider resource handbook.

- **In addition to the WHIN metrics work, DOH partners with DSHS/RDA through the Adult Quality Medicaid Measures Grant. The purpose of this work is to gather and provide feedback to CMS on at least 16 of the 36 CMS core quality measures. DOH's recent focus includes:**
  - **Diabetes measures** - we are currently gathering feedback from the Washington State Diabetes Network on **Diabetes Short-Term Complications Admission Rate; Comprehensive Diabetes Care: LDL-C Screening; and Comprehensive Diabetes Care: Hemoglobin A1c Testing**, as well as some supporting measures such as screening for depression
  - **OB/women's health measures** - we are currently gathering feedback from the Washington Statewide Perinatal Collaborative on **Elective Delivery; Antenatal Steroids; and Postpartum Care Rate, as well as some supporting measures**
  - **Transitional care measures** – where we are working with the Health Care Authority and the Medicaid Managed Care Organizations

### **Breast, Cervical and Colon Health Program**

#### **Procedural changes:**

- New enrollment process clients went into effect October 1st.
- Updated communication materials—web site, program brochure, fact sheets, policies, PC web sites.
- Ongoing partnership with HCA regarding transition phase of the treatment program.
- Working with in-person assister organizations to help clients find insurance.
- Educating clients regarding insurance options.
- Continuing relationships with all of our statewide partners to ensure access to care.

#### **Ongoing Gaps/Concerns:**

##### **Clients might not be able to afford coverage**

- Men and women above 138% FPL may not be able to afford the subsidized plans available through Healthplanfinder.
- These clients may opt to continue screening through the BCCHP, but may have difficulty accessing and affording treatment.

##### **Clients might miss the open enrollment period for subsidized plans (October 1, 2013 - March 31, 2014)**

- If people wait too long to enroll, or are diagnosed through the BCCHP after enrollment closes they will not be able to purchase a subsidized health plan to cover treatment until the next enrollment period (October 1, 2014 through December 31, 2014). BCCHP will assist these clients in finding resources to pay for treatment costs, but treatment resources are not guaranteed.

##### **Newly insured people will face diagnostic and treatment costs**

- Men and women with an income above 138% FPL who purchase a subsidized health plan through Healthplanfinder will have coverage for screenings with no out-of-pocket costs, but diagnostics will be subject to out-of-pocket expenses (deductibles, co-pays, and co-insurance) which may be expensive.
- These same people, if diagnosed with cancer, will be subject to additional out-of-pocket costs for their treatment.

##### **Undocumented clients may face treatment costs**

- Undocumented clients with incomes at or below 138% FPL will be able to access treatment through AEM. Undocumented clients or legal immigrants that have not lived in the US for five years with incomes above 138% FPL are not eligible to apply for subsidized health plans. BCCHP will assist these clients in finding resources to pay for treatment costs, but treatment resources are not guaranteed.

## **Transitions/Mental Health and Substance Abuse**

- In an effort to improve the health of Washingtonians, and in alignment with the ACA goal of **reducing avoidable readmissions and improving the health of patients with chronic disease**, DOH is **working with partners at Health Care Authority, the Washington Medicaid managed care organizations (MCOs), the Washington State Hospital Association(WSHA) and the CHOICE Regional Health Network to improve the transition process from the acute care setting to the community, and to increase routine use of Behavioral Health and Developmental Screening tools in the primary care setting.**
- The five MCOs are, as part of a Transitions Workgroup, facilitated by DOH, working collaboratively toward the goal of improving transitions and reducing readmissions. The group has conducted a literature review, heard from regional leaders, and reviewed the combined Medicaid readmission claims information from their company claims databases. They are currently in the process of initiating a pilot with St. Joseph Medical Center in Tacoma and recruiting a second pilot organization/community for efforts to partner with local healthcare providers to remove barriers to further reduce avoidable readmissions. Indicators of success selected are 1) a provider visit within 7 days of discharge and 2) avoidable readmission rate. Interventions will be customized to the pilot participants and currently include provision of primary care provider of record, and a high risk indicator, as determined by the enrollees health plan. In addition the MCOs have created a quick list of MCO contacts with information on how to contact the Case Management and Customer Service departments for each MCO.
- DOH is also providing consulting expertise to projects in the state related to improving Care Coordination and Transitions that are occurring through Washington State Hospital Association, CHOICE Regional Health Network and others.
- In addition, DOH is partnering with the MCOs to increase the routine use of Behavioral Health screening, Substance Abuse screening, and Developmental screening in the primary care setting by providing regional and online educational opportunities. Three trainings for Adult Behavioral Health Screening and Motivational Interviewing were provided to more than 150 participants at regional locations in October and November. The training included information on Washington Screening and Brief Intervention and Referral to Treatment (SBIRT), and the use of adult behavioral health and substance abuse screening tools (PHQ-9, GAD-7, DAST and Audit). Other partners involved in this work include DSHS Dept of Behavioral Health Resources, the University of Washington, and the Universal Developmental Screening Partnership Committee at DOH. Online opportunities for training in Developmental Screening are now available and additional training modules are anticipated on the Washington Healthcare Improvement Network's (WHIN) Institute. It is free of charge to participating providers and provides Continuing Medical Education credit from the American Academy of Family Physicians upon successful completion of the interactive training modules.

## **Washington Health Care Improvement Network**

**Currently work is occurring in two areas: Whatcom and Thurston, Lewis, Mason and Grays Harbor. In addition, we offer an online pathway for providers to take trainings in a self paced manner.**

### Whatcom Health Home Collaborative:

- **Behavioral health and primary care integration work continues,**
- **Monthly education and regularly scheduled site visits continue with 8 teams representing 19 sites. Topics covered included Treat to target for hypertension, diabetes and depression, Lean flow in ambulatory care, High performance teams and team roles in team based care, and an overview of the Patient-Centered Medical Home with examples from clinics. This week features a webinar on tobacco cessation**
- Lake Whatcom Residential and Treatment Center continues to work on the integration of an ARNP on site to serve their clients with severe and persistent mental illness. The electronic medical record recently purchased for the mental health side of the work lacks some functions needed for primary care and so they are working with the vendor. This is a common struggle and an impediment to full integration and population management measures across the integration; e.g. diabetes care and BMI measures for the mental health clients.
- Also of note is that Lake Whatcom is working on accurate blood pressure measurement and tobacco cessation with their client population and has developed the population measures.
- Mt. Shuskan, a small ARNP family medicine clinic has achieved significant improvement in hypertension control through health coaching calls linked to patient self-monitoring, a top ranked CDC evidence based strategy for Million Hearts.
- Lake Whatcom is also a care coordination provider under the new Health Home networks for Medicaid and has completed the initial training.

### Thurston/Mason/ Lewis/Eastern Grays Harbor Medical/Health Home Collaborative:

- **17 of 18 clinics have received initial site visits, with the 18th scheduled for 11/22.**
- **All 18 teams are in the process of selecting their three clinical measures for monthly reporting.**
- **Monthly education to date has focused on quality improvement plan-do-study-act cycles, the use of health information technology for quality improvement in medical homes, and next is a workshop on transitions between hospitals and primary care, with hospitals sending staff to engage in dialogue with the primary care practices.**
- Themes that have come up related to the ACA during site visits: concerns about Medicaid payments not covering costs and slowness to pay claims, questions about payment reforms, frustrations and challenges with electronic medical records related to population management functions and reports, excitement about opportunities to learn from other teams, and most have expressed pride in the care they deliver and are eager to master outcome measures so they can prove that they are ready for a climate of pay for performance on quality measures.
- The clinic integrating behavioral health and primary care, a collaboration of Behavioral Health Services and Valley View Community Health Center will open to patients in Olympia on December 16.

### WHIN Institute-Statewide Pathway

- Ten critical access hospital rural primary care clinics in NE WA are enrolled and have participated in 2 webinars on the NCQA “Must Pass” Elements for Medical Home Recognition. These are talk show style webinars that use clinic examples.
- **New e-learning modules uploaded to the site include Developmental Screening, Clinical Preventive Services and Family Health Histories. Quality 101 is nearing completion and a tobacco cessation module is nearing production stage. The total number of completed modules with CME is now 28.**
- **With staffing stabilized and both regions now started fully, we will begin marketing the statewide platform with a series of strategies.**

## Health System Quality Assurance

Community Based Para medicine Program: (briefing paper attached)

The physician Medical Program Directors (MPD's) in Washington State formed an ad hoc work group to address the **Community Based Para Medicine concept** in Washington State. The goal of this group is to provide the Department of Health with a general recommendation about the feasibility, level of complexity and role of community based paramedic programs in Washington State. Currently, all certified EMS providers in Washington State practice based on the clinical oversight provided by the MPD. They must also follow the MPD's approved patient care protocols. Expanding the role of the EMS provider will require oversight by a supervising physician.

The MPD ad hoc work group will provide the Department with a recommendation based upon their discussions about:

- The additional education that would be required to implement CBPM.
- The appropriate scope of practice for a CBPM program.
- What environment may be appropriate for CBPM programs (e.g., rural settings, rural hospitals, clinics, urban settings, etc.)?
- Identification or development of a community assessment tool that can be used to identify the need for a CBPM program.
- What laws and rules may need to be revised to allow CBPM programs in the State?
- What might be the role of the MPD in overseeing CBPM programs?
- How does CBPM impact current defend and hold harmless language that exists for the MPD and certified EMS providers?

### Rural Health Work Group (charter attached)

- The Department of Health (DOH) and Washington State Hospital Association (WSHA) met at their annual retreat in September 2013. They determined there was a strong need for a proposal on how health care in rural communities could change to better meet the needs of each community and respond to healthcare reform.
- This proposal would include new models of care delivery, particularly for hospitals, and cover the continuum of care from prevention and wellness to acute care and long term care to support aging in place. New payment methods could be suggested. Secretary of Health John Wiesman and WSHA CEO Scott Bond charged staff in both organizations with convening a workgroup to develop the proposal.
- The purpose of the workgroup is to develop recommendations for a new rural community health system model that meets the needs of individual communities and the goals of healthcare reform and the Triple Aim. The recommendations could include new models of care delivery and cover the continuum of care from prevention and wellness to acute care and long term care to support health across the lifespan

**Issue: Community Based Paramedicine**

**Prepared By: Office of Community Health Systems, EMS and Trauma Section**

### Overview

Community Based Paramedicine (CBPM) is a concept that uses Emergency Medical Services (EMS) personnel to bridge identified gaps in health care resources. CBPM programs do not replace existing health care resources or providers.

Models of CBPM vary and are based upon a community's health care resource needs. The reasons for development of CBPM programs include:

- Projected short fall of certain health care professionals.
- The Patient Protection and Affordable Care Act.
- Repetitive/chronic users of the 9-1-1 emergency care system.
- Emergency Department (E.D.) overcrowding.
- Unnecessary hospital re-admission.
- Low acuity/chronically ill people using EMS as the primary health care resource.

CBPM programs are found throughout the world. Australia and Great Britain have well established CBPM programs. In the United States, CBPM programs are functioning in 46 states. A recently completed survey of CBPM programs operating in the United States reveals:

- There are 231 different programs operating in 46 states.
- The states with the most programs include Texas, Indiana, Illinois, Virginia and North Carolina.
- CBPM programs are relatively evenly distributed among urban, suburban and rural settings.
- The survey respondents identified that CBPM programs were started based on identified gaps found during community health assessments.
- CBPM program models include:
  - Programs that focus on hospital readmission avoidance;
  - Programs that reduce or eliminate frequent, repetitive use of EMS;
  - Primary care/physician extender models;
  - Referral to alternate destination (vs. hospital E.D.) after performing a patient assessment;
  - 9-1-1 Nurse Triage models.

### **Current Status in Washington State**

There are several programs that fall under the broad category of Community Based Paramedicine in Washington State. A partial list of current programs that are in place in the State include:

- The "FD CARES" program operated by the Kent Regional Fire Authority in King County. ([www.FDCARES.com](http://www.FDCARES.com))
- A pilot project that is currently operating in Prosser, WA. This program is run by Prosser Memorial Hospital and the hospital's EMS operation.
- Other FD CARES programs in Snohomish and Spokane County.
- Several proposed pilot projects in conjunction with the second round of CMS Innovations grants. This round seeks to identify innovative models of reimbursement for non-traditional EMS services (i.e., patient destination other than hospital E.D., capitated payment models, models that demonstrate efficacy of patient centered destination decisions vs. reimbursement for hospital ED destination).

Each of these programs currently operates within the scope of practice for EMS personnel that is defined in Washington statute and rule.

The physician Medical Program Directors (MPD's) in Washington State formed an ad hoc work group to address the CBPM concept in Washington State. The goal of this group is to provide the Department of Health with a general recommendation about the feasibility, level of complexity and role of community based paramedic programs in Washington State. Currently, all certified EMS providers in Washington State practice based on the clinical oversight provided by the MPD. They must also follow the MPD's approved patient care protocols. Expanding the role of the EMS provider will require oversight by a supervising physician. The MPD ad hoc work group will provide the Department with a recommendation based upon their discussions about:

- The additional education that would be required to implement CBPM.
- The appropriate scope of practice for a CBPM program.

- What environment may be appropriate for CBPM programs (e.g., rural settings, rural hospitals, clinics, urban settings, etc.)?
- Identification or development of a community assessment tool that can be used to identify the need for a CBPM program.
- What laws and rules may need to be revised to allow CBPM programs in the State?
- What might be the role of the MPD in overseeing CBPM programs?
- How does CBPM impact current defend and hold harmless language that exists for the MPD and certified EMS providers?

### **Conclusion**

Success in establishing CBPM programs in the State requires a thoughtful and deliberative approach. Key issues for consideration include:

- What are the legal and regulatory implications for CBPM programs?
- How is current statute regarding defend and hold harmless language for MPD's, hospitals and EMS personnel maintained in the CBPM environment?
- Identifying an appropriate, reliable community assessment tool. The tool should identify gaps in the health care system that might be addressed by a CBPM program.
- Collaboration with other health care provider groups (MD, RN, PA, Home Health Care, etc.) to eliminate perceptions of role and scope infringement by CBPM programs.
- Creating CBPM programs that are economically sustainable. Current reimbursement for EMS is fee for service and requires patients to be transported to hospitals or nursing homes.
- How is oversight of CBPM programs provided and by whom?