



Final Agenda

Wednesday • May 13, 2015

9:30 a.m. – 4:00 p.m.

South Seattle Community College

Georgetown Campus

C-122 Multi-Purpose Room

6737 Corson Avenue South, Seattle, 98108

- 9:30 a.m. CALL TO ORDER & INTRODUCTIONS** Emma Medicine White Crow, Council Chair
- 9:35 a.m.** 1. Approval of Agenda Emma Medicine White Crow, Council Chair
—Action
- 9:40 a.m.** 2. Approval of February 11, 2015 Minutes Emma Medicine White Crow, Council Chair
—Action
- 9:45 a.m.** 3. Announcements and Council Business Christy Hoff, Council Staff
- 9:55 a.m.** 4. Briefing—Health Disparities Data Emma Medicine White Crow, Council Chair
Gail Brandt, Council Member
Dennis McDermot, Department of Health
Cathy Wasserman, Department of Health
- 11:15 a.m.** 5. Public Comment
- 11:50 p.m. LUNCH**
- 12:50 p.m.** 6. Adverse Birth Outcomes Emma Medicine White Crow, Council Chair
Recommendations Christy Hoff, Council Staff
—Possible Action Devon Love, Center for MultiCultural
Health
Shelly Means, Native American Women's
Dialogue on Infant Mortality
Heather Weiher, Health Care Authority
- 1:30 p.m.** 7. Guidance for Promoting Equity in State Emma Medicine White Crow, Council Chair
Policies and Programs Sierra Rotakhina, Council Staff
—Possible Action
- 2:10 p.m. BREAK**
- 2:20 p.m.** 8. Review Action Plan Update Emma Medicine White Crow, Council Chair
—Possible Action Christy Hoff, Council Staff
- 2:50 p.m.** 9. Update—Health Impact Reviews Sierra Rotakhina, Council Staff
- 3:20 p.m.** 10. Update—CLAS Project Yris Lance, Council Staff
Katie Meehan, Department of Health
- 3:40 p.m.** 11. Council Member Announcements Emma Medicine White Crow, Council Chair
- 4:00 p.m. ADJOURNMENT**

PLEASE NOTE: Times above are estimates only. The Council reserves the right to alter the order of the agenda. For information regarding testimony, handouts, other questions, or for people needing special accommodation, please contact Melanie Hisaw at the Board office at (360) 236-4104 by May 8, 2015. This meeting site is barrier free. Emergency contact number during the meeting is (360) 701-2398.

P.O. Box 47990 • Olympia, Washington • 98504-7990

Phone: 360/236-4110 • Fax: 360/236-4088 • Email: healthequity@sboh.wa.gov • Web: healthequity.wa.gov



Draft Minutes of the Governor's Interagency Council on Health Disparities
February 11, 2015
Department of Health, Point Plaza East, Rooms 152/153
310 Israel Road S.E., Tumwater, WA 98501

HDC members present:

Marietta Bobba	Frankie Manning, Council Vice Chair
Vazaskia Caldwell	Gwendolyn Shepherd
Sarah Franklin	Jan Olmstead
Mona Johnson	Millie Piazza
Diane Klontz	Greg Williamson

HDC members participating by phone:

Kim Eads	Nora Coronado
----------	---------------

HDC members absent:

Sofia Aragon	Stephen Kutz
Gail Brandt	Emma Medicine White Crow
Nova Gattman	

HDC Staff present:

Timothy Grisham, Communications Consultant	Melanie Hisaw, Executive Assistant
Christy Hoff, Health Policy Analyst	

Guests and Other Participants:

Sharon Eloranta, Qualis Health	Cathy Wasserman, Department of Health
Vickie Bouvier, Department of Health	Lilia Lopez, Office of the Attorney General
Karen Jensen, Department of Health	Jamie Judkins, Shoalwater Bay Tribe
Frances Limtiaco, Department of Health	Maria Gardipee, Department of Health

Frankie Manning, Council Vice Chair, called the public meeting to order at 9:02a.m. and read from a prepared statement (on file).

1. APPROVAL OF AGENDA

Motion: Approve February 11, 2015 agenda

Motion/Second: Diane Klontz/Vazaskia Caldwell. Approved unanimously.

2. ADOPTION OF DECEMBER 11, 2014 MEETING MINUTES

Motion: Approve December 11, 2014 minutes

Motion/Second: Greg Williamson/Marietta Bobba. Approved unanimously.

3. ANNOUNCEMENTS AND COUNCIL BUSINESS

Christy Curwick Hoff, Council Staff, shared that the State Board of Health hired two part-time employees for four-month projects—Mike Glass is assisting the Board with its newborn screening projects and Kelly Gilmore is assisting with Health Impact Reviews. She said that Timothy Grisham

accepted a position as the Communications Director for the Washington Association of County Officials. Ms. Hoff thanked Mr. Grisham for his valuable work creating the Council logo, updating the Web site, and developing a social media presence. Vice Chair Manning thanked Mr. Grisham for all his assistance. Ms. Hoff welcomed Sara Franklin, Council Member, representing the Commission on African American Affairs. Member Franklin shared information about her experience and interests and said she was honored to serve on the Council and continue the work that her mother, Senator Rosa Franklin, created. Council members welcomed Member Franklin to the Council.

Ms. Hoff referred Council members to a letter of support provided to the University of Washington for its proposal to create a Center of Excellence on Latina Environmental Health Disparities (on file at Tab 3). She also provided an update on bills the Council was tracking because they aligned with past Council recommendations or they made changes to Council authority. Council members shared information on other bills of potential interest as they relate to health equity. Ms. Hoff provided a brief update on health impact reviews completed so far during the session—HB 1295 concerning breakfast after the bell programs and HB 1671 concerning increasing access to opioid antagonists. She said they were currently working on a review of HB 1449 related to oil transportation safety.

4. OPEN PUBLIC MEETINGS ACT TRAINING

Vice Chair Manning referred Council members to the memo under Tab 4. She said the Council is subject to the Open Public Meetings Act (OPMA) and there are new requirements for members to receive training at least once every four years. She introduced Lilia Lopez, Office of the Attorney General. Ms. Lopez said that the OPMA is one of the state's transparency laws along with the public disclosure law and went through her presentation (on file at Tab 4). Members discussed how it was likely unfeasible to have an open public meeting via email. They also discussed advisory committees and how, depending on the work, those meetings can be subject to the OPMA.

5. BRIEFING-ANENCEPHALY CLUSTER INVESTIGATION

Vice Chair Manning said that during the last few years a few counties in central Washington have been experiencing a higher than expected rate of anencephaly, which is a serious birth defect that affects the development of a baby's brain and skull. She said that Council Member, Nora Coronado, has been participating on an advisory committee, which is providing guidance to the Department of Health as it investigates the cluster. She introduced Cathy Wasserman, State Epidemiologist for Non-Infectious Conductions at the Department of Health. Dr. Wasserman gave her presentation (on file at Tab 5), which highlighted findings from the Department's initial case-control study, its advisory committee, prevention strategies, and plans for additional study. Member Franklin asked how much it costs to test private wells. Dr. Wasserman said she is aware of pilot studies and other efforts to develop less expensive screening tests. She said she would get back to the Council with additional information. Diane Klontz, Council Member, offered to help disseminate some of the outreach messages through the Department of Commerce's programs in the area. Millie Piazza, Council Member, said the clean drinking water act does not cover private wells. She added that in addition to cost being a potential barrier, some farmworker families face additional barriers to having their water tested. Vice Chair Manning asked if there was much mobility within the three county area. Dr. Wasserman said they have been trying to follow up with cases for their current investigation and are finding that people have moved out of the area.

6. BRIEFING-PULLING TOGETHER FOR WELLNESS

Vice Chair Manning said the American Indian Health Commission's Pulling Together for Wellness framework was designed to reduce chronic disease among American Indians and Alaska Natives and address health across the lifespan. Jan Olmstead, Council Member, introduced herself and gave her

presentation (on file at Tab 6). She emphasized that at the last Tribal Health Leaders' Summit, health leaders asked that state agencies incorporate the framework into their related programs. She asked that Council members consider if their agencies had ongoing activities that could benefit from incorporating the framework and offered to bring this presentation to other agencies. Member Olmstead provided an overview of the project, highlighted data on health disparities experienced by American Indian and Alaska Native (AI/AN) populations, described the process taken to develop the framework, and provided examples of strategies in the healthy communities matrix. Vazaskia Caldwell, Council Member, asked if there were strategies to obtain better data on health disparities for the AI/AN populations. Member Olmstead said it was an important and ongoing conversation. Greg Williamson, Council Member, said there is a need to build capacity within state agencies, adding that the government-to-government training is very good.

Jamie Judkins, Grant Program Coordinator, Shoalwater Bay Tribe, said the Shoalwater Bay is a small Tribe that has experienced disparities in birth outcomes. She provided information on their Pulling Together for Wellness Multi-Sector Team, highlighting that it has a tremendous amount of diversity. She shared the results of their community survey, which identified many important priorities for the health of the Tribe. She said they shared the results during a community dinner.

Frances Limtiaco, Tobacco Prevention and Health Equity Consultant, Department of Health, shared what the framework means from the perspective of a state program working with Tribal community partners. She said the tobacco program has a long history of working with Tribes. She said that despite the work in Tribal communities, disparities persisted. She shared some tips on how to define and cultivate their partnerships with Tribes (on file in the presentation at Tab 6). Vice Chair Manning said that the concepts could be applied with many different communities. Member Franklin asked how youth are engaged in the conversations. Member Olmstead said that youth will have a seat on their advisory committee. Vice Chair Manning reflected on how important it is to remember the sovereignty of Tribes.

The Council recessed for break at 11:00a.m. and reconvened at 11:10a.m.

7. PUBLIC COMMENT

No members of the public provided testimony at the meeting.

8. UPDATE-ADVERSE BIRTH OUTCOMES ADVISORY COMMITTEE

Vice Chair Manning referred members to the memo at Tab 8 and asked Ms. Hoff to provide the update. Ms. Hoff said they are convening the adverse birth outcomes committee tomorrow (February 12, 2015). She said they have six meetings scheduled between February and April and the meetings will rotate between Seattle and Olympia. She referred members to the committee roster (on file at Tab 8). She said the committee currently has representatives from the Department of Health, Health Care Authority, and Department of Early Learning but that if the committee identifies areas of focus that impact other agencies, she would reach out to those Council members for guidance. She acknowledged Kelly Gilmore, who has started to pull articles on evidence-based and promising practices to inform the committee's work.

9. COUNCIL MEMBER COMMENTS

Member Caldwell said the state received the innovation plan grant for \$65 million. She said they have awarded pilot and design grants. They are having a kick off on February 27 from 9-10 am via webinar. Mona Johnson, Council Member, asked for additional info on the webinar—Ms. Hoff will send out the information to all members. Member Caldwell said she is excited about the adverse

birth outcomes committee, adding that the Health Care Authority is working with their managed care plans on an effort to reduce adverse birth outcomes and she will work to ensure alignment.

Member Williamson provided information on a research study looking at disproportionate outcomes for the Hispanic/Latino population.

Marietta Bobba, Council Member, said that the Department of Social and Health Services and the Health Care Authority are about to finalize contracts with two tribes to pilot test health home services

Gwendolyn Shepherd, Council Member, said that in role with the NAACP and the National Association of Colored Women's Clubs, she is working with the Agency for Healthcare Research and Quality on a grant application related to readiness and preparedness. They are planning a train-the-trainer project for retired community members who are underutilized. She said they have some grant writers that they are working with.

Member Johnson shared that HB 1760 related to providing students with skills that promote mental health and well-being and increase academic performance may be of interest to Council members.

Vice Chair Manning asked members to introduce themselves and their work to Member Franklin. She thanked Timothy Grisham again for all his assistance and helping to get the Council caught up with technology.

ADJOURNMENT

Vice Chair Manning adjourned the meeting at 12:04 p.m.



STATE OF WASHINGTON
GOVERNOR'S INTERAGENCY COUNCIL ON HEALTH DISPARITIES

Washington State Board of Health

PO Box 47990 • Olympia, Washington 98504-7990

March 3, 2015

Seattle Human Services Department
Aging and Disability Services
700 5th Ave., 58th Floor
Seattle, WA 98104-5017

Attn: Angela Miyamoto, RFP Coordinator

The Governor's Interagency Council on Health Disparities strongly supports the Chinese Information and Service Center's application for the 2015 Community Living Connection-Aging and Disability Resource Network (CLC-ADRC) grant opportunity. Since 1972, the Chinese Information and Service Center (CISC) has enjoyed an excellent reputation as the leading provider of linguistically and culturally appropriate social services to the Seattle and King County area Asian American community. CISC provides a wide range of programs that serve immigrant families, youth, children and—most notably—elderly and disabled populations.

CISC's comprehensive approach to service delivery and outreach, the agency's experience working with Seattle and King County Asian American elderly, and the commitment of its staff demonstrate that CISC can provide the highest quality of service to the underserved populations that will be supported with this grant funding.

The Governor's Interagency Council on Health Disparities develops recommendations to eliminate health disparities by race/ethnicity and gender. The Council recognizes that the social services CISC provides have a direct positive impact on the health of the community and therefore assist in promoting health equity. We strongly support CISC's efforts to help senior citizens and those with disabilities get the care and support they need to lead healthy and productive lives.

Sincerely,

Emma Medicine White Crow, Chair
Governor's Interagency Council on Health Disparities



STATE OF WASHINGTON
GOVERNOR'S INTERAGENCY COUNCIL ON HEALTH DISPARITIES

Washington State Board of Health

PO Box 47990 • Olympia, Washington 98504-7990

March 3, 2015

Seattle Human Services Department
Aging and Disability Services
700 5th Ave., 58th Floor
Seattle, WA 98104-5017

Attn: Angela Miyamoto, RFP Coordinator

The Governor's Interagency Council on Health Disparities strongly supports the Chinese Information and Service Center's (CISC) funding application for the 2015 Family Caregiver Support Program.

CISC has a record of supporting unpaid family caregivers through information and education, personal support, and direct assistance. The comprehensive support CISC provides family caregivers enables them to continue in their roles while promoting the quality of life for both caregivers and care recipients. CISC's wraparound approach to service delivery, its expertise in working with at-risk populations, and its staff commitment demonstrate that CISC can successfully promote the Family Caregiver Support Program.

The Governor's Interagency Council on Health Disparities develops recommendations to eliminate health disparities by race/ethnicity and gender. The Council recognizes that the health and social services CISC provides have a direct positive impact on the health of the community and therefore assist in promoting health equity. We strongly support CISC's application and hope they can continue the good work they are doing in the community to support family caregivers and care recipients.

Sincerely,

Emma R. Medicine White Crow

Emma Medicine White Crow, Chair
Governor's Interagency Council on Health Disparities



STATE OF WASHINGTON
GOVERNOR'S INTERAGENCY COUNCIL ON HEALTH DISPARITIES

Washington State Board of Health

PO Box 47990 • Olympia, Washington 98504-7990

Attorney General's Office
Consumer Protection Division
Grant Review Committee
800 5th Avenue, Suite 2000
Seattle WA 9814-3188

Dear Grant Review Committee,

The Governor's Interagency Council on Health Disparities is pleased to provide a letter in support of the Asia Pacific Cultural Center (APCC) and its new project, the Immigration Fraud Awareness Program. This program will assist help Asian and Pacific Islander immigrants who are most vulnerable to deceptive and manipulative immigration practices. Through proactive outreach and culturally sensitive workshops, this program can help prevent people from being victims of immigration fraud. APCC's position in the community and their cultural awareness make them a trusted community partner that can reach many Asian and Pacific Islander immigrants who can benefit from this program.

The Governor's Interagency Council on Health Disparities is charged with developing recommendations to eliminate health disparities by race/ethnicity and gender. The Council recognizes that many social and environmental factors have a strong influence on health of communities. Preventing immigration fraud can have positive safety, security, economic, and health benefits for affected communities.

We ask you to consider supporting the APCC's Immigration Fraud Awareness Program as an investment in the lives of those in the Asia Pacific community in Washington State.

Sincerely,

Emma R. Medicine White Crow

Emma Medicine White Crow, Chair
Governor's Interagency Council on Health Disparities



DATE: May 13, 2015

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

FROM: Emma Medicine White Crow, Chair

SUBJECT: BRIEFING—HEALTH DISPARITIES DATA

Background and Summary:

Statute requires that the Council develop policy recommendations to address select health topics, including the social determinants of health, on an incremental basis and to include these recommendations in its reports to the Governor and Legislature. In identifying its priorities the Council must consider data on the prevalence of the condition or indicator as well as the level of disparity.

Past Council priorities have included education, health insurance coverage, healthcare workforce diversity, obesity, diabetes, poverty, environmental exposures and hazards, behavioral health, the state system, adverse childhood experiences, CLAS standards, and adverse birth outcomes.

As the Council finishes its work to develop adverse birth outcomes recommendations, we need to start the process of identifying new priorities. To guide that work, it is important that we have an understanding of the current health and health disparities data in Washington State. Today, I am pleased to introduce Dennis McDermot and Cathy Wasserman from the Department of Health, who will provide a briefing on disparities data, including leading causes of death as well as chronic disease and related risk factors.

Recommended Council Action:

None at this time.



Health and Disparities in Washington

Governor's Interagency Council on Health Disparities

May 13, 2015

Cathy Wasserman, PhD, MPH

Dennis McDermot, PhD

Gail Brandt, MPH, EdD

PUBLIC HEALTH
ALWAYS WORKING FOR A SAFER AND
HEALTHIER COMMUNITY



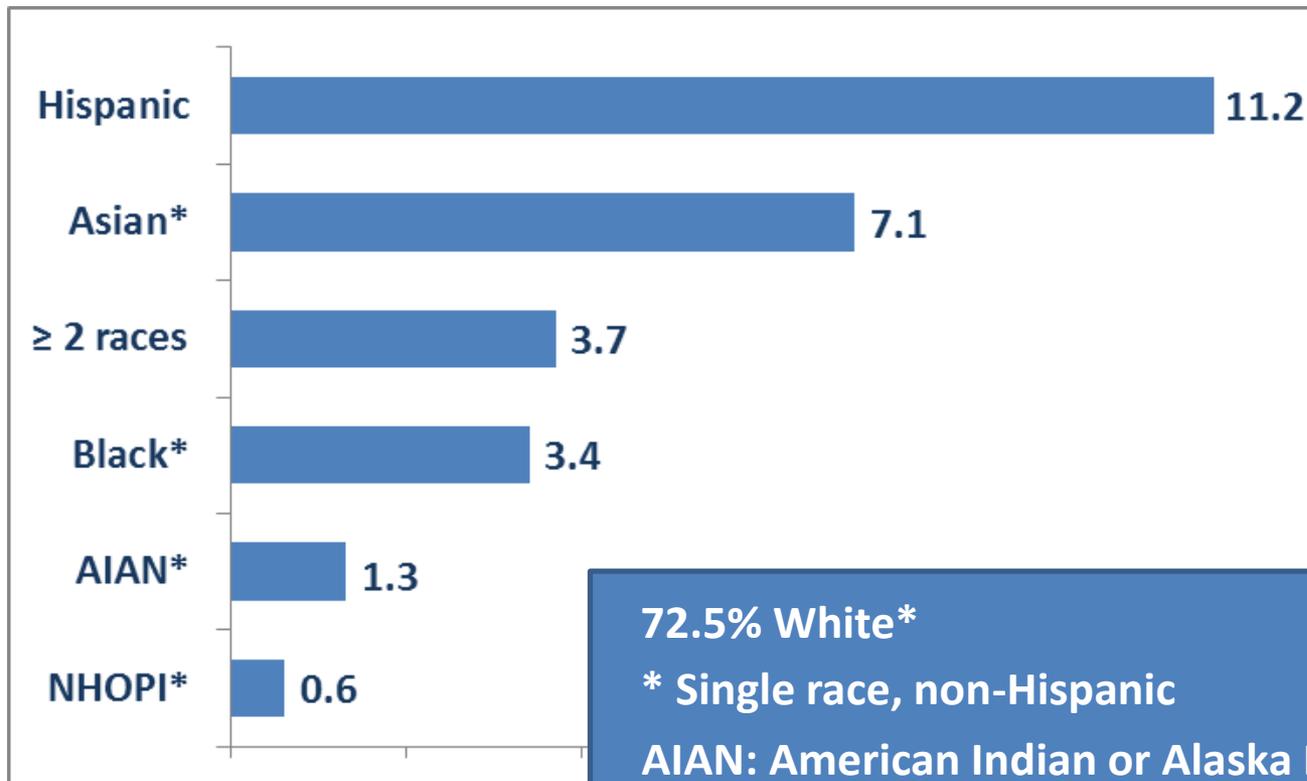
What we will cover:

- Demographics
- Conceptual framework of how inequities arise
- Social Determinants of Health
- Causes of death and disease
- Risk factors that impact health

Who are we?

Almost 6.9 million people in 2013 (OFM Population Estimates)

2010 U.S. Census showed...



72.5% White*

* Single race, non-Hispanic

AIAN: American Indian or Alaska Native

NHOPI: Native Hawaiian or Other Pacific Islander

Who are we?

2010

- About 12% ages 65 and older – 1 in 8
- About 26% ages 19 and younger

2020

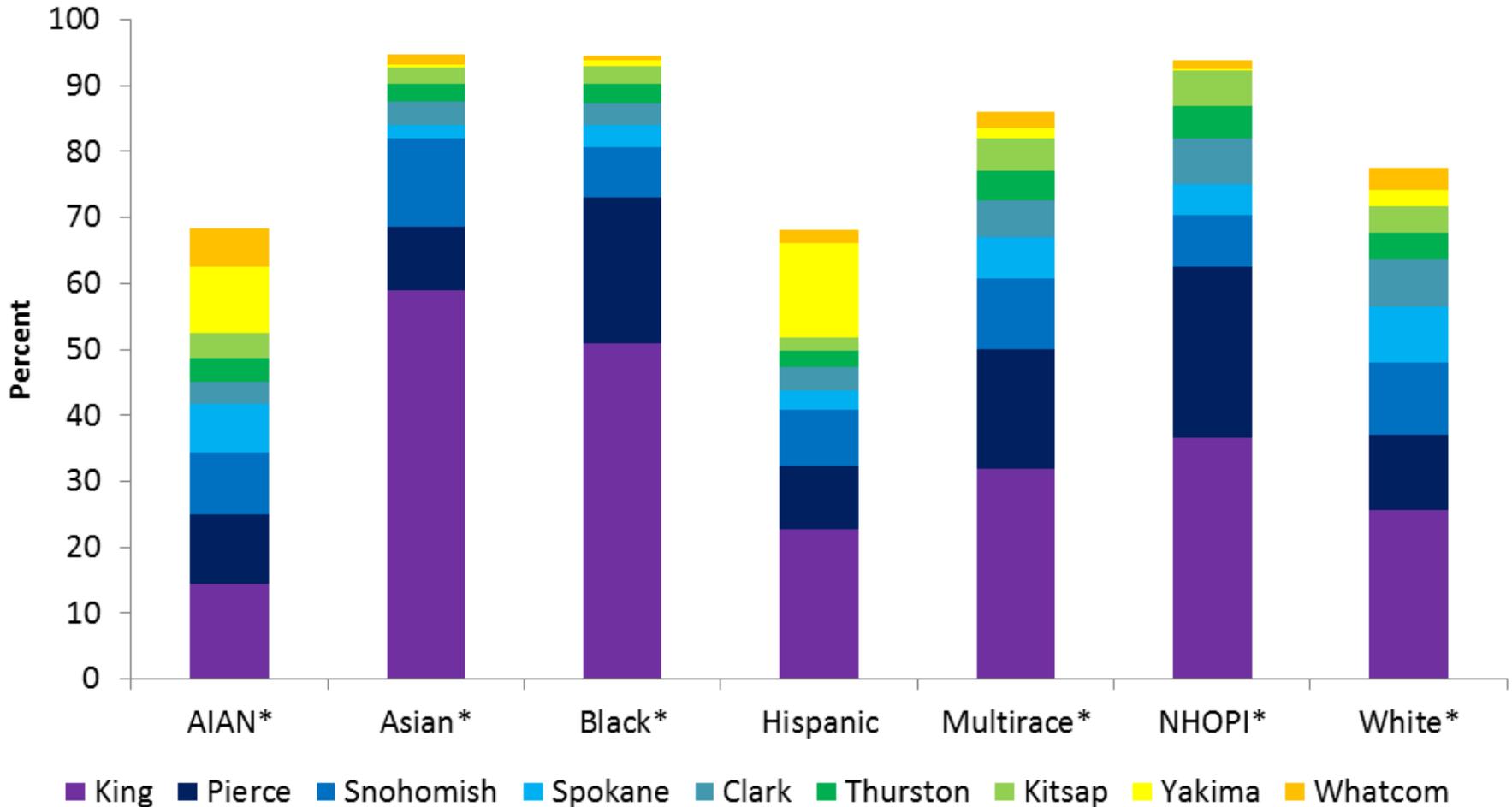
- About 17% ages 65 and older – 1 in 6
- About 25% ages 19 and younger

2030

- About 21% ages 65 and older – 1 in 5
- About 24% ages 19 and younger

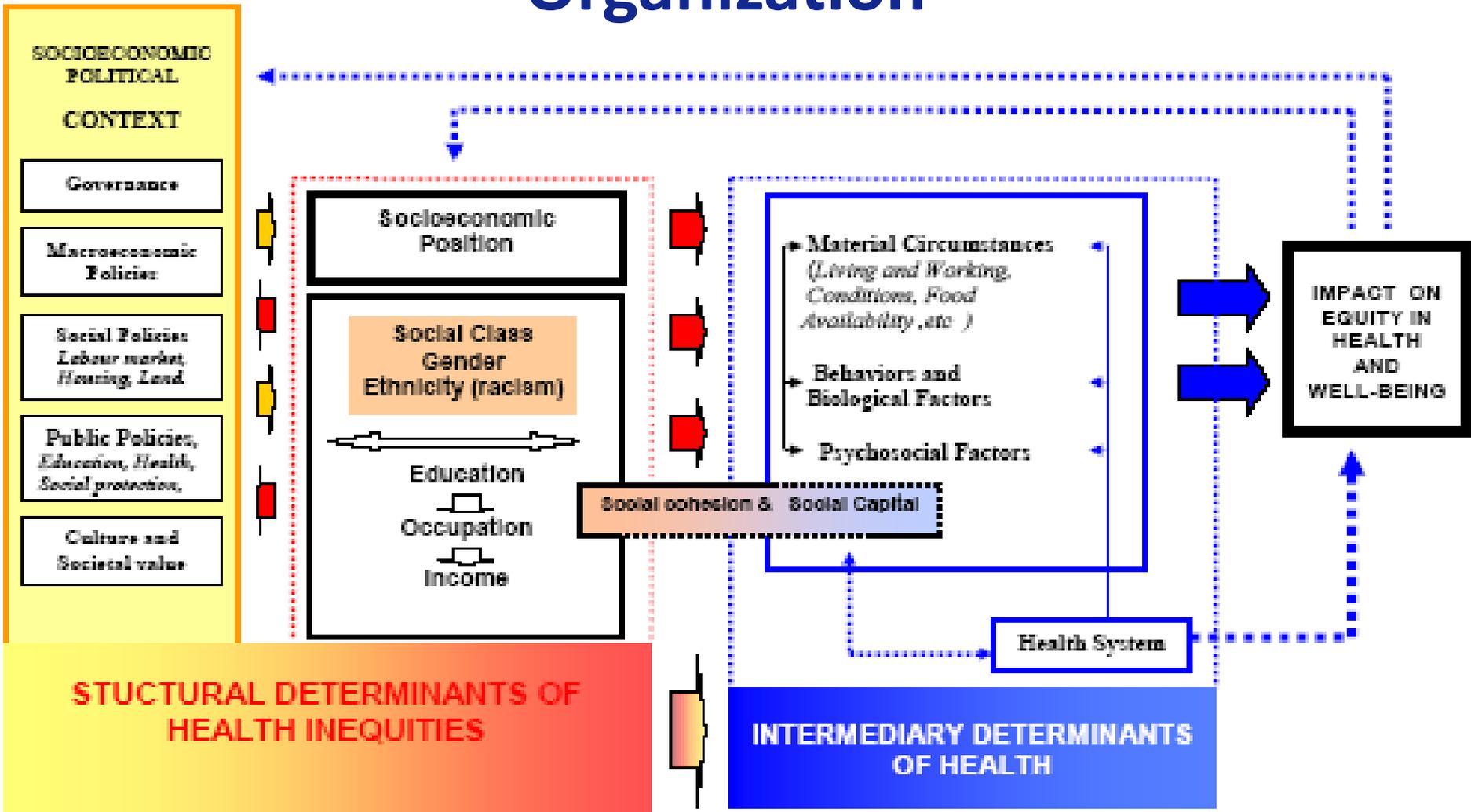
Where are we?

Percent of Race/Ethnic Groups in 9 most Populous WA Counties



*Single race, Non-Hispanic

Conceptual Framework: World Health Organization



Conceptual Framework Simplified

Social,
economic
and
cultural
settings

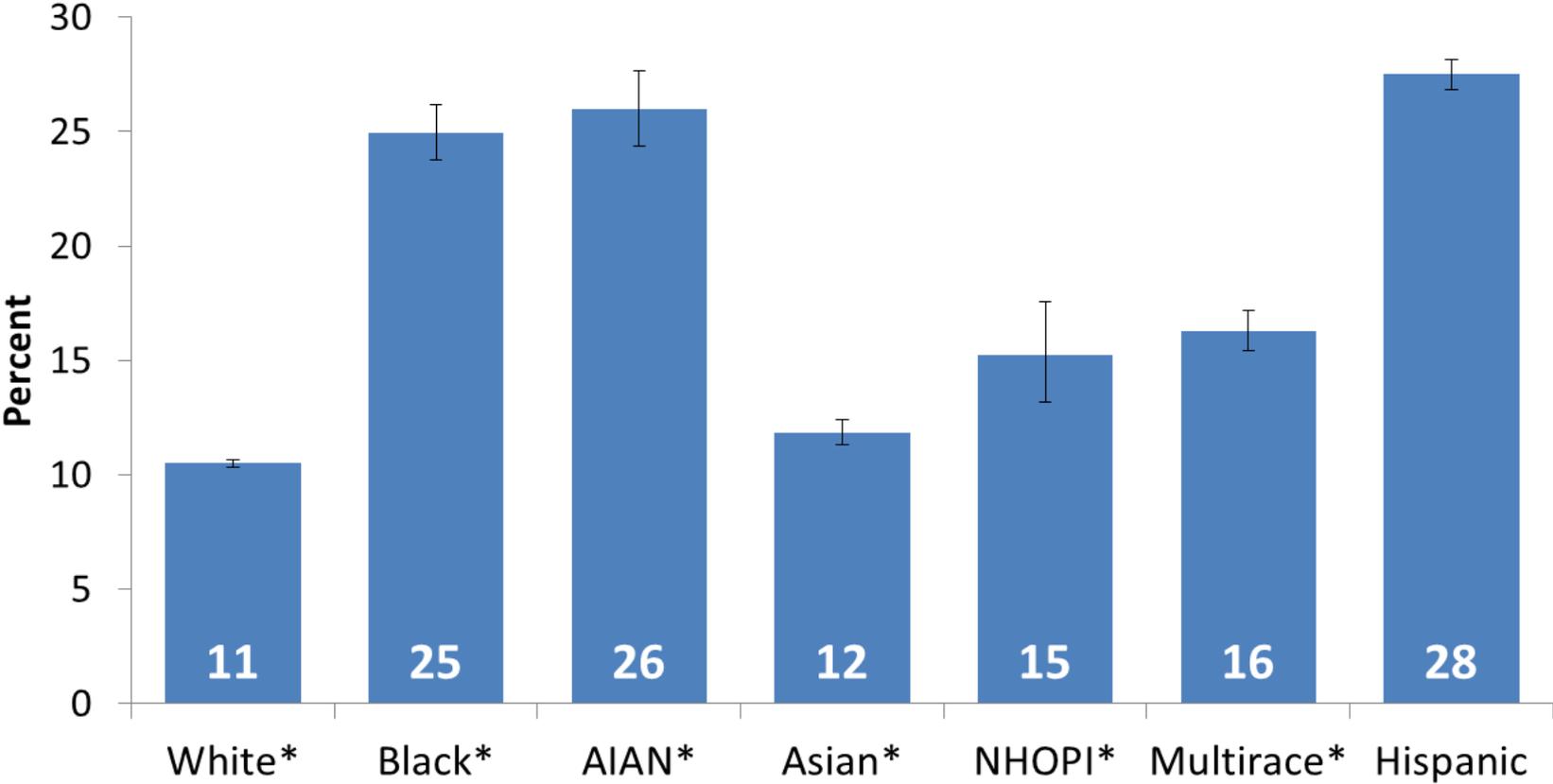
influence

Health-
related
behaviors
and
access to
care

affect

Morbidity
and
mortality

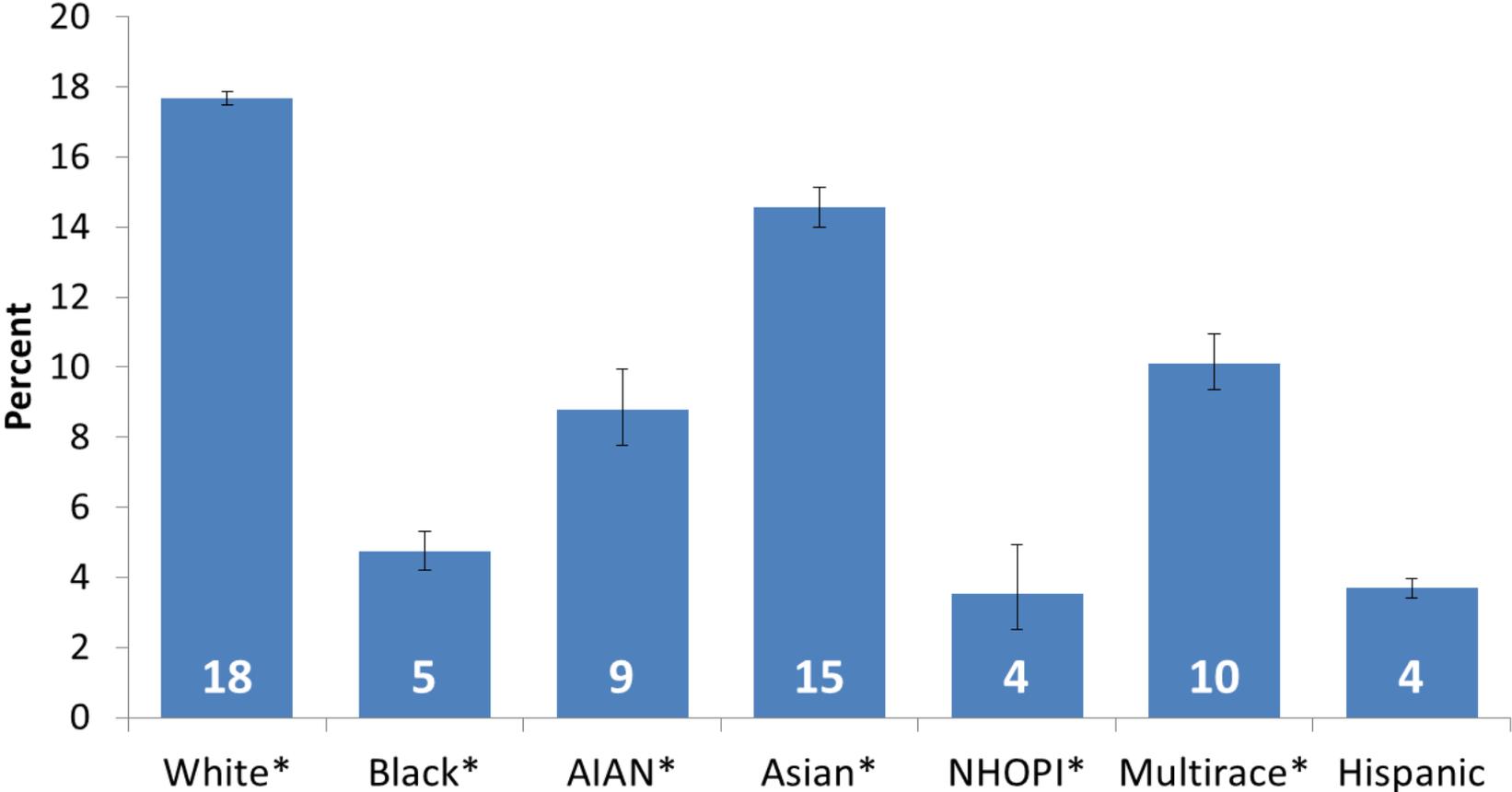
Income below Poverty by Race/Ethnicity, Washington, 2009-2013



* Non Hispanic

Source: American Community Survey PUMS, 2009-2013

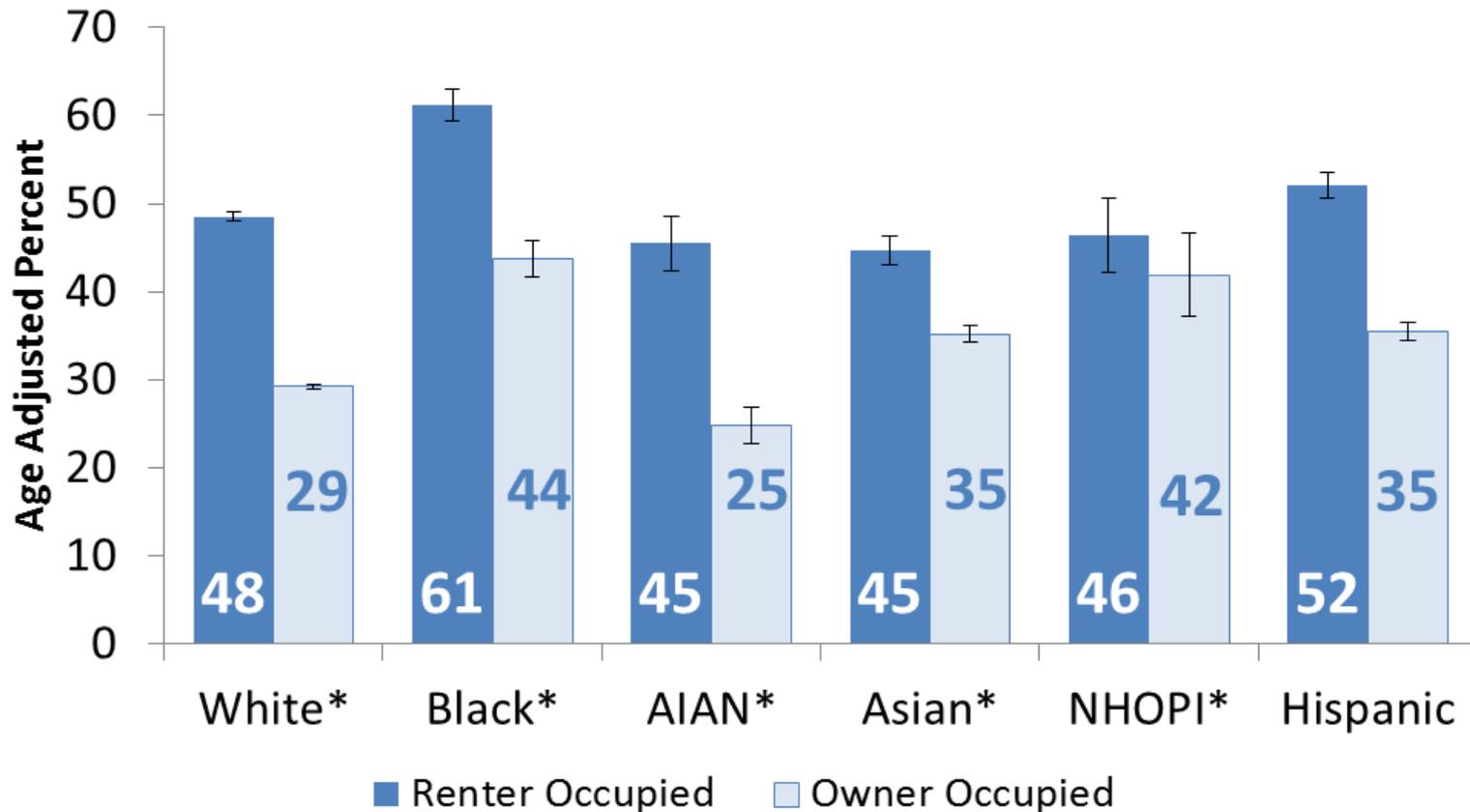
Rent, Dividend or Interest Income by Race/Ethnicity, Washington, 2009-2013



* Non Hispanic

Source: American Community Survey PUMS, 2009-2013

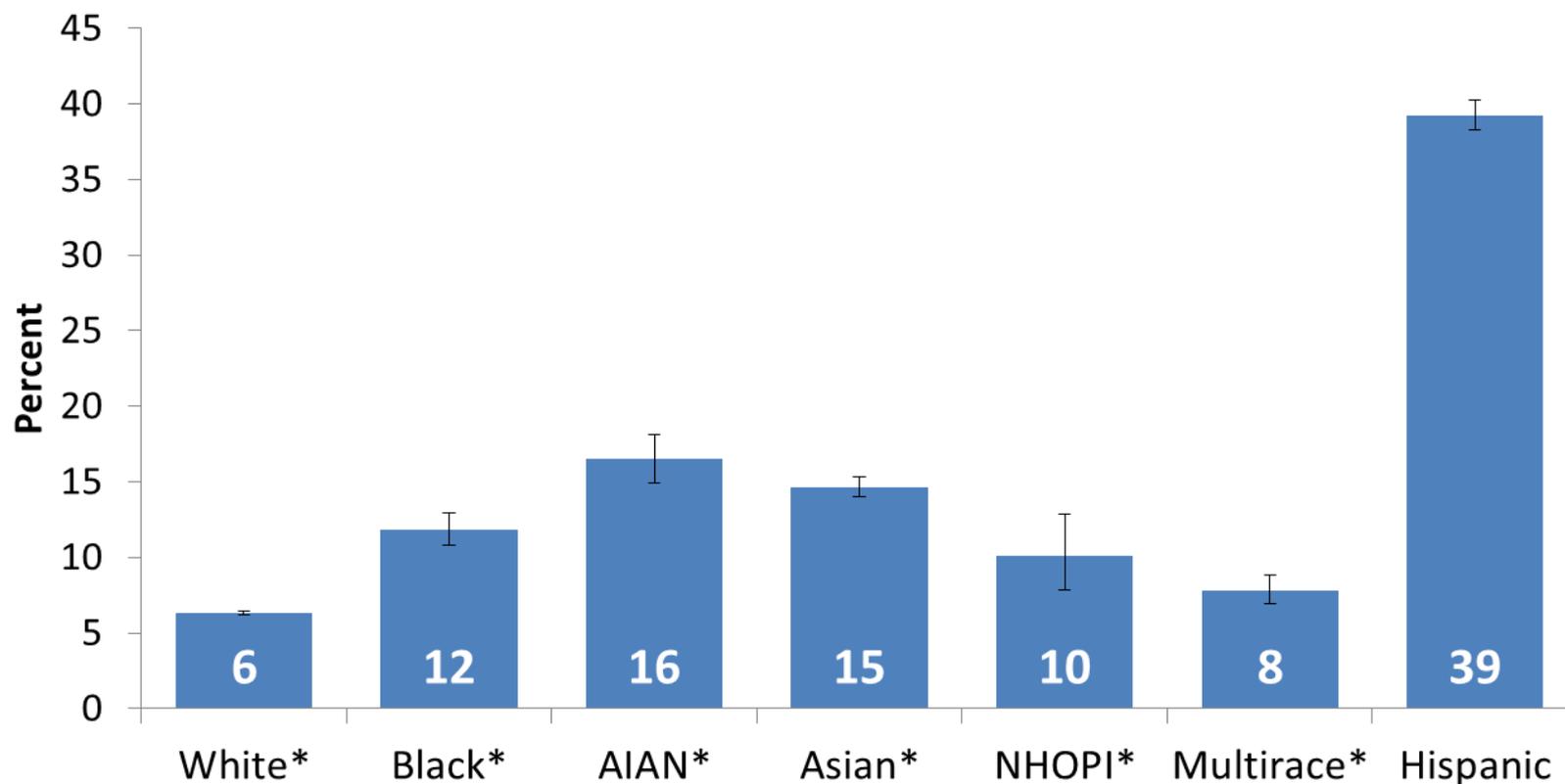
Affordable Housing by Race/Ethnicity, Washington, 2009-2013



* Non-Hispanic

Source: American Community Survey, 2011-2013

Less than High School Education** by Race/Ethnicity, Washington, 2009-2013

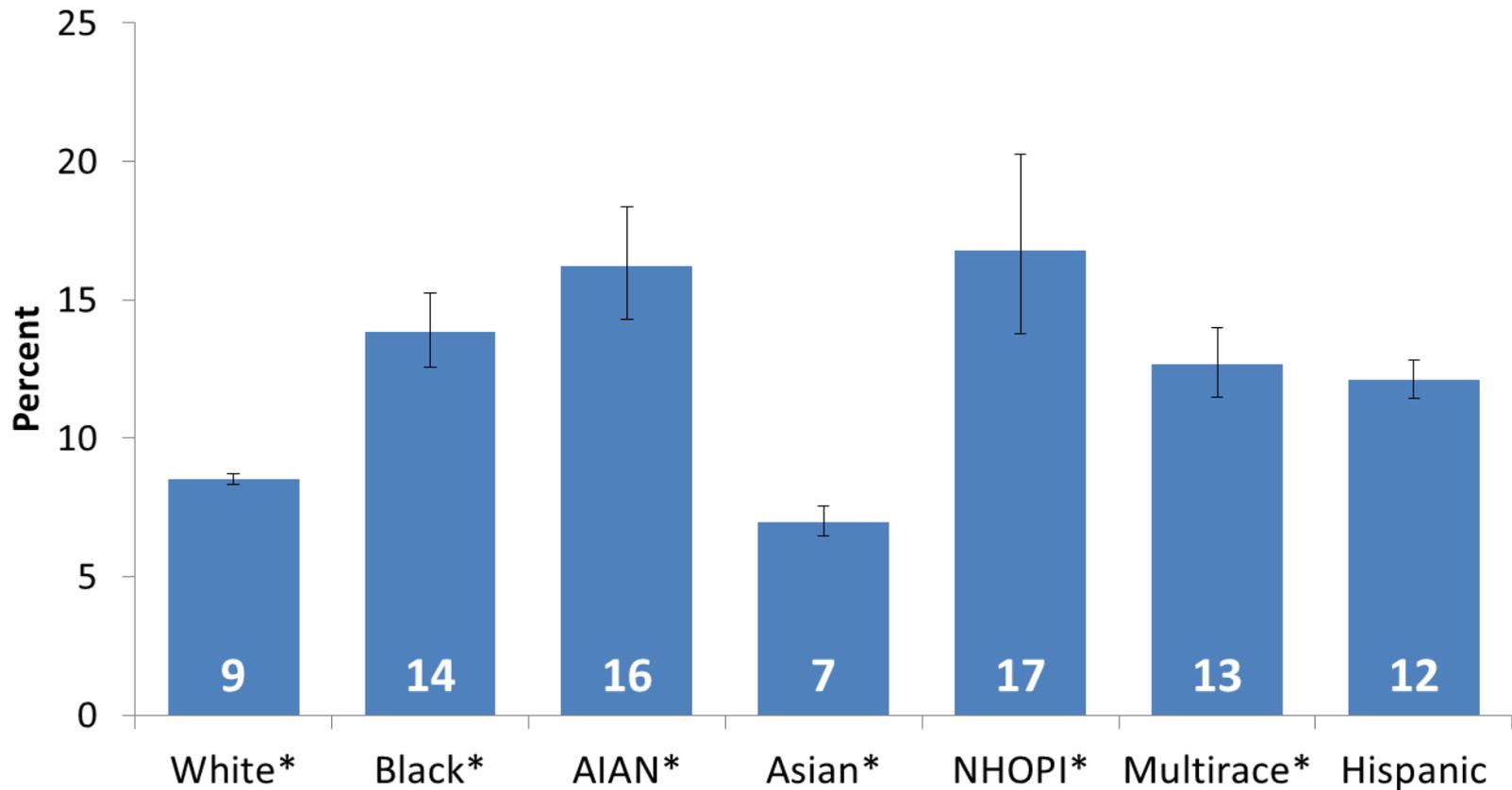


* Non Hispanic

** Ages 25+

Source: American Community Survey PUMS, 2009-2013

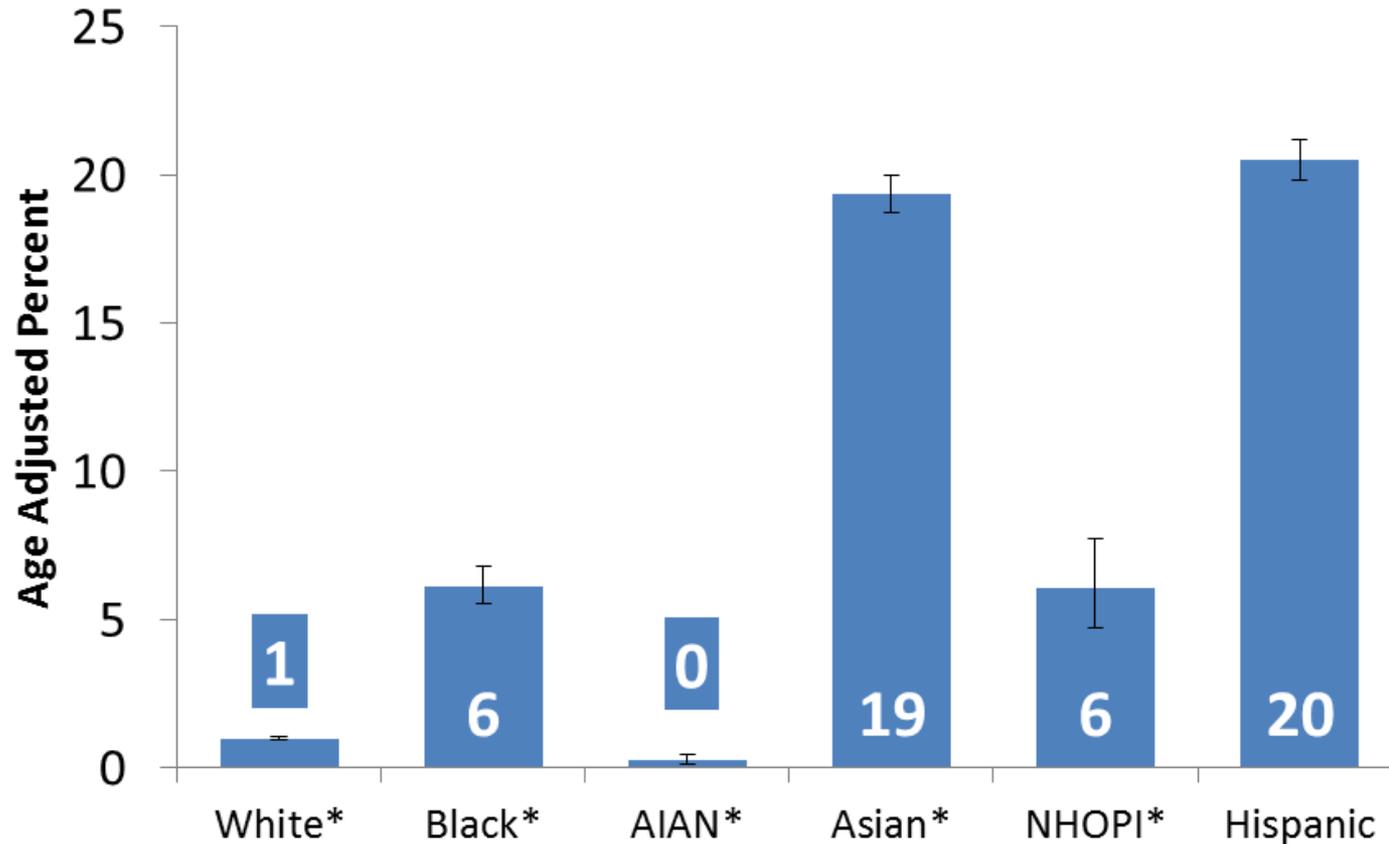
Unemployment by Race/Ethnicity, Washington, 2009-2013



* Non Hispanic

Source: American Community Survey PUMS, 2009-2013

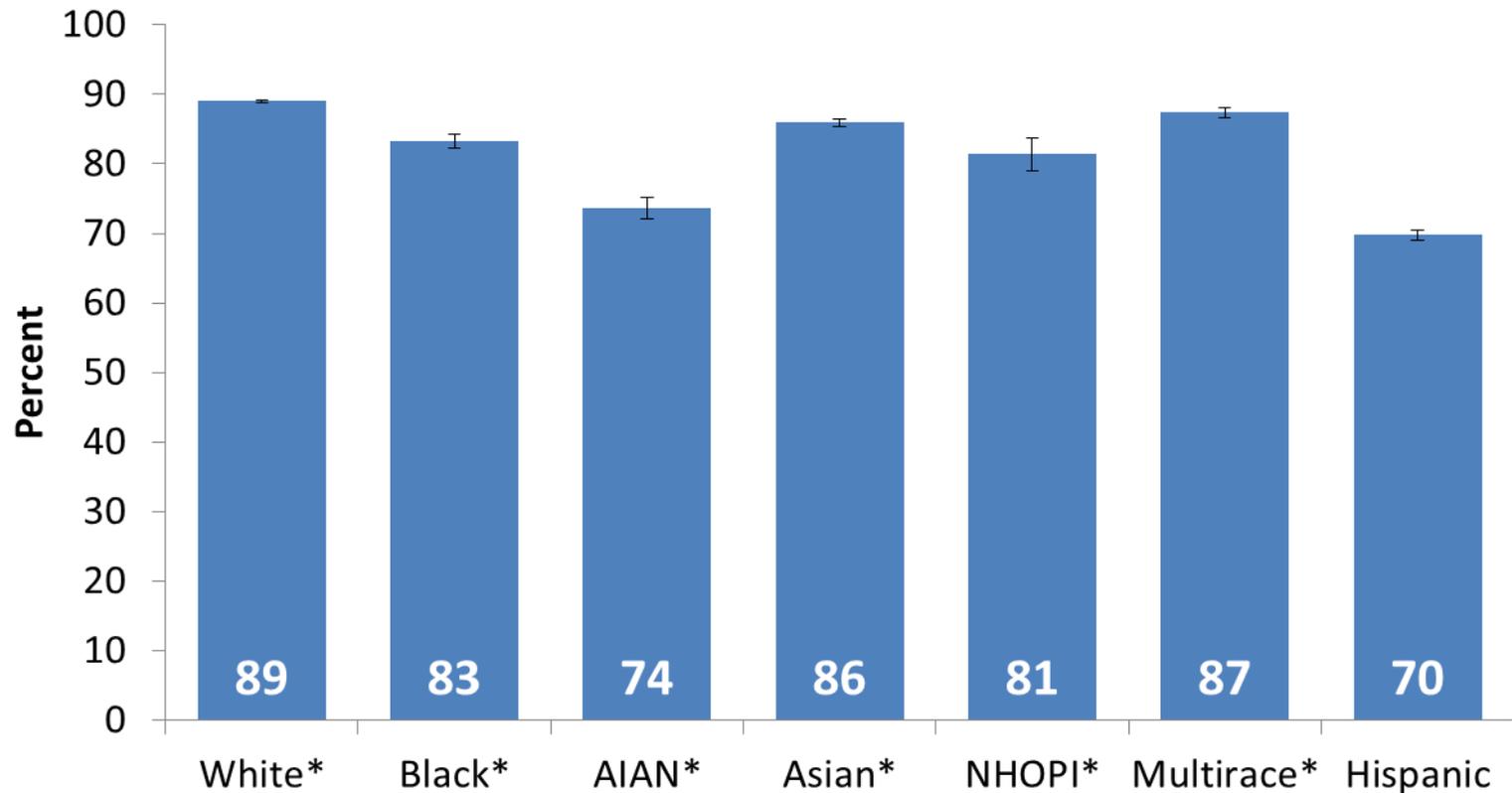
Linguistic Isolation Washington, 2009-2013



* Non-Hispanic

Source: American Community Survey PUMS, 2009-2013

Health Insurance by Race/Ethnicity, Washington, 2009-2013



* Non Hispanic

Source: American Community Survey PUMS, 2009-2013

Social Determinants by Race/Ethnicity

Black*

- Low income
- Low wealth
- Lack affordable housing
- High unemployment

AIAN*

- Low income
- High unemployment
- Low health insurance

Asian*

- Linguistic isolation

NHOPI*

- Low wealth
- High unemployment

Hispanic

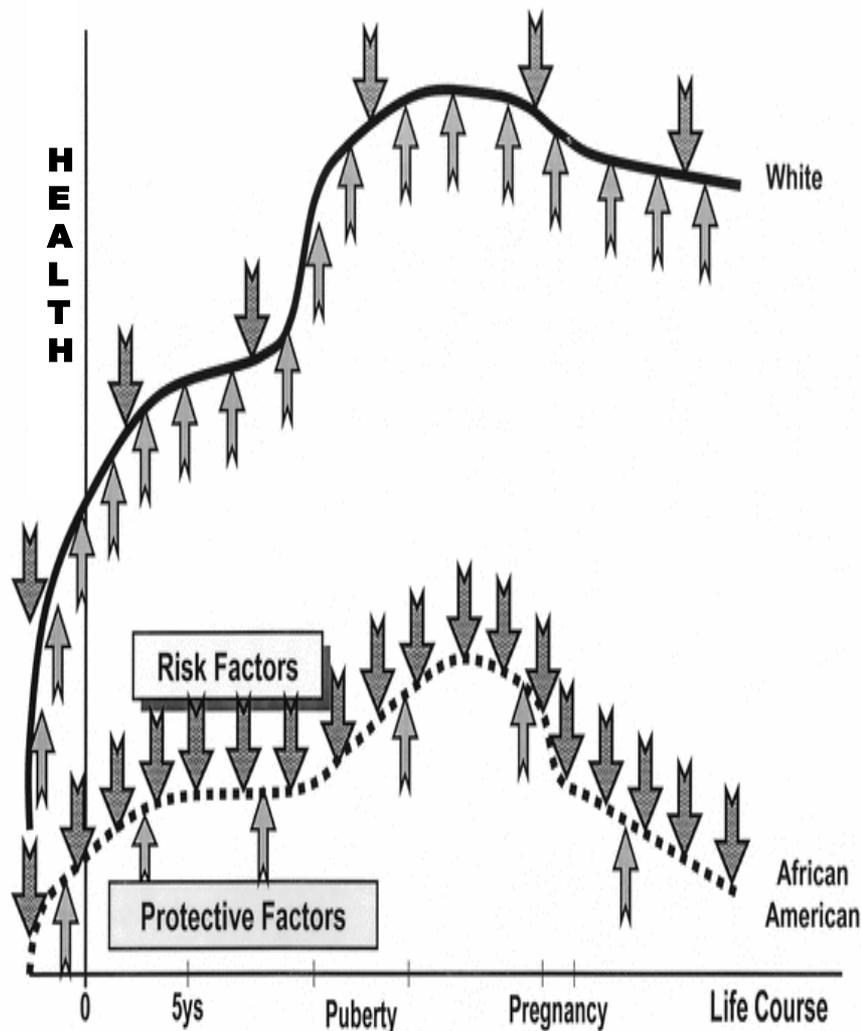
- Low income
- Low wealth
- Low education
- Low health insurance
- Linguistic isolation

White*

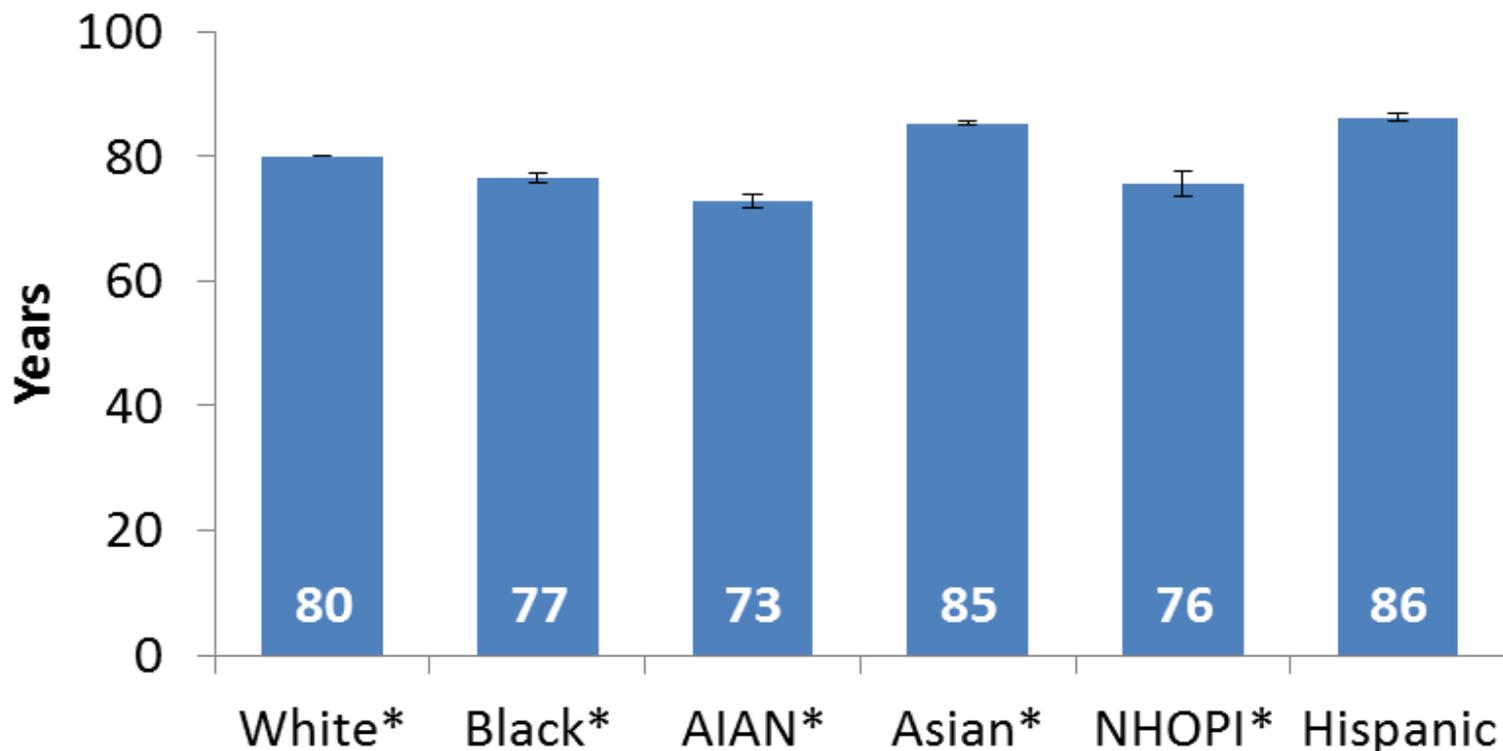
* Non-Hispanic

Life Course Perspective

- One stage affects the next trajectory
- Cumulative burden
- Sensitive OR critical periods
- Together they explain health inequities



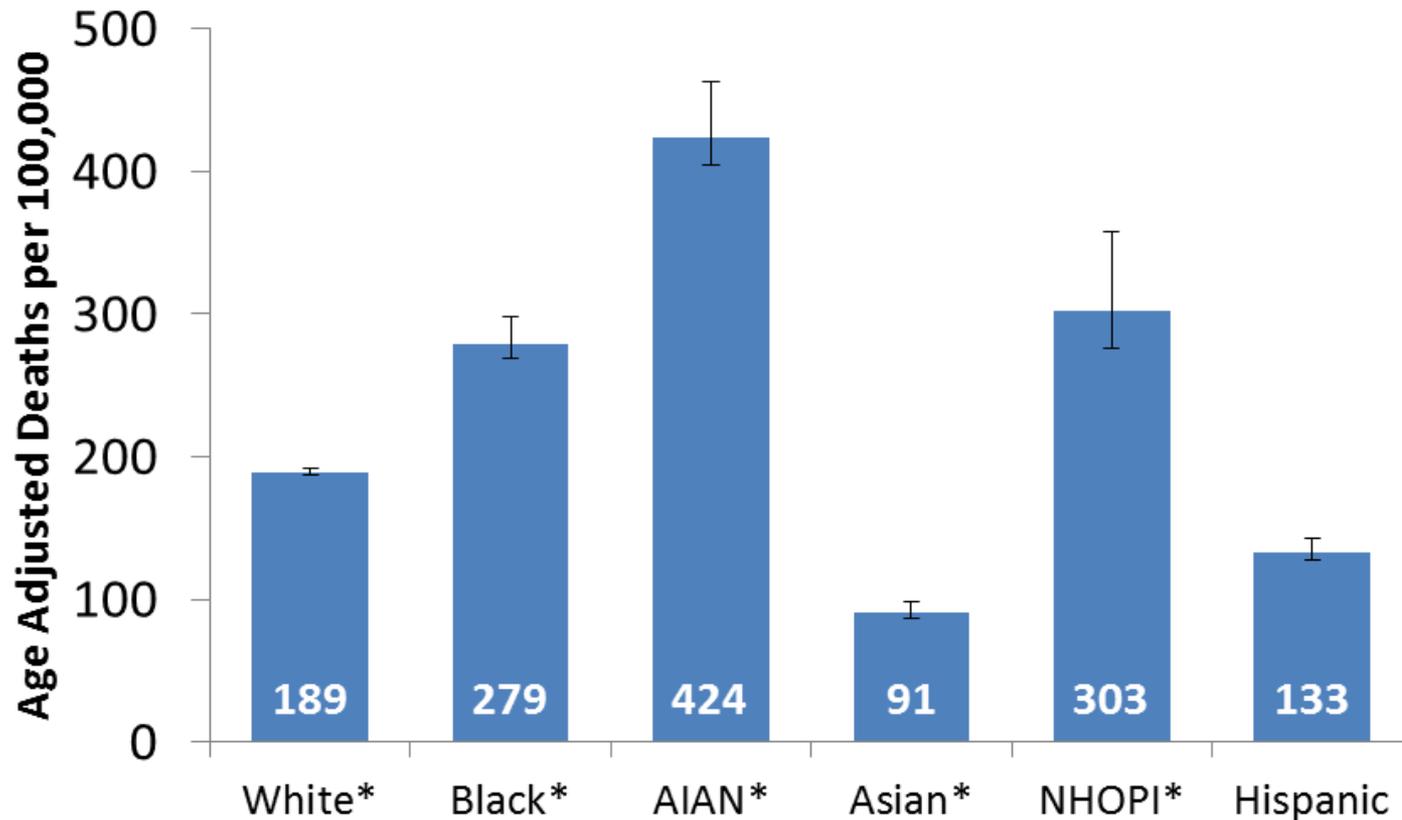
Life Expectancy at Birth, Washington 2013



*Single race, Non-Hispanic

Source: Washington State Death Certificates, 2013

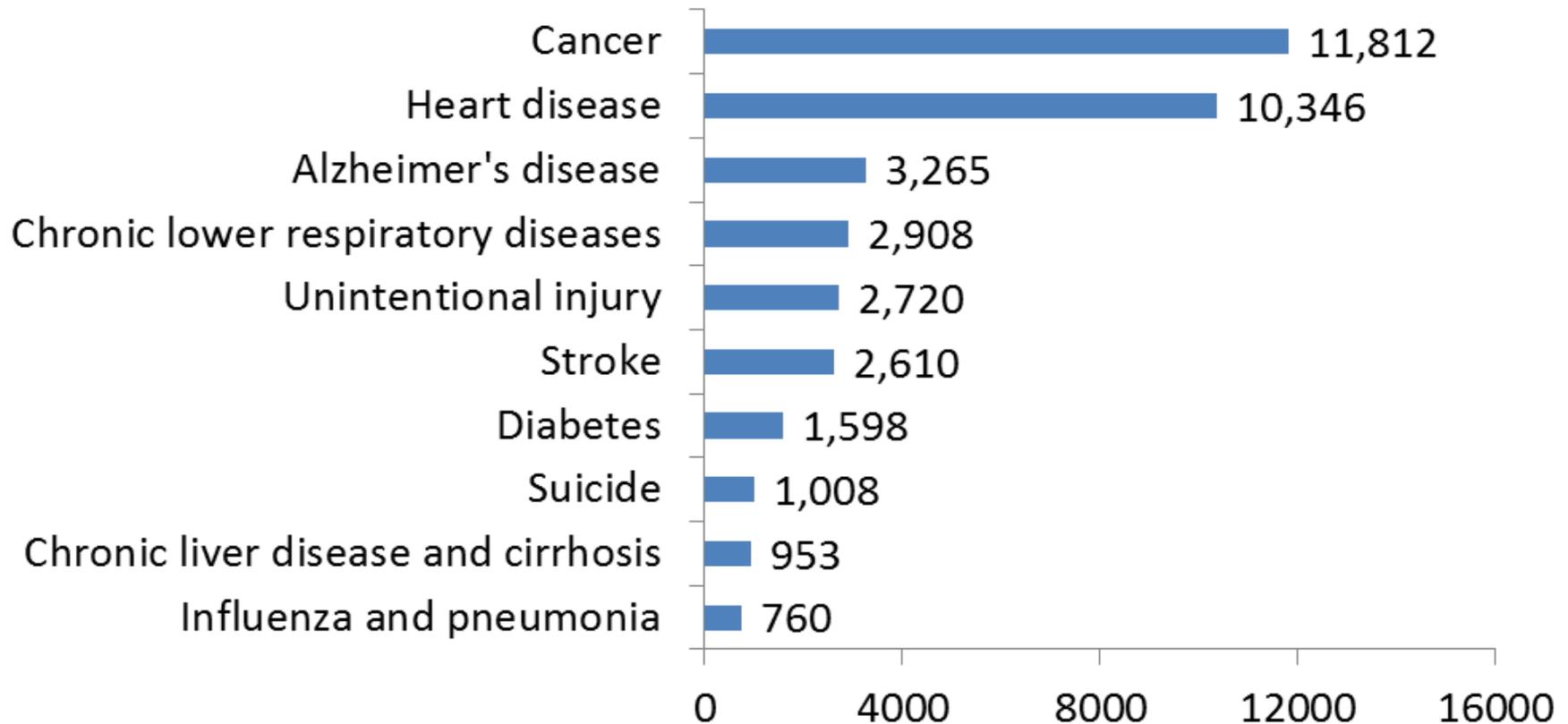
Premature Mortality Rate - < 65 years Washington 2009-2013



*Single race, Non-Hispanic

Source: Washington State Death Certificates, 2013

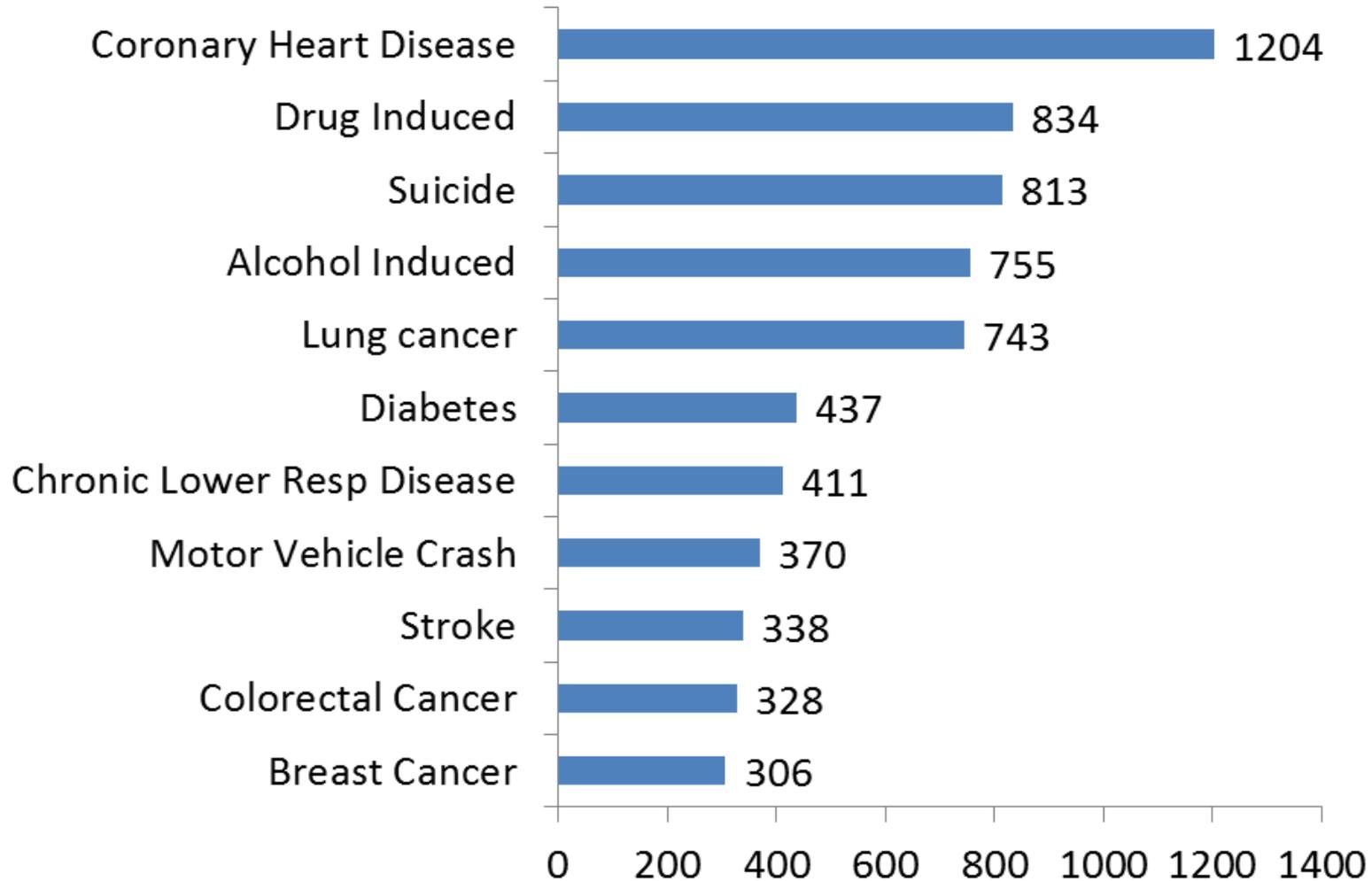
Leading Causes of Death, Washington 2013



National Center for Health Statistics, major categories

Source: Washington State Death Certificates, 2013

Underlying Cause of Death, Washington 2013, Ages 0-64 years



Source: Washington State Death Certificates, 2013

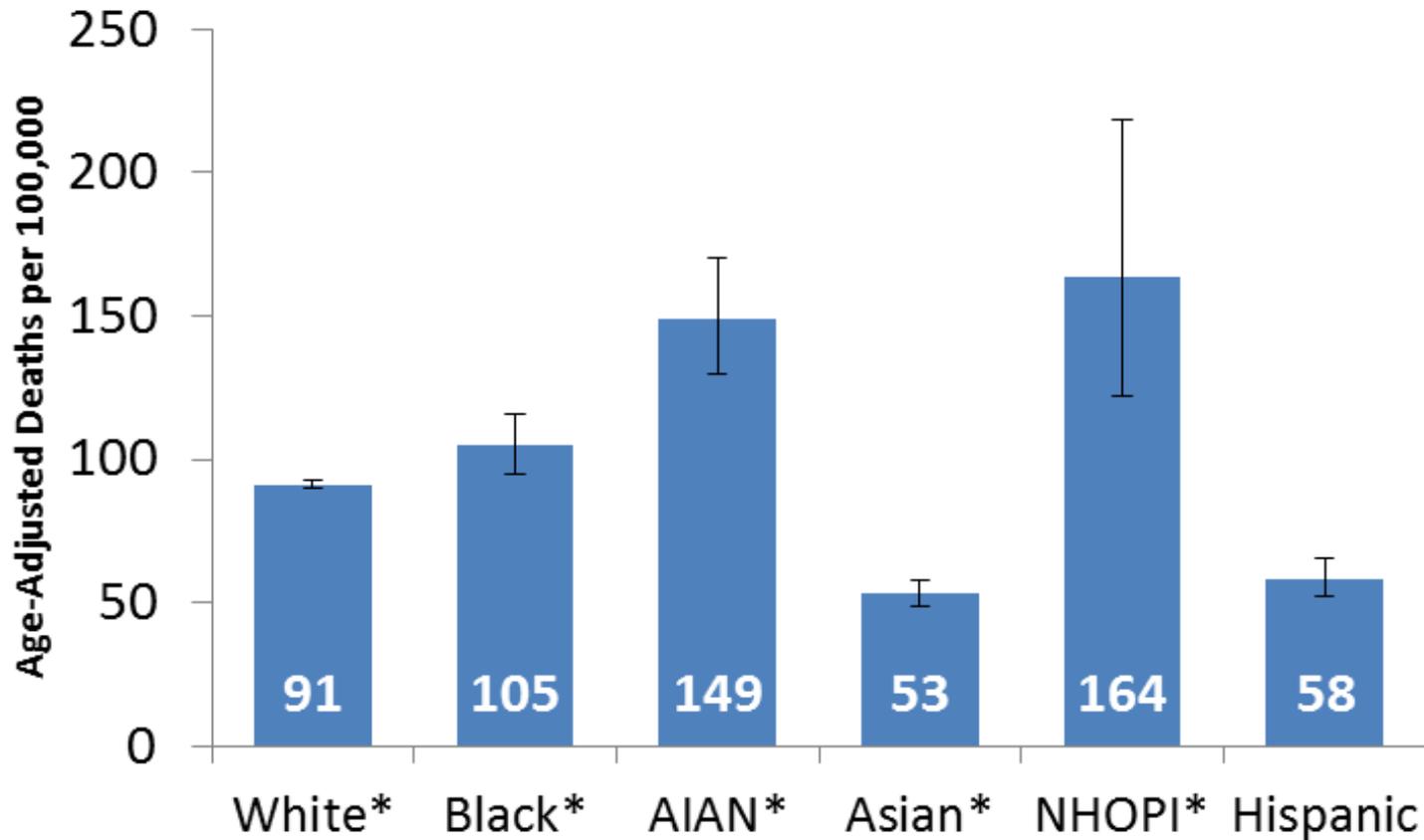
Comparison Deaths and Hospitalizations Washington 2013, < 65 yrs

	Deaths	Hospitalization	Hosps/Death
Coronary Heart Disease	1204	21,804	18
Drug Abuse and Dependence	956	33,679	35
Suicide	813	3,675	5
Alcohol Abuse and Dependence	755	21,102	28
Lung Cancer	743	1,997	3
Diabetes	437	45,692	105
Chronic Lower Lung Disease	411	43,025	105
Motor Vehicle	370	3,252	9
Stroke	338	9,364	28
Hepatitis	161	9,903	62
Pneumonia/Influenza	106	16,038	151

Note: Hospitalizations are not unduplicated

Source: Washington State Death Certificates and Hospitalizations, 2013

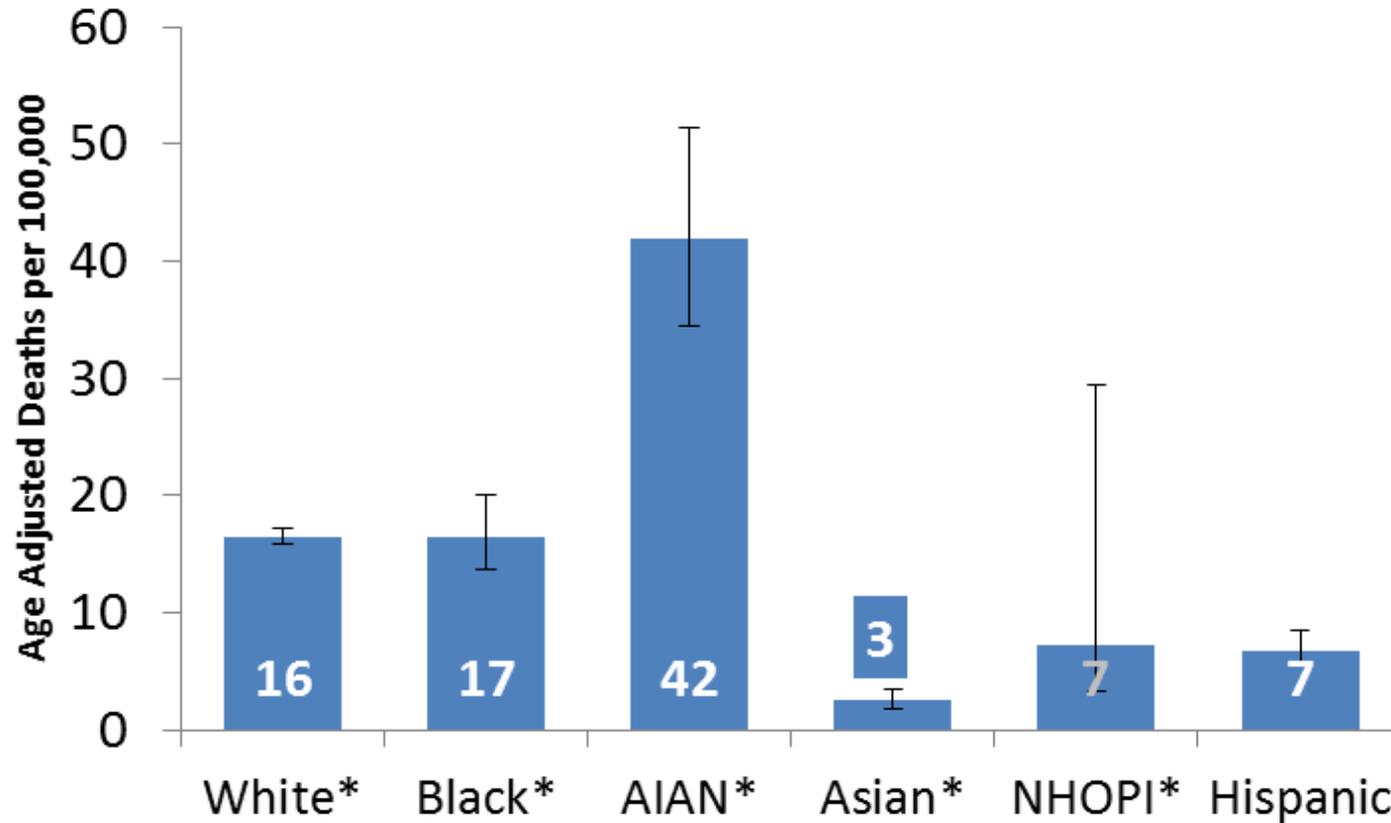
Coronary Heart Disease Deaths Washington 2011-2013



* Non-Hispanic

Source: Washington State Death Certificates, 2013

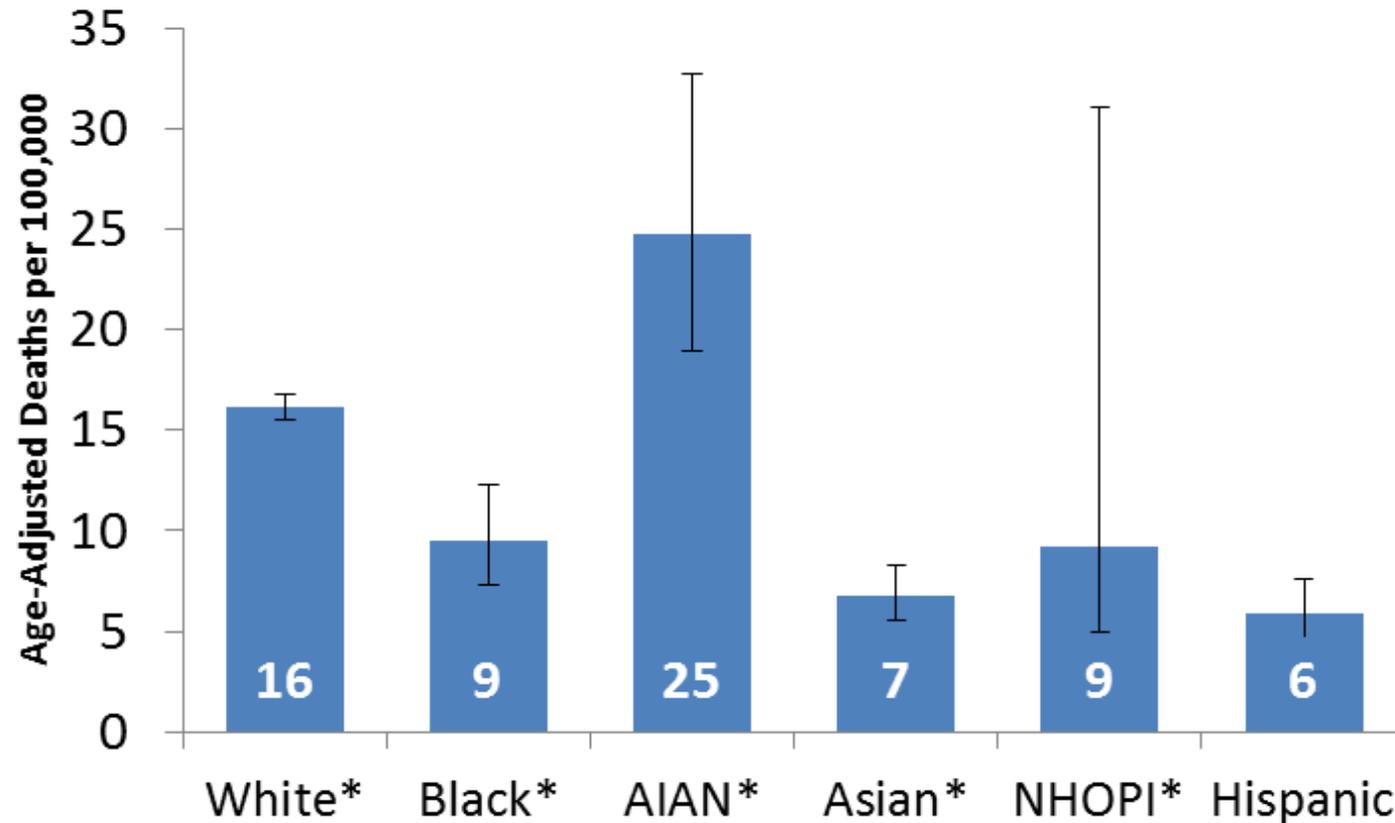
Drug-Induced Deaths Washington 2011-2013



* Non-Hispanic

Source: Washington State Death Certificates, 2013

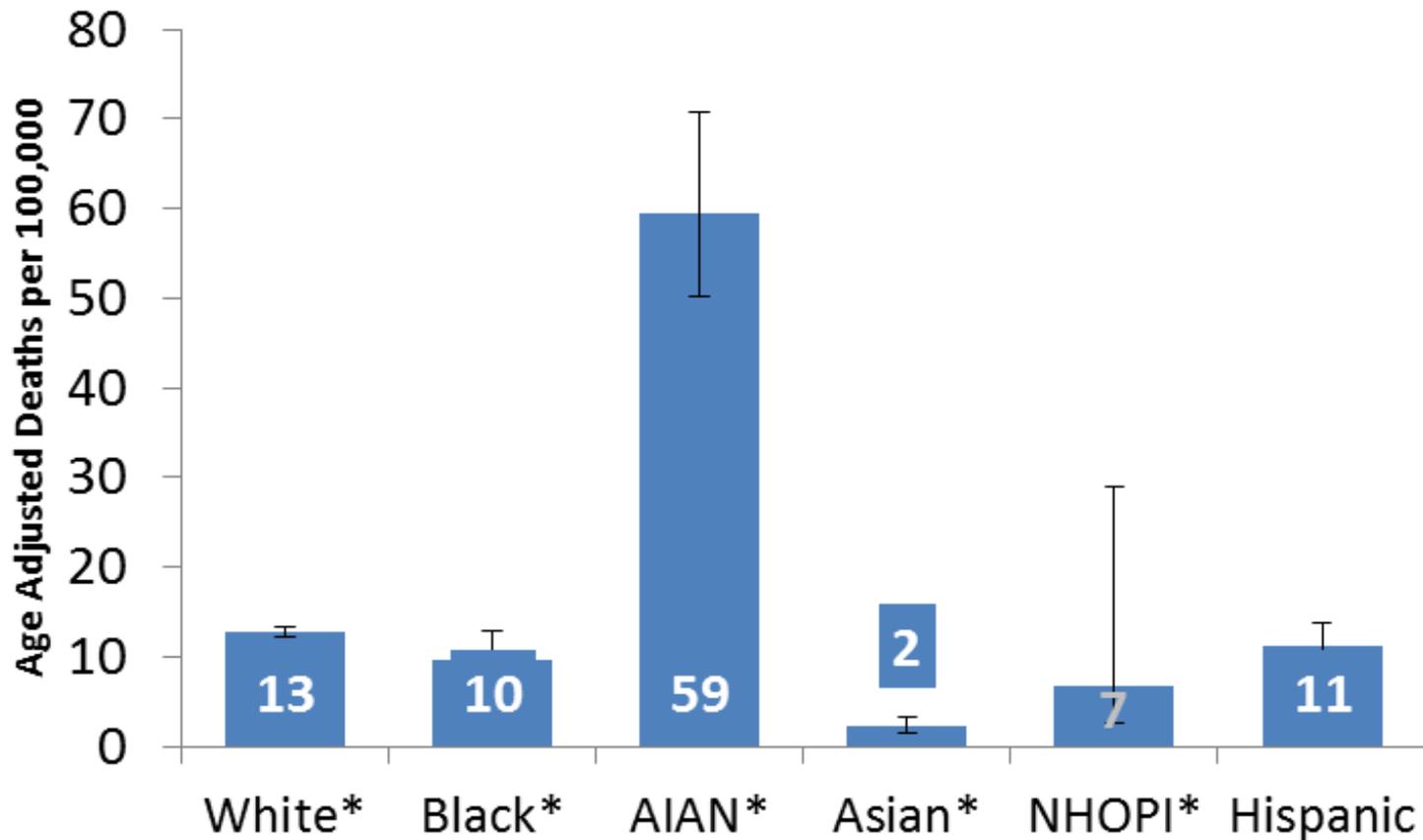
Suicide Deaths Washington 2011-2013



* Non-Hispanic

Source: Washington State Death Certificates, 2013

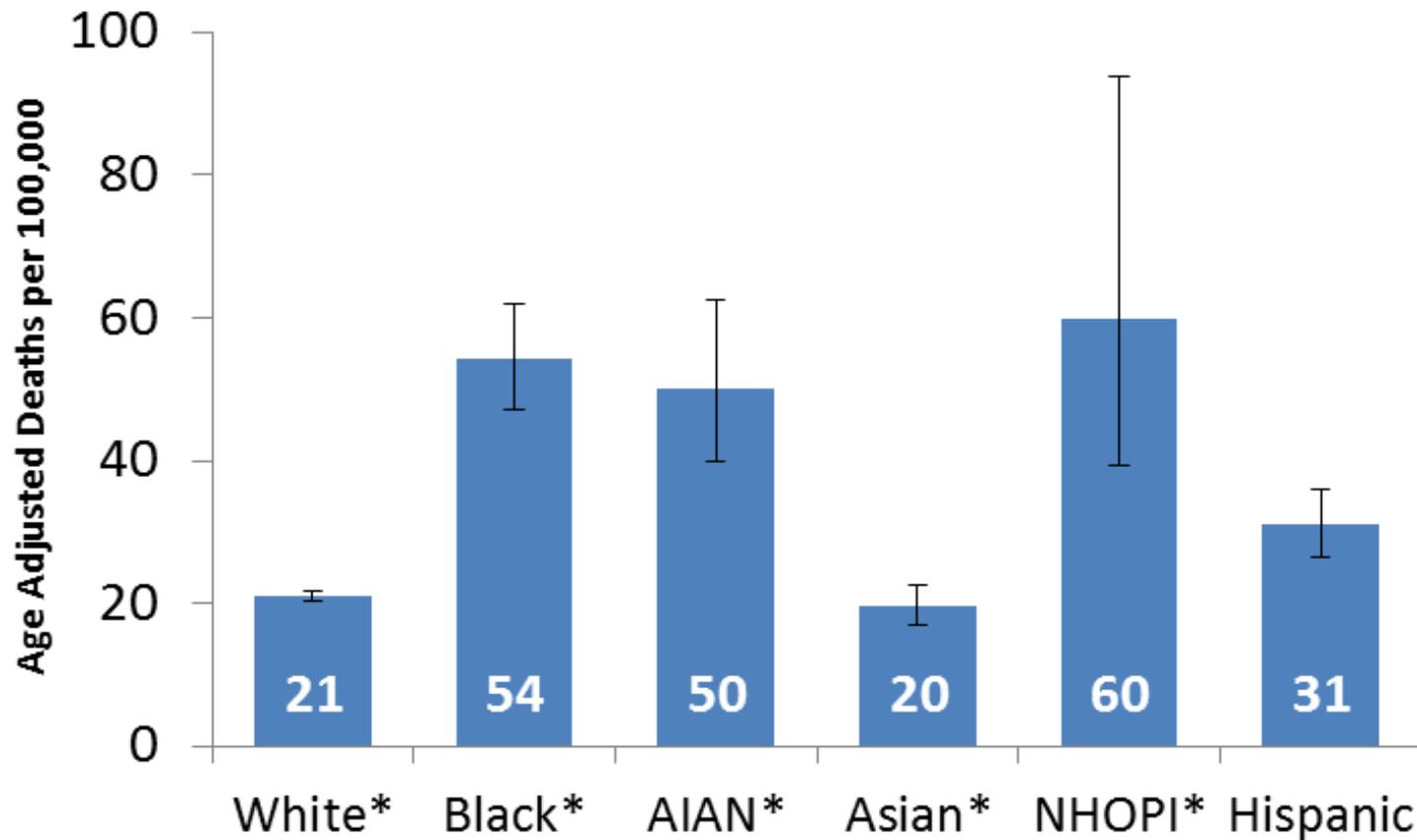
Alcohol-Induced Deaths Washington 2011-2013



* Non-Hispanic

Source: Washington State Death Certificates, 2013

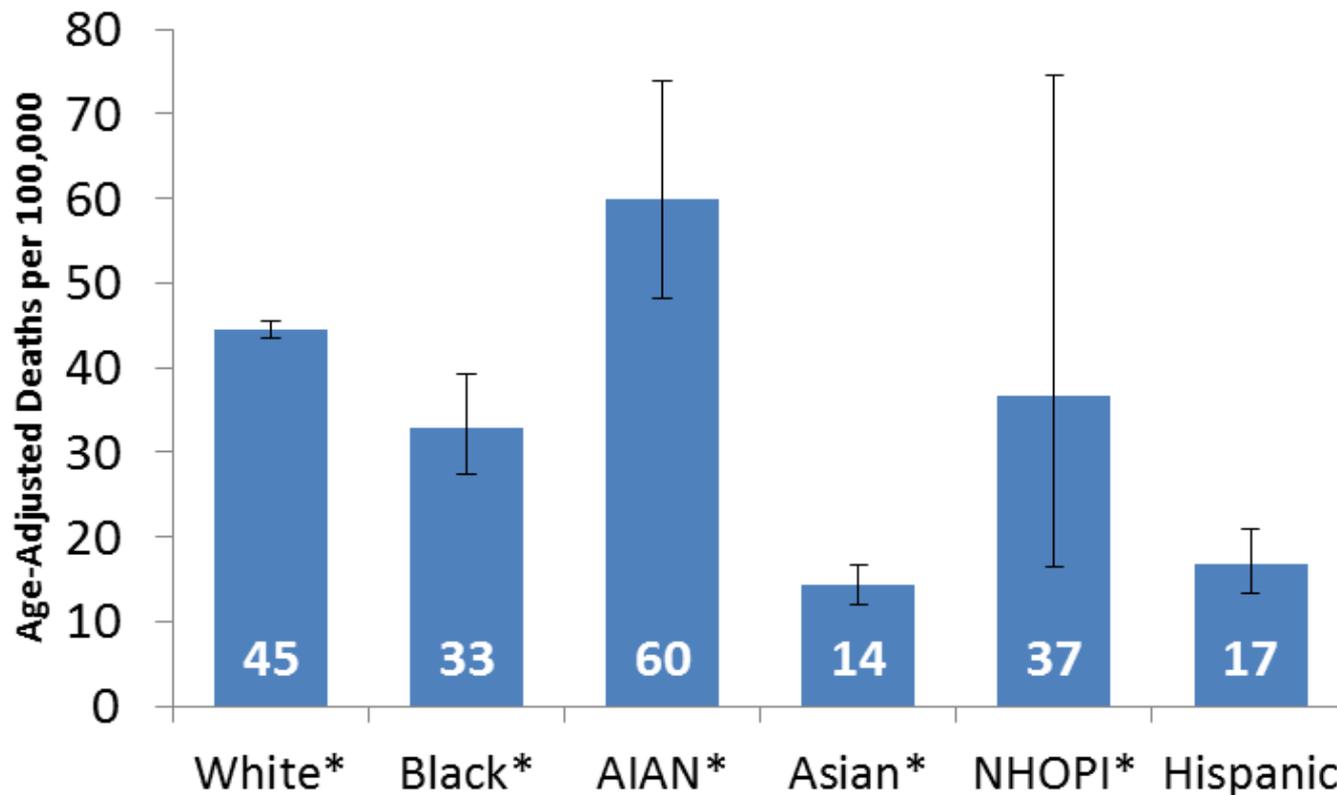
Diabetes Deaths Washington 2011-2013



* Non-Hispanic

Source: Washington State Death Certificates, 2013

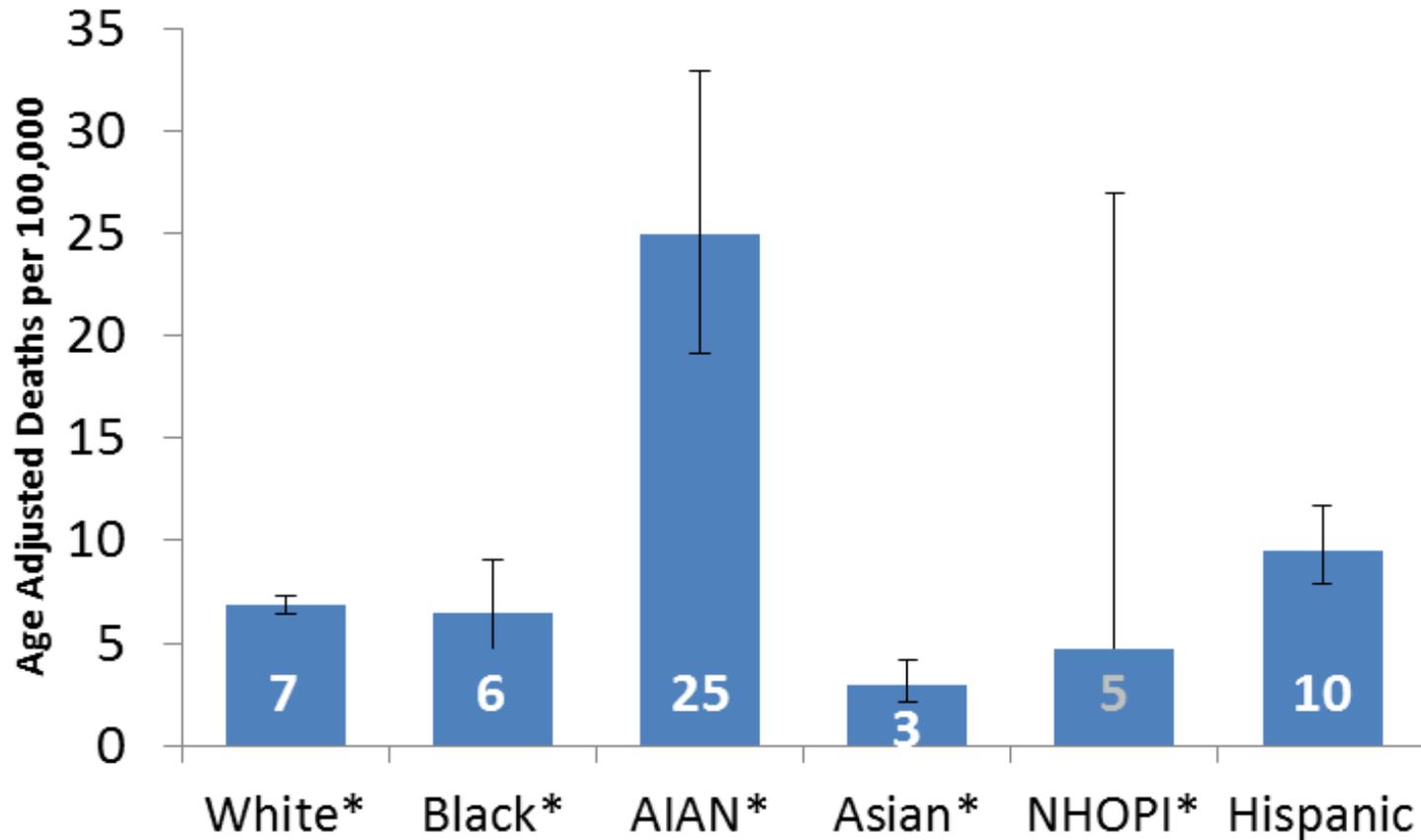
Chronic Lower Respiratory Disease Deaths Washington 2011-2013



* Non-Hispanic

Source: Washington State Death Certificates

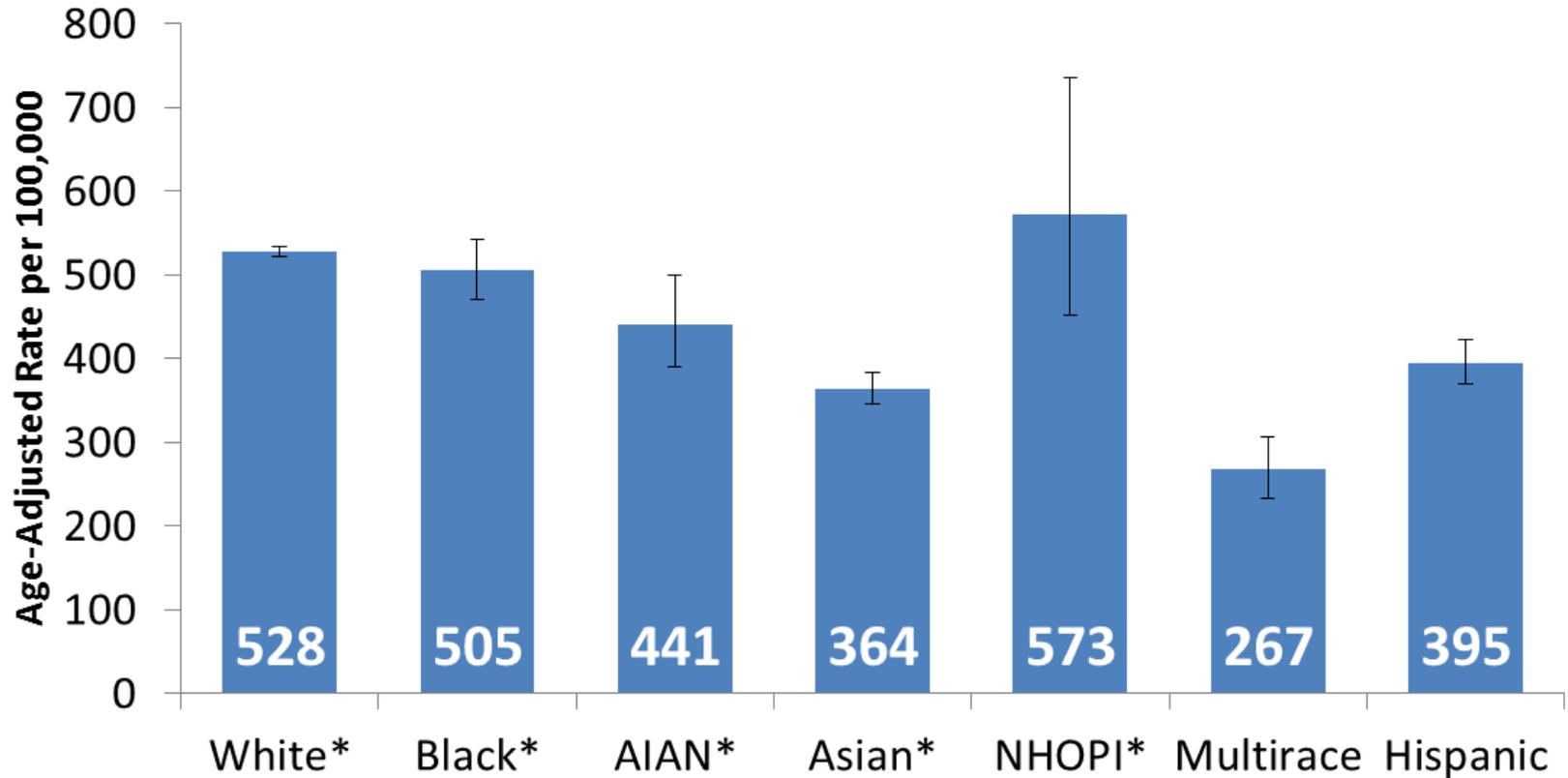
Motor Vehicle Crash Deaths Washington 2011-2013



* Non-Hispanic

Source: Washington State Death Certificates, 2013

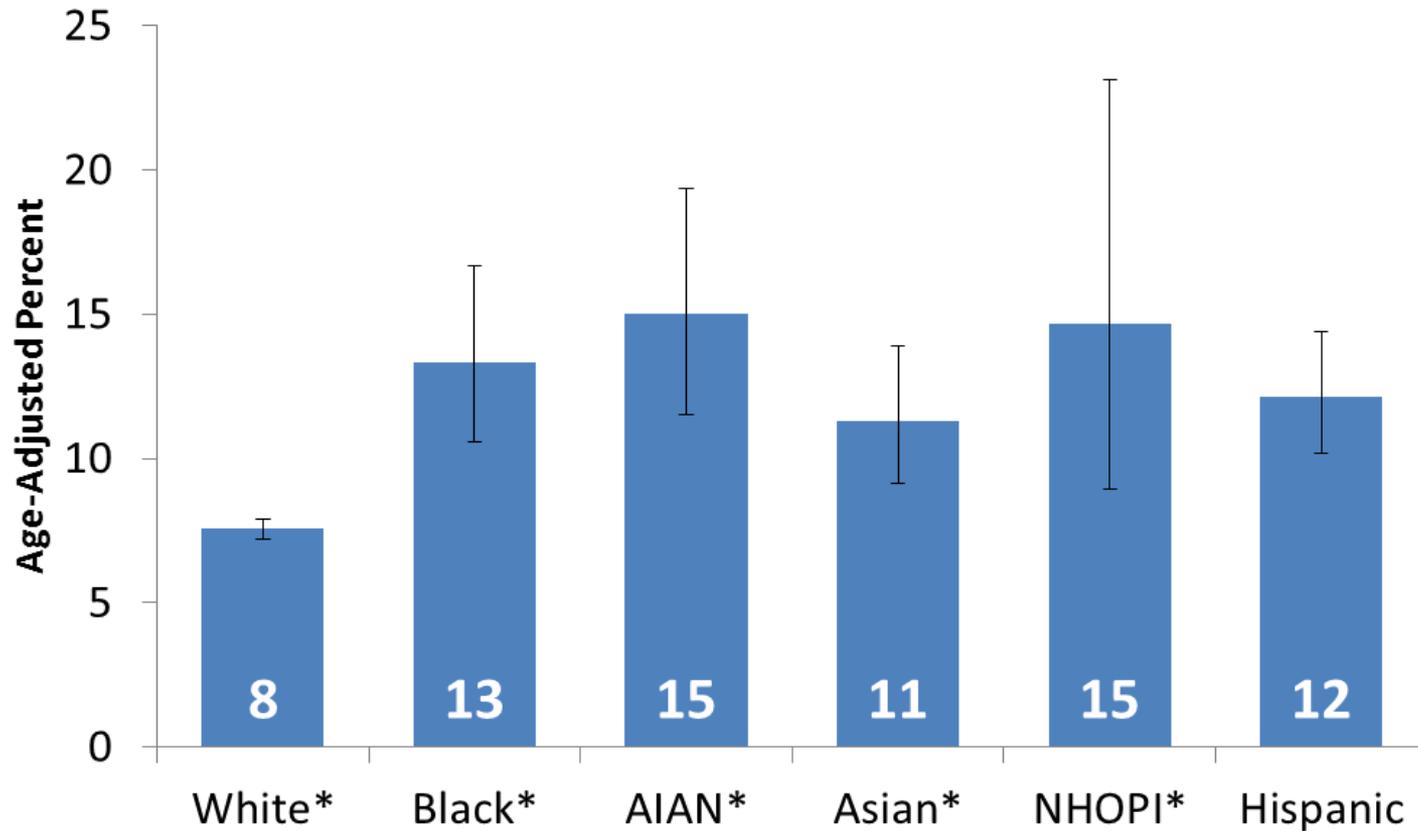
All Site Cancer Incidence Washington 2011



* Non-Hispanic

Source: Washington State Death Certificates, 2013

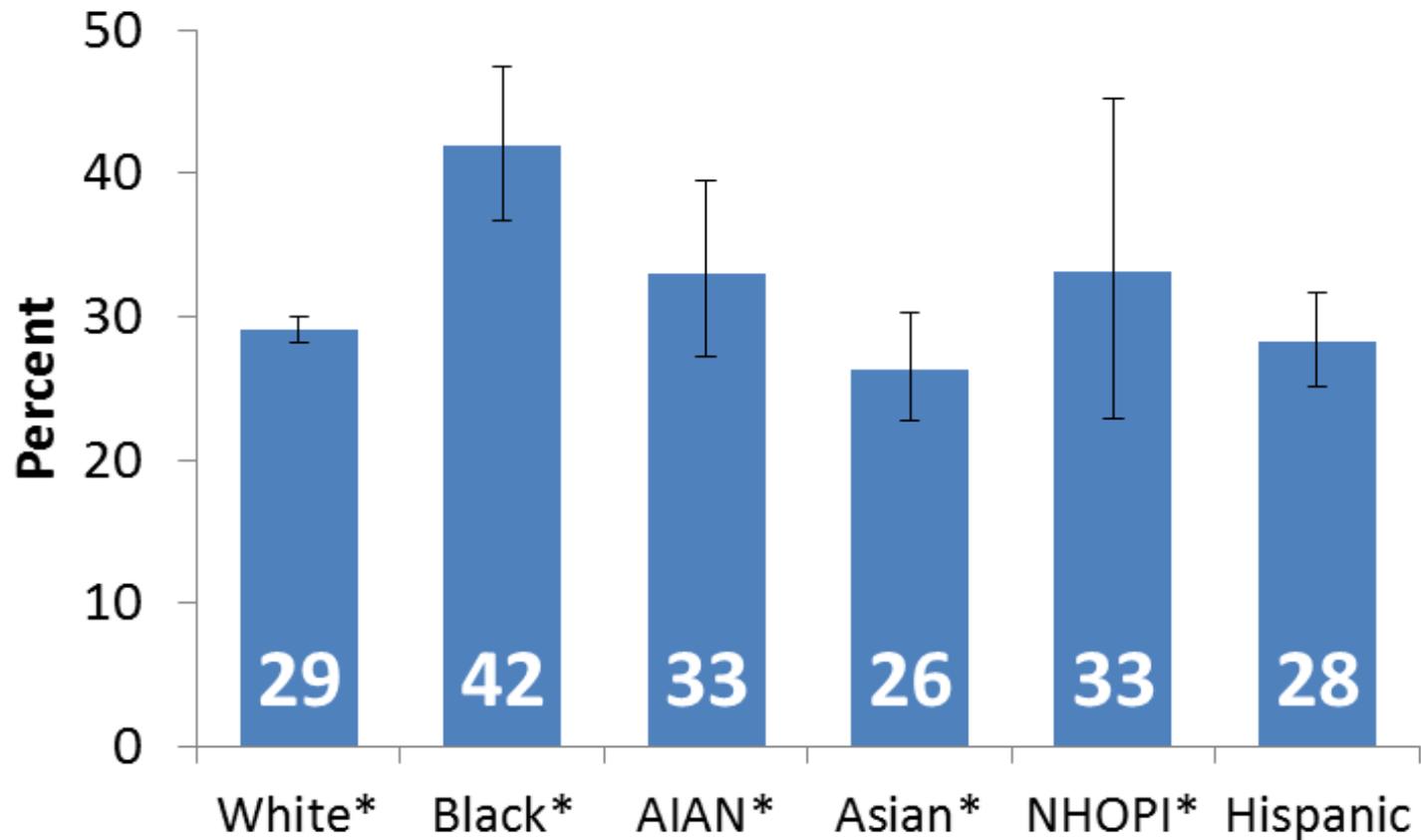
Adult Diabetes (18+ years) Washington 2011-2013



* Non-Hispanic

Source: Washington Behavioral Risk Factor Surveillance System

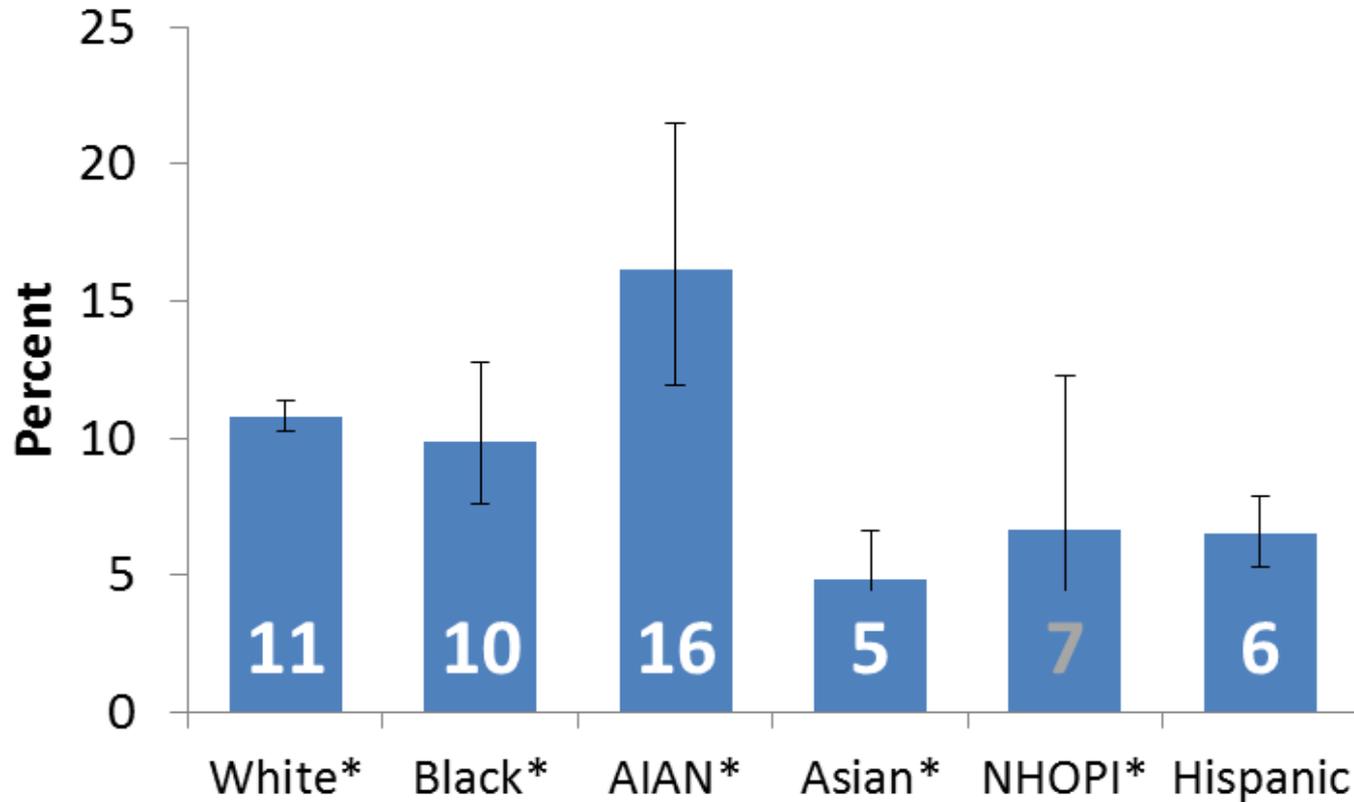
Adult Hypertension (18+ years) Washington 2011-2013



* Non-Hispanic

Source: Washington Behavioral Risk Factor Surveillance System

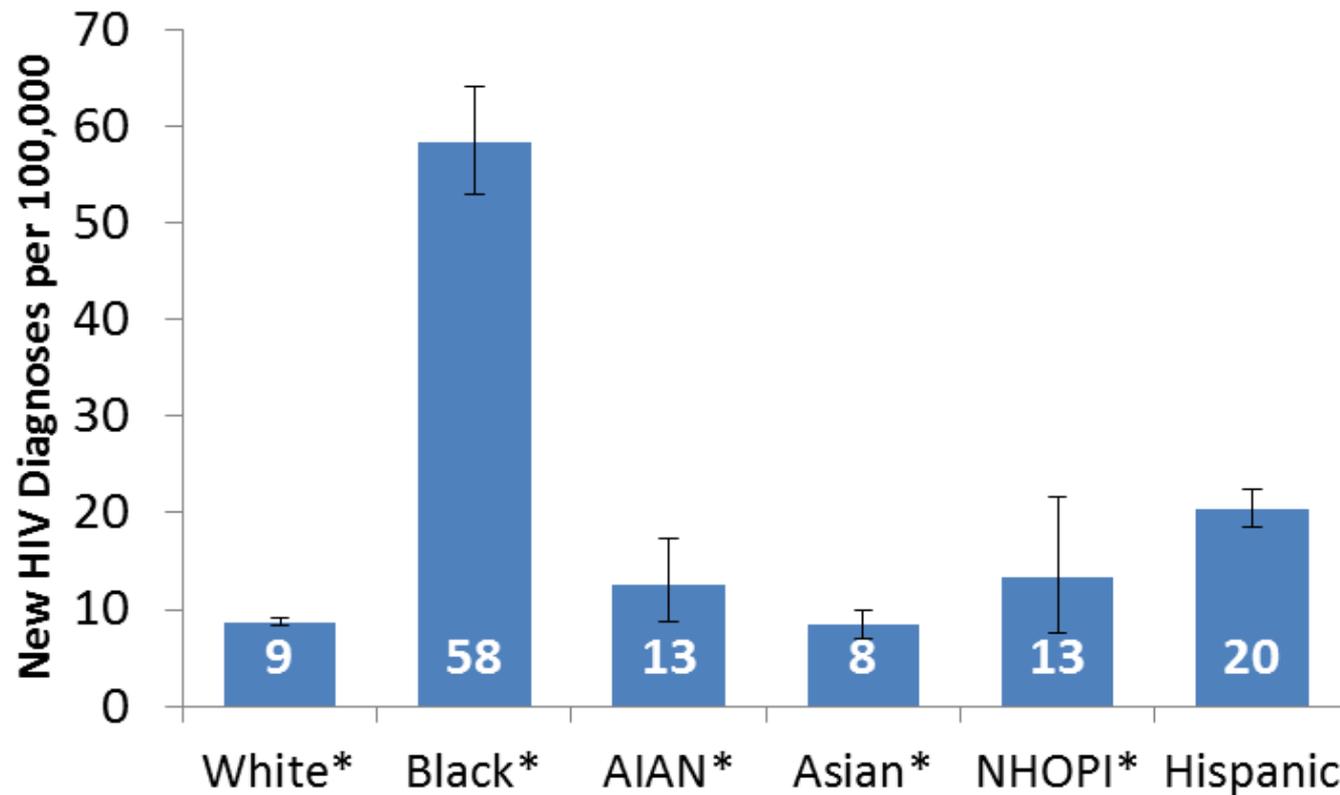
Adult Asthma (18+ yrs) Washington 2011-2013



* Non-Hispanic

Source: Washington Behavioral Risk Factor Surveillance System

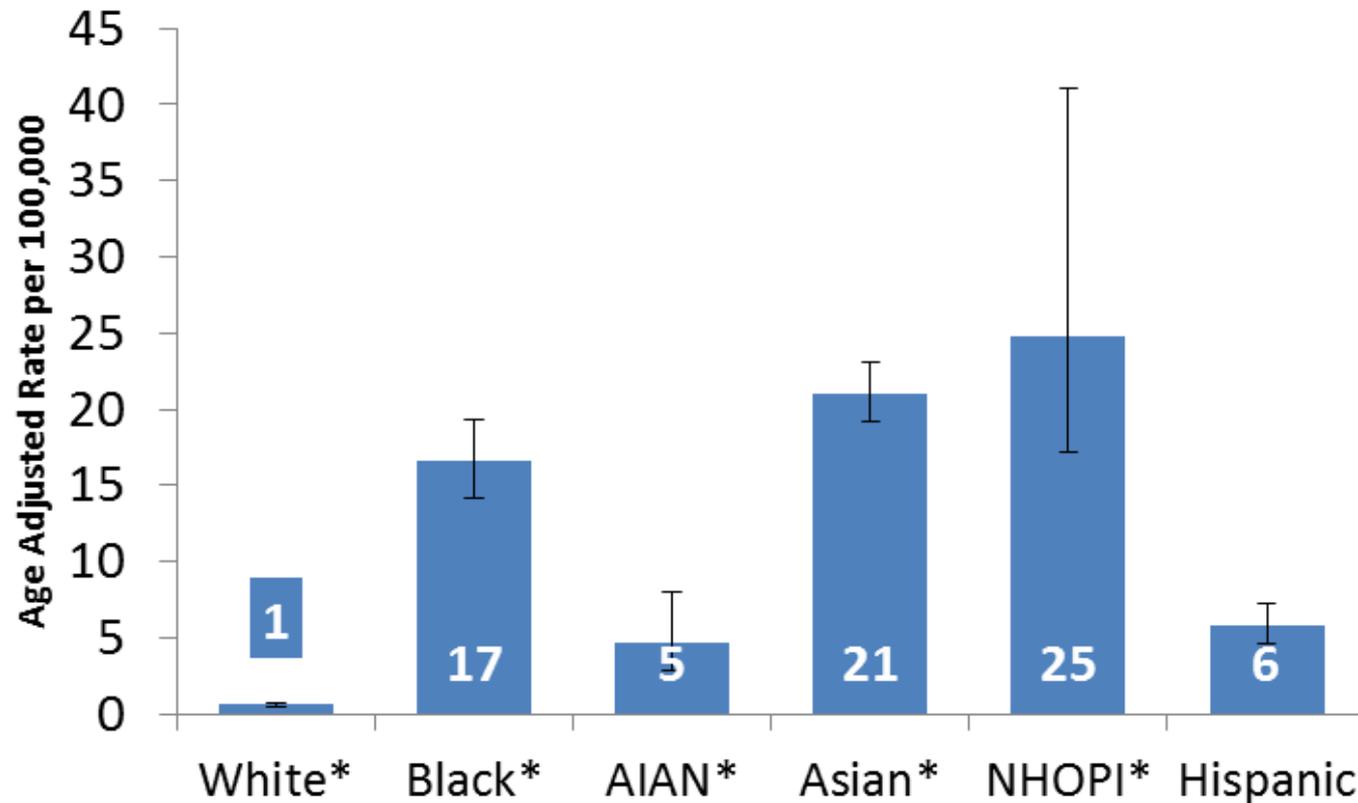
New HIV Diagnoses Washington, 2008-2012



* Non-Hispanic

Source: Washington State Enhanced HIV AIDS Reporting System (eHARS)

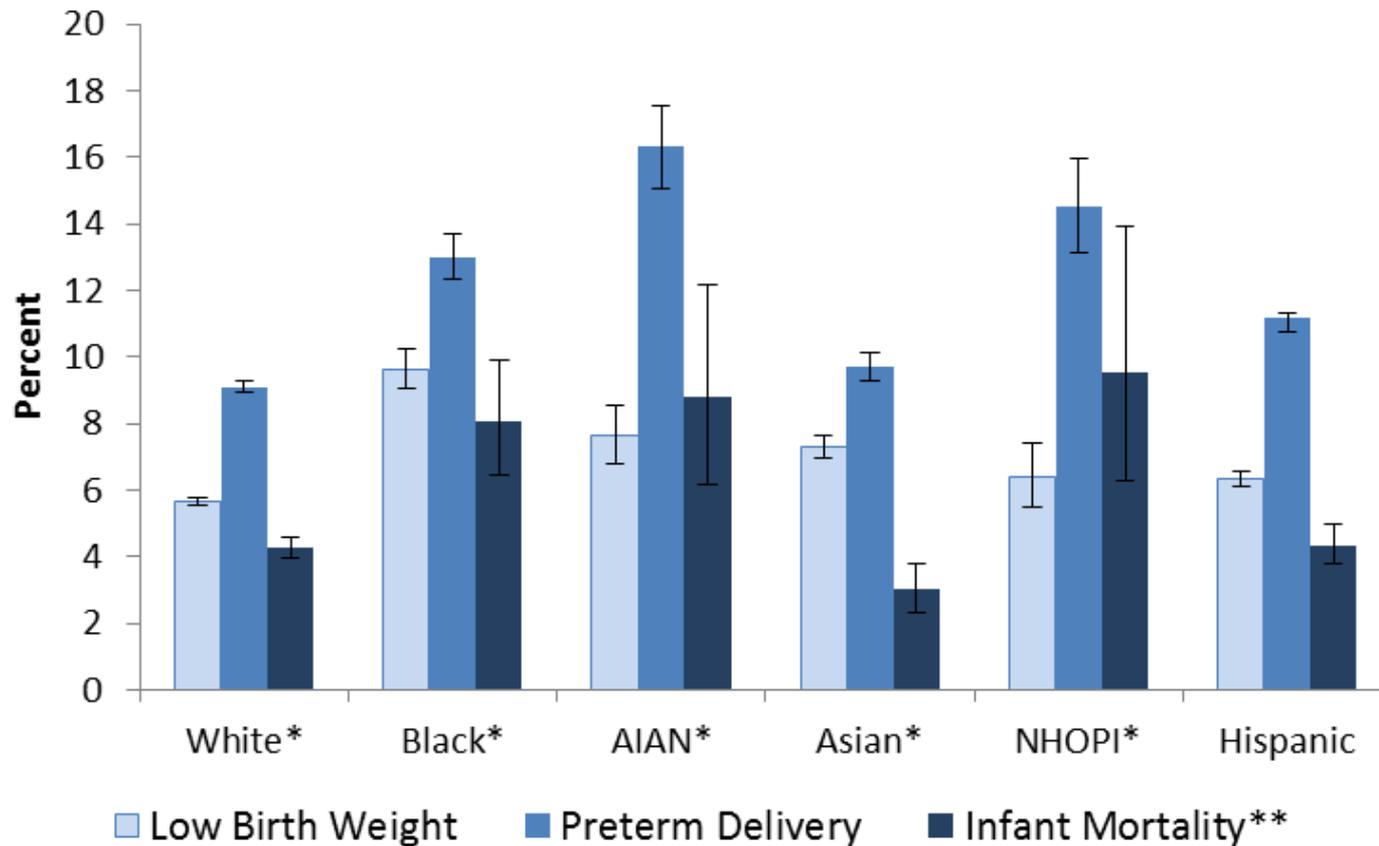
Tuberculosis Incidence Washington 2011-2013



* Non-Hispanic

Source: Washington State Notifiable Conditions Reporting

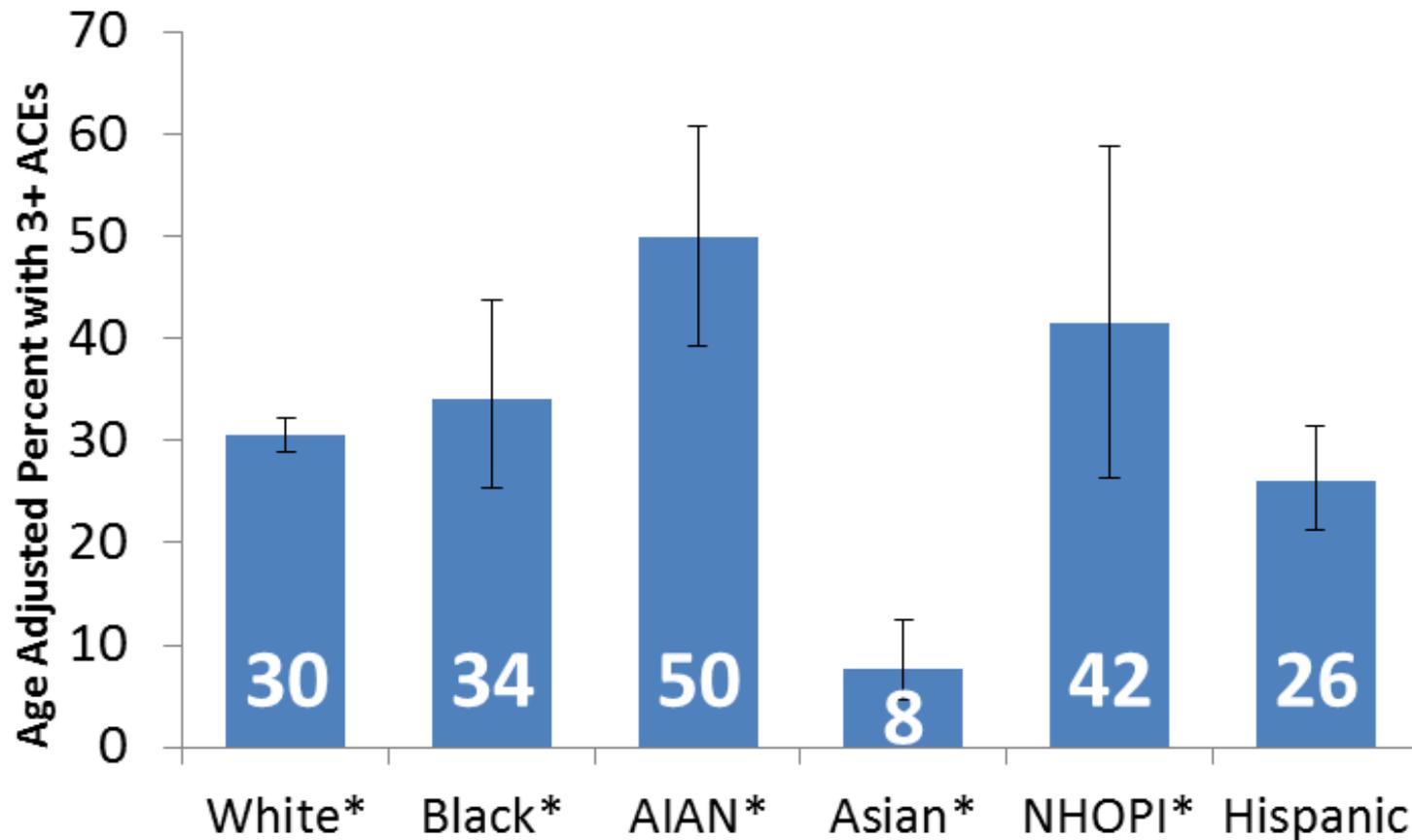
Infant Birth Outcomes Washington 2010-2012



* Non-Hispanic

Source: Washington State Vital Statistics

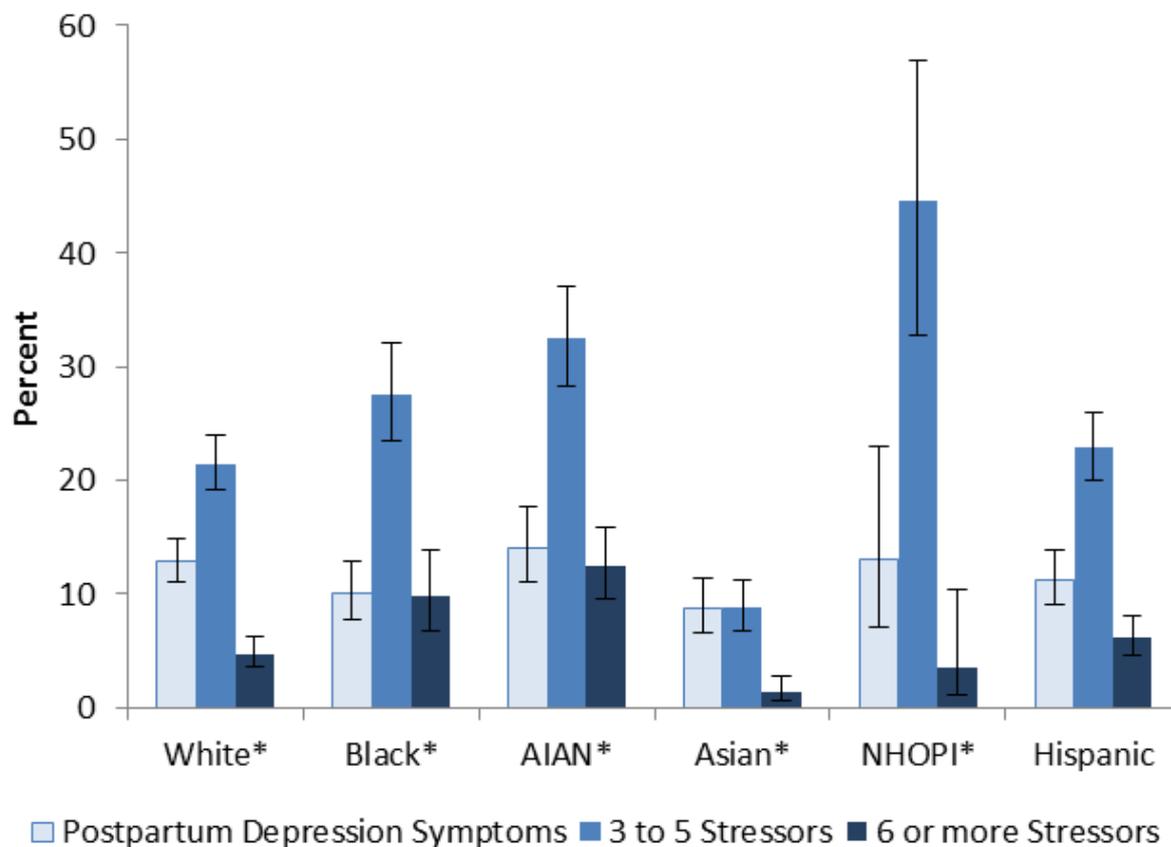
Adult Adverse Childhood Experiences (18+ years) Washington 2011-2013



* Non-Hispanic

Source: Washington Behavioral Risk Factor Surveillance System

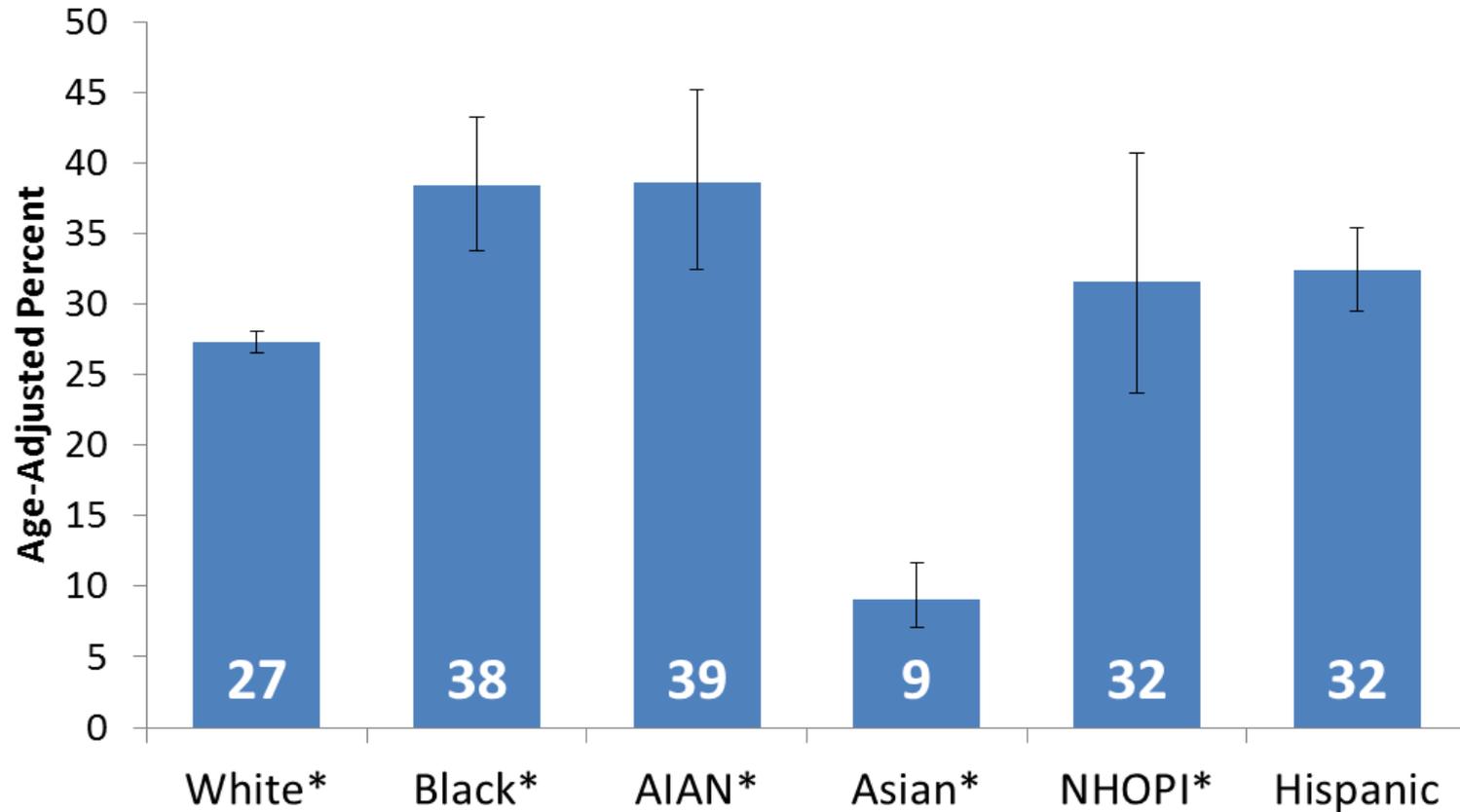
Postpartum Depression Symptoms & Stressors Washington 2009-2011



* Non-Hispanic

Source: Washington Pregnancy Risk Assessment Monitoring System

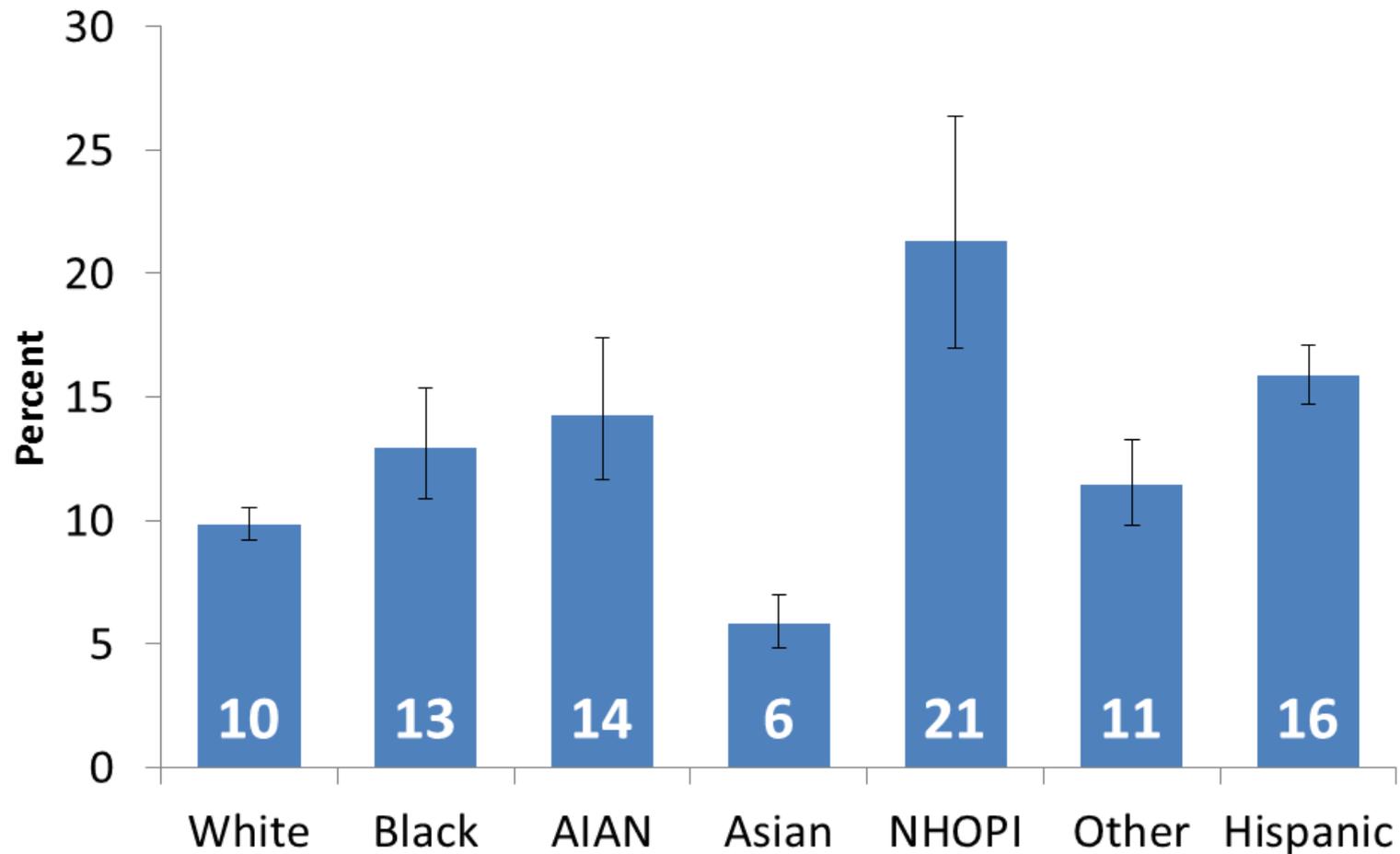
Adult Obesity (18+ years) Washington 2011-2013



* Non-Hispanic

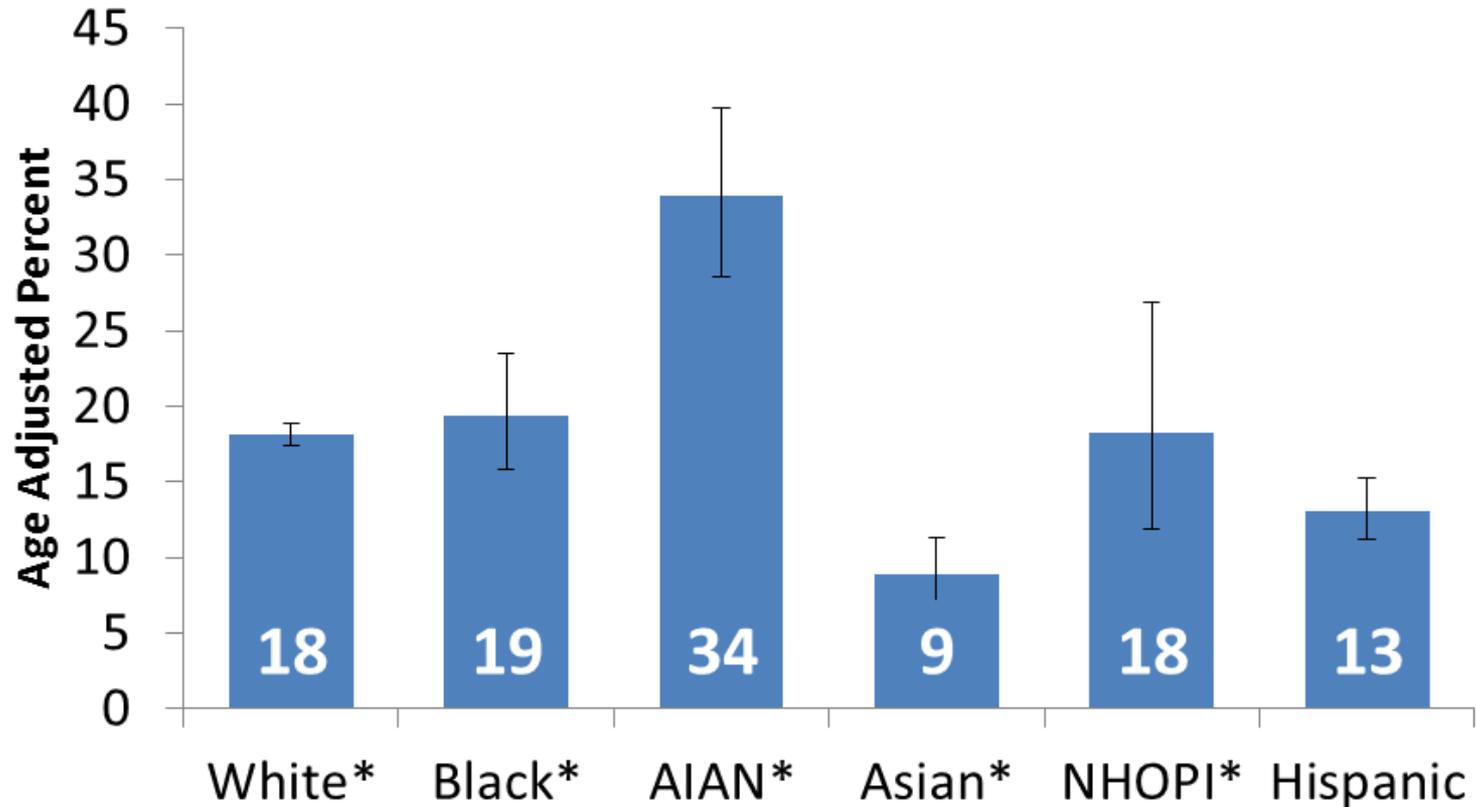
Source: Washington Behavioral Risk Factor Surveillance System

Obesity among 10th Grade Youth Washington 2014



Source: Washington Healthy Youth Survey

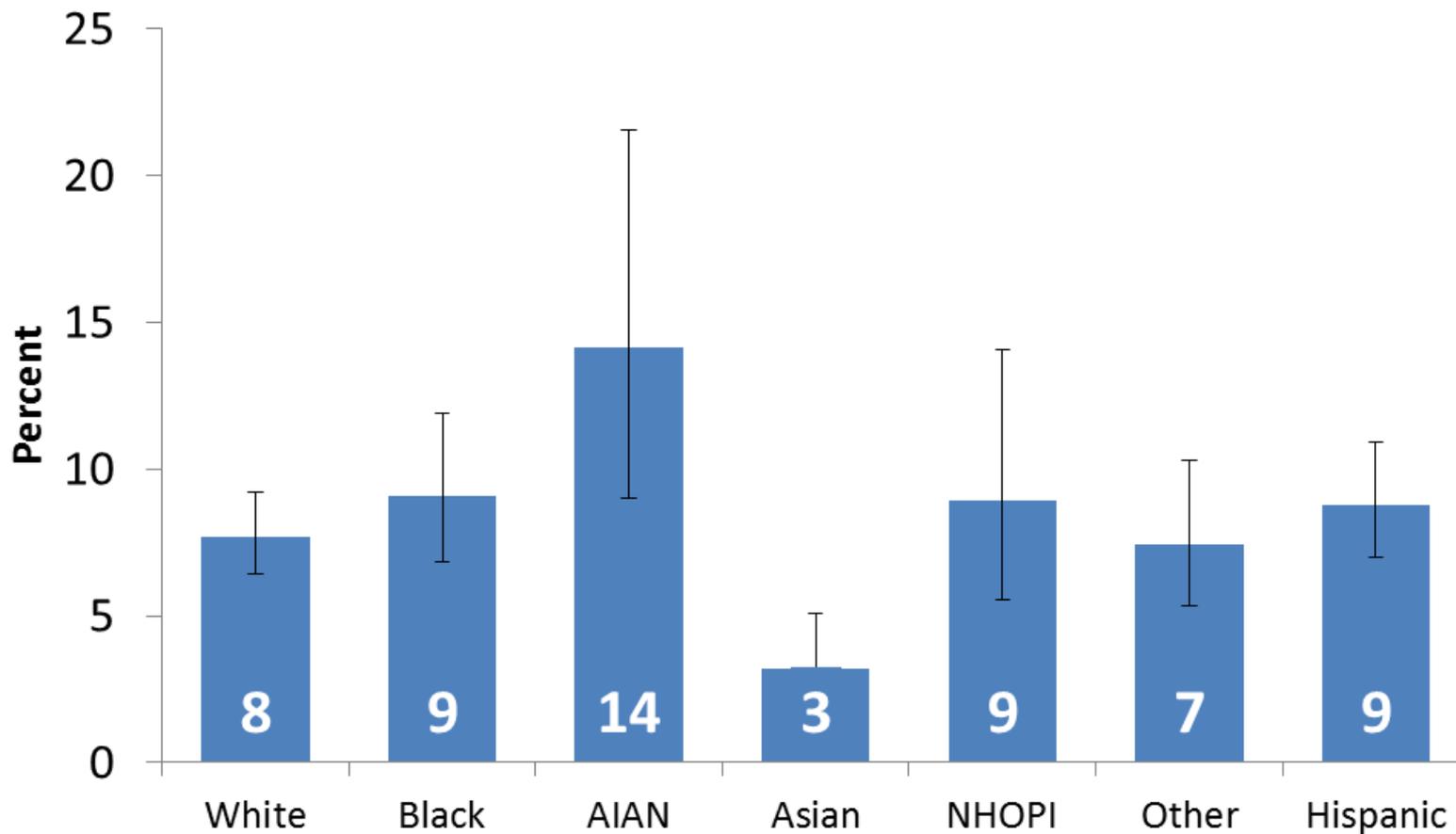
Adult Smoking (18+ years) Washington 2011-2013



* Non-Hispanic

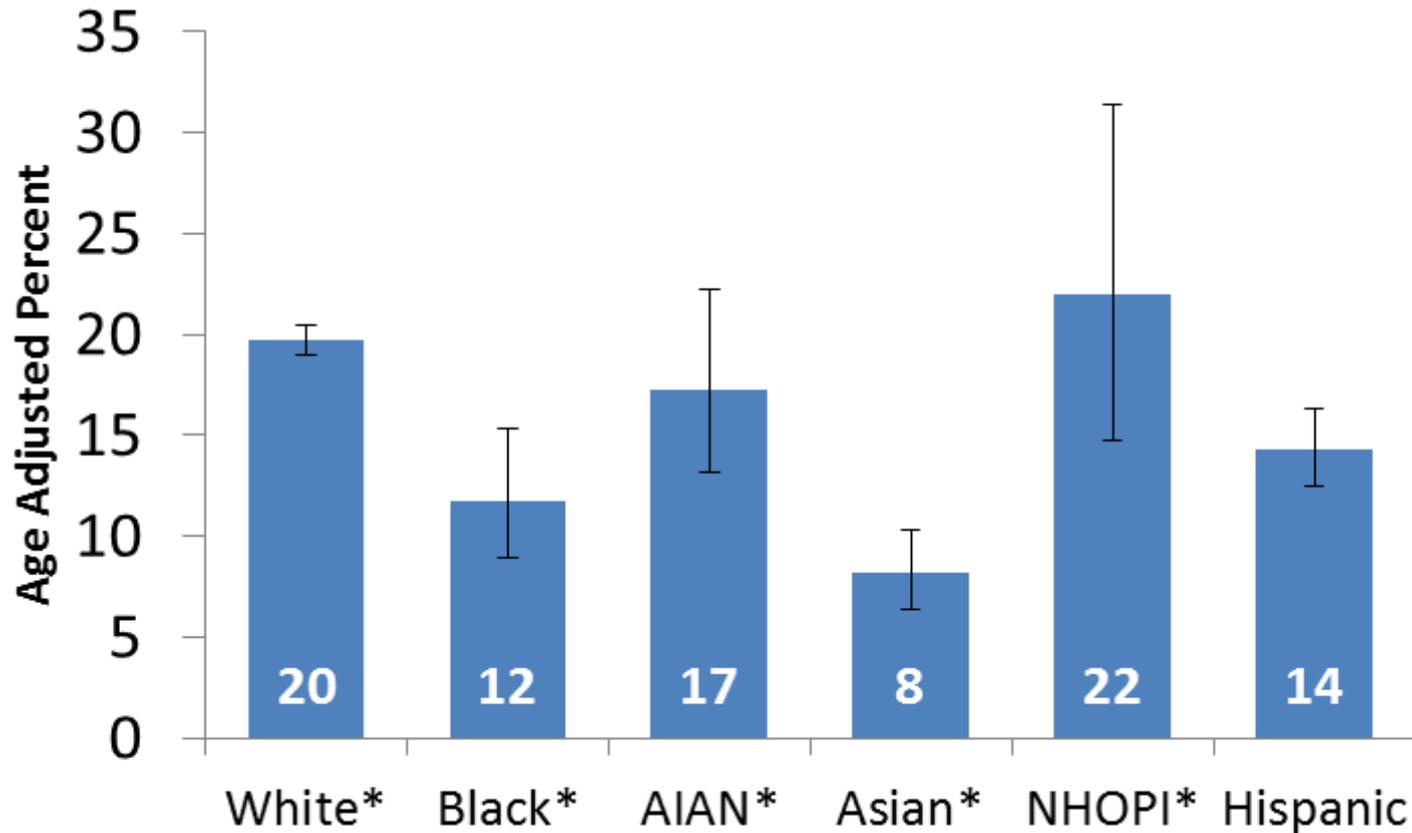
Source: Washington Behavioral Risk Factor Surveillance System

Smoking among 10th Grade Youth Washington 2014



Source: Washington Healthy Youth Survey

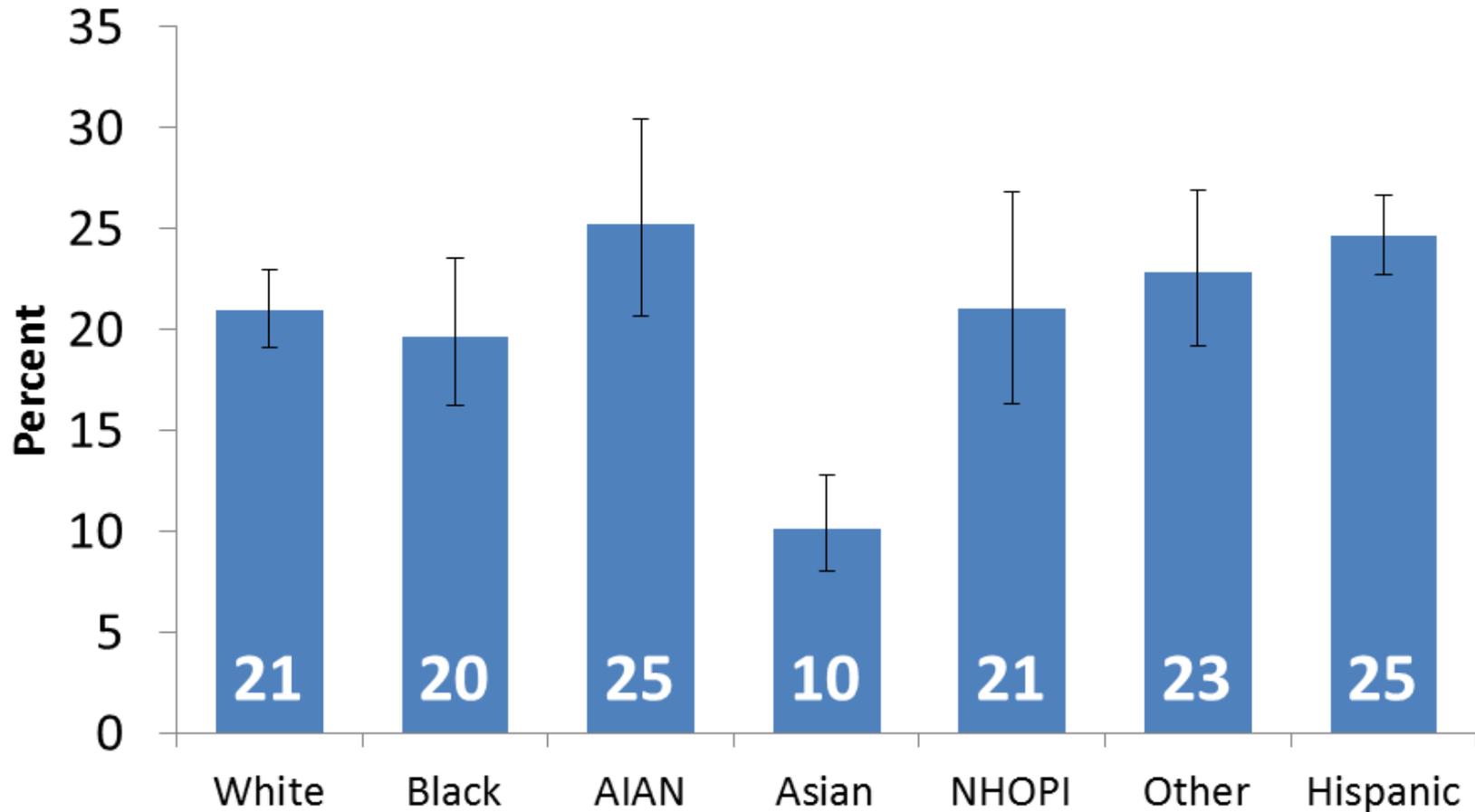
Adult Binge Drinking (18+ years) Washington 2011-2013



* Non-Hispanic

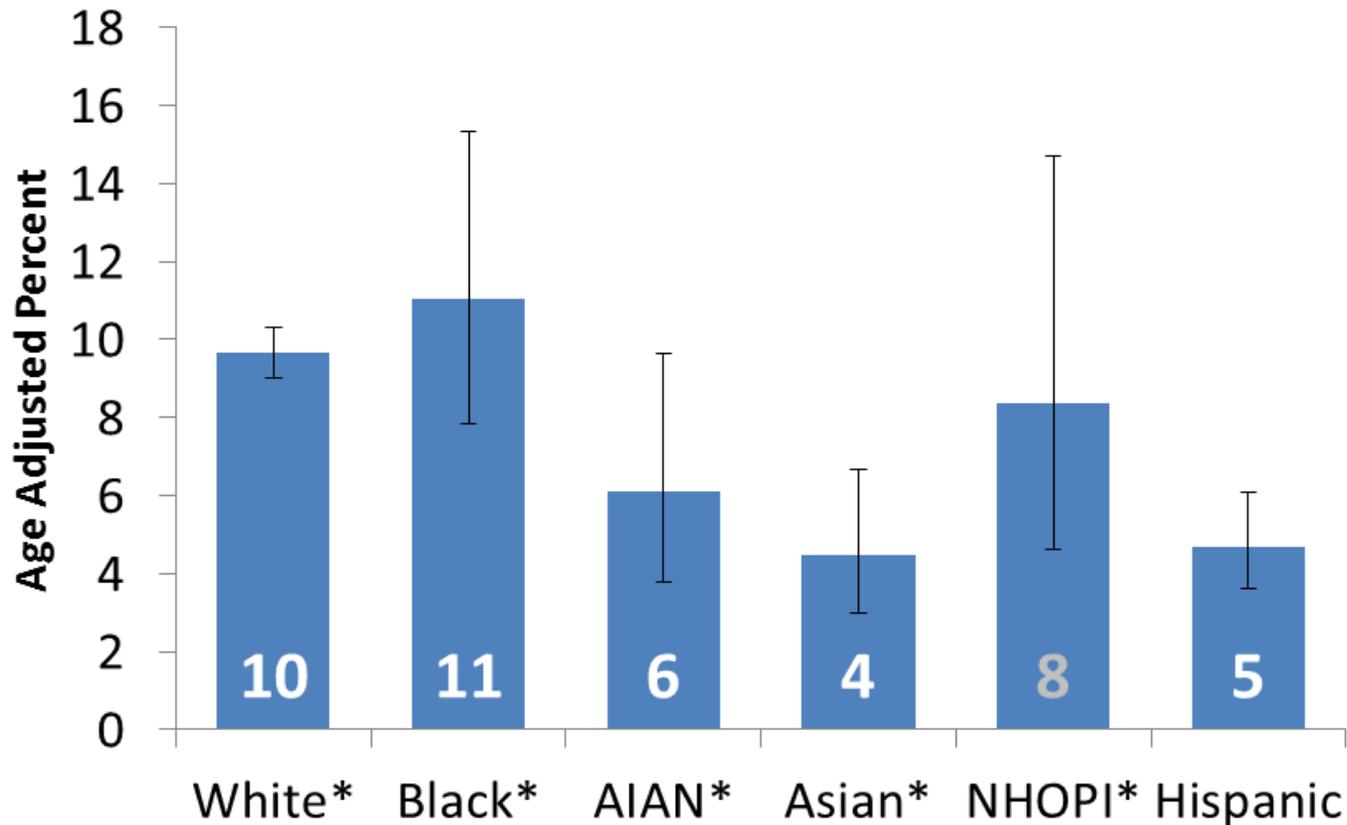
Source: Washington Behavioral Risk Factor Surveillance System

Alcohol Use among 10th Grade Youth Washington 2014



Source: Washington Healthy Youth Survey

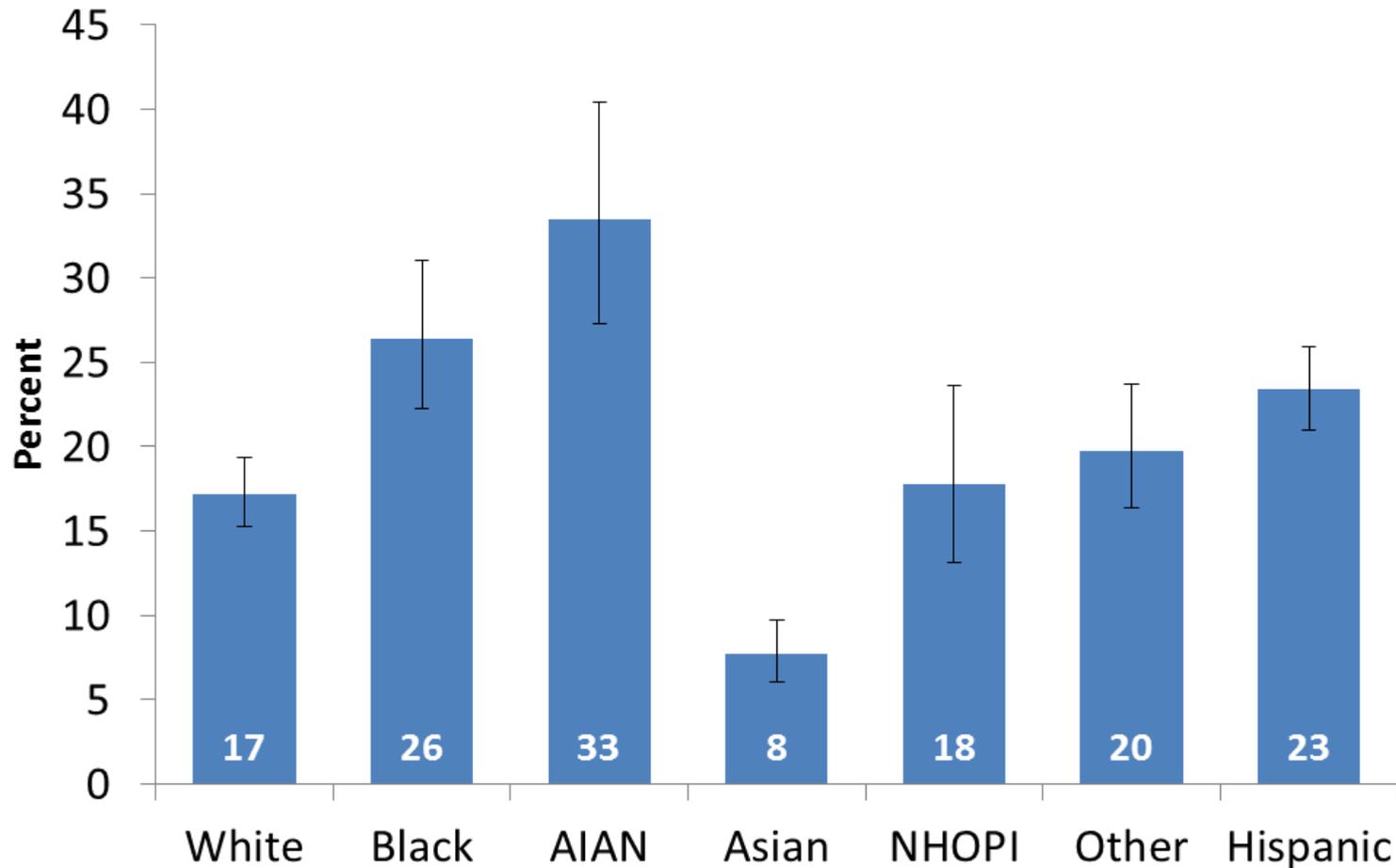
Adult Marijuana Use (18+ years) Washington 2011-2013



* Non-Hispanic

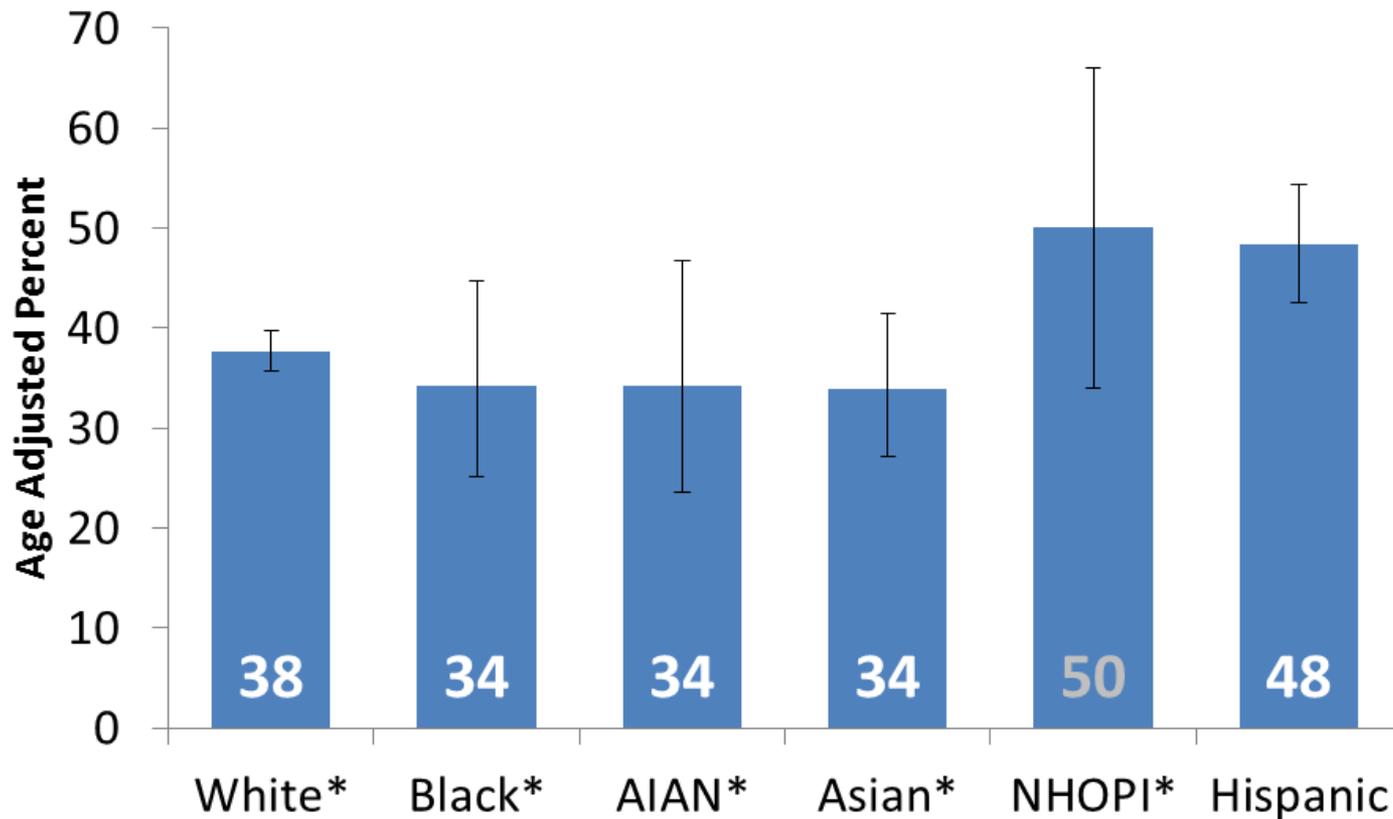
Source: Washington Behavioral Risk Factor Surveillance System

Marijuana Use among 10th Grade Youth Washington 2014



Source: Washington Healthy Youth Survey

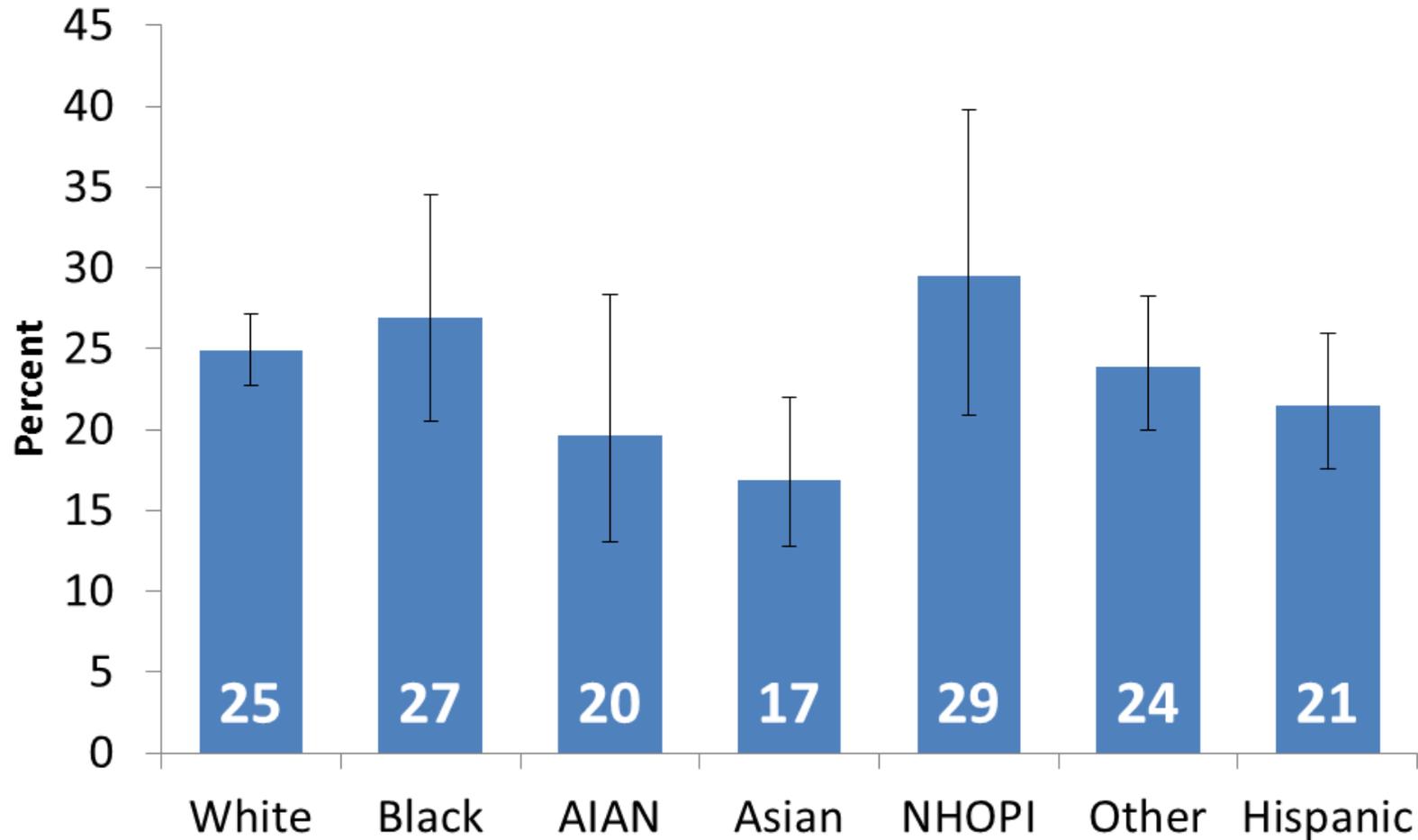
Adult Low Physical Activity (18+ years) Washington 2011-2013



* Non-Hispanic

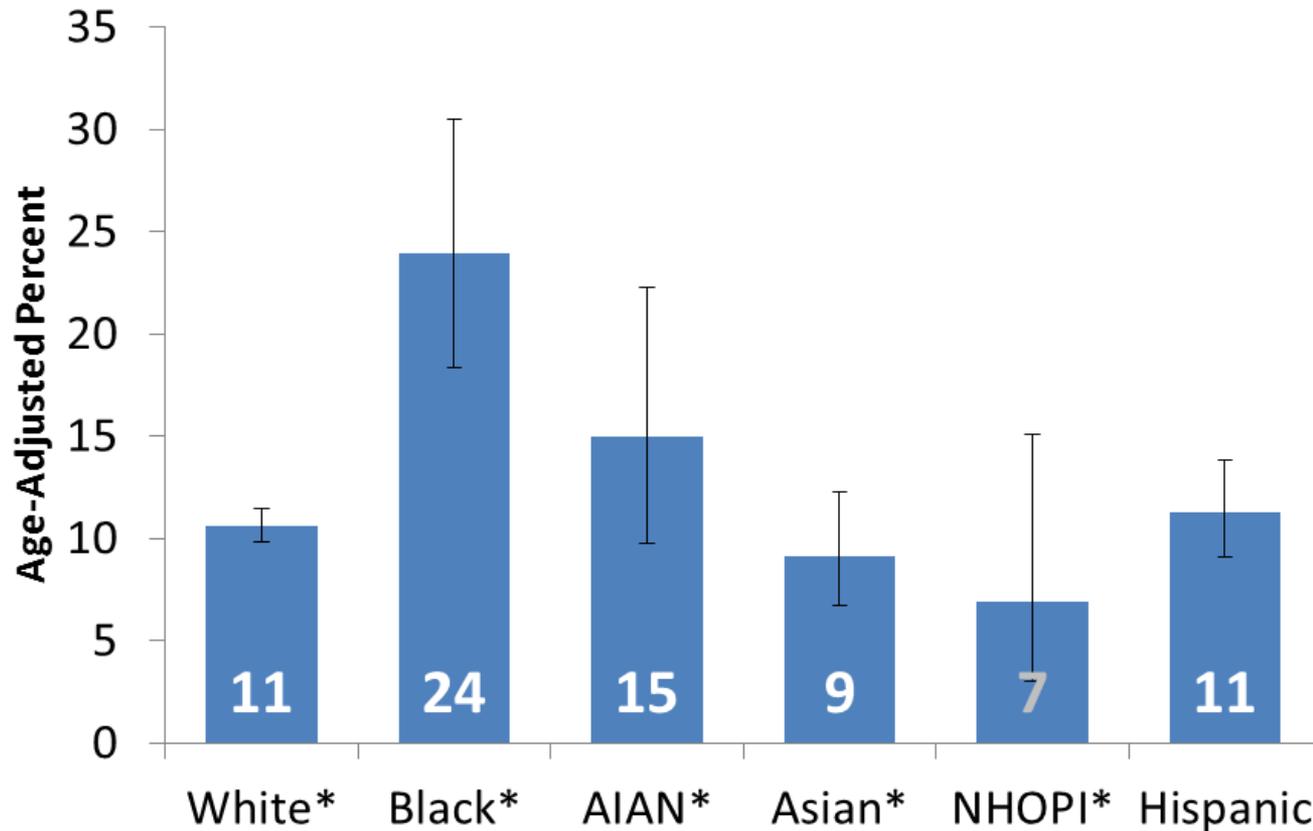
Source: Washington Behavioral Risk Factor Surveillance System

Physical Activity among 10th Grade Youth Washington 2014



Source: Washington Healthy Youth Survey

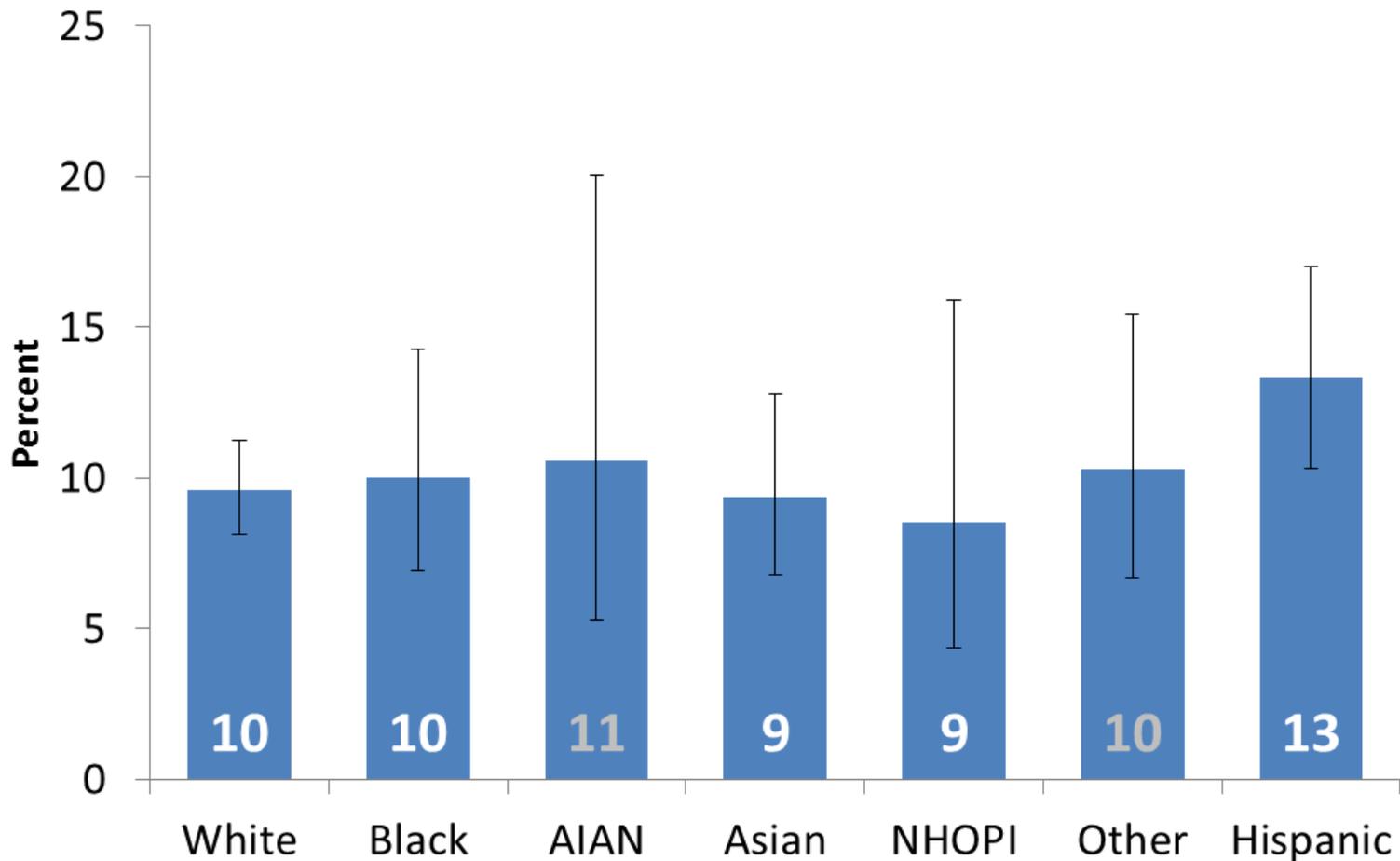
Adult Poor Nutrition (18+ years) Washington 2011-2013



* Non-Hispanic

Source: Washington Behavioral Risk Factor Surveillance System

No Fruits/Vegetables among 10th Grade Youth Washington 2014



Source: Washington Healthy Youth Survey

High Risk Disease & Risk Factors

AIAN*

- CHD Deaths
- Drug Induced Deaths
- Suicide
- Alcohol Deaths
- Diabetes
- Chr Lower Resp Dx
- Motor Vehicle Crash
- Asthma
- Preterm Delivery
- Infant Mortality
- ACEs & stressors
- Obesity
- Smoking
- Alcohol use

Black*

- Diabetes
- Chr Lower Resp Dx
- Cancer
- Hypertension
- HIV
- Tuberculosis
- Preterm Delivery
- Low Birth Weight
- Infant Mortality
- Obesity
- Marijuana Use
- Poor Nutrition

NHOPI*

- CHD Deaths
- Diabetes
- Chr Lower Resp Dx
- Cancer
- Tuberculosis
- Preterm Delivery
- Infant Mortality
- Preg Stressors
- Obesity
- Alcohol Use

* Non-Hispanic

High Risk Disease & Risk Factors

White

- Suicide
- Chr Lower Resp Dx
- Cancer
- Obesity
- Alcohol Use
- Marijuana Use

Hispanic

- Obesity
- Low Physical Activity

Asian*

- Tuberculosis

* Non-Hispanic



- What information presented today do you find most compelling?
- In addition to what you learned today, what other data or information do you need to help with Council planning?
- How do you envision using this information to prioritize, strategize and plan Council activities?



DATE: May 13, 2015

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

FROM: Emma Medicine White Crow, Chair

SUBJECT: **ADVERSE BIRTH OUTCOMES DISPARITIES RECOMMENDATIONS**

Background and Summary:

Infant mortality is a marker of a society's overall health, serving as an indicator of underlying issues like poor access to and quality of healthcare services and health inequity. As such, it is an important indicator in Results Washington, and decreasing disparities in low birthweight for African American and American Indian and Alaska Native babies is one specific objective.

In recognition of the significant and persisting disparities in adverse birth outcomes that exist in the state and out of a desire to align its work with Results Washington, the Governor's Interagency Council on Health Disparities selected adverse birth outcomes as a priority health topic. In selecting it as a priority, the Council hoped to add value to ongoing state efforts to reduce infant mortality by focusing on recommendations for state actions to promote equitable birth outcomes and reduce disparities.

On February 12, 2015, the Council convened an advisory committee to assist with developing its recommendations. Today, I have asked staff to prepare a briefing on the advisory committee's recommendations for consideration by the full Council. I am pleased that three members of the advisory committee, Devon Love from the Center for Multicultural Health, Shelley Means from the Native American Women's Dialogue on Infant Mortality, and Heather Weiher from the Health Care Authority, will join in today's presentation.

Recommended Council Action:

After reviewing the draft adverse birth outcomes report and recommendations, the Council may choose to consider, amend if necessary, and adopt the following motion:

Motion: The Council approves in concept the draft adverse birth outcomes report and recommendations as submitted on May 13, 2015, directs staff to incorporate changes from today's discussion as necessary, and authorizes the chair to approve the final version for inclusion in the Council's June 2015 Update Report.



Adverse Birth Outcomes Recommendations

Devon Love, Center for MultiCultural Health

Shelley Means, Native American Women's Dialogue on Infant Mortality

Heather Weiher, Health Care Authority

May 13, 2015

Presentation Overview

- ▶ Committee Overview
- ▶ Committee Deliberations
- ▶ Proposed Recommendations
- ▶ Additional Considerations
- ▶ Next Steps

Committee Overview

Purpose: To create proposed recommendations to eliminate disparities in in adverse birth outcomes

6 meetings

15 members & additional contributors

Committee Members

Sofia Aragon, Commission on Asian Pacific American Affairs

Vazaskia Caldwell, Council Member

Sheila Capestany, Open Arms Perinatal Services

Maria Carlos, Public Health—Seattle & King County

Kathy Chapman, Department of Health

Nora Coronado, Commission on Hispanic Affairs

Emma Medicine White Crow, Council Chair

Sharon Eloranta, Qualis Health

Neve Gerke, Midwives Association of Washington State

Lori Hernandez, Department of Early Learning

Gina Legaz, March of Dimes

Devon Love, Center for MultiCultural Health

Shelley Means, Native American Women's Dialogue on Infant Mortality

Leah Tanner, Global Alliance to Prevent Prematurity and Stillbirth

Heather Weiher, Health Care Authority

Other Contributors

Meghan Donohue, Qualis Health

Stephanie Dunkel, Department of Health

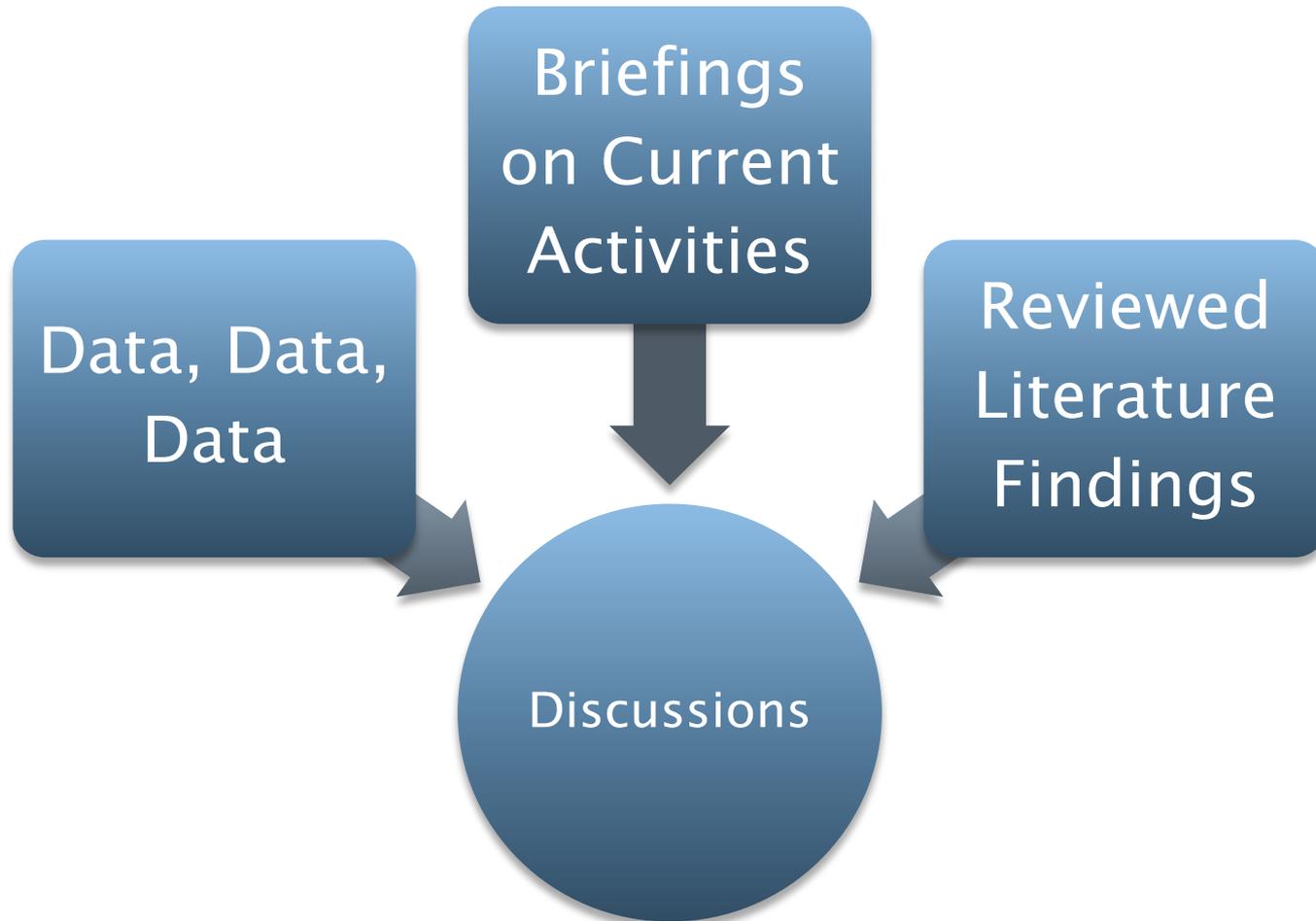
Lea Johnson, Tacoma Pierce County Public Health

Ann Mumford, Black Infant Health Program

Eva Wong, Public Health—Seattle & King County

Casey Zimmer, Health Care Authority

Committee Deliberations



Committee Deliberations



WordItOut

Criteria

Focus on reducing disparities

Be actionable, measurable, focused, feasible, and strategic

Build on practice-based evidence

Address any federal or state barriers if they exist

Prioritization

DOULAS

RACISM

PAID
FAMILY
LEAVE

FIRST
STEPS

SUPPORT
COMMUNITY

LARC

HOME
VISITING

Rec 1: Support Community

- ▶ DOH should conduct a preliminary analysis to identify local communities at high risk.
- ▶ The Legislature should provide funding to support local communities.
- ▶ Support should include funding for project implementation, technical assistance, and evaluation.
- ▶ Support should be prioritized for innovative, culturally-connected projects led by community-based organizations that are trusted among those they serve.

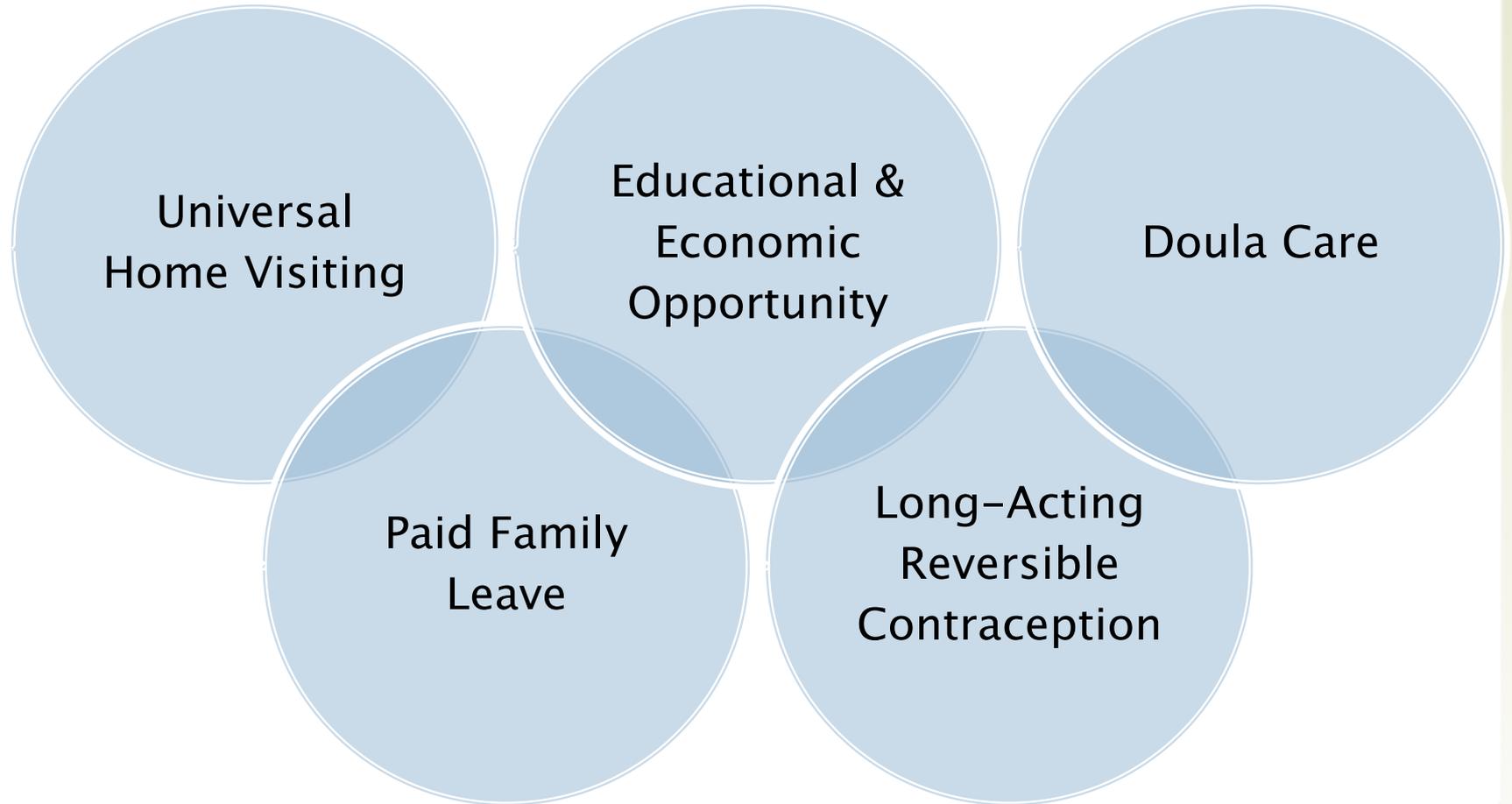
Rec 2: Enhance First Steps

- ▶ The Legislature should increase funding for the First Steps program in order to:
 - Increase the number of allowable MSS units
 - Allocate units to only be used during postpartum period
 - Enhance reimbursement for childbirth education
 - Reinstate additional payments to address performance measures
- ▶ HCA should seek input from MSS providers, community groups, and maternal and infant health experts in determining the number of units and reimbursement rate.

Rec 3: Equity in State Gov't

- ▶ The Council should create a list of cultural humility trainings and equity impact tools.
- ▶ State agencies should require employees receive training and incorporate the use of equity tools in decision making.
- ▶ The Legislature should provide funding to increase capacity for health impact reviews.

Additional Considerations



Next Steps

- ▶ Council Deliberations
- ▶ More Committee Meetings
- ▶ More Committee Recommendations



ADVERSE BIRTH OUTCOMES DISPARITIES RECOMMENDATIONS

The Governor’s Interagency Council on Health Disparities has identified three recommendations for the Legislature and state agencies to reduce disparities in adverse birth outcomes:

- **Support community-driven approaches**
- **Enhance the First Steps program**
- **Promote equity in state government**

More detailed information on these recommendations begins on page 5.

Persisting Disparities

In 2011, 387 infants died in their first year of life in Washington State. These deaths were not shared across the population uniformly. Infants whose mothers were American Indian/Alaska Native were more than three times likely to die than infants born to Asian mothers and more than two times likely to die than infants born to White mothers. Infants of Black mothers also had higher infant mortalityⁱ than those born to Asians or Whites. Infants of Pacific Islander and Hispanic mothers had elevated rates compared to those of Asians.¹ In general, disparities persist even after controlling for factors such as income, education, and socio-economic status. While the infant mortality rate has been declining in Washington during the last decade, the rate among American Indians/Alaska Natives has been increasing.²

Leading causes of infant death in Washington are birth defects, Sudden Infant Death Syndrome (SIDS), and preterm birth.³ Babies born with very low birthweightⁱⁱ are usually very premature. From 2009-2011, very low birthweight babies accounted for 1% of births yet made up 42% of all infant deaths in the state. Disparities in low birthweight and very low birthweight rates exist for all racial/ethnic groups, with rates being twice as high for African Americans as for Whites.⁴ Risk factors that contribute to the many causes of infant mortality include social isolation, poverty, smoking and other substance use during pregnancy, and maternal stress, among others. Preconception care, early and continuous prenatal care, and family planning are important strategies for preventing adverse birth outcomes. Disparities in receiving first trimester prenatal careⁱⁱⁱ exist for American Indian/Alaska Native, Black, Pacific Islander and Hispanic women.⁵

A Statewide Priority

Infant mortality is a marker of a society’s overall health, serving as an indicator of underlying issues like poor access to and quality of healthcare services and health inequity. As such, it is an important indicator in Results Washington⁶ and decreasing disparities in low birthweight is one specific objective.

Results Washington Indicator:

Decrease the percentage of infants born with low birthweight among Blacks from 9.6% in 2011 to 9.3% in 2016 and among American Indian and Alaska Native populations from 8.7% in 2011 to 8.5% in 2016.

ⁱ Infant mortality is the death of a child under one year of age.

ⁱⁱ Very low birthweight is less than 3 pounds, 5 ounces. Low birthweight is less than 5 pounds, 8 ounces.

ⁱⁱⁱ Prenatal care is comprehensive health care provided during pregnancy.

Adverse Birth Outcomes Disparities Recommendations

For Consideration by the Governor's Interagency Council on Health Disparities, May 13, 2015

There are many ongoing statewide activities aimed at promoting healthy birth outcomes. Just a few examples include:

- **Safe Deliveries Roadmap.** Led by the Washington State Hospital Association, this public-private partnership aims to improve healthcare quality during pre-pregnancy, pregnancy, labor management, and postpartum.
- **Infant Mortality CoIIN.** National effort to reduce infant mortality and improve birth outcomes across the nation. The Washington CoIIN Collaboration is supporting the Safe Deliveries Roadmap, exploring the influence of substance use and abuse on various causes of infant mortality, and identifying gaps, barriers, and potential strategies.
- **Healthier Washington.** Initiative based on the Washington State Health Care Innovation Plan. Related performance measures include unintended pregnancies and prevalence of cesarean-section for women delivering their first baby (singleton) at term and head-down.
- **Bree Collaborative.** Public-private initiative to improve healthcare quality, outcomes, and cost effectiveness. Related goals include eliminating all elective deliveries before the 39th week of pregnancy (when not medically necessary), decreasing elective inductions of labor between 39 and up to 41 weeks, and decreasing variation among Washington hospitals in the cesarean-section rate for women who have never had a cesarean-section.
- **Tribal Maternal-Infant Health Strategic Plan.** Created by the American Indian Health Commission, the Tribal Maternal-Infant Health Strategic Plan sets goals, objectives, and strategies to bring American Indians to parity with the total population in Washington State for maternal and infant health. It also suggests model programs and promising practices to carry out the strategies.
- **Apple Health Performance Improvement Plan.** Apple Health's external quality review organization, Qualis Health is in the process of developing a performance improvement plan for the Apple Health Managed Care Plans to reduce low birthweight in the African American and American Indian/Alaska Native populations.

In recognition of the significant and persisting disparities in adverse birth outcomes that exist in the state and out of a desire to align its work with Results Washington, the Governor's Interagency Council on Health Disparities selected adverse birth outcomes as a priority health topic. In selecting it as a priority, the Council expects to add value to ongoing state efforts to reduce infant mortality by focusing on recommendations for state actions to promote equitable birth outcomes and reduce disparities. The Council strongly believes that investment in maternal health, before a woman becomes pregnant, and infant health up to age one, will help put all Washington children on a path to lifelong health and success.

Adverse Birth Outcomes Disparities Advisory Committee

On February 12, 2015, the Council convened an advisory committee to assist with developing recommendations to eliminate disparities in infant mortality, low birthweight, and other adverse birth outcomes. The committee met six times from February through April 2015. Committee members represented community-based organizations and coalitions, health care providers, state and local governmental organizations, and other nonprofit organizations. Table 1 includes a list of committee members.

Adverse Birth Outcomes Disparities Recommendations

For Consideration by the Governor’s Interagency Council on Health Disparities, May 13, 2015

The committee reviewed statewide data, including perinatal periods of risk analyses, and received briefings on current activities at the national, state, and local levels to reduce infant mortality and promote healthy birth outcomes. The committee also reviewed and discussed findings from the scientific literature on potentially effective strategies. The committee discussed how evaluation of programs at the community level, particularly in communities of color, is rarely conducted. Therefore, the evidence-base to support community-based prevention activities is lacking—not because the programs are not effective, but because they have not been well researched.

Through its deliberations, the committee identified and discussed the merits of nearly 80 strategies in areas such as the social determinants of health, institutional racism, data, social support, nutrition and hunger, women’s health, family planning, innovative care models, the healthcare delivery system, healthcare workforce, parenting skills, infant health, and others.

The committee then conducted a series of prioritization activities to narrow the list to three final recommendations using the following criteria:

- Focus on reducing disparities
- Be actionable, measurable, focused, feasible, and strategic
- Build on practice-based evidence
- Address any federal or state barriers if they exist

Table 1: Adverse Birth Outcomes Disparities Advisory Committee Members	
Name	Organization/Affiliation
Sofia Aragon	Commission on Asian Pacific American Affairs
Vazaskia Caldwell	Governor’s Interagency Council on Health Disparities
Sheila Capestany	Open Arms Perinatal Services
Maria Carlos	Public Health—Seattle King County
Kathy Chapman	Department of Health
Nora Coronado	Commission on Hispanic Affairs
Emma Medicine White Crow (Chair)	Governor’s Interagency Council on Health Disparities
Sharon Eloranta	Qualis Health
Neve Gerke	Midwives Association of Washington State
Lori Hernandez	Department of Early Learning
Gina Legaz	March of Dimes
Devon Love	Center for MultiCultural Health
Shelley Means	Native American Women’s Dialogue on Infant Mortality
Leah Tanner	Global Alliance to Prevent Prematurity and Stillbirth
Heather Weiher	Health Care Authority
Consultants, Alternate Members, and Other Contributors: Meghan Donohue, Qualis Health; Stephanie Dunkel, Department of Health; Lea Johnson, Tacoma Pierce County Public Health; Ann Mumford, Black Infant Health Program; Eva Wong, Public Health—Seattle & King County; Casey Zimmer, Health Care Authority	

Recommendations

Recommendation 1—Support Community-Driven Approaches

The Department of Health should conduct a preliminary analysis to identify local communities in the state at high risk for adverse birth outcomes, such as infant mortality, fetal deaths, low birthweight, birth defects and premature birth. The Legislature should provide funding for the Department of Health to complete the analysis and create a comprehensive program to support local communities at high risk as identified through the Department's analysis or based on a community's own data and information. Support should include funding for project implementation in the community, technical assistance, and evaluation. Support should be prioritized for innovative, culturally-connected projects that are led by community-based organizations that are trusted among the communities they serve.

How do community-driven programs reduce disparities in adverse birth outcomes?

- Inequities in birth outcomes are long-standing.⁷ In order to reduce disparities, funding and other resources need to be targeted for communities at greatest risk.
- Social support for at-risk pregnant women, when delivered by a health care worker or community health worker, and continued through the prenatal and postnatal period decreases infant mortality and improves other important maternal and child health outcomes.⁸
- Anecdotally, community-based programs that provide education, resources, linkages, and support to pregnant women and to families postpartum have potential to promote equity in birth outcomes.
- More research is needed to evaluate the effectiveness of community-based programs,⁹ particularly those aimed at reducing adverse birth outcomes among diverse communities.

Recommendation 2—Enhance the First Steps program

The Legislature should increase funding for the First Steps program in order to increase the number of allowable Maternity Support Services (MSS) units^{iv}, allocate units to only be used during the postpartum period, enhance the reimbursement rate for childbirth education, and reinstate additional payments for providers to address performance measures for family planning and tobacco cessation. The Health Care Authority should seek input from MSS providers, community groups that work to improve equity in birth outcomes, and other maternal and infant health experts in determining the appropriate number of allowable MSS units and reimbursement rate.

How will enhancing the First Steps program reduce disparities in adverse birth outcomes?

- Prior to March 1, 2011, all pregnant women were eligible to receive 60 MSS units during pregnancy and 60 days postpartum. Since March 1, 2011, the allowable number of units is based on a woman's risk factors that may lead to poor birth outcomes, with the maximum allowable units being 30.
- Anecdotal information from MSS providers indicates that current unit allotments based on risk are not sufficient and many women are going without needed services. MSS providers also highlight an important need for additional postpartum units.
- The number of women receiving MSS services and the number of visits received has decreased from 2004 through 2013. In 2004, 71% of Medicaid women with deliveries received MSS, compared to 55% of

^{iv} All pregnant women enrolled in Medicaid are eligible to receive MSS and level of service is based on risk. Services are provided based on the number of allowable units and a unit is equal to 15 minutes. MSS is provided by an interdisciplinary team consisting of at least a community health nurse, a registered dietician, a behavioral health specialist, and at the discretion of the provider, a community health worker.

Adverse Birth Outcomes Disparities Recommendations

For Consideration by the Governor's Interagency Council on Health Disparities, May 13, 2015

similar women in 2013. The average number of MSS visits has decreased from 7.9 in 2004 to 5.6 in 2013.¹⁰

- In Washington State, expenditures for MSS peaked in 2005 at \$25.5 million, plus \$3.6 million for Infant Case Management and \$0.5 million for other services including Child Birth Education. By 2014, expenditures for MSS had decreased to \$7.1 million and \$1.2 million for Infant Case Management.¹¹
- Disparities in adverse birth outcomes and other related indicators continue to exist for women receiving Medicaid compared to women who do not receive Medicaid. For example, the infant mortality rate for women receiving Medicaid-funded maternity care is higher than that of infants whose mothers did not receive Medicaid-funded maternity care. In addition, women receiving Medicaid have lower rates of first trimester prenatal care and higher rates of late/no prenatal care than women who do not receive Medicaid.¹²
- A study evaluating the effect of Washington State's expansion of prenatal services, found significant improvement in low birthweight rates for single adults, African American adults, and adults and teenagers with medically high-risk conditions.¹³ In another study, an evaluation of the First Steps program from 1999-2002, showed the program was associated with a significant reduction in low birthweight, particularly among Hispanic women.¹⁴

Recommendation 3—Promote equity in state government

The Governor's Interagency Council on Health Disparities should compile a list of quality cultural humility^v trainings and make this list available to all state agencies. The Council strongly encourages state agencies to require that all employees receive cultural humility training and that all employees who work with Tribes or American Indian/Alaska Native populations receive the Government-to-Government training offered by the Governor's Office of Indian Affairs. The Council should also compile a list of tools and resources (including equity impact assessment tools) that agencies can use to assess equity impacts before policy, program, and budget decisions are made. The Council strongly encourages state agencies to incorporate the systematic use of such tools into agency decision making. The Legislature should provide additional funding to the State Board of Health to increase capacity for Health Impact Reviews, which are objective analyses of legislative and budgetary proposals to determine if there are impacts on health and health disparities.

How will equity in state government reduce disparities in adverse birth outcomes?

- There is strong evidence that maternal perceived discrimination in a variety of situations (at school, getting a job, at work, getting housing, getting medical care, and from the police or in the courts) is linked to increased rates of preterm birth, low birthweight and very low birthweight babies.¹⁵
- There is evidence that maternal stress due to discrimination causes inflammatory and infection responses in the body that lead to adverse birth outcomes.¹⁶
- Emerging practices to reduce racial disparities in birth outcomes take into account social, political, and ecological factors that influence the health of mothers and families and recognize the intergenerational effects of stress and poverty as a result of prejudice on the health of mothers and children.¹⁷

^v Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances, and to developing mutually beneficial partnerships with communities on behalf of individuals and defined populations. Citation: Tervalon and Murray-Garcia (1998). Cultural humility versus cultural competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education. *Journal of Health Care for the Poor and Underserved*;9(2):117-125

Adverse Birth Outcomes Disparities Recommendations

For Consideration by the Governor's Interagency Council on Health Disparities, May 13, 2015

- In order for the state to play a role in effectively redressing the persistent disparities in adverse birth outcomes, equity needs to be proactively considered and addressed in state policies, programs, and decisions that affect health and the social determinants of health, such as education, economic development, housing, transportation, and the environment.

Additional Considerations

The large number of potential strategies identified by the group and the difficulty the group had in narrowing the list to a few recommendations speak to how there is still so much that could and should be done to achieve equity in birth outcomes. While the committee was able to agree on three final recommendations, the committee wanted to highlight other important strategies that have potential to reduce inequities in birth outcomes.

- **Long-Acting Reversible Contraceptives (LARC).** Unintended, unwanted, and mistimed pregnancies are associated with a significant increased risk of pre-term birth and low birthweight.¹⁸ LARC methods are more than 99% effective¹⁹ at preventing pregnancy, are safe for most women and teens,²⁰ and are underutilized.²¹ The committee suggests exploring ways to reduce barriers to LARC use and encouraging healthcare providers to discuss LARC along with other contraceptive choices.
- **Universal Home Visiting.** Home visitation programs have been shown to significantly increase the use of prenatal care and improve child and infant health outcomes and depending on the specific program model, some have seen positive effects on preterm birth and low birthweight.²² The committee suggests exploring options for all women to have access to an initial prenatal home visit with appropriate levels of follow up based on need.
- **Paid Family Leave.** Mothers who are able to use the Family Medical Leave Act to take time off for pregnancy in the US tend to be wealthier and experience improved birth outcomes as a result of their ability to take leave.²³ Internationally, long duration paid parental leave has been shown to significantly decrease infant mortality.²⁴ The committee recommends exploring options for funding paid family leave in Washington State.
- **Doula Care.** There is strong evidence that doula care improves labor outcomes by reducing caesarian deliveries, length of labor, and pain medication use.²⁵ There is also strong evidence that doula care increases rates of breastfeeding.²⁶ The committee recommends exploring Medicaid reimbursement for care provided by doulas.
- **Educational and Economic Opportunity.** There is a substantial body of evidence linking education and income to various health outcomes,²⁷ including birth outcomes. The committee recommends exploring options to enhance early learning programs in communities of color, including integrating coping skills and resilience. The committee also recommends exploring educational and economic opportunities for women of color through actions such as promoting affordable housing and a living wage.

References

¹ Washington State Department of Health (June 2014). Infant Mortality: MCH Data Report. DOH 160-015.

² Washington State Department of Health (April 2013). Perinatal Indicators Report for Washington Residents: 2011 Data. DOH 950-153.

**Adverse Birth Outcomes Disparities Recommendations
For Consideration by the Governor's Interagency Council on Health Disparities, May 13, 2015**

- ³ Washington State Department of Health (March 2013). Infant Mortality: Health of Washington State.
- ⁴ Washington State Department of Health (March 2013). Infant Mortality: Health of Washington State.
- ⁵ Washington State Department of Health (June 2014). Prenatal Care: MCH Data Report. DOH 160-015.
- ⁶ Results Washington. Goal 4: Healthy & Safe Communities. Accessed at: <http://www.results.wa.gov/what-we-do/measure-results/healthy-safe-communities/goal-map>
- ⁷ Blumenshine et al. (2010). Socioeconomic disparities in adverse birth outcomes: a systematic review. *American Journal of Preventive Medicine*. 39(3):263-272.
- ⁸ Hodnett et al. (2010). Support during pregnancy for women at increased risk of low birthweight babies. *The Cochrane database of systematic reviews*. 6:Cd000198.
- Olds et al. (2002). Home visiting by paraprofessionals and by nurses: a randomized, controlled trial. *Pediatrics*. 110(3):486-496.
- Lewin et al. (2010). Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases. *The Cochrane database of systematic reviews*. 3:Cd004015.
- Olds et al. (2014). Effect of home visiting by nurses on maternal and child mortality: results of a 2-decade follow up of a randomized clinical trial. *Journal of American Medical Association Pediatrics*. 168(9):800-806.
- ⁹ Minkler (2010). Linking science and policy through community-based participatory research to study and address health disparities. *American Journal of Public Health*. 100(Suppl. 1):S81-S87.
- ¹⁰ Cawthon, L. Characteristics of Women Who Gave Birth in Washington State. Washington State Department of Social and Health Services, First Steps Database, 10/31/2012.
- ¹¹ Cawthon, L. Characteristics of Women Who Gave Birth in Washington State. Washington State Department of Social and Health Services, First Steps Database, 10/31/2012.
- ¹² Cawthon, L. Characteristics of Women Who Gave Birth in Washington State. Washington State Department of Social and Health Services, First Steps Database, 10/31/2012.
- ¹³ Baldwin et al (1998). The effect of expanding Medicaid prenatal services on birth outcomes. *American Journal of Public Health*. 88(1):1623-1629.
- ¹⁴ Arima et al (2009). The impact of the First Steps prenatal care program on birth outcomes among women receiving Medicaid in Washington State. *Health Policy*. 92(1): 49-54.
- ¹⁵ Giurgescu et al (2011). Racial Discrimination and the Black-White Gap in Adverse Birth Outcomes: A Review. *Journal of Midwifery and Women's Health*. 56:362-370.
- ¹⁶ Culhane (2011). Racial Disparities in Preterm Birth. *Seminars in Perinatology*. 35:234-239.
- ¹⁷ Pies et al. (2012). Integrating the life course perspective into a local maternal and child health program. *Maternal and Child Health Journal*. 16(3):649-655.
- Zone BB. Best Babies Zone. 2014; <http://www.bestbabieszone.org/>. Accessed 2.11.15.
- Derek et al. (2012). Practices to Reduce Infant Mortality through Equity (PRIME) Green Paper. Ann Arbor, MI: University of Michigan,
- ¹⁸ Shah et al. (2011). Intention to become pregnant and low birth weight and preterm birth: a systematic review. *Maternal and Child Health Journal*. 15(2):205-216.
- ¹⁹ Brooke et al. (2012). Effectiveness of Long-Acting Reversible Contraception. *The New England Journal of Medicine*. 366(21):1998-2007.
- ²⁰ Stoddard et al. (2011). Efficacy and safety of long-acting reversible contraception. *Drugs*. 71(8):969-980.
- ²¹ Koray Taffner et al. (2000). Why Are US Women Not Using Long-Acting Contraceptives? *Family Planning Perspectives*. July/August;32(4).
- Sonfield (2007). Popularity Disparity: Attitudes About the IUD in Europe and the United States. New York, NY: The Guttmacher Institute.
- ²² Issel et al. (2011). A review of prenatal home-visiting effectiveness for improving birth outcomes. *Journal of Obstetric, Gynecologic, and Neonatal Nursing: JOGNN / NAACOG*. 40(2):157-165.

**Adverse Birth Outcomes Disparities Recommendations
For Consideration by the Governor's Interagency Council on Health Disparities, May 13, 2015**

²³ Rossin (2011). The effects of maternity leave on children's birth and infant health outcomes in the United States. *Journal of Health Economics*.30(2):221-239

²⁴ Ruhm (2000). *Journal of Health Economics*. 19(6):931-960.

Staehelin et al. (2007). Length of maternity leave and health of mother and child--a review. *International Journal of Public Health*. 52(4):202-209.

Tanaka (2005). Parental leave and child health across OECD countries. *ECOJ The Economic Journal*. 115(501):F7-F28

²⁵ Scott et al (1999). The obstetrical and postpartum benefits of continuous support during childbirth. *Journal of Womens Health and Gender-Based Medicine*. 8(10):1257-1264.

²⁶ Mottl-Santiago et al (2008). A hospital-based doula program and childbirth outcomes in an urban, multicultural setting. *Maternal and Child Health Journal*. 12(3):372-377.

²⁷ VanEenwyk et al. (2013). *Health of Washington State Report: Social and Economic Determinants of Health*. Washington State Department of Health.



DATE: May 13, 2015

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

FROM: Emma Medicine White Crow, Chair

SUBJECT: GUIDANCE FOR PROMOTING EQUITY IN STATE POLICIES AND PROGRAMS

Background and Summary:

One of the Council's statutory responsibilities under RCW 43.20.275(2) is to "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." Over the years, we have sought public comment on what the state is doing well and how it can improve in its efforts to reduce health disparities. In addition, we have received numerous briefings on state and local activities and initiatives related to health equity and social justice, including briefings on tools developed to assist agencies to be intentional in promoting equity. The Council even decided to focus on the state system as one of its priorities and included recommendations to enhance access to state services and information for people with limited English proficiency.

Recently, through our partnership with the Governor's Healthiest Next Generation initiative, the Council was given the opportunity to develop a set of guidance that state agencies, the Governor's office, and the Legislature can use to promote equity in state government policy and program decisions. This guidance will be included in the Healthiest Next Generation final report to the Governor and Legislature as well as our next update report.

Today I have asked Council staff to provide a briefing on the process used to create the guidance as well as the specific considerations that state program staff, policy makers, and other decision makers should use in an effort to ensure that state government actions promote equity and work to redress health disparities.

Recommended Council Action:

After reviewing the draft *Guidance for Promoting Equity in State Policy and Program Development*, 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 Guidance for Promoting Equity in State Policy and Program Development as submitted on May 13, 2015, directs staff to incorporate changes from today's discussion as necessary, and authorizes the chair to approve the final version for inclusion in the Council's June 2015 Update Report.



Promoting Equity in State Policies and Programs

Governor's Interagency Council on Health Disparities

May 15, 2015

Overview

- ▶ Process
- ▶ Review Document
- ▶ Stakeholder Feedback
- ▶ Next Steps

Process



TIMELINE



STAKEHOLDERS



RESEARCH

Acknowledgments

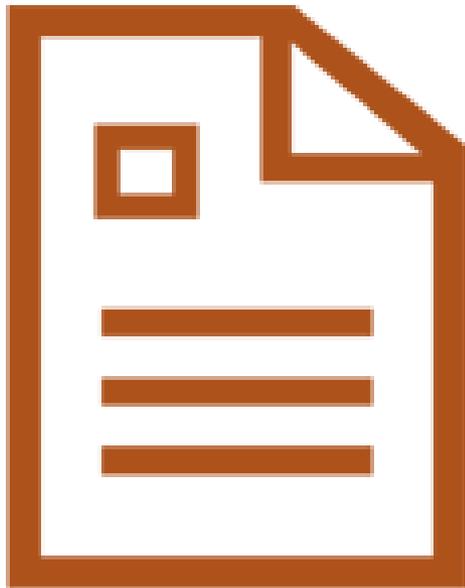
Sofia Aragon	Commission on Asian Pacific American Affairs
Michael Itti	Commission on Asian Pacific American Affairs
Nora Coronado	Commission on Hispanic Affairs
Melanie Anderson	Department of Commerce
Diane Klontz	Department of Commerce
Eli Kern	Public Health – Seattle and King County
Heather Villanueva	SEIU 775
Chris Genese	Washington Community Action Network

This is not a complete list of individuals who provided valuable insights for this document. We are still waiting for permission from some individuals to include their names and/or affiliations. We would like to thank all of the individuals who provided insight and feedback for this document.

Equity Promoting Language



Document Content



Sample Language

Frameworks and
Strategies

Equity Work

EQUITY



Promoting Equity in State Policies and Programs



Section I: Sample Language to Promote Equity in Policy

Section II: Frameworks and Important Considerations to Promote Equity

Next Steps



PROMOTING EQUITY IN STATE POLICY AND PROGRAM DEVELOPMENT

Guidance for State Agencies, the Governor's Office, and the Legislature to Promote Equity in State Government Policy and Program Decisions

Our health, and the health of our communities, is largely determined by societal factors such as access to healthy foods, safe and healthy housing, safe places to be physically active, and employment and educational opportunities. Public policy and state government influence these structural factors and therefore affect the opportunities available to all Washingtonians to be healthy. . State government has the ability to promote equity and decrease disparities. Equity means “all people have full and equal access to opportunities that enable them to attain their full potential.”¹ Disparities refer to significant differences in social or health outcomes among different groups. All Washingtonians, regardless of race/ethnicity, family income, language spoken at home, national origin, culture, immigration status, disability status, sexual orientation, gender identity or expression, education level, zip code, or any other factor, should have the opportunity to lead a happy and healthy life.

This document includes the following sections:

- **Section I:** Suggested language that can be tailored to and inserted into state policies, plans, programs, budgets, rules, grants, contracts, and solicitation documents (i.e. Request for Proposals [RFP], Request for Quotations [RFQ], Request for Qualifications and Quotations [RFQQ]) to promote equitable opportunities for health and well-being
- **Section II:** Integrated frameworks and important considerations to promote equity

SECTION I. SAMPLE LANGUAGE TO PROMOTE EQUITY IN POLICIES AND PROGRAMS

State policies and programs can cause inequity if the language is written in a way that a) negatively affects communities who are disproportionately impacted by adverse health and other outcomes, or b) benefits the majority of the population but does not provide equitable and culturally appropriate opportunities and access to resources. The Governor's Interagency Council on Health Disparities has developed this sample language to assist policy-makers in being intentional about promoting equity. The sample policy language in this document can be categorized into four distinct sections:

- Language for interventions and/or funding for populations impacted by inequity (Table 1)
- Language requiring engagement and consultation with representatives from diverse communities in decision-making processes (Table 2)
- Language requiring collection, analysis, and/or reporting of disaggregated data (Table 3)
- Inclusive language for policies and programs that can be used to strive for the greatest inclusion possible (Table 4)

¹ This definition of “equity” is from King County [Ordinance 16948](#)

Tables 1-3 highlight *examples* of language that can be inserted into state policies, plans, programs, budgets, rules, grants, contracts, and solicitation documents and does not provide a comprehensive list. Policy language in itself is not sufficient—in order for this language to be effective it needs to be paired with equity promoting processes. Every governmental decision should include thoughtful consideration of how it will serve all Washingtonians and how it will impact equity. There is no one-size-fits-all solution; however this sample language provides one tool for integrating equity considerations into state government. Table 1 is focused on provisions that can be inserted into policies and does not include guidance on writing policies with the express intention of promoting equity. These types of policies, such as anti-discrimination policies or those that are written to change a system that is creating inequity, are also an essential part of ensuring that state government actions promote equity and work to address health disparities. An example of a policy written with the intention of promoting equity is Georgia’s HB 1176 which was signed into law in 2012. This policy addresses racial/ethnic disparities in Georgia’s justice system by re-writing and editing multiple existing laws to decrease recidivism, focus on crime prevention rather than punishment, and to make diversion programs available.

Table 1. Language for interventions and/or funding for populations impacted by inequity	
Sample Language	Considerations
<p>Sample Policy Language The[campaign/funding/intervention/program/ resources/etc.] shall be culturally and linguistically appropriate and prioritized among [schools/early learning centers/communities/ etc.] that [experience the largest disparities/ experience the largest opportunity gaps/with X% of students eligible for free and reduced-price meals/that are identified through the state accountability system as challenged schools in need of improvement under RCW 28A.657.020/whose enrollment of English language learner students has increased an average of more than five percent per year over the previous three years/etc.] or targeted to reach persons from [diverse cultural, racial/ethnic, and economic backgrounds; who live in geographically isolated areas; who have mental, intellectual, sensory, or physical disabilities; who have low literacy skills, limited proficiency in the English language, or insecure immigration status; or who are part of protected or other special populations, including veterans, refugees, or homeless, gay, lesbian, bisexual, or transgender individuals.]</p>	<p>Funding and resources can promote equity when they are targeted to populations impacted by inequity. However, unfunded mandates can have disproportionate negative impacts on these same communities so it is important to pair resources with requirements particularly for communities already facing disparities.</p> <p>When possible, do not use income or other indicators as a proxy for race/ethnicity as it does not guarantee that resources will be targeted to address disparities by race/ethnicity or that outcomes will be measured by race/ethnicity.</p> <p>When deciding which indicator to use (e.g. percent of students on free and reduced price lunch, communities experiencing the largest disparities, etc.) it is important to consider what the best indicator is for the particular policy or program.</p> <p>Disparities or opportunity gaps can be gaps based on race/ethnicity, income, English proficiency, literacy, special learning needs, gender identity, sexual orientation, sex, geography, immigration status, veteran status, housing status, refugee status, disability status, etc.</p>

	While targeting resources to schools or districts experiencing inequities will help promote interschool equity, also explore potential policy language that will ensure that students who are in higher-income schools or high-performing schools that are experiencing educational disparities are also considered so that intraschool equity is also achieved. The same concept applies to early learning centers, communities, etc.
Sample Language for Solicitation Documents [State agency/etc.] is committed to serving underserved racial/ethnic and/or rural populations. XX percent of the total possible points to be awarded in this RFP have been assigned to the Social Equity criteria below: (List Criteria)	This example language can be included in RFPs and other solicitation documents. This language includes race/ethnicity and geography and is just an example. Other populations who experience inequity should also be considered such as those that are traditionally under- or inappropriately-served due to, for example: sexual orientation, gender identity, sex, housing status, income, level of English proficiency, literacy, immigration status, housing status, veteran status, refugee status, or disability status. The language should be vetted with the populations that the solicitation or policy is trying to represent or serve.
Sample Language for Solicitation Documents Preference will be given to proposals addressing underserved racial/ethnic and/or rural populations. A total of XX points are available for proposals addressing underserved racial/ethnic and/or rural populations.	

Table 2. Language requiring engagement and consultation with representatives from diverse communities in decision-making processes	
Sample Language	Considerations
In fulfilling its responsibilities under this section, the [state agency/etc.] shall collaborate with Washington’s tribes, tribal organizations, and/or urban Indian organizations; the four state ethnic commissions; nonprofit organizations knowledgeable about equity, [the opportunity gap/hunger and food security issues/housing insecurity/income insecurity/gender equity/etc.]; advocacy organizations; community based organizations; and representatives from diverse communities and populations that will be impacted.	This language should be adapted to include representatives from specific communities who will be impacted by the policy, particularly those that are frequently underrepresented in state decision-making processes. This may include lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ) individuals; veterans; refugees; adolescents and youth; or individuals with mental or physical disabilities, insecure immigration status, limited English proficiency, insecure housing status, or limited literacy skills. Other state bodies to consider including (depending on the topic area) are the Educational Opportunity Gap Oversight and Accountability Committee, the Governor’s Interagency Council on Health Disparities, and the Washington State Supreme Court Minority and Justice Commission.
The [Taskforce/Council/Board/Commission/Advisory Committee/etc.] must include X representative(s) of	

<p>federally recognized Indian tribes whose traditional lands and territories lie within the borders of Washington State, designated by the federally recognized tribes; X members appointed by the Governor in consultation with the state ethnic commissions, who represent the following populations: African-Americans, Hispanic Americans, Asian Americans, and Pacific Islander Americans; and X representative(s) from diverse communities that will be impacted.</p>	<p>It is important that these decision-makers facilitate meaningful community engagement with individuals who actually represent communities rather than selecting representatives for political reasons out of convenience. It is also essential to consider that some communities may not have traditional organizational infrastructure and that thoughtful and culturally sensitive approaches must be used in order to engage these communities. For example, some community representatives may not work for an organization that can reimburse them for travel expenses, so planning should include how these individuals are reimbursed for their time and/or personal expenses.</p>
--	--

Table 3. Language requiring collection, analysis, and/or reporting of disaggregated data	
Sample Language	Considerations
<p>The [state agency/etc.] must collect all [student/health/ incarceration/birth certificate/death certificate/etc.] race/ethnicity data using the 2015-2016 Office of Superintendent of Public Instruction’s Comprehensive Education Data Research System (CEDARS) Data Manual Appendices Y and Z, including the subracial and subethnic categories within those guidelines, with the following modifications to the subracial and subethnic categories:</p> <ul style="list-style-type: none"> (a) Further disaggregation of the Black category to differentiate [students/individuals] of African origin and [students/individuals] native to the United States with African ancestors; (b) Further disaggregation of the White category to include subethnic categories for Eastern European nationalities that have significant populations in Washington. (c) For [students/individuals who report as multiracial, collection of their racial and ethnic combination of categories. 	<p>When populations made up of diverse subpopulations are aggregated during data collection or analysis important distinctions between the subpopulations are masked. Collecting, analyzing, and reporting accurate data disaggregated by subracial and subethnic categories to the extent allowed by the data and with consideration to protecting confidentiality is essential to identifying and addressing disparities and monitoring if the policy, program, or funding interventions are affectively working toward equity and alleviating these disparities. For example, diverse subpopulations of Asian and Pacific Islanders are often collapsed into one Asian/Pacific Islander (API) data category, masking the unique outcomes and needs of these diverse communities. The 2015-2016 OSPI Manual calls for more detailed disaggregation for API and other populations which is why these standards are included in the sample language rather than U.S. Health and Human Services or Office of Management and Budget standards. However, even within a population with the same country of origin, there can be dramatic differences in outcomes and needs based on other factors such as English proficiency, immigration status, and refugee status.</p>

<p>All data-related reports prepared by the [state agency/etc.] under this title must be disaggregated by at least the following subgroups: White, Black, Hispanic, American Indian/Alaskan Native, Asian, Pacific Islander/Hawaiian Native, Multiple Races, and Other. All data-related reports must also be prepared displaying additional disaggregation of data if analysis of the data indicates significant differences among categories of individuals as it pertains to the subject of the report.</p>	<p>This example only includes data collection and reporting by race/ethnicity, but reporting by other information should be included as available and appropriate. For example, income, language spoken at home, English proficiency, literacy, gender identity, sexual orientation, sex, geography, immigration status, veteran status, housing status, refugee status, disability status, etc., can be included. How data are collected and reported should be as inclusive as possible. For example, data is frequently collected using only binary male or female response options for sex which is exclusive and ignores transgender/non-conforming people, who experience discrimination and consequent disparities. Consider including language in the policy indicating that the sex question should be open-ended rather than binary or should provide additional response options. One recommendation is to ask this as a two-part question with the second portion being provided as an open-ended question: 1) What sex were you assigned at birth? (male/female) 2) How do you identify your gender today? (male/female/transgender/genderqueer/agender/bigender/etc.). Community members can provide valuable insights on policy language in order to ensure that it does not create data collection and reporting processes which are exclusive or inappropriate.</p> <p>Reporting guidelines should also be catered to the sector. For example education reports can also include disaggregation by transitional bilingual students, special education students, or students covered by section 504 of the federal rehabilitation act of 1973, as amended (29 U.S.C. Sec. 794).</p>
--	---

Policies that are written to ensure specific populations and groups are included in the text of a policy often call for detailed language to describe the targeted group(s). Table 4 provides some language suggestions to make sure that the policy includes everybody who may identify as part of that group. It is also important to consider that policies and programs themselves can be exclusive if the language is not carefully considered. For example, gender binary language can create situations where transgender individuals are excluded. The list below is in no way exhaustive; the best course of action is to connect with members of the community or groups for which policies are written to ensure the language in the policy will translate effectively into practice.

Table 4. Inclusive language for policies and programs	
Group	Suggested Language
All racial and ethnic groups and subgroups	race, ethnicity, national origin, or color
Persons of any religious faith	religion or spiritual faith
Sex/Gender	sex assigned at birth and/or gender
LGBTQ persons*	Actual or perceived sex, sexual orientation, gender identity and/or gender expression
Creed	creed/beliefs
Tribal entities**	sovereign tribal governments and persons belonging to sovereign tribal governments
Persons with disabilities	persons with mental, intellectual, physical, or sensory disabilities
Veteran or military status	all veterans regardless of type of discharge, or persons with active military status
Immigrant/Refugee communities	national origin, English language proficiency, or immigration status
Victims of crime or domestic violence***	victims of crime and/or domestic violence, harassment or stalking
Persons convicted of a crime	offenders, convicted felons, persons convicted of misdemeanor charges and/or persons with adult or juvenile criminal records
Persons accused of a crime	persons awaiting trial and/or acquitted of a crime.
Incarcerated persons	individuals incarcerated in jail, adult or juvenile detention
Low-income persons	Persons with incomes at or below [fifty percent] of the Area Median Income (AMI) for the county or standard metropolitan statistical area in which they reside, or at or below [XX%] of the Federal Poverty Limit
Children and adolescents	juveniles/minors/individuals under XX years old
Older/aging adults	older/aging adults; persons over XX years old and/or persons perceived to be over XX years old
Pregnant women	pregnant women, breastfeeding women, and caregivers of young children
Agricultural workers	migrant and agricultural workers including persons with temporary or long-term work VISAs
<p>*In many areas, there are still fundamental misunderstandings about the unique gender identities and expressions of LGBTQ persons. LGBTQ persons are regularly misidentified based on false assumptions of appearance. In LGBTQ inclusive policies is important to cover people who may be mistaken for a specific LGBTQ identity that is inaccurate.</p> <p>** A large percentage of American Indian/Alaska Native people in Washington are urban Indians and/or are not members of a Tribal government; therefore, consider using the language "American Indian/Alaska Native" if Tribal affiliation is not needed.</p> <p>*** Victims of domestic violence, stalking, and harassment often require special policy considerations for housing, employment and privacy, as they may need to leave a job or break a lease on short notice for their own safety or the safety of their families.</p>	

SECTION II. INTEGRATED FRAMEWORKS AND IMPORTANT CONSIDERATIONS TO PROMOTE EQUITY

In developing this guidance, Council staff reached out to numerous stakeholders to seek their input. These stakeholders (Table 5) provided valuable input throughout the development of this document. Stakeholders highlighted that every policy is different and boiler-plate language will not be enough to address equity in all situations and institutions. While integrating equity-promoting language into government texts is important, creating equity in Washington State's government will require a holistic and integrated framework. The Washington State Department of Health's [Health Equity Review Planning Tool](#), the State Board of Health and the Governor's Interagency Council on Health Disparities [Health Impact Reviews](#), and Race Forward's Racial [Equity Impact Assessment Toolkit](#) are examples of tool and resources that already exist which can be used to analyze policies and programs to determine their likely impacts on equity. King County's [Equity and Social Justice Integrated Effort](#) is also an example framework to integrate equity into all levels of county government that could be adapted to state government.

During these conversations, stakeholders also identified the following important additional considerations to address equity in Washington State:

- **Collect, analyze, and use accurate disaggregated data by subracial/subethnic categories to direct state resources and programs.** Disaggregated data and community feedback should be used in tandem to ensure equitable outcomes in addition to equitable inputs. When providing inputs (funding, resources, etc.) with the *intent* of promoting equity, it is important to also create capacity to examine outcomes and adjust implementation if the outcomes are not actually promoting equity.
- **Promote diversity in state government hiring, contracting, recruitment, retention and promotion.** This includes fostering an understanding that diversity (linguistic, cultural, etc.) is an asset that should be considered in hiring practices and that a workforce that reflects the demographics of Washington will be able to better serve Washingtonians.
- **Provide cultural humility/awareness/competency training or diversity training for government employees and other public workers or occupations licensed through the state.** These trainings aim to develop competencies in working with individuals from diverse cultural backgrounds; building effective cross-cultural relationships, partnerships, and communication; and fostering more inclusive teams, environments, and communities. Some state agencies have committed to ensuring that all staff receive cultural competency/humility training.
- **Ensure that policies and practices promote full civic participation from communities that are facing inequities and do not perpetuate or create new barriers to participation.** A number of barriers can exist that prevent individuals from full civic participation such as public meeting times and locations that conflict with work schedules or childcare needs; lack interpreters at public meetings; lack of translated materials or culturally and linguistically appropriate outreach; and historical and current distrust of government. Policies can also hinder civic engagement if they create barriers to participation. Examples

would include policies that restrict voting rights or create barriers to voting or that prohibit reimbursement for travel expenses incurred while participating on a board, council, commission, or other entity.

- **Evaluate the potential equity impacts of proposed legislation, policies, and programs before implementation.** When making decisions, focus on the impact not only the intent of the decision. Individuals who have expertise in equity should contribute to this process. State agency tribal liaisons should also be involved in this process.
- **Ensure all state services and programs are culturally and linguistically appropriate for the diverse communities of Washington State.** Institute policies and processes that ensure the communication needs of the population are met, the legal requirements for language access are complied with, and the ways to implement language assistance services are understood.
- **Address the structural, institutional, and interpersonal “isms” (e.g. racism, sexism, ageism, sizeism, etc.) in state government.** Hold intentional conversations about race and other “isms” to engage political and community leaders.
- **Explore and address the equity impacts of Washington’s regressive tax system.** Washington State has the most regressive tax system of any state in the U.S.² Regressive tax systems require the lowest income individuals to pay the largest share of their income in taxes and create an inequitable tax structure.
- **Foster a consistent and respectful acknowledgement of the sovereignty of the tribal governments.** Government-to-Government Training and state agency tribal liaisons are important resources already available to state employees and elected or appointed officials. Representatives of tribal governments can provide the best guidance on if policies, programs, and actions are respecting tribal sovereignty.
- **Prioritize meaningful community engagement and relationship building.** Communities can provide the best insight into policies, processes, and programs that will work to promote equity. Community engagement is also an important way to ensure that interventions will be continued by the community if/when state-level support ends. For example, the community should be engaged when drafting solicitations for contracts or grants. A diverse advisory committee could provide feedback on draft versions of solicitation documents to ensure that the language will promote opportunity and equity and not perpetuate disparities.

² Davis C, Davis K, Gardner M, et al. Who Pays? A Distributional Analysis of the Tax Systems in All 50 States: Fifth Edition. Institute on Taxation and Economic Policy. Available at <http://www.itep.org/pdf/whopaysreport.pdf>.

Table 5. Stakeholders who Provided Guidance and Feedback on this Document

Sofia Aragon	Commission on Asian Pacific American Affairs
Michael Itti	Commission on Asian Pacific American Affairs
Nora Coronado	Commission on Hispanic Affairs
Melanie Anderson	Department of Commerce
Diane Klontz	Department of Commerce
Eli Kern	Public Health – Seattle and King County
Heather Villanueva	SEIU 775
Chris Genese	Washington Community Action Network
This is not a complete list of individuals who provided valuable insights for this document. We are still waiting for permission from some individuals to include their names and/or affiliations. We would like to thank all of the individuals who provided insight and feedback for this document.	



DATE: May 13, 2015

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

FROM: Emma Medicine White Crow, Chair

SUBJECT: **REVIEW ACTION PLAN UPDATE**

Background and Summary:

In accordance with statute, the Council submits biannual update reports to the Governor and Legislature. Today, we will have the opportunity to review and provide comment on the draft text for our *June 2015 Update* report. This latest update includes the Council's recommendations for reducing disparities in adverse birth outcomes, Council guidance for promoting equity in state policy and program development, and an update on health impact reviews.

As was done with past reports, 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 *June 2015 Update*, 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 June 2015 Update as submitted on May 13, 2015, 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.



June 2015 Update

State Action Plan to Eliminate Health Disparities

Contents

Introduction

Adverse Birth Outcomes Disparities Recommendations

Promoting Equity in State Policy and Program Development

Health Impact Reviews

Council Membership

Council Reports

June 2015

Governor's Interagency Council on Health Disparities

PO Box 47990

Olympia, WA 98504-7990

Phone: 360-236-4110

Fax: 360-236-4088

E-mail: healthequity@sboh.wa.gov

Web: <http://healthequity.wa.gov>

INTRODUCTION

The Governor’s Interagency Council on Health Disparities (Council) is charged with identifying priorities and creating recommendations for the Governor and the Legislature to eliminate health disparities by race/ethnicity and gender.

This report highlights the Council’s recommendations to eliminate disparities in adverse birth outcomes, its guidance to promote equity in state policy development and program implementation, and its partnership with the State Board of Health to complete health impact reviews.

ADVERSE BIRTH OUTCOMES DISPARITIES RECOMMENDATIONS

The Governor’s Interagency Council on Health Disparities has identified three recommendations for the Legislature and state agencies to reduce disparities in adverse birth outcomes:

- **Support community-driven approaches**
- **Enhance the First Steps program**
- **Promote equity in state government**

More detailed information on these recommendations begins on page 5.

Persisting Disparities

In 2011, 387 infants died in their first year of life in Washington State. These deaths were not shared across the population uniformly. Infants whose mothers were American Indian/Alaska Native were more than three times likely to die than infants born to Asian mothers and more than two times likely to die than infants born to White mothers. Infants of Black mothers also had higher infant mortalityⁱ than those born to Asians or Whites. Infants of Pacific Islander and Hispanic mothers had elevated rates compared to those of Asians.¹ In general, disparities persist even after controlling for factors such as income, education, and socio-economic status. While the infant mortality rate has been declining in Washington during the last decade, the rate among American Indians/Alaska Natives has been increasing.²

Leading causes of infant death in Washington are birth defects, Sudden Infant Death Syndrome (SIDS), and preterm birth.³ Babies born with very low birthweightⁱⁱ are usually very premature. From 2009-2011, very low birthweight babies accounted for 1% of births yet made up 42% of all infant deaths in the state. Disparities in low birthweight and very low birthweight rates exist for all racial/ethnic groups, with rates being twice as high for African Americans as for Whites.⁴ Risk factors that contribute to the many causes of infant mortality include social isolation, poverty,

ⁱ Infant mortality is the death of a child under one year of age.

ⁱⁱ Very low birthweight is less than 3 pounds, 5 ounces. Low birthweight is less than 5 pounds, 8 ounces.

smoking and other substance use during pregnancy, and maternal stress, among others. Preconception care, early and continuous prenatal care, and family planning are important strategies for preventing adverse birth outcomes. Disparities in receiving first trimester prenatal careⁱⁱⁱ exist for American Indian/Alaska Native, Black, Pacific Islander and Hispanic women.⁵

A Statewide Priority

Infant mortality is a marker of a society's overall health, serving as an indicator of underlying issues like poor access to and quality of healthcare services and health inequity. As such, it is an important indicator in Results Washington⁶ and decreasing disparities in low birthweight is one specific objective.

There are many ongoing statewide activities aimed at promoting healthy birth outcomes. Just a few examples include:

Results Washington Indicator:
Decrease the percentage of infants born with low birthweight among Blacks from 9.6% in 2011 to 9.3% in 2016 and among American Indian and Alaska Native populations from 8.7% in 2011 to 8.5% in 2016.

- **Safe Deliveries Roadmap.** Led by the Washington State Hospital Association, this public-private partnership aims to improve healthcare quality during pre-pregnancy, pregnancy, labor management, and postpartum.
- **Infant Mortality CoIN.** National effort to reduce infant mortality and improve birth outcomes across the nation. The Washington CoIN Collaboration is supporting the Safe Deliveries Roadmap, exploring the influence of substance use and abuse on various causes of infant mortality, and identifying gaps, barriers, and potential strategies.
- **Healthier Washington.** Initiative based on the Washington State Health Care Innovation Plan. Related performance measures include unintended pregnancies and prevalence of cesarean-section for women delivering their first baby (singleton) at term and head-down.
- **Bree Collaborative.** Public-private initiative to improve healthcare quality, outcomes, and cost effectiveness. Related goals include eliminating all elective deliveries before the 39th week of pregnancy (when not medically necessary), decreasing elective inductions of labor between 39 and up to 41 weeks, and decreasing variation among Washington hospitals in the cesarean-section rate for women who have never had a cesarean-section.
- **Tribal Maternal-Infant Health Strategic Plan.** Created by the American Indian Health Commission, the Tribal Maternal-Infant Health Strategic Plan sets goals, objectives, and strategies to bring American Indians to parity with the total population in Washington State for maternal and infant health. It also suggests model programs and promising practices to carry out the strategies.
- **Apple Health Performance Improvement Plan.** Apple Health's external quality review organization, Qualis Health is in the process of developing a performance improvement plan for the Apple Health Managed Care Plans to reduce low birthweight in the African American and American Indian/Alaska Native populations.

ⁱⁱⁱ Prenatal care is comprehensive health care provided during pregnancy.

In recognition of the significant and persisting disparities in adverse birth outcomes that exist in the state and out of a desire to align its work with Results Washington, the Governor’s Interagency Council on Health Disparities selected adverse birth outcomes as a priority health topic. In selecting it as a priority, the Council expects to add value to ongoing state efforts to reduce infant mortality by focusing on recommendations for state actions to promote equitable birth outcomes and reduce disparities. The Council strongly believes that investment in maternal health, before a woman becomes pregnant, and infant health up to age one, will help put all Washington children on a path to lifelong health and success.

Adverse Birth Outcomes Disparities Advisory Committee

On February 12, 2015, the Council convened an advisory committee to assist with developing recommendations to eliminate disparities in infant mortality, low birthweight, and other adverse birth outcomes. The committee met six times from February through April 2015. Committee members represented community-based organizations and coalitions, health care providers, state and local governmental organizations, and other nonprofit organizations. Table 1 includes a list of committee members.

The committee reviewed statewide data, including perinatal periods of risk analyses, and received briefings on current activities at the national, state, and local levels to reduce infant mortality and promote healthy birth outcomes. The committee also reviewed and discussed findings from the scientific literature on potentially effective strategies. The committee discussed how evaluation of programs at the community level, particularly in communities of color, is rarely conducted. Therefore, the evidence-base to support community-based prevention activities is lacking—not because the programs are not effective, but because they have not been well researched.

Through its deliberations, the committee identified and discussed the merits of nearly 80 strategies in areas such as the social determinants of health, institutional racism, data, social support, nutrition and hunger, women’s health, family planning, innovative care models, the healthcare delivery system, healthcare workforce, parenting skills, infant health, and others.

The committee then conducted a series of prioritization activities to narrow the list to three final recommendations using the following criteria:

- Focus on reducing disparities
- Be actionable, measurable, focused, feasible, and strategic
- Build on practice-based evidence
- Address any federal or state barriers if they exist

Table 1: Adverse Birth Outcomes Disparities Advisory Committee Members	
Name	Organization/Affiliation
Sofia Aragon	Commission on Asian Pacific American Affairs
Vazaskia Caldwell	Governor’s Interagency Council on Health Disparities
Sheila Capestany	Open Arms Perinatal Services
Maria Carlos	Public Health—Seattle King County

Kathy Chapman	Department of Health
Nora Coronado	Commission on Hispanic Affairs
Emma Medicine White Crow (Chair)	Governor’s Interagency Council on Health Disparities
Sharon Eloranta	Qualis Health
Neve Gerke	Midwives Association of Washington State
Lori Hernandez	Department of Early Learning
Gina Legaz	March of Dimes
Devon Love	Center for MultiCultural Health
Shelley Means	Native American Women’s Dialogue on Infant Mortality
Leah Tanner	Global Alliance to Prevent Prematurity and Stillbirth
Heather Weiher	Health Care Authority
Consultants, Alternate Members, and Other Contributors: Meghan Donohue, Qualis Health; Stephanie Dunkel, Department of Health; Lea Johnson, Tacoma Pierce County Public Health; Ann Mumford, Black Infant Health Program; Eva Wong, Public Health—Seattle & King County; Casey Zimmer, Health Care Authority	

Recommendations

Recommendation 1—Support Community-Driven Approaches

The Department of Health should conduct a preliminary analysis to identify local communities in the state at high risk for adverse birth outcomes, such as infant mortality, fetal deaths, low birthweight, birth defects and premature birth. The Legislature should provide funding for the Department of Health to complete the analysis and create a comprehensive program to support local communities at high risk as identified through the Department’s analysis or based on a community’s own data and information. Support should include funding for project implementation in the community, technical assistance, and evaluation. Support should be prioritized for innovative, culturally-connected projects that are led by community-based organizations that are trusted among the communities they serve.

How do community-driven programs reduce disparities in adverse birth outcomes?

- Inequities in birth outcomes are long-standing.⁷ In order to reduce disparities, funding and other resources need to be targeted for communities at greatest risk.
- Social support for at-risk pregnant women, when delivered by a health care worker or community health worker, and continued through the prenatal and postnatal period decreases infant mortality and improves other important maternal and child health outcomes.⁸
- Anecdotally, community-based programs that provide education, resources, linkages, and support to pregnant women and to families postpartum have potential to promote equity in birth outcomes.
- More research is needed to evaluate the effectiveness of community-based programs,⁹ particularly those aimed at reducing adverse birth outcomes among diverse communities.

Recommendation 2—Enhance the First Steps program

The Legislature should increase funding for the First Steps program in order to increase the number of allowable Maternity Support Services (MSS) units^{iv}, allocate units to only be used during the postpartum period, enhance the reimbursement rate for childbirth education, and reinstate additional payments for providers to address performance measures for family planning and tobacco cessation. The Health Care Authority should seek input from MSS providers, community groups that work to improve equity in birth outcomes, and other maternal and infant health experts in determining the appropriate number of allowable MSS units and reimbursement rate.

How will enhancing the First Steps program reduce disparities in adverse birth outcomes?

- Prior to March 1, 2011, all pregnant women were eligible to receive 60 MSS units during pregnancy and 60 days postpartum. Since March 1, 2011, the allowable number of units is based on a woman's risk factors that may lead to poor birth outcomes, with the maximum allowable units being 30.
- Anecdotal information from MSS providers indicates that current unit allotments based on risk are not sufficient and many women are going without needed services. MSS providers also highlight an important need for additional postpartum units.
- The number of women receiving MSS services and the number of visits received has decreased from 2004 through 2013. In 2004, 71% of Medicaid women with deliveries received MSS, compared to 55% of similar women in 2013. The average number of MSS visits has decreased from 7.9 in 2004 to 5.6 in 2013.¹⁰
- In Washington State, expenditures for MSS peaked in 2005 at \$25.5 million, plus \$3.6 million for Infant Case Management and \$0.5 million for other services including Child Birth Education. By 2014, expenditures for MSS had decreased to \$7.1 million and \$1.2 million for Infant Case Management.¹¹
- Disparities in adverse birth outcomes and other related indicators continue to exist for women receiving Medicaid compared to women who do not receive Medicaid. For example, the infant mortality rate for women receiving Medicaid-funded maternity care is higher than that of infants whose mothers did not receive Medicaid-funded maternity care. In addition, women receiving Medicaid have lower rates of first trimester prenatal care and higher rates of late/no prenatal care than women who do not receive Medicaid.¹²
- A study evaluating the effect of Washington State's expansion of prenatal services, found significant improvement in low birthweight rates for single adults, African American adults, and adults and teenagers with medically high-risk conditions.¹³ In another study, an evaluation of the First Steps program from 1999-2002, showed the program was associated with a significant reduction in low birthweight, particularly among Hispanic women.¹⁴

Recommendation 3—Promote equity in state government

^{iv} All pregnant women enrolled in Medicaid are eligible to receive MSS and level of service is based on risk. Services are provided based on the number of allowable units and a unit is equal to 15 minutes. MSS is provided by an interdisciplinary team consisting of at least a community health nurse, a registered dietician, a behavioral health specialist, and at the discretion of the provider, a community health worker.

The Governor's Interagency Council on Health Disparities should compile a list of quality cultural humility^v trainings and make this list available to all state agencies. The Council strongly encourages state agencies to require that all employees receive cultural humility training and that all employees who work with Tribes or American Indian/Alaska Native populations receive the Government-to-Government training offered by the Governor's Office of Indian Affairs. The Council should also compile a list of tools and resources (including equity impact assessment tools) that agencies can use to assess equity impacts before policy, program, and budget decisions are made. The Council strongly encourages state agencies to incorporate the systematic use of such tools into agency decision making. The Legislature should provide additional funding to the State Board of Health to increase capacity for Health Impact Reviews, which are objective analyses of legislative and budgetary proposals to determine if there are impacts on health and health disparities.

How will equity in state government reduce disparities in adverse birth outcomes?

- There is strong evidence that maternal perceived discrimination in a variety of situations (at school, getting a job, at work, getting housing, getting medical care, and from the police or in the courts) is linked to increased rates of preterm birth, low birthweight and very low birthweight babies.¹⁵
- There is evidence that maternal stress due to discrimination causes inflammatory and infection responses in the body that lead to adverse birth outcomes.¹⁶
- Emerging practices to reduce racial disparities in birth outcomes take into account social, political, and ecological factors that influence the health of mothers and families and recognize the intergenerational effects of stress and poverty as a result of prejudice on the health of mothers and children.¹⁷
- In order for the state to play a role in effectively redressing the persistent disparities in adverse birth outcomes, equity needs to be proactively considered and addressed in state policies, programs, and decisions that affect health and the social determinants of health, such as education, economic development, housing, transportation, and the environment.

Additional Considerations

The large number of potential strategies identified by the group and the difficulty the group had in narrowing the list to a few recommendations speak to how there is still so much that could and should be done to achieve equity in birth outcomes. While the committee was able to agree on three final recommendations, the committee wanted to highlight other important strategies that have potential to reduce inequities in birth outcomes.

- **Long-Acting Reversible Contraceptives (LARC).** Unintended, unwanted, and mistimed pregnancies are associated with a significant increased risk of pre-term birth and low birthweight.¹⁸ LARC methods are more than 99% effective¹⁹ at preventing pregnancy, are safe for most women and

^v Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances, and to developing mutually beneficial partnerships with communities on behalf of individuals and defined populations. Citation: Tervalon and Murray-Garcia (1998). Cultural humility versus cultural competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education. *Journal of Health Care for the Poor and Underserved*;9(2):117-125

teens,²⁰ and are underutilized.²¹ The committee suggests exploring ways to reduce barriers to LARC use and encouraging healthcare providers to discuss LARC along with other contraceptive choices.

- **Universal Home Visiting.** Home visitation programs have been shown to significantly increase the use of prenatal care and improve child and infant health outcomes and depending on the specific program model, some have seen positive effects on preterm birth and low birthweight.²² The committee suggests exploring options for all women to have access to an initial prenatal home visit with appropriate levels of follow up based on need.
- **Paid Family Leave.** Mothers who are able to use the Family Medical Leave Act to take time off for pregnancy in the US tend to be wealthier and experience improved birth outcomes as a result of their ability to take leave.²³ Internationally, long duration paid parental leave has been shown to significantly decrease infant mortality.²⁴ The committee recommends exploring options for funding paid family leave in Washington State.
- **Doula Care.** There is strong evidence that doula care improves labor outcomes by reducing caesarian deliveries, length of labor, and pain medication use.²⁵ There is also strong evidence that doula care increases rates of breastfeeding.²⁶ The committee recommends exploring Medicaid reimbursement for care provided by doulas.
- **Educational and Economic Opportunity.** There is a substantial body of evidence linking education and income to various health outcomes,²⁷ including birth outcomes. The committee recommends exploring options to enhance early learning programs in communities of color, including integrating coping skills and resilience. The committee also recommends exploring educational and economic opportunities for women of color through actions such as promoting affordable housing and a living wage.

References

¹ Washington State Department of Health (June 2014). Infant Mortality: MCH Data Report. DOH 160-015.

² Washington State Department of Health (April 2013). Perinatal Indicators Report for Washington Residents: 2011 Data. DOH 950-153.

³ Washington State Department of Health (March 2013). Infant Mortality: Health of Washington State.

⁴ Washington State Department of Health (March 2013). Infant Mortality: Health of Washington State.

⁵ Washington State Department of Health (June 2014). Prenatal Care: MCH Data Report. DOH 160-015.

⁶ Results Washington. Goal 4: Healthy & Safe Communities. Accessed at:

<http://www.results.wa.gov/what-we-do/measure-results/healthy-safe-communities/goal-map>

⁷ Blumenshine et al. (2010). Socioeconomic disparities in adverse birth outcomes: a systematic review. *American Journal of Preventive Medicine*. 39(3):263-272.

⁸ Hodnett et al. (2010). Support during pregnancy for women at increased risk of low birthweight babies. *The Cochrane database of systematic reviews*. 6:Cd000198.

Olds et al. (2002). Home visiting by paraprofessionals and by nurses: a randomized, controlled trial. *Pediatrics*. 110(3):486-496.

Lewin et al. (2010). Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases. *The Cochrane database of systematic reviews*. 3:Cd004015.

Olds et al. (2014). Effect of home visiting by nurses on maternal and child mortality: results of a 2-decade follow up of a randomized clinical trial. *Journal of American Medical Association Pediatrics*. 168(9):800-806.

⁹ Minkler (2010). Linking science and policy through community-based participatory research to study and address health disparities. *American Journal of Public Health*. 100(Suppl. 1):S81-S87.

¹⁰ Cawthon, L. Characteristics of Women Who Gave Birth in Washington State. Washington State Department of Social and Health Services, First Steps Database, 10/31/2012.

¹¹ Cawthon, L. Characteristics of Women Who Gave Birth in Washington State. Washington State Department of Social and Health Services, First Steps Database, 10/31/2012.

¹² Cawthon, L. Characteristics of Women Who Gave Birth in Washington State. Washington State Department of Social and Health Services, First Steps Database, 10/31/2012.

¹³ Baldwin et al (1998). The effect of expanding Medicaid prenatal services on birth outcomes. *American Journal of Public Health*. 88(1):1623-1629.

¹⁴ Arima et al (2009). The impact of the First Steps prenatal care program on birth outcomes among women receiving Medicaid in Washington State. *Health Policy*. 92(1): 49-54.

¹⁵ Giurgescu et al (2011). Racial Discrimination and the Black-White Gap in Adverse Birth Outcomes: A Review. *Journal of Midwifery and Women's Health*. 56:362-370.

¹⁶ Culhane (2011). Racial Disparities in Preterm Birth. *Seminars in Perinatology*. 35:234-239.

¹⁷ Pies et al. (2012). Integrating the life course perspective into a local maternal and child health program. *Maternal and Child Health Journal*. 16(3):649-655.

Zone BB. Best Babies Zone. 2014; <http://www.bestbabieszone.org/>. Accessed 2.11.15.

Derek et al. (2012). Practices to Reduce Infant Mortality through Equity (PRIME) Green Paper. Ann Arbor, MI: University of Michigan,

¹⁸ Shah et al. (2011). Intention to become pregnant and low birth weight and preterm birth: a systematic review. *Maternal and Child Health Journal*. 15(2):205-216.

¹⁹ Brooke et al. (2012). Effectiveness of Long-Acting Reversible Contraception. *The New England Journal of Medicine*. 366(21):1998-2007.

²⁰ Stoddard et al. (2011). Efficacy and safety of long-acting reversible contraception. *Drugs*. 71(8):969-980.

²¹ Koray Taffner et al. (2000). Why Are US Women Not Using Long-Acting Contraceptives? *Family Planning Perspectives*. July/August;32(4).

Sonfield (2007). *Popularity Disparity: Attitudes About the IUD in Europe and the United States*. New York, NY: The Guttmacher Institute.

²² Issel et al. (2011). A review of prenatal home-visiting effectiveness for improving birth outcomes. *Journal of Obstetric, Gynecologic, and Neonatal Nursing: JOGNN / NAACOG*. 40(2):157-165.

²³ Rossin (2011). The effects of maternity leave on children's birth and infant health outcomes in the United States. *Journal of Health Economics*. 30(2):221-239

²⁴ Ruhm (2000). *Journal of Health Economics*. 19(6):931-960.

Staehelin et al. (2007). Length of maternity leave and health of mother and child--a review. *International Journal of Public Health*. 52(4):202-209.

Tanaka (2005). Parental leave and child health across OECD countries. *ECJ The Economic Journal*. 115(501):F7-F28

²⁵ Scott et al (1999). The obstetrical and postpartum benefits of continuous support during childbirth. *Journal of Womens Health and Gender-Based Medicine*. 8(10):1257-1264.

²⁶ Mottl-Santiago et al (2008). A hospital-based doula program and childbirth outcomes in an urban, multicultural setting. *Maternal and Child Health Journal*. 12(3):372-377.

²⁷ VanEenwyk et al. (2013). *Health of Washington State Report: Social and Economic Determinants of Health*. Washington State Department of Health.

PROMOTING EQUITY IN STATE POLICY AND PROGRAM DEVELOPMENT

Guidance for State Agencies, the Governor’s Office, and the Legislature to Promote Equity in State Government Policy and Program Decisions

Our health, and the health of our communities, is largely determined by societal factors such as access to healthy foods, safe and healthy housing, safe places to be physically active, and employment and educational opportunities. Public policy and state government influence these structural factors and therefore affect the opportunities available to all Washingtonians to be healthy. . State government has the ability to promote equity and decreases disparities. Equity means “all people have full and equal access to opportunities that enable them to attain their full potential.”^{vi} Disparities refer to significant differences in social or health outcomes among different groups. All Washingtonians, regardless of race/ethnicity, family income, language spoken at home, national origin, culture, immigration status, disability status, sexual orientation, gender identity or expression, education level, zip code, or any other factor, should have the opportunity to lead a happy and healthy life.

This document includes the following sections:

- **Section I:** Suggested language that can be tailored to and inserted into state policies, plans, programs, budgets, rules, grants, contracts, and solicitation documents (i.e. Request for Proposals [RFP], Request for Quotations [RFQ], Request for Qualifications and Quotations [RFQQ]) to promote equitable opportunities for health and well-being
- **Section II:** Integrated frameworks and important considerations to promote equity

SECTION I. SAMPLE LANGUAGE TO PROMOTE EQUITY IN POLICIES AND PROGRAMS

State policies and programs can cause inequity if the language is written in a way that a) negatively affects communities who are disproportionately impacted by adverse health and other outcomes, or b) benefits the majority of the population but does not provide equitable and culturally appropriate opportunities and access to resources. The Governor’s Interagency Council on Health Disparities has developed this sample language to assist policy-makers in being intentional about promoting equity. The sample policy language in this document can be categorized into four distinct sections:

- Language for interventions and/or funding for populations impacted by inequity (Table 1)
- Language requiring engagement and consultation with representatives from diverse communities in decision-making processes (Table 2)
- Language requiring collection, analysis, and/or reporting of disaggregated data (Table 3)

^{vi} This definition of “equity” is from King County [Ordinance 16948](#)

- Inclusive language for policies and programs that can be used to strive for the greatest inclusion possible (Table 4)

Tables 1-3 highlight **examples** of language that can be inserted into state policies, plans, programs, budgets, rules, grants, contracts, and solicitation documents and does not provide a comprehensive list. Policy language in itself is not sufficient—in order for this language to be effective it needs to be paired with equity promoting processes. Every governmental decision should include thoughtful consideration of how it will serve all Washingtonians and how it will impact equity. There is no one-size-fits-all solution; however this sample language provides one tool for integrating equity considerations into state government. Table 1 is focused on provisions that can be inserted into policies and does not include guidance on writing policies with the express intention of promoting equity. These types of policies, such as anti-discrimination policies or those that are written to change a system that is creating inequity, are also an essential part of ensuring that state government actions promote equity and work to address health disparities. An example of a policy written with the intention of promoting equity is Georgia’s HB 1176 which was signed into law in 2012. This policy addresses racial/ethnic disparities in Georgia’s justice system by re-writing and editing multiple existing laws to decrease recidivism, focus on crime prevention rather than punishment, and to make diversion programs available.

Table 1. Language for interventions and/or funding for populations impacted by inequity	
Sample Language	Considerations
<p>Sample Policy Language The[campaign/funding/intervention/program/ resources/etc.] shall be culturally and linguistically appropriate and prioritized among [schools/early learning centers/communities/ etc.] that [experience the largest disparities/ experience the largest opportunity gaps/with X% of students eligible for free and reduced-price meals/that are identified through the state accountability system as challenged schools in need of improvement under RCW 28A.657.020/ whose enrollment of English language learner students has increased an average of more than five percent per year over the previous three years/etc.] or targeted to reach persons from [diverse cultural, racial/ethnic, and economic backgrounds; who live in geographically isolated areas; who have mental, intellectual, sensory, or</p>	<p>Funding and resources can promote equity when they are targeted to populations impacted by inequity. However, unfunded mandates can have disproportionate negative impacts on these same communities so it is important to pair resources with requirements particularly for communities already facing disparities.</p> <p>When possible, do not use income or other indicators as a proxy for race/ethnicity as it does not guarantee that resources will be targeted to address disparities by race/ethnicity or that outcomes will be measured by race/ethnicity.</p> <p>When deciding which indicator to use (e.g. percent of students on free and reduced price lunch, communities experiencing the largest disparities, etc.) it is important to consider what the best indicator is for the particular policy or program.</p>

<p>physical disabilities; who have low literacy skills, limited proficiency in the English language, or insecure immigration status; or who are part of protected or other special populations, including veterans, refugees, or homeless, gay, lesbian, bisexual, or transgender individuals.]</p>	<p>Disparities or opportunity gaps can be gaps based on race/ethnicity, income, English proficiency, literacy, special learning needs, gender identity, sexual orientation, sex, geography, immigration status, veteran status, housing status, refugee status, disability status, etc.</p> <p>While targeting resources to schools or districts experiencing inequities will help promote interschool equity, also explore potential policy language that will ensure that students who are in higher-income schools or high-performing schools that are experiencing educational disparities are also considered so that intraschool equity is also achieved. The same concept applies to early learning centers, communities, etc.</p>
<p>Sample Language for Solicitation Documents [State agency/etc.] is committed to serving underserved racial/ethnic and/or rural populations. XX percent of the total possible points to be awarded in this RFP have been assigned to the Social Equity criteria below: (List Criteria)</p>	<p>This example language can be included in RFPs and other solicitation documents. This language includes race/ethnicity and geography and is just an example. Other populations who experience inequity should also be considered such as those that are traditionally under- or inappropriately-served due to, for example: sexual orientation, gender identity, sex, housing status, income, level of English proficiency, literacy, immigration status, housing status, veteran status, refugee status, or disability status. The language should be vetted with the populations that the solicitation or policy is trying to represent or serve.</p>
<p>Sample Language for Solicitation Documents Preference will be given to proposals addressing underserved racial/ethnic and/or rural populations. A total of XX points are available for proposals addressing underserved racial/ethnic and/or rural populations.</p>	<p>This example language can be included in RFPs and other solicitation documents. This language includes race/ethnicity and geography and is just an example. Other populations who experience inequity should also be considered such as those that are traditionally under- or inappropriately-served due to, for example: sexual orientation, gender identity, sex, housing status, income, level of English proficiency, literacy, immigration status, housing status, veteran status, refugee status, or disability status. The language should be vetted with the populations that the solicitation or policy is trying to represent or serve.</p>

Table 2. Language requiring engagement and consultation with representatives from diverse communities in decision-making processes	
Sample Language	Considerations
<p>In fulfilling its responsibilities under this section, the [state agency/etc.] shall collaborate with Washington’s tribes, tribal organizations, and/or urban Indian organizations; the four state ethnic commissions; nonprofit organizations knowledgeable about equity, [the opportunity gap/hunger and food security issues/housing insecurity/income insecurity/gender equity/etc.]; advocacy organizations; community based organizations; and representatives from diverse communities and populations that will be impacted.</p>	<p>This language should be adapted to include representatives from specific communities who will be impacted by the policy, particularly those that are frequently underrepresented in state decision-making processes. This may include lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ) individuals; veterans; refugees; adolescents and youth; or individuals with mental or physical disabilities, insecure immigration status, limited English proficiency, insecure housing status, or limited literacy skills. Other state bodies to consider including (depending on the topic area) are the Educational Opportunity Gap Oversight and Accountability Committee, the Governor’s Interagency Council on Health Disparities, and the Washington State Supreme Court Minority and Justice Commission.</p>
<p>The [Taskforce/Council/Board/Commission/Advisory Committee/etc.] must include X representative(s) of federally recognized Indian tribes whose traditional lands and territories lie within the borders of Washington State, designated by the federally recognized tribes; X members appointed by the Governor in consultation with the state ethnic commissions, who represent the following populations: African-Americans, Hispanic Americans, Asian Americans, and Pacific Islander Americans; and X representative(s) from diverse communities that will be impacted.</p>	<p>It is important that these decision-makers facilitate meaningful community engagement with individuals who actually represent communities rather than selecting representatives for political reasons out of convenience. It is also essential to consider that some communities may not have traditional organizational infrastructure and that thoughtful and culturally sensitive approaches must be used in order to engage these communities. For example, some community representatives may not work for an organization that can reimburse them for travel expenses, so planning should include how these individuals are reimbursed for their time and/or personal expenses.</p>

Table 3. Language requiring collection, analysis, and/or reporting of disaggregated data

Sample Language	Considerations
<p>The [state agency/etc.] must collect all [student/health/ incarceration/birth certificate/death certificate/etc.] race/ethnicity data using the 2015-2016 Office of Superintendent of Public Instruction’s Comprehensive Education Data Research System (CEDARS) Data Manual Appendices Y and Z, including the subracial and subethnic categories within those guidelines, with the following modifications to the subracial and subethnic categories:</p> <ul style="list-style-type: none"> (a) Further disaggregation of the Black category to differentiate [students/individuals] of African origin and [students/individuals] native to the United States with African ancestors; (b) Further disaggregation of the White category to include subethnic categories for Eastern European nationalities that have significant populations in Washington. (c) For [students/individuals who report as multiracial, collection of their racial and ethnic combination of categories. 	<p>When populations made up of diverse subpopulations are aggregated during data collection or analysis important distinctions between the subpopulations are masked. Collecting, analyzing, and reporting accurate data disaggregated by subracial and subethnic categories to the extent allowed by the data and with consideration to protecting confidentiality is essential to identifying and addressing disparities and monitoring if the policy, program, or funding interventions are affectively working toward equity and alleviating these disparities. For example, diverse subpopulations of Asian and Pacific Islanders are often collapsed into one Asian/Pacific Islander (API) data category, masking the unique outcomes and needs of these diverse communities. The 2015-2016 OSPI Manual calls for more detailed disaggregation for API and other populations which is why these standards are included in the sample language rather than U.S. Health and Human Services or Office of Management and Budget standards. However, even within a population with the same country of origin, there can be dramatic differences in outcomes and needs based on other factors such as English proficiency, immigration status, and refugee status.</p>

<p>All data-related reports prepared by the [state agency/etc.] under this title must be disaggregated by at least the following subgroups: White, Black, Hispanic, American Indian/Alaskan Native, Asian, Pacific Islander/Hawaiian Native, Multiple Races, and Other. All data-related reports must also be prepared displaying additional disaggregation of data if analysis of the data indicates significant differences among categories of individuals as it pertains to the subject of the report.</p>	<p>This example only includes data collection and reporting by race/ethnicity, but reporting by other information should be included as available and appropriate. For example, income, language spoken at home, English proficiency, literacy, gender identity, sexual orientation, sex, geography, immigration status, veteran status, housing status, refugee status, disability status, etc., can be included. How data are collected and reported should be as inclusive as possible. For example, data is frequently collected using only binary male or female response options for sex which is exclusive and ignores transgender/non-conforming people, who experience discrimination and consequent disparities. Consider including language in the policy indicating that the sex question should be open-ended rather than binary or should provide additional response options. One recommendation is to ask this as a two-part question with the second portion being provided as an open-ended question: 1) What sex were you assigned at birth? (male/female) 2) How do you identify your gender today? (male/female/transgender/genderqueer/agender/bigender/etc.). Community members can provide valuable insights on policy language in order to ensure that it does not create data collection and reporting processes which are exclusive or inappropriate.</p> <p>Reporting guidelines should also be catered to the sector. For example education reports can also include disaggregation by transitional bilingual students, special education students, or students covered by section 504 of the federal rehabilitation act of 1973, as amended (29 U.S.C. Sec. 794).</p>
--	---

Policies that are written to ensure specific populations and groups are included in the text of a policy often call for detailed language to describe the targeted group(s). Table 4 provides some language suggestions to make sure that the policy includes everybody who may identify as part of that group. It is also important to consider that policies and programs themselves can be exclusive if the language is not carefully considered. For example, gender binary language can create situations where transgender individuals are excluded. The list below is in no way exhaustive; the best course of action is to connect with members of the community or groups for which policies are written to ensure the language in the policy will translate effectively into practice.

Table 4. Inclusive language for policies and programs	
Group	Suggested Language
All racial and ethnic groups and subgroups	race, ethnicity, national origin, or color
Persons of any religious faith	religion or spiritual faith
Sex/Gender	sex assigned at birth and/or gender
LGBTQ persons*	Actual or perceived sex, sexual orientation, gender identity and/or gender expression
Creed	creed/beliefs
Tribal entities**	sovereign tribal governments and persons belonging to sovereign tribal governments
Persons with disabilities	persons with mental, intellectual, physical, or sensory disabilities
Veteran or military status	all veterans regardless of type of discharge, or persons with active military status
Immigrant/Refugee communities	national origin, English language proficiency, or immigration status
Victims of crime or domestic violence***	victims of crime and/or domestic violence, harassment or stalking
Persons convicted of a crime	offenders, convicted felons, persons convicted of misdemeanor charges and/or persons with adult or juvenile criminal records
Persons accused of a crime	persons awaiting trial and/or acquitted of a crime.
Incarcerated persons	individuals incarcerated in jail, adult or juvenile detention
Low-income persons	Persons with incomes at or below [fifty percent] of the Area Median Income (AMI) for the county or standard metropolitan statistical area in which they reside, or at or below [XX%] of the Federal Poverty Limit
Children and adolescents	juveniles/minors/individuals under XX years old
Older/aging adults	older/aging adults; persons over XX years old and/or persons perceived to be over XX years old

Pregnant women	pregnant women, breastfeeding women, and caregivers of young children
Agricultural workers	migrant and agricultural workers including persons with temporary or long-term work VISAs
<p>*In many areas, there are still fundamental misunderstandings about the unique gender identities and expressions of LGBTQ persons. LGBTQ persons are regularly misidentified based on false assumptions of appearance. In LGBTQ inclusive policies is important to cover people who may be mistaken for a specific LGBTQ identity that is inaccurate.</p> <p>** A large percentage of American Indian/Alaska Native people in Washington are urban Indians and/or are not members of a Tribal government; therefore, consider using the language "American Indian/Alaska Native" if Tribal affiliation is not needed.</p> <p>*** Victims of domestic violence, stalking, and harassment often require special policy considerations for housing, employment and privacy, as they may need to leave a job or break a lease on short notice for their own safety or the safety of their families.</p>	

SECTION II. INTEGRATED FRAMEWORKS AND IMPORTANT CONSIDERATIONS TO PROMOTE EQUITY

In developing this guidance, Council staff reached out to numerous stakeholders to seek their input. These stakeholders (Table 5) provided valuable input throughout the development of this document. Stakeholders highlighted that every policy is different and boiler-plate language will not be enough to address equity in all situations and institutions.

While integrating equity-promoting language into government texts is important, creating equity in Washington State’s government will require a holistic and integrated framework. The Washington State Department of Health’s [Health Equity Review Planning Tool](#), the State Board of Health and the Governor’s Interagency Council on Health Disparities [Health Impact Reviews](#), and Race Forward’s Racial [Equity Impact Assessment Toolkit](#) are examples of tool and resources that already exist which can be used to analyze policies and programs to determine their likely impacts on equity. King County’s [Equity and Social Justice Integrated Effort](#) is also an example framework to integrate equity into all levels of county government that could be adapted to state government.

During these conversations, stakeholders also identified the following important additional considerations to address equity in Washington State:

- **Collect, analyze, and use accurate disaggregated data by subracial/subethnic categories to direct state resources and programs.** Disaggregated data and community feedback should be used in tandem to ensure equitable outcomes in addition to equitable inputs. When providing inputs (funding, resources, etc.) with the *intent* of promoting equity, it is important to also create capacity to examine outcomes and adjust implementation if the outcomes are not actually promoting equity.

- **Promote diversity in state government hiring, contracting, recruitment, retention and promotion.** This includes fostering an understanding that diversity (linguistic, cultural, etc.) is an asset that should be considered in hiring practices and that a workforce that reflects the demographics of Washington will be able to better serve Washingtonians.
- **Provide cultural humility/awareness/competency training or diversity training for government employees and other public workers or occupations licensed through the state.** These trainings aim to develop competencies in working with individuals from diverse cultural backgrounds; building effective cross-cultural relationships, partnerships, and communication; and fostering more inclusive teams, environments, and communities. Some state agencies have committed to ensuring that all staff receive cultural competency/humility training.
- **Ensure that policies and practices promote full civic participation from communities that are facing inequities and do not perpetuate or create new barriers to participation.** A number of barriers can exist that prevent individuals from full civic participation such as public meeting times and locations that conflict with work schedules or childcare needs; lack interpreters at public meetings; lack of translated materials or culturally and linguistically appropriate outreach; and historical and current distrust of government. Policies can also hinder civic engagement if they create barriers to participation. Examples would include policies that restrict voting rights or create barriers to voting or that prohibit reimbursement for travel expenses incurred while participating on a board, council, commission, or other entity.
- **Evaluate the potential equity impacts of proposed legislation, policies, and programs before implementation.** When making decisions, focus on the impact not only the intent of the decision. Individuals who have expertise in equity should contribute to this process. State agency tribal liaisons should also be involved in this process.
- **Ensure all state services and programs are culturally and linguistically appropriate for the diverse communities of Washington State.** Institute policies and processes that ensure the communication needs of the population are met, the legal requirements for language access are complied with, and the ways to implement language assistance services are understood.
- **Address the structural, institutional, and interpersonal “isms” (e.g. racism, sexism, ageism, sizeism, etc.) in state government.** Hold intentional conversations about race and other “isms” to engage political and community leaders.
- **Explore and address the equity impacts of Washington’s regressive tax system.** Washington State has the most regressive tax system of any state in the U.S.^{vii} Regressive tax systems require the lowest income individuals to pay the largest share of their income in taxes and create an inequitable tax structure.
- **Foster a consistent and respectful acknowledgement of the sovereignty of the tribal governments.** Government-to-Government Training and state agency tribal liaisons are important resources already available to state employees and elected or appointed

^{vii} Davis C, Davis K, Gardner M, et al. Who Pays? A Distributional Analysis of the Tax Systems in All 50 States: Fifth Edition. Institute on Taxation and Economic Policy. Available at <http://www.itep.org/pdf/whopaysreport.pdf>.

officials. Representatives of tribal governments can provide the best guidance on if policies, programs, and actions are respecting tribal sovereignty.

- **Prioritize meaningful community engagement and relationship building.** Communities can provide the best insight into policies, processes, and programs that will work to promote equity. Community engagement is also an important way to ensure that interventions will be continued by the community if/when state-level support ends. For example, the community should be engaged when drafting solicitations for contracts or grants. A diverse advisory committee could provide feedback on draft versions of solicitation documents to ensure that the language will promote opportunity and equity and not perpetuate disparities.

Table 5. Stakeholders who Provided Guidance and Feedback on this Document	
Sofia Aragon	Commission on Asian Pacific American Affairs
Michael Itti	Commission on Asian Pacific American Affairs
Nora Coronado	Commission on Hispanic Affairs
Melanie Anderson	Department of Commerce
Diane Klontz	Department of Commerce
Eli Kern	Public Health – Seattle and King County
Heather Villanueva	SEIU 775
Chris Genese	Washington Community Action Network

HEALTH IMPACT REVIEWS

The State Board of Health collaborates with the Governor’s Interagency Council on Health Disparities to conduct health impact reviews. A health impact review is an analysis of a proposed legislative or budgetary change to determine if it will likely have an effect on health and health disparities. Health impact reviews provide information and scientific evidence that policymakers can use to promote health and equity in decision making and minimize any unintended adverse consequences.

New Strength of Evidence Criteria

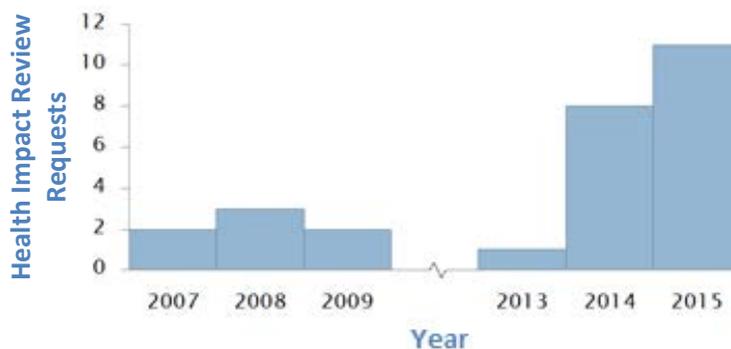
When conducting a health impact review, Board and Council staff researches the different pathways through which the provisions in the bill may impact health and whether certain populations are more likely to be effected. For each pathway staff evaluates the evidence to determine its strength.

Recently, the Board and Council revised the strength of evidence criteria to increase objectivity and improve inter-rater reliability and partnered with the University of Washington Community Oriented Public Health Practice program to pilot the new criteria. The pilot testing revealed that the criteria were solid, allowing staff to differentiate and rate bodies of evidence from “a fair amount of evidence” to “strong evidence” to “very strong evidence.” The pilot also provided valuable information to help improve the likelihood that any analyst applying the criteria would end up with the same strength of evidence rating. The new strength of evidence criteria serves as an example of how the Board and Council strive to maximize objectivity of its reviews.

Health Impact Review Growth

Health impact reviews were created in 2006 with the passage of legislation. Funding was then suspended in 2009 and reinstated in 2013. Figure 1 shows the growth in health impact review requests since their creation. In addition to growth in the number of requests, there has also been growth in the number of legislators requesting reviews. From 2007-2009, the Board and Council completed 7 health impact reviews at the request of 2 legislators. From the end of 2013 through April of 2015, 20 requests were received from 15 different legislators.

Figure 1: Health Impact Review Growth



Health impact reviews are becoming more normalized and integrated into legislative processes in other ways as well. For example, during the 2015 legislative session, staff was asked to testify on health impact review findings at 11 public hearings for 7 different bills. Health impact reviews have also been referenced in bill reports, mentioned in staff reports, cited by legislators during public hearings, and mentioned in media reports.

During the 2015 legislative session, the State Board of Health was able to use some savings resulting from a short term position vacancy to hire a part-time, 4-month

During the 2015 regularly scheduled session, health impact review requests actually exceeded staff capacity.

project analyst to assist with reviews. Despite the additional support, staff capacity to conduct health impact reviews was reached during the majority of the regularly scheduled session. In fact, capacity was actually exceeded, as several legislators who inquired about making a request, opted not to after learning there was a waiting list.

Health impact reviews can only be requested by the Governor or members of the Legislature. During legislative session, staff must complete health impact reviews within ten days. During the interim, staff works with the requester to determine a deadline.

Executive summaries and full reports for each review are available on the State Board of Health's [Health Impact Review Web page](#). A summary of reviews completed during the 2015 legislative session (including two completed during the interim prior to session) is included in Table 1.

For more information or to request a review, please contact the Board at hir@sboh.wa.gov.

Table 1: Health Impact Reviews Completed for the 2015 Legislative Session

Subject of Request	Requester	Overall Findings
HB 1356 - Minimum standards for sick and safe leave	Representative Jinkins	Evidence indicates that HB 1356 has potential to improve financial security; decrease the transmission of communicable disease; improve health outcomes; and decrease disparities by income, educational attainment, race/ethnicity, and geography.
SB 6029 (Sections 7 & 8 only) - Establishing a living wage	Senator Miloscia	Evidence indicates that the provisions of SB 6029 that increase minimum wage (sections 7 and 8) would likely increase incomes and improve health outcomes for low-wage workers, thereby decreasing health disparities by income and race/ethnicity as well as health disparities faced by rural Washingtonians.
HB 1674 - Regarding youthful offenders	Representative Pettigrew	Evidence indicates that HB 1674 has potential to improve health outcomes and decrease recidivism for youthful offenders convicted as adults; which has potential to decrease disparities for this population as well as disparities by race/ethnicity.
SB 5870 - Prohibiting the use of aversion therapy treatment of minors	Senator Lias	Evidence indicates that SB 5870 has potential to mitigate harms and improve health outcomes among lesbian, gay, bisexual, transgender, queer, and questioning patients, a population that is disproportionately impacted by poor health outcomes, thereby decreasing disparities.
SB 5346 - Providing first responders with life alert information during an emergency	Senator Ranker	Evidence and expert opinion at both the local and state level indicate that SB 5346 has potential to improve health outcomes for some individuals who are disproportionately impacted by death, illness, and injury during disasters, thereby helping to decrease health disparities.
HB 1449 - Concerning oil transportation safety	Representative Farrell	Evidence indicates that decreasing risks from oil spills on land and water would likely decrease risks to water quality and public health, particularly for communities of color, low-income communities, and populations with lower levels of education.
HB 1671 - Increasing access to opioid antagonists	Representative Walkinshaw	Evidence indicates that HB 1671 has potential to increase the number of opioid antagonist rescue kits that are distributed and administered and in turn decrease health complications and deaths from opioid overdose and decrease health disparities.
HB 1295 - Concerning breakfast after the bell programs	Representative Hudgins	Evidence indicates that HB 1295 has potential to increase the number of low-income students and students of color who eat breakfast, which in turn has potential to narrow educational opportunity gaps, narrow income gaps, and decrease disparities.
SSB 6554 - Providing life alert services	Senator Ranker	Evidence and expert opinion at both the local and state level indicate that SSB 6554 has potential to improve health outcomes for individuals who are disproportionately impacted by death, illness, and injury during disasters, and to decrease disparities.
HB 2321 - Concerning mid-level dental professionals	Representative Cody	Evidence indicates that HB 2321 has potential to improve oral health and overall health outcomes, particularly for low-income and communities of color and individuals with medical disabilities or chronic conditions and to decrease disparities for these groups.

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 health care consumers. A list of current Council members is provided below. 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 health care issues, but also the social factors that influence health, such as education, poverty, employment, and the environment.

Governor’s Interagency Council on Health Disparities Membership	
Governor’s Representative and Council Chair:	Emma Medicine White Crow
Consumer Representative and Council Vice Chair:	Frankie T. Manning
Consumer Representative:	Gwendolyn Shepherd
Commission on African American Affairs:	Sara Franklin
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:	Greg Williamson
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 ^{viii} :	Willie Frank Jan Olmstead (alternate)
Health Care Authority:	Vazaskia Caldwell
Office of Superintendent of Public Instruction:	Dan Newell Mona Johnson (alternate)
State Board of Health:	Stephen Kutz
Workforce Training and Education Coordinating Board:	Nova Gattman

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

COUNCIL REPORTS

The Governor’s Interagency Council on Health Disparities is required to create an action plan to eliminate health disparities by race/ethnicity and gender and to update the plan biannually. A description of past Council action plans and report updates are included below.

Council Reports	
December 2014 Update: State Policy Action Plan to Eliminate Health Disparities	Highlights the Council’s partnership with the Healthiest Next Generation initiative; reports findings from the Council’s state agency survey on language access; and provides updates on the Council’s CLAS project and health impact reviews.
June 2014 Update: State Policy Action Plan to Eliminate Health Disparities	Includes recommendations on language access; aligns Council work with Results Washington; and provides status updates on CLAS standards and health impact reviews.
December 2013 Update: State Policy Action Plan to Eliminate Health Disparities	Highlights Council work on the CLAS Standards and health impact reviews and provides status updates on select recommendations.
June 2013 Update: State Policy Action Plan to Eliminate Health Disparities	Highlights progress toward implementing the recommendations in the 2012 action plan.
2012 State Policy Action Plan to Eliminate Health Disparities (December 2012)	Includes recommendations on behavioral health, environmental exposures and hazards, and poverty.
2010 State Policy Action Plan to Eliminate Health Disparities (June 2010)	Includes recommendations on education, health insurance coverage, health care workforce diversity, obesity, and diabetes.
<p>All reports are available on the Council’s Web site: HealthEquity.wa.gov</p>	

¹ Washington State Department of Health (June 2014). Infant Mortality: MCH Data Report. DOH 160-015.

² Washington State Department of Health (April 2013). Perinatal Indicators Report for Washington Residents: 2011 Data. DOH 950-153.

³ Washington State Department of Health (March 2013). Infant Mortality: Health of Washington State.

⁴ Washington State Department of Health (March 2013). Infant Mortality: Health of Washington State.

-
- ⁵ Washington State Department of Health (June 2014). Prenatal Care: MCH Data Report. DOH 160-015.
- ⁶ Results Washington. Goal 4: Healthy & Safe Communities. Accessed at: <http://www.results.wa.gov/what-we-do/measure-results/healthy-safe-communities/goal-map>
- ⁷ Blumenshine et al. (2010). Socioeconomic disparities in adverse birth outcomes: a systematic review. *American Journal of Preventive Medicine*. 39(3):263-272.
- ⁸ Hodnett et al. (2010). Support during pregnancy for women at increased risk of low birthweight babies. *The Cochrane database of systematic reviews*. 6:Cd000198.
- Olds et al. (2002). Home visiting by paraprofessionals and by nurses: a randomized, controlled trial. *Pediatrics*. 110(3):486-496.
- Lewin et al. (2010). Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases. *The Cochrane database of systematic reviews*. 3:Cd004015.
- Olds et al. (2014). Effect of home visiting by nurses on maternal and child mortality: results of a 2-decade follow up of a randomized clinical trial. *Journal of American Medical Association Pediatrics*. 168(9):800-806.
- ⁹ Minkler (2010). Linking science and policy through community-based participatory research to study and address health disparities. *American Journal of Public Health*. 100(Suppl. 1):S81-S87.
- ¹⁰ Cawthon, L. Characteristics of Women Who Gave Birth in Washington State. Washington State Department of Social and Health Services, First Steps Database, 10/31/2012.
- ¹¹ Cawthon, L. Characteristics of Women Who Gave Birth in Washington State. Washington State Department of Social and Health Services, First Steps Database, 10/31/2012.
- ¹² Cawthon, L. Characteristics of Women Who Gave Birth in Washington State. Washington State Department of Social and Health Services, First Steps Database, 10/31/2012.
- ¹³ Baldwin et al (1998). The effect of expanding Medicaid prenatal services on birth outcomes. *American Journal of Public Health*. 88(1):1623-1629.
- ¹⁴ Arima et al (2009). The impact of the First Steps prenatal care program on birth outcomes among women receiving Medicaid in Washington State. *Health Policy*. 92(1): 49-54.
- ¹⁵ Giurgescu et al (2011). Racial Discrimination and the Black-White Gap in Adverse Birth Outcomes: A Review. *Journal of Midwifery and Women's Health*. 56:362-370.
- ¹⁶ Culhane (2011). Racial Disparities in Preterm Birth. *Seminars in Perinatology*. 35:234-239.
- ¹⁷ Pies et al. (2012). Integrating the life course perspective into a local maternal and child health program. *Maternal and Child Health Journal*. 16(3):649-655.
- Zone BB. Best Babies Zone. 2014; <http://www.bestbabieszone.org/>. Accessed 2.11.15.
- Derek et al. (2012). Practices to Reduce Infant Mortality through Equity (PRIME) Green Paper. Ann Arbor, MI: University of Michigan,
- ¹⁸ Shah et al. (2011). Intention to become pregnant and low birth weight and preterm birth: a systematic review. *Maternal and Child Health Journal*. 15(2):205-216.
- ¹⁹ Brooke et al. (2012). Effectiveness of Long-Acting Reversible Contraception. *The New England Journal of Medicine*. 366(21):1998-2007.
- ²⁰ Stoddard et al. (2011). Efficacy and safety of long-acting reversible contraception. *Drugs*. 71(8):969-980.
- ²¹ Koray Taffner et al. (2000). Why Are US Women Not Using Long-Acting Contraceptives? *Family Planning Perspectives*. July/August;32(4).
- Sonfield (2007). Popularity Disparity: Attitudes About the IUD in Europe and the United States. New York, NY: The Guttmacher Institute.
- ²² Issel et al. (2011). A review of prenatal home-visiting effectiveness for improving birth outcomes. *Journal of Obstetric, Gynecologic, and Neonatal Nursing: JOGNN / NAACOG*. 40(2):157-165.

²³ Rossin (2011). The effects of maternity leave on children's birth and infant health outcomes in the United States. *Journal of Health Economics*.30(2):221-239

²⁴ Ruhm (2000). *Journal of Health Economics*. 19(6):931-960.

Staehelin et al. (2007). Length of maternity leave and health of mother and child--a review. *International Journal of Public Health*. 52(4):202-209.

Tanaka (2005). Parental leave and child health across OECD countries. *ECOJ The Economic Journal*. 115(501):F7-F28

²⁵ Scott et al (1999). The obstetrical and postpartum benefits of continuous support during childbirth. *Journal of Womens Health and Gender-Based Medicine*. 8(10):1257-1264.

²⁶ Mottl-Santiago et al (2008). A hospital-based doula program and childbirth outcomes in an urban, multicultural setting. *Maternal and Child Health Journal*. 12(3):372-377.

²⁷ VanEenwyk et al. (2013). *Health of Washington State Report: Social and Economic Determinants of Health*. Washington State Department of Health.



DATE: May 13, 2015

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

FROM: Emma Medicine White Crow, Chair

SUBJECT: **UPDATE—HEALTH IMPACT REVIEWS**

Background and Summary:

In accordance with RCW 43.20.285, the State Board of Health, in collaboration with the Governor's Interagency Council on Health Disparities, completes health impact reviews at the request of the Governor or a legislator. A health impact review is an objective analysis of a legislative or budgetary proposal to determine if there are likely impacts on health and health disparities.

Today I have asked staff to provide an update on health impact reviews conducted during the 2015 legislative session. The presentation will also highlight new strength of evidence criteria and ways that health impact reviews have become a more recognized tool during the legislative process.

Recommended Council Action:

None at this time.



Health Impact Reviews

Governor's Interagency Council on Health Disparities

May 13, 2015

OVERVIEW

- ☑ New strength-of-evidence criteria
- ☑ Health impact review growth
- ☑ Health impact reviews conducted this session
- ☑ Health impact reviews requested for the interim

NEW STRENGTH-OF-EVIDENCE CRITERIA

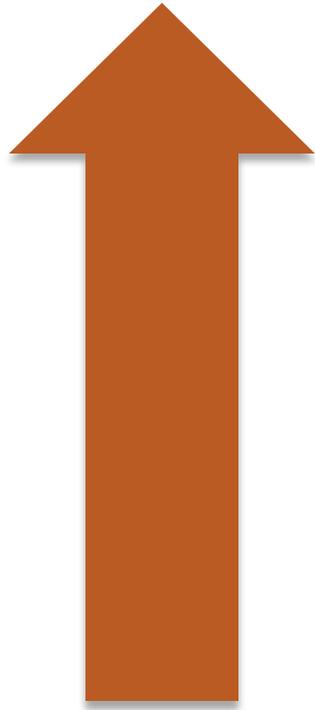


Health Impact Review Process



STRENGTH-OF-EVIDENCE CRITERIA

Strength-of-Evidence Criteria



VERY STRONG EVIDENCE

STRONG EVIDENCE

A FAIR AMOUNT OF EVIDENCE

EXPERT OPINION

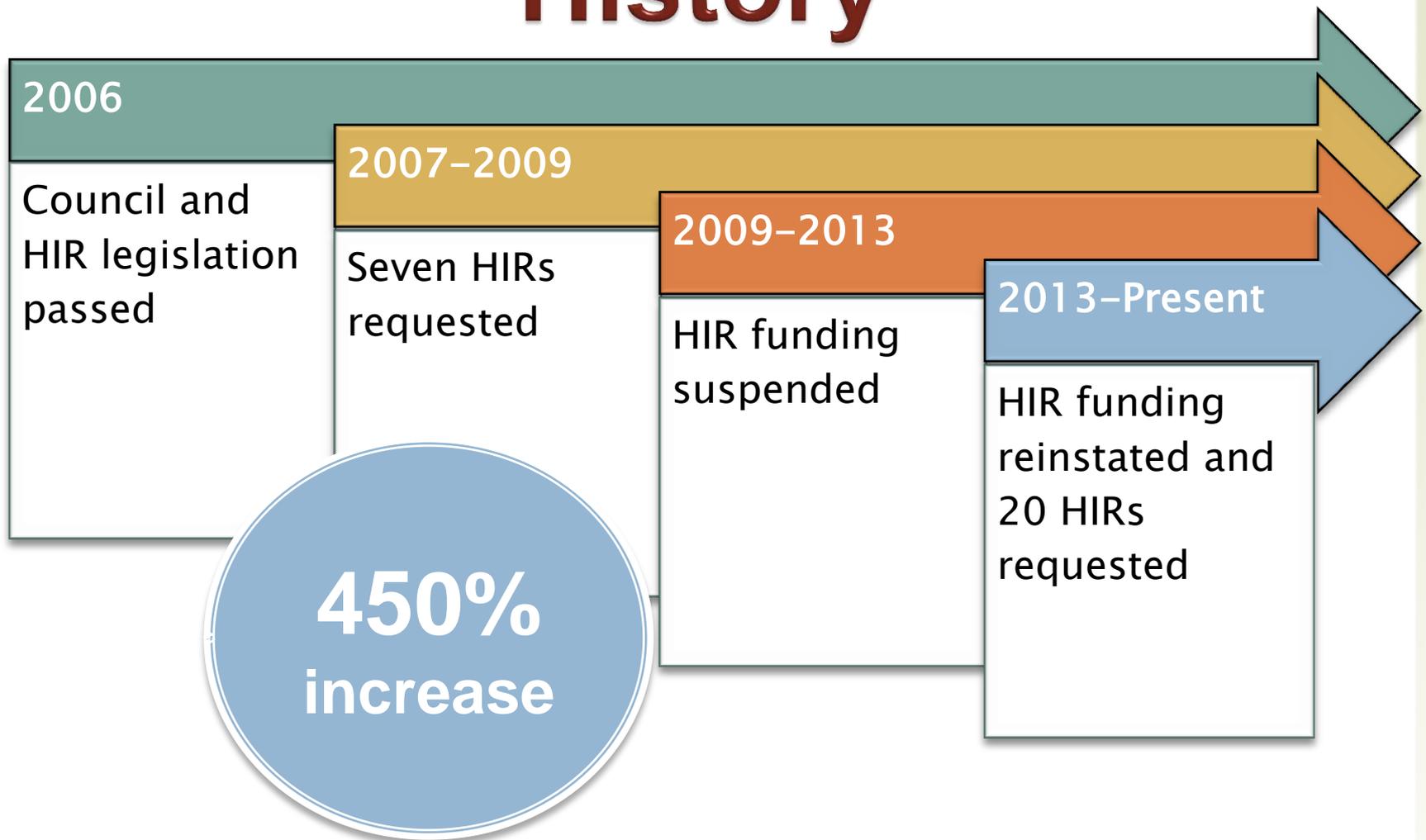
NOT WELL RESEARCHED

STRENGTH-OF-EVIDENCE CRITERIA

HEALTH IMPACT REVIEW GROWTH

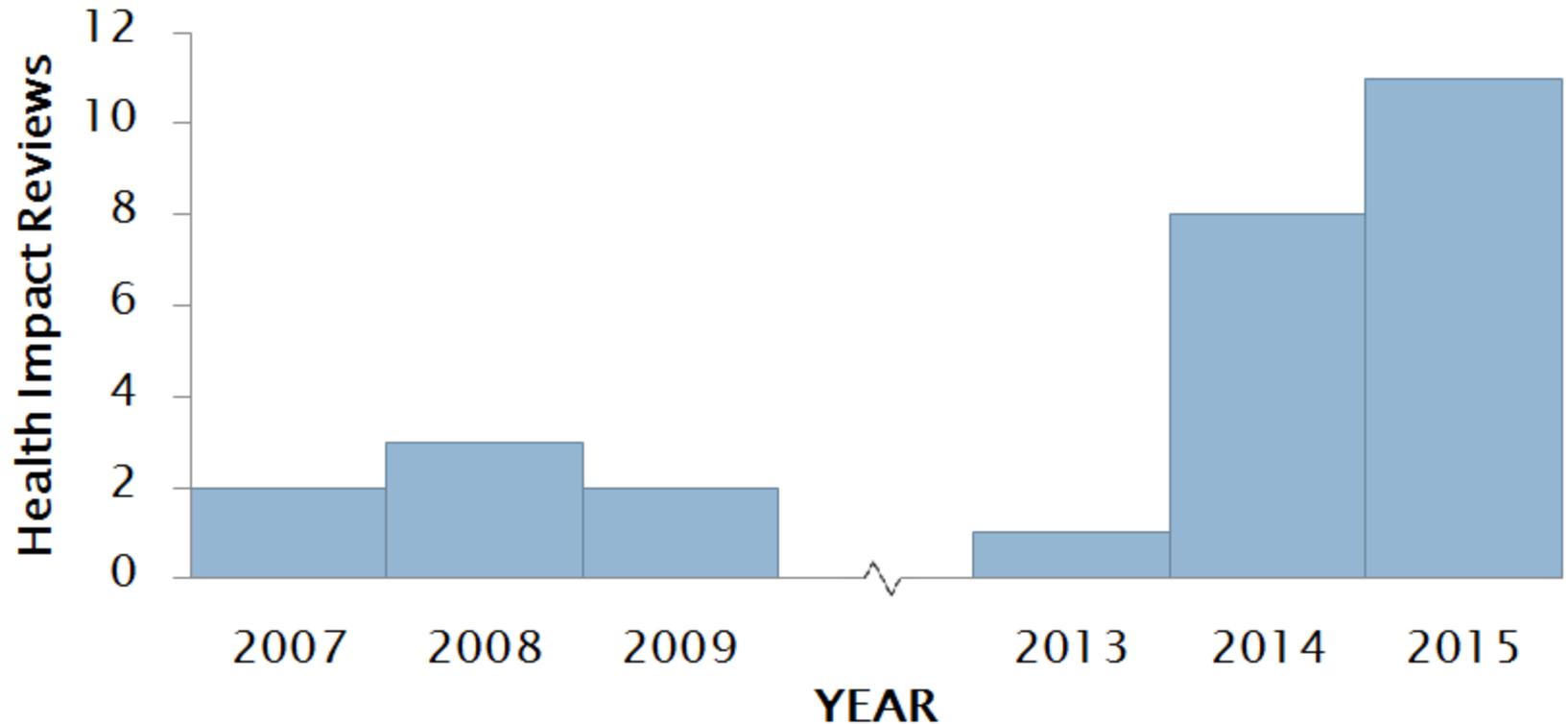


History



HEALTH IMPACT REVIEW GROWTH

Health Impact Reviews Requested



HEALTH IMPACT REVIEW GROWTH

Gaining Traction



Increase in number of legislators requesting

Wider variety of requests

HEALTH IMPACT REVIEW GROWTH

HIRs and Decision-Making



Testimony

Bill Reports

Legislators

Media Reports

HEALTH IMPACT REVIEW GROWTH

HIRS CONDUCTED THIS SESSION AND INTERIM REQUESTS



2015 Legislative Session Health Impact Reviews



HB 1295
BREAKFAST AFTER THE BELL



HB 1671
ACCESS TO OPIOID ANTAGONISTS



HB 1449
OIL TRANSPORTATION SAFETY

2015 SESSION AND INTERIM HIRs

2015 Legislative Session Health Impact Reviews



SB 5346

PERSONAL EMERGENCY RESPONSE SYSTEMS



SB 5870

**PROHIBITING THE USE OF AVERSION
THERAPY TREATMENT IN MINORS**



SB 6029: (SECTIONS 7 & 8)

ESTABLISHING A LIVING WAGE

2015 SESSION AND INTERIM HIRs

2015 Legislative Session Health Impact Reviews



HB 1356

ESTABLISHING MINIMUM STANDARDS
FOR SICK AND SAFE LEAVE

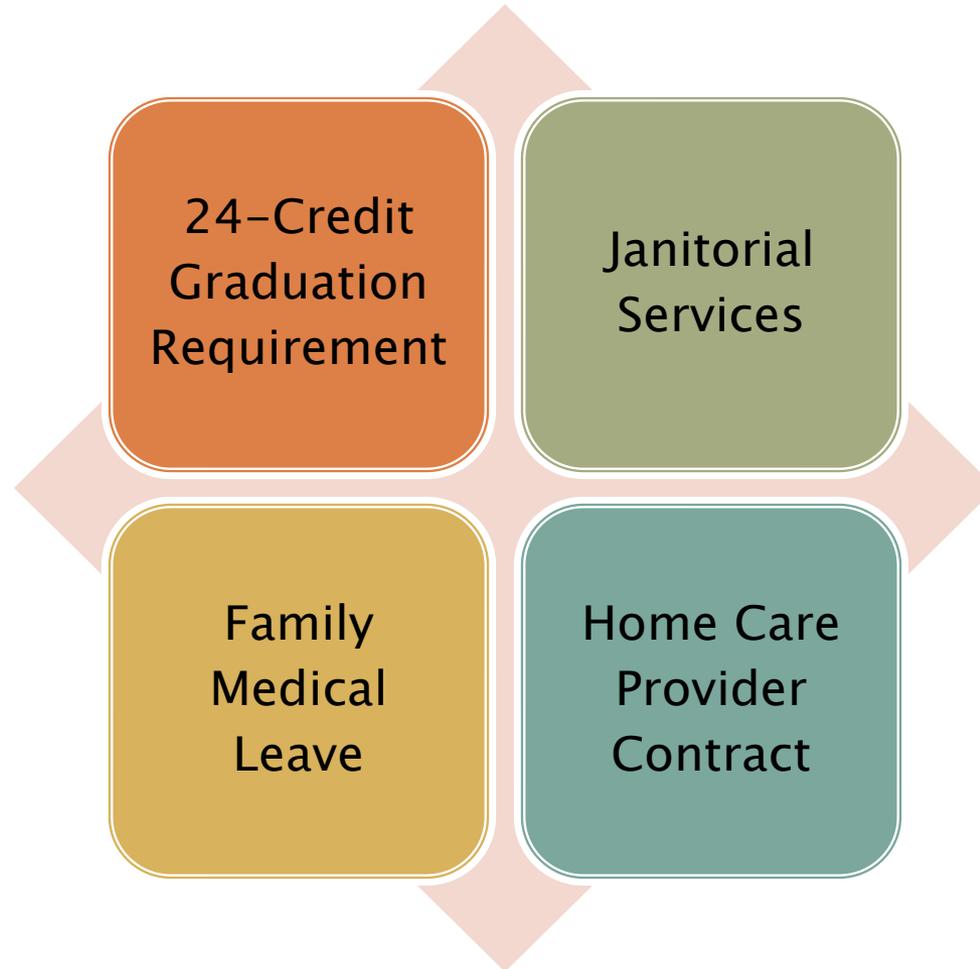


HB 1674

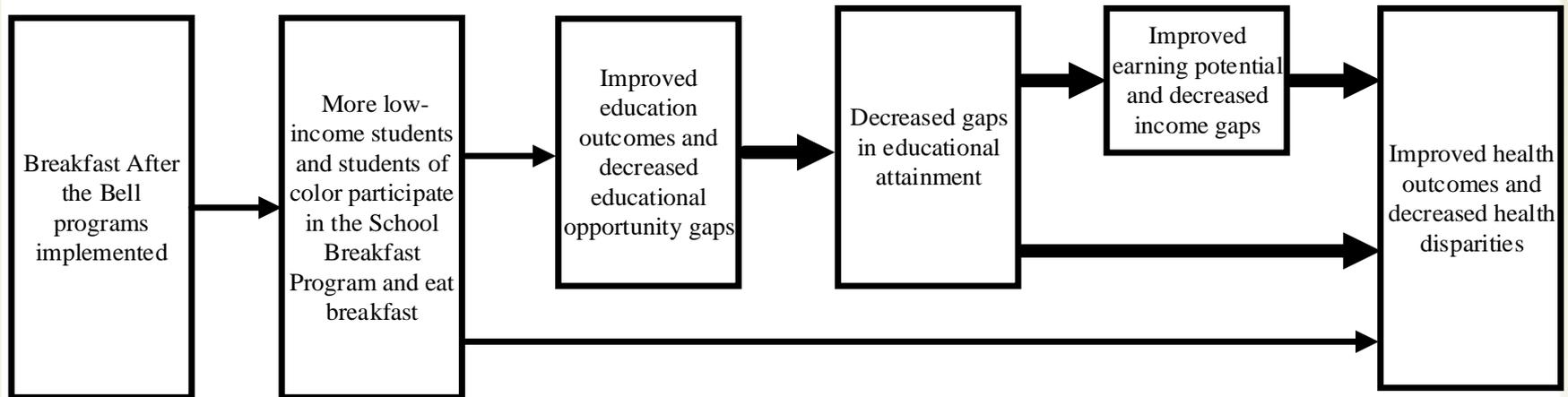
ALLOWING YOUTHFUL OFFENDERS WHO
COMPLETE THEIR CONFINEMENT PRIOR TO 21
YEARS OF AGE ACCESS TO THE FULL
CONTINUUM OF SERVICES

2015 SESSION AND INTERIM HIRs

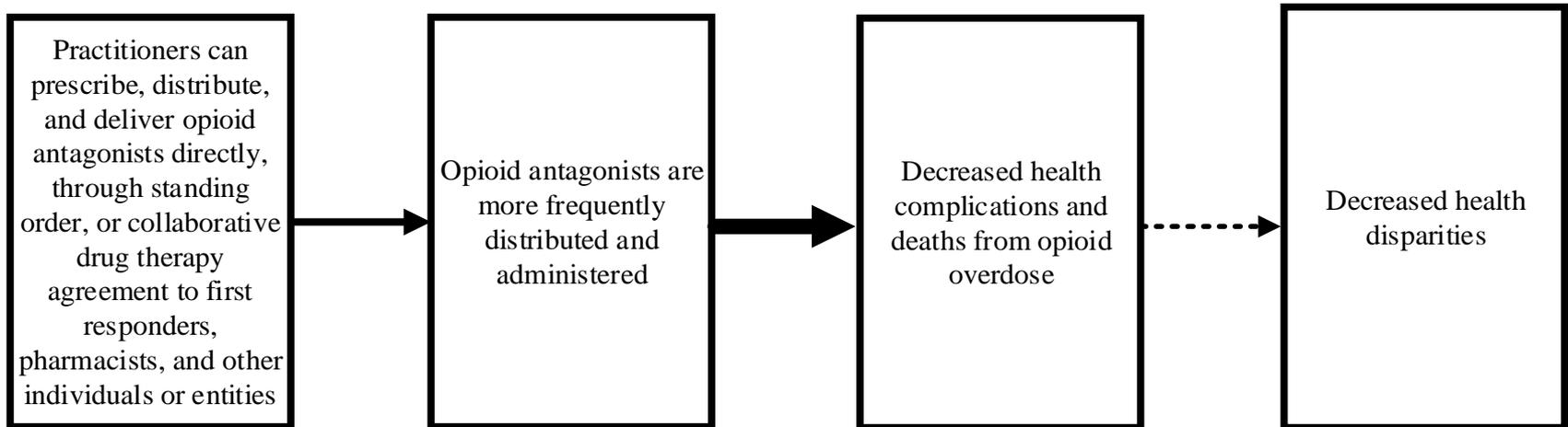
Current HIR Requests



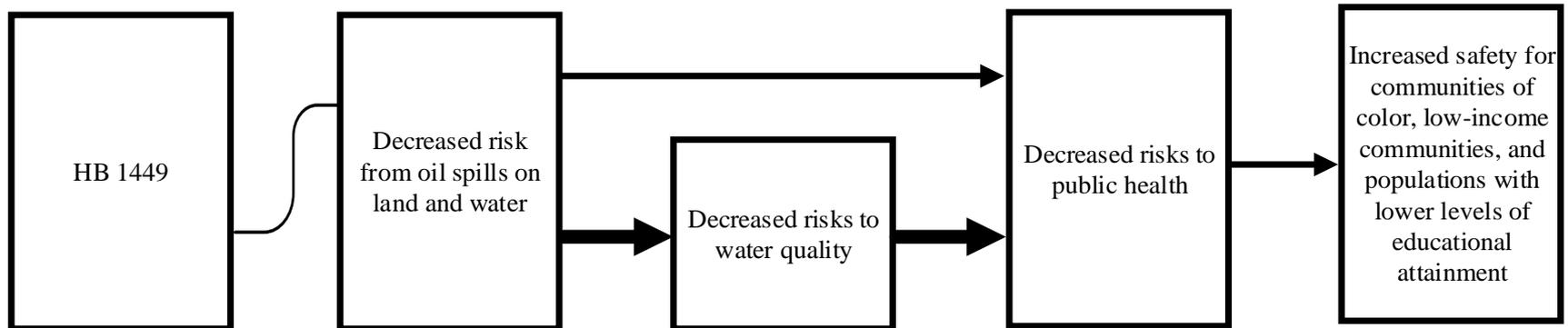
HB 1295 (2015-2016)



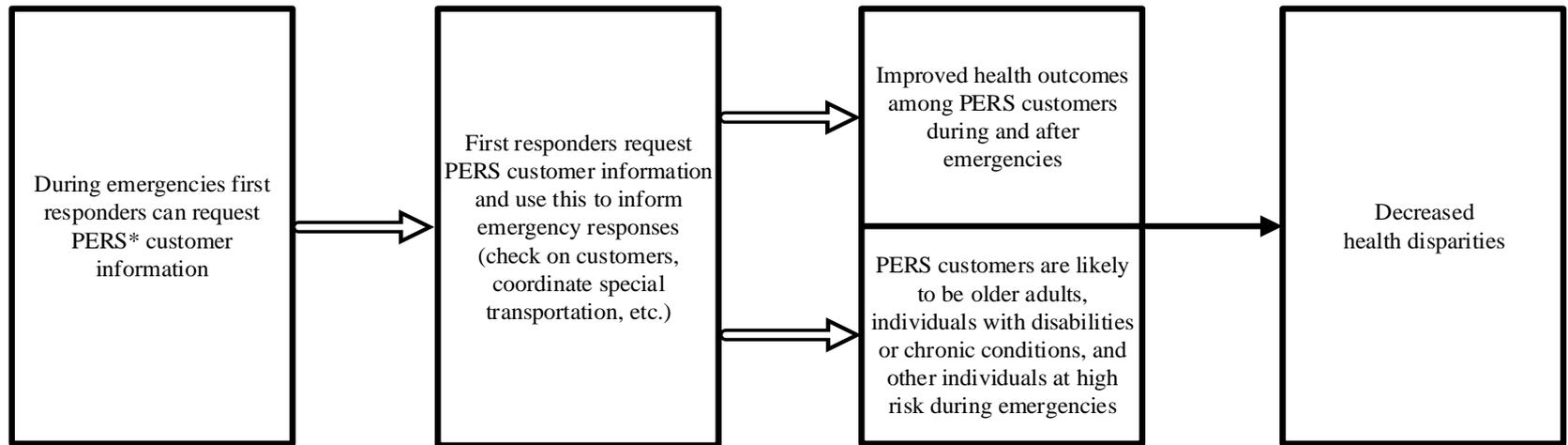
HB 1671 (2015-2016)



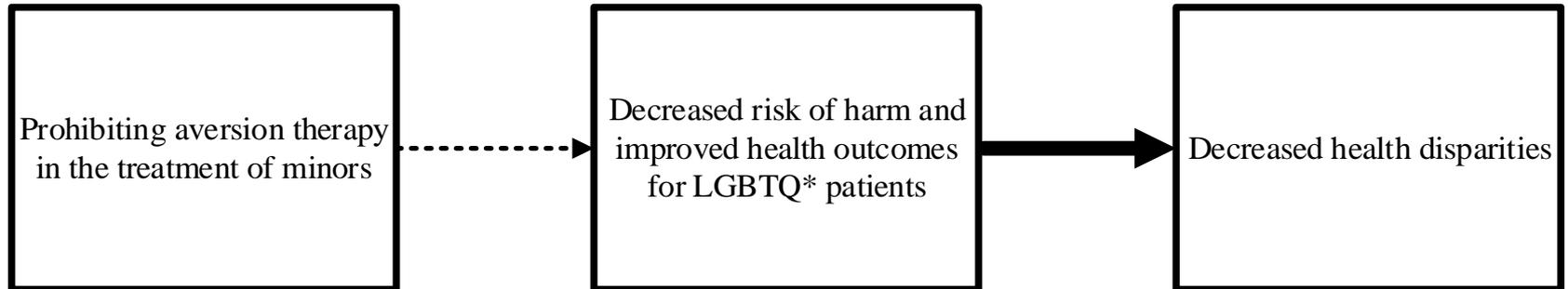
HB 1449 (2015-2016)



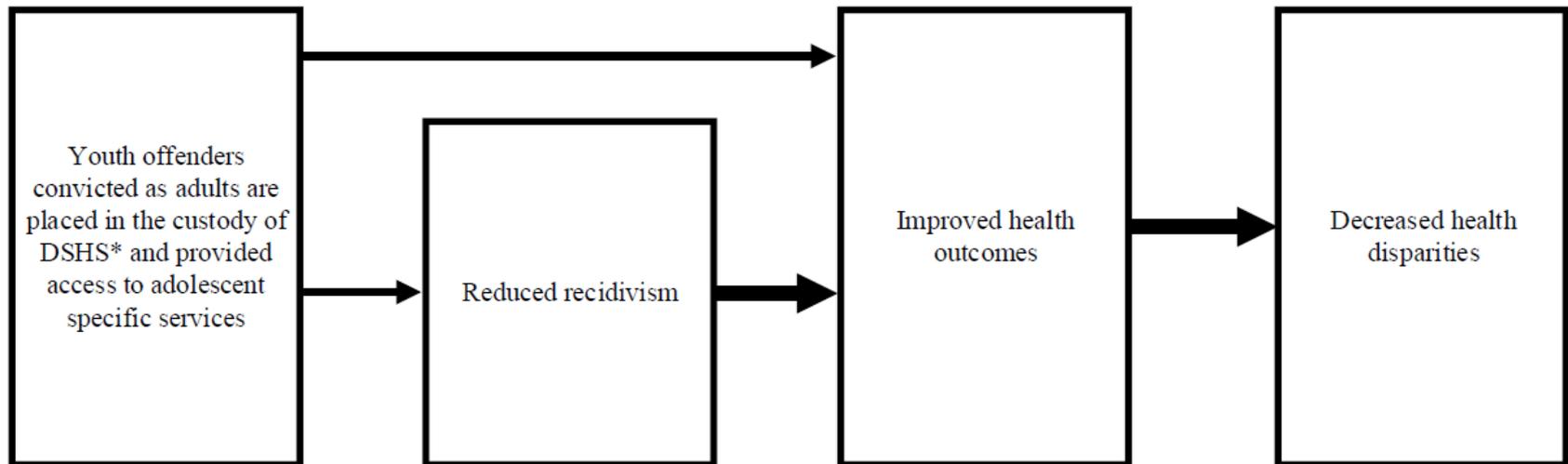
SB 5346 (2015-2016)



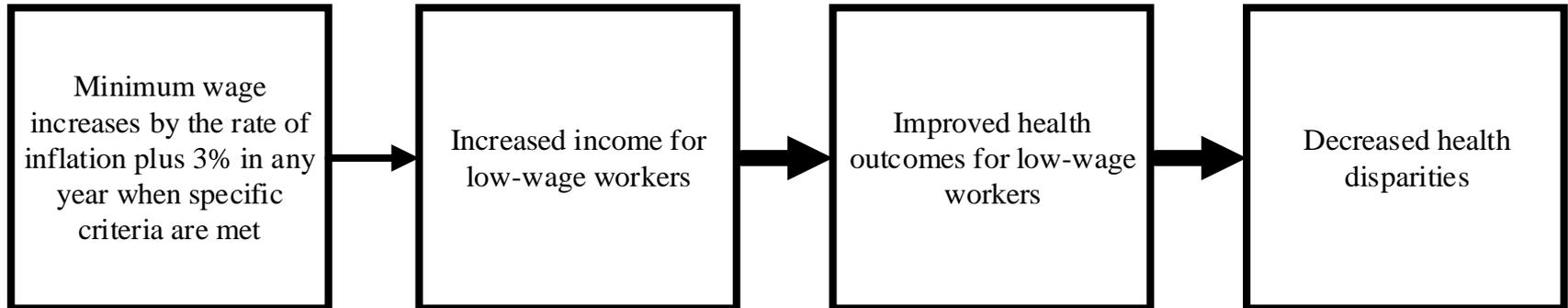
SB 5870 (2015-2016)



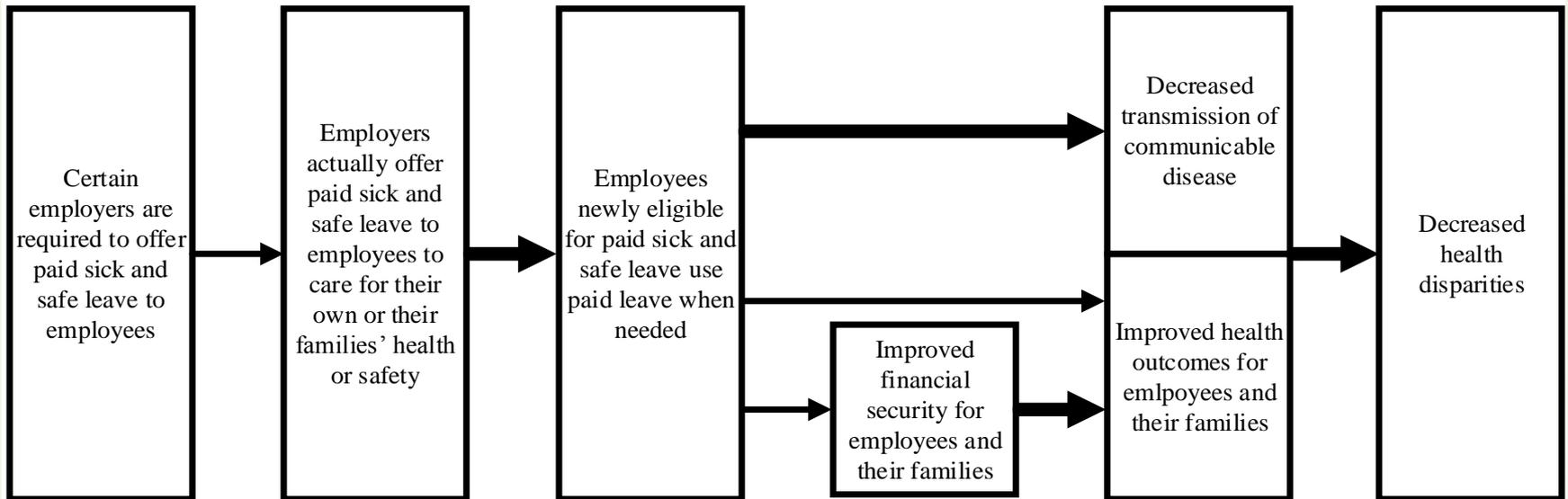
SB 1674 (2015-2016)



Section 7 & 8 of SB 6029 (2015-2016)



HB 1356 (2015-2016)





DATE: May 13, 2015

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

FROM: Emma Medicine White Crow, Chair

SUBJECT: UPDATE—CLAS PROJECT

Background and Summary:

One of the Council's statutory responsibilities under RCW 43.20.275(3) is to "recommend initiatives for improving the availability of culturally appropriate health literature and interpretive services within public and private health-related agencies." Over the years, the Council held a public forum on this topic, received numerous briefings, and included related recommendations in its *2010 State Policy Action Plan to Eliminate Health Disparities* as well as its *June 2014 Update* report to the Governor and Legislature. At its September 11, 2013 meeting, the Council selected the implementation of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) as a priority, furthering its commitment and work in this area.

Since September 2013, the Council has implemented a grant project funded by the Department of Health and Human Services Office of Minority Health to promote adoption of the National CLAS Standards throughout the state. Funding for that project ends at the end of August. Today I have asked staff to provide a final update on the CLAS project, including future activities for the remainder of the grant period.

Recommended Council Action:

None at this time.



Project Update: Implementing National CLAS Standards in Washington State May 13, 2015

Yris Lance, MA
CLAS Standards Project Manager
Governor's Interagency Council on Health Disparities

Kathie Meehan
Health Educator
Washington State Department of Health

Implementing National CLAS Standards in Washington State

A two-year grant awarded by the Office of
Minority Health to:

- ▶ Increase development, adoption, and implementation of CLAS policies among government agencies and other organizations.
- ▶ Provide education and technical assistance.

Final Project Update

- Partnership Development
- Community Relations and Engagement
- Data Collection
- Training, Information, and Technical Assistance

CLAS in Washington State Agencies

- All agencies with representatives on the Council received and shared CLAS information.
- Agencies working on CLAS/Language access policy development include:
 - Department of Early Learning
 - Department of Health
 - Department of Social and Health Services
 - Department of Agriculture
 - Department of Ecology
 - Health Care Authority

Other Health and Health Care Quality Organizations

- WA Association of Community and Migrant Health Centers
- Northwest Primary Care Association
- Washington State Nurses Association
- Washington State Medical Association
- Molina
- Health Plan of Washington
- Premera
- Qualis

Interagency LEP Workgroup

Forum for sharing best practices in providing language assistance services across agencies.

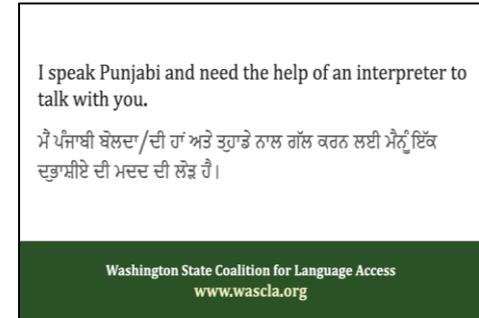
- ▶ 6 meetings (2 additional planned):
 - Translation best practices
 - Using dual-language staff and interpreters
 - Policy development (ESD, L&I, ECY, OIC, ATG)
 - LEP population data
 - SharePoint site
- ▶ Assistance with agency language access survey

WASCLA Tools for Health Toolkit

- ▶ The Tools for Health Toolkit offers materials about consumer rights and language services.

2014– Toolkit included

- ▶ Know Your Rights Flyers
- ▶ ISpeak Cards
- ▶ Request Form for Cards or Flyers



2015– Toolkit will also include

- ▶ A fact sheet – Practitioners’ responsibilities to provide language access and culturally appropriate services

CLAS Standards On-site Training

Five 1.5 hour modules

Module One: Introduction to the CLAS Standards



Module Two: Governance, Leadership, and Workforce Strategy

Planning systematically an
a plan of action
Cluster of decision
what actions to take,

Module Three: Communication and



Module Four: Community Engagement, Continuous Improvement, and Accountability



Module Five: Integrating CLAS into Policy and Practice

**SE HABLA
ESPAÑOL**



CLAS Standards On-line Training

1024 768 356

Click Arrow to Continue

Session One
introduction to the
CLAS
Standards

HEALTH EQUITY
Governor's Interagency Council
on Health Disparities

CLAS Standards On-line Training

1024 768 356

Cultural Differences

- Age
- Country of Origin
- Education
- Employment
- Family
- Household
- Gender
- Geographic Location
- Immigration Status
- Income
- Literacy
- Military Experience
- Parental Status
- Physical and Cognitive Abilities
- Race
- Ethnicity
- Religion
- Sexual Orientation



Click Arrow to Continue

Navigation controls: Home, Play/Pause, Previous, Next, Full Screen, Close

CLAS Standards On-line Training

1024 768 356



Do you identify with a person or flag here?

Yes, I identify. No, I don't.

Navigation controls: play, previous, next, progress bar, volume, close.

CLAS Standards On-line Training

1024 768 356

Do you identify with anyone here?

Yes, I identify. No, I don't.

CLAS and Cultural Competency Presentations and Trainings

- State agencies
- Health related organizations
- Conferences and symposiums
- Local Health Jurisdictions

Resources

Enhanced CLAS Standards and the Blueprint for Advancing and Sustaining CLAS Policy and Practice

Think Cultural Health

<https://www.thinkculturalhealth.hhs.gov>

For more information contact:

Yris Lance, MA

CLAS Standards Project Manager

Yris.Lance@sboh.wa.gov

Phone: 360-480-2057

Paying Medicaid Enrollees To Get Checkups, Quit Smoking and Lose Weight: Will It Pay Off?

By Phil Galewitz | May 4, 2015



When Bruce Hodgins went to the doctor for a checkup in Sioux City, Iowa, he was asked to complete a lengthy survey to gauge his health risks. In return for filling it out, he saved a \$10 monthly premium for his Medicaid coverage.

In Las Cruces, N.M., Isabel Juarez had her eyes tested, her teeth cleaned and recorded how many steps she walked with a pedometer. In exchange, she received a \$100 gift card from Medicaid to help her buy health care products including mouthwash, vitamins, soap and toothpaste.

Taking a cue from workplace wellness programs, Iowa and New Mexico are among more than a dozen states offering incentives to Medicaid beneficiaries to get them to make healthier decisions — and potentially save money for the state-federal health insurance program for the poor.

The stakes are huge because Medicaid enrollees are more likely to engage in unhealthy practices, such as smoking, and are less likely to get preventive care, studies show.



For years, private employers and insurers have used incentives to spur employees and members to quit smoking, lose weight and get prenatal care, although the record of those programs for changing long-term behavior is mixed, studies show. “Financial incentives are effective at improving healthy behaviors, though the effect of incentives may decrease over time,” said a [report](#) last year by the Center for Health Care Strategies, a research group based in Hamilton, N.J.

This KHN story also ran in [USA Today](#). It can be republished for free ([details](#)).



Another [analysis](#) published this month in the journal *Preventive Medicine*, which looked at 34 studies, found that workplace and other incentives can change health behaviors in the short term, but the effects dissipated once the incentives were taken away.

The Affordable Care Act is behind the latest push of wellness incentives in Medicaid. Besides Iowa and New Mexico, several other states that have expanded Medicaid under the health law have incorporated such incentives, including Indiana, Pennsylvania, New Hampshire and Michigan. Montana, which is about to become the 29th state to extend Medicaid, also plans to include such incentives.

“People are looking for some creative ways to pass Medicaid expansion and incentivizing healthy behaviors is pretty palatable to both conservatives and liberals,” said Maia Crawford, program officer of the Center for Health Care Strategies. “It’s a potential win-win because of the potential for cost savings and health improvement.”

But getting them to participate in incentive programs can be challenging. For example, [an Idaho program](#) that offered a \$100 voucher to entice Medicaid recipients to lose weight or quit smoking attracted less than 2 percent of eligible adults after two years.

Among the biggest obstacles is simply getting the word out to enrollees, Crawford said. But there are other issues, too: Poor people are less likely to understand how the incentives work and to face transportation and other barriers to get to doctor appointments or educational classes that are part of the program.

‘Long Way To Go’ To Learn What Works

Little is actually known about what types of incentives get people’s attention or help change their behavior, said Jean Abraham, associate professor of health policy and management at the University of Minnesota. It’s not clear, for instance, whether rewards

are more effective in prodding people to take a concrete step, such as getting a colonoscopy or a mammogram, rather than in changing long-term behaviors, such as smoking. “We have a long way to go to understand what’s most effective,” she said.

The health law sought to get answers to some of those questions by including \$85 million to [test incentives](#) in 10 state Medicaid programs.

States started the studies in 2012 and 2013 and some are struggling to get participants. Connecticut, for instance, has enrolled only half of the 6,000 people it sought for a smoking cessation program. The program pays Medicaid recipients as much as \$350 in gift cards over a year for participating in smoking cessation counseling, using a counseling phone line and having a breathalyzer test showing they haven’t recently smoked. The \$10 million, three-year study will compare that group’s health costs against those of a control group of Medicaid recipients who smoke but received no help.

Other states that received funding are California, Hawaii, Minnesota, New York, Nevada, New Hampshire, Montana, Texas and Wisconsin.

Separate from the health law, one of the largest incentives program is New Mexico Medicaid’s [Centennial Rewards](#), which gives most of the state’s 600,000 recipients the chance to earn points to buy health care items.

They gain points each time they engage in a healthy behavior, such as getting a checkup or seeing a dentist. So far, only about 45,000 have registered and only half of those have redeemed points for gift cards.

New Mexico officials say they are not disappointed. “It is not only a new program for us, but a new concept for most Medicaid programs,” said Medicaid spokesman Matt Kennicott.

‘I’ve Never Felt This Good’

Juarez, 57, of Las Cruces, said the program has motivated her to walk every day at the mall where she works as a hair stylist and helped bring down her blood sugar levels.

“I’ve never felt this good,” she said. “This program motivates me to do more — it’s not so much the money as it’s the improvement in my body.”

Charles Milligan, who until last month was senior vice president of Presbyterian Health Plan in New Mexico, another Medicaid plan, said he's seen an increase in members seeking preventive care, such as diabetes screenings and prenatal care. "The rewards program helps us engage with our members," he said. Still, only about 30,000 of their 200,000 members have registered for it.

[Iowa](#) has also faced challenges getting Medicaid enrollees to complete the wellness exam and health risk assessment survey — even though some will have to pay a \$5 or \$10 monthly Medicaid premium if they don't. About 19,500 of the state's 125,000 enrollees have faced the potential penalty. Of those, about a third completed the wellness exam and assessment.

"The goal is to get people involved and to take a more active role in their own health and we are impressed with what we have achieved," said Andria Seip, Iowa Medicaid's Affordable Care Act policy manager.

Hodgins, who enrolled in Iowa Medicaid in January, said he's glad his community health center advised him about the wellness exam and health survey —not because it saved him money but because he found out that he had high cholesterol and blood sugar, which he's now working to bring under control.

"I've been blessed with decent health for 57 years," said Hodgins, who recently started a delivery company and doesn't mind the state prodding him to get examined. "I have to be responsible for my own health. That's my obligation."

pgalewitz@kff.org | [@philgalewitz](https://twitter.com/philgalewitz)

 EMAIL

 TWEET

 SHARE

 SHARE

We want to hear from you: [Contact KHN](#)

PREVIOUS FROM [MEDICAID](#)

 [Florida House Goes Home Early Over Medicaid Impasse](#)

Top Stories



A Matter Of Faith And Trust: Why African-Americans Don't Use Hospice MAY 5



Patients Not Hurt When Their Hospitals Close, Study Finds MAY 4



Paying Medicaid Enrollees To Get Checkups, Quit Smoking and Lose Weight: Will It Pay Off? MAY 4

RSS 

KHN Morning Briefing

SUMMARIES OF THE NEWS

Senate Gives Final OK To 10-Year, Cost-Cutting Budget Blueprint 9:21 AM EDT

Health Law Critics Say States Are Not Rechecking Eligibility Of New Medicaid Recipients 9:21 AM EDT

Fla. Gov. In DC To Push For Hospital Funds To Cover Uninsured 9:21 AM EDT

[View All](#) 

Email Sign-Up

Stay informed by signing up for the KHN Morning Briefing and other emails.

Most Popular

- 1** [Patients Not Hurt When Their Hospitals Close, Study Finds](#)
- 2** [Paying Medicaid Enrollees To Get Checkups, Quit Smoking and Lose Weight: Will It Pay Off?](#)
- 3** [A Matter Of Faith And Trust: Why African-Americans Don't Use Hospice](#)
- 4** [Rural Indiana Struggles With Drug-Fueled HIV Epidemic](#)
- 5** [Medicare Itemizes Its \\$103 Billion Drug Bill](#)

More From KHN



A Matter Of Faith And Trust: Why African-Americans Don't Use Hospice

Patients Not Hurt When Their Hospitals Close, Study Finds

Paying Medicaid Enrollees To Get Checkups and Lose Weight: Will It Work?

Rural Indiana Struggles With Drug-Fueled HIV Epidemic

[HOME](#) [THE HEALTH LAW](#) [MEDICARE](#) [MEDICAID](#) [STATES](#) [COST & QUALITY](#)

[HEALTH INDUSTRY](#) [INSURANCE](#) [AGING](#) [MENTAL HEALTH](#) [UNINSURED](#)

REPUBLISH OUR CONTENT

Original KHN stories can be republished for free, and XML feeds are available.

[Learn More](#) →

WAYS TO FOLLOW US

 [@KHNews](#)

 [Facebook](#)

 [LinkedIn](#)

 [RSS Feeds](#)

EMAIL SIGN-UP

The KHN Morning Briefing and other emails.

[SIGN UP](#)



© 2015 Kaiser Family Foundation. All rights reserved.

[About Us](#) | [Contact Us](#) | [Editorial Policy](#) | [Staff](#)

Powered by [WordPress.com](#) VIP