HEALTH EQUITY
Governor's Interagency Council on Health Disparities

December 2015 Update

State Action Plan to Eliminate Health Disparities

Contents

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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 second set of recommendations to eliminate disparities in adverse birth outcomes (previous recommendations were submitted in the Council's June 2015 Update), provides information on the Council's efforts to raise awareness and promote adoption of the National Standards for Culturally and Linguistically Appropriate Services, and provides an update on Health Impact Reviews completed since the last report.

ADVERSE BIRTH OUTCOMES DISPARITIES RECOMMENDATIONS

The Governor's Interagency Council on Health Disparities, in its previous report to the Governor and Legislature, submitted three recommendations to work toward the elimination of disparities in adverse birth outcomes. In brief, those recommendations were to:

- Fund local communities at high risk for adverse birth outcomes to develop and implement community-driven prevention programs.
- Increase funding for First Steps to enhance the Maternity Support Services program.
- Promote equity in state government through cultural humility and Government-to-Government training for state employees, the use of equity assessment tools in agency decision making, and increased capacity for Health Impact Reviews.

More detailed information on those recommendations, including evidence for their effectiveness, as well as background information and data on adverse birth outcomes is included in the June 2015 Update report. As a brief summary, racial/ethnic disparities in low birthweight, infant mortality, and other adverse birth outcomes persist for Washington's communities of color, particularly African American and American Indian/Alaska Native populations. As a result, Governor Inslee has made the elimination of disparities in low birthweight a priority in Results Washington.

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.

Adverse Birth Outcomes Disparities Advisory Committee

In order to contribute to ongoing efforts in the state to address adverse birth outcomes (also detailed in the June 2015 Update), the Council convened an advisory committee to assist with developing recommendations. The committee represented community-based organizations and coalitions, health care practitioners, state and local governmental organizations, tribal organizations, and other nonprofit entities. The committee originally met six times from

February through April 2015 and presented its recommendations to the Council at its May 13, 2015 meeting. It then decided to continue working to develop further recommendations and met four more times from June through October 2015. Table 1 includes a list of committee members and consultants who participated in the process, either in the development of the first round of recommendations, the second, or both.

Table 1: Adverse Birth Outcomes Disparities Advisory Committee Members and Consultants	
Name	**Organization/Affiliation**
Laura Alfani	Department of Early Learning
Sofia Aragon	Commission on Asian Pacific American Affairs (formerly with)
Vazaskia Crockrell	Governor's Interagency Council on Health Disparities
Sheila Capestany	King County Department of Community and Human Services
Maria Carlos	Public Health—Seattle King County (formerly with)
Kathy Chapman	Department of Health
Nora Coronado	Commission on Hispanic Affairs
Marsha Crane	American Indian Health Commission
Emma Medicine White Crow	Governor's Interagency Council on Health Disparities
Meghan Donohue	Qualis Health
Stephanie Dunkel	Department of Health (formerly with)
Sharon Eloranta	Qualis Health
Cindy Gamble	American Indian Health Commission
Neve Gerke	Midwives Association of Washington State
Kelly Reese Harmon	Open Arms Perinatal Services (Board)
Lori Hernandez	Department of Early Learning
Katie Hess	United Indians of All Tribes Foundation
Kim James	DoulaMatch
Lonnie Johns-Brown	Office of the Insurance Commissioner
Lea Johnson	Tacoma Pierce County Public Health
Annie Kennedy	Simkin Center for Allied Birth Vocations, Bastyr University
Judy King	Department of Early Learning
Michelle Kinne	St. Joseph Medical Center
Gina Legaz	March of Dimes
Laurie Lippold	Home Visiting Coalition
Devon Love	Center for MultiCultural Health (formerly with)
Shelley Means	Native American Women's Dialogue on Infant Mortality
Marcy Miller	Thrive Washington
Ann Mumford	Black Infant Health Program
Sharon Muza	Certified Birth Doula and Lamaze Certified Childbirth Educator
Jan Olmstead	American Indian Health Commission
Dila Perera	Open Arms Perinatal Services
Michelle Sarju	Open Arms Perinatal Services
Leah Tanner	Global Alliance to Prevent Prematurity and Stillbirth
Polly Taylor	Department of Health
Crystal Tetrick	Public Health—Seattle & King County
Heather Weiher	Health Care Authority
Laura Wells	Home Visiting Coalition
Eva Wong	Public Health—Seattle & King County
Liv Woodstrom	Thrive Washington
Casey Zimmer	Health Care Authority

New Recommendations

Recommendation 1 —Medicaid Reimbursement for Doula Care
The Legislature should provide the Health Care Authority funding to provide Medicaid reimbursement for doulas as Community Health Workers or Community Health Representatives. When integrating doula care, the Health Care Authority should:

- Allow reimbursement for prenatal visits, attending the birth, and postnatal follow-up.
- Ensure that qualified doulas meet the following criteria:
    - Must receive professional doula training.
    - Must be certified through a certifying organization such as PALS Doulas or DONA International.
- Contract with Tribal or Urban Indian Health Organizations or accredited **community-based doula programs** that ensure competency and appropriately match childbearing individuals to doulas that align with their culture, language, religion, and other characteristics.

Community-based doula programs meet five essential components: (1) employ women who are trusted members of the target community, (2) extend and intensify the role of doula with families from early pregnancy through the first months postpartum, (3) collaborate with community stakeholders/institutions and use a diverse team approach, (4) facilitate experiential learning using popular education techniques and the HC One training curriculum, and (5) value the doula's work with salary, supervision and support. *Source: Health Connect One.*

In addition, the Legislature should explore options for funding and/or incentivizing the development of more community-based doula programs and a more diverse doula workforce.

How does doula care reduce disparities in adverse birth outcomes? And how can Medicaid reimbursement for doula care generate cost-savings?

- A birth doula is a "trained and experienced professional who provides continuous physical, emotional and informational support to the mother before, during and just after birth."[1]
- A 2013 Cochrane research review concluded that, "Continuous support during labour has clinically meaningful benefits for women and infants and no known harm. All women should have support throughout labour and birth." The review found doula support was associated with lower rates of cesarean births and lower use of pain medications and vacuum extraction or use of forceps. Those who received doula care had slightly shorter labor and were more likely to report being satisfied. Babies born to individuals receiving doula care were less likely to have low five-minute Apgar scores. Doula care was not associated with any adverse effects. The review also found that doula support was most effective when the doula was not affiliated with the hospital nor a part of the childbearing person's own social network.[2]
- In 2014, the American College of Obstetricians and Gynecologists released a consensus statement that concluded, "Published data indicate that one of the most effective tools to improve labor and delivery outcomes is the continuous presence of support

personnel, such as a doula…Given that there are no associated measurable harms, this resource is probably underutilized."[3]

- Women of color and those with public health insurance are more likely to experience adverse birth outcomes and are more likely to desire but not have access to doula care.[4]
- Recent research compared birth outcomes for Medicaid recipients in Minnesota who received coverage for prenatal and birth support from doulas to outcomes from a national sample of Medicaid recipients. The study found that cesarean rates were significantly lower for women receiving doula care (22.3% vs. 31.5%). Preterm birth rates were also lower for those receiving doula care (6.1% vs. 7.3%); however the differences in preterm birth rates were not statistically significant. The authors conclude that, "Among vulnerable subgroups, such as Black women, lower cesarean and preterm rates for doula-supported births are indicative of the role doulas could play in reducing persistent racial/ethnic disparities in these outcomes if high-quality doula services were made financially and culturally accessible to women at highest risk of poor outcomes."[5]
- The study in Minnesota also modeled cost-savings associated with reduced cesarean rates for state Medicaid programs, including Washington State. The models estimated that at a $200 reimbursement rate for doulas, the Washington State Medicaid program could save between $286,442 and $14,721,406 per year depending on the percent reduction in cesarean deliveries achieved.[6]
- Community-based doula programs are evidence-based, culturally appropriate programs that match childbearing persons to doulas from their community. Evidence shows their effectiveness, particularly in lowering cesarean rates and improving breastfeeding rates.[7]

Recommendation 2—Support the American Indian Health Commission's Maternal-Infant Health Strategic Plan

In an effort to improve access to services and improve birth outcomes for American Indian/Alaska Native women, as well as other people of color, the Legislature should support the recommendations outlined in the American Indian Health Commission's Maternal-Infant Health Strategic Plan.

How will supporting the American Indian Health Commission's Maternal-Infant Health Strategic Plan improve birth outcomes and reduce disparities experienced by American Indians/Alaska Natives?

- The American Indian Health Commission (AIHC) is a Tribally-driven, non-profit organization in Washington State. The AIHC is comprised of delegates appointed to serve by resolutions from 28 Tribes and two Urban Indian Organizations. Its mission is to improve the overall health of American Indian and Alaska Natives through advocacy, policy and programs to advance best practices.[8]
- In December 2010, the AIHC released its Maternal-Infant Health Strategic Plan,[9] following two years of careful research and development strategies. To develop the plan, the AIHC created a Maternal-Infant Health Workgroup; reviewed literature and data; conducted interviews with key informants; surveyed Tribal and Urban Indian Health Organization directors; conducted interviews with Tribal Women Infants and

Children program staff; held nine meetings of the Maternal-Infant Health Workgroup to facilitate review and discussion of recommendations; and held focus groups with women and teen Tribal members and Urban Indians. The AIHC reviewed portions of the plan at meetings and in October 2010 passed a resolution accepting the Maternal-Infant Health Strategic Plan for presentation, review, and discussion at the Tribal Leaders Health Summit later that year.

- The Maternal-Infant Health Strategic Plan was developed using the following guiding principles: (1) to identify the most significant problems where interventions can make the greatest difference, (2) to create measurable goals to eliminate disparities, (3) to adopt strategies using approaches proven to be effective, (4) **to recognize that Tribes and Urban Indian programs can deliver the most culturally appropriate and geographically accessible programs to American Indians**, (5) to recognize that each Tribe and Urban Indian program must prioritize the actions they will take, (6) to look for solutions that are cost-effective, (7) to recognize that state investment in maternal and infant health for American Indian/Alaska Natives will reduce Medicaid costs, and (8) to integrate state-funded and federally funded programs with existing Tribal, Urban Indian, and Indian Health Services programs.

HEALTH IMPACT REVIEWS

The Council collaborates with the State Board of Health to conduct Health Impact Reviews. A Health Impact Review is an objective 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.

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.

During the last two years, staff has completed twenty Health Impact Reviews—policy topics have been diverse and included education, emergency response, mental health, public safety, environment, oral health, wage and labor, and juvenile justice.

During the 2015 regularly scheduled session, Health Impact Review requests actually exceeded staff capacity. As Health Impact Review requests have increased and the reviews have become more normalized and integrated into legislative processes, additional staff capacity has become needed. The Council recently included a recommendation for the Legislature to provide additional funding to the State Board of Health to increase capacity for Health Impact Reviews in its recommendation to promote equity in state government (see the Council's June 2015 Update, page 7).

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 recent reviews completed since the Council submitted its June 2015 Update is included in Table 2. For more information or to request a review, please contact the State Board of Health at hir@sboh.wa.gov.

Table 2: Recent Health Impact Reviews Completed (since June 2015)		
Subject of Request	**Requester**	**Overall Findings**
SHB 1458-Concerning the age of individuals at which sale or distribution of tobacco and vapor products may be made	Representative Orwall	Evidence indicates that SHB 1458 has potential to decrease use of tobacco and vapor products among youth and young adults, thereby improving health outcomes. Potential impacts on health disparities are unclear; however some evidence suggests that the effect on disparities may be neutral.
Funding the 2015-2017 Individual Provider Home Care Contract	Representative Moscoso	Evidence indicates that funding the wage and retirement provisions of the 2015-2017 Individual Provider Home Care Contract would likely improve health outcomes and decrease health disparities by race/ethnicity and income.
SB 5459-Implementing family and medical leave insurance	Senator Keiser	Evidence indicates that SB 5459 has potential to improve financial security; to improve maternal, child, and family health; and to decrease health disparities by income, educational attainment, and race/ethnicity.
H-0915.3/15 3rd draft-Concerning commercial janitorial services	Representative Gregerson	Evidence indicates that there are high rates of injury among commercial janitors; that commercial janitors often report having inadequate time to complete work; and that reducing workload and rushing among commercial janitors would likely decrease workplace injury disparities by race/ethnicity, English language proficiency, country of origin, education, and income. It is unclear if the specific standards required in H-0915.3/15 would lead to decreased workload and rushing.

NATIONAL CLAS STANDARDS

One of the Council's statutory responsibilities is to "…assess through public hearings, review of existing data, and other means, and recommend initiatives for improving the availability of culturally appropriate health literature and interpretive services within public and private health-related agencies" (RCW 43.20.275(3)).

In alignment with this responsibility, in September 2013, the Council adopted the implementation of the National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards) as a priority. The CLAS Standards are guidelines developed by the Department

of Health and Human Services Office of Minority Health to advance health equity, improve quality of services, and work toward the elimination of health disparities. The CLAS Standards can be implemented by any entity wishing to provide services that are responsive to the diverse cultural, language, literacy and other needs of the populations it serves.

From September 2013 through August 2015, the Council received a grant from the federal Office of Minority Health to raise awareness and promote adoption of the CLAS Standards. During the two year grant period, Council staff provided information, resources, technical assistance, and training on the CLAS Standards to several state agencies and other public and private health-related organizations.

The Council also partnered with the State Department of Health to create both an in-person CLAS training curriculum as well as CLAS e-learning sessions based on adult learning theory and principles. The in-person training curriculum consists of five 1.5 hour modules created to provide an in-depth understanding of all 15 standards and implementation strategies. Materials for the in-person training, including PowerPoint slide presentations, facilitator guides, activity directions, and handouts are available on the Council's CLAS Web page. Any individual wishing to provide training in their organization can download and use the training materials for free. The four CLAS e-learning sessions include an introduction to the CLAS Standards, a session on governance, leadership, and workforce; a session on communication and language assistance; and a session on engagement, continuous improvement, and accountability. Each takes about a half hour to complete and they are also available on the Council's CLAS Web page for any individual to take for free.

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:	Lori Wada
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[i]:	Willie Frank Jan Olmstead (alternate)
Health Care Authority:	Vazaskia Crockrell
Office of Superintendent of Public Instruction:	Mona Johnson
State Board of Health:	Stephen Kutz
Workforce Training and Education Coordinating Board:	Nova Gattman

[i] 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	
June 2015 Update: State Policy Action Plan to Eliminate Health Disparities	Provides Council recommendations to eliminate disparities in adverse birth outcomes, includes guidance to promote equity in state policy and program development, and provides an update on Health Impact Reviews.
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.
All reports are available on the Council's website: HealthEquity.wa.gov	

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[4] Kozhimannil et al. (2014). Potential Benefits of Increased Access to Doula Support During Childbirth. AJMC. Accessed at: http://www.ajmc.com/journals/issue/2014/2014-vol20-n8/potential-benefits-of-increased-access-to-doula-support-during-childbirth/P-7 on 11/24/2015.
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[6] Ibid.
[7] Health Connect One (2014). The Perinatal Revolution: New research supports the critical role Community-Based Doula Programs can play in improving maternal and child health in underserved birthing populations. Accessed at: http://www.healthconnectone.org/pages/new_study__the_perinatal_revolution/362.php on 11/24/2015.
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[9] American Indian Health Commission (2010). Healthy Communities: A Tribal Maternal-Infant Health Strategic Plan. Accessed at http://www.aihc-wa.com/about-us/who-we-are/ on 11/24/2015.