June 2015 Update

State Action Plan to Eliminate Health Disparities

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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 Council recommendations to eliminate disparities in adverse birth outcomes, guidance to promote equity in state policy and program development, 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 mortality[i] than those born to Asians or Whites and infants of Pacific Islander and Hispanic mothers had elevated rates compared to those of Asians.[1] 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] In general, disparities persist even after controlling for factors such as income, education, and socio-economic status. It's important to note that due to a lack of finer disaggregation, these data likely mask important disparities that may exist for racial/ethnic subgroups, among U.S. born versus foreign born and/or by acculturation status, and by language spoken.

Leading causes of infant death in Washington are birth defects, Sudden Infant Death Syndrome (SIDS), and preterm birth.[3] Babies born with very low birthweight[ii] 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

[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.

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 care[iii] 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 or quality of healthcare services and health inequity. As such, it is an important indicator in Results Washington[6] and decreasing disparities in low birthweight is one 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.

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

- **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.

[iii] Prenatal care is comprehensive health care provided during pregnancy.

- **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.

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]
- Community-based programs that provide education, resources, linkages, and support to pregnant women and families postpartum can promote equitable 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 additional 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 addition, the number of providers has decreased from 96 in 2010 to 61 in 2014.
- 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 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

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[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.

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]
- 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.

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[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

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% effective[19] 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.

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

Background

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, the Council has sought public comment on what the state is doing well and how it can improve in its efforts to reduce health disparities. It has also received briefings on state and local health equity and social justice efforts, including briefings on tools developed to assist agencies to be intentional in promoting equity. In addition, the Council chose 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 in its June 2014 Update.

Recently, through our partnership with the Governor's Healthiest Next Generation (HNG) Initiative, the Council was asked to develop guidance that state agencies, the Governor's office, and the Legislature can use to promote equity in state government policy and program decisions. HNG partners thought that such guidance would be useful in ensuring the initiative's recommendations were implemented in ways that prioritized communities most in need. The Council was pleased to take this project on and the guidance will be included in the HNG final report to the Governor and Legislature.

In order to develop the guidance, Council staff interviewed or received written comments from 22 experts across the state who do equity-promoting work (see Table 2). Staff contacted individuals who work closely with the community and/or do social justice work and then asked these stakeholders to connect us with other experts. Stakeholders shared resources and provided insights in the early stages of this project and also reviewed and provided feedback on drafts of the document. In addition, staff reviewed policy and other document language that has been used in Washington and across the country, current local equity initiatives and frameworks, and publications on social justice. A draft of the equity guidance was posted on the Council's website and the public was invited to provide feedback. The Council adopted the guidance at its public meeting on May 28, 2015 which was held at the South Seattle Community College Georgetown Campus.

Table 2: Stakeholders Who Provided Guidance and Feedback	
Name	**Organization/Affiliation**
Melanie Anderson	Department of Commerce
Sofia Aragon	Commission on Asian Pacific American Affairs
Laura Flores Cantrell	Washington Dental Service Foundation
Nora Coronado	Commission on Hispanic Affairs
Adrian Dominguez	Spokane Regional Health District and Eastern Washington University
Sara Franklin	Commission on African American Affairs
Chris Genese	Washington Community Action Network
Michael Itti	Commission on Asian Pacific American Affairs
Eli Kern	Public Health—Seattle and King County
Diane Klontz	Department of Commerce
Jan Olmstead	American Indian Health Commission
Millie Piazza	Department of Ecology
Joana Ramos	Washington State Coalition for Language Access
Genya Shimpkin	The Q Card: Empowering Queer Youth in Healthcare
Matías Valenzuela	Office of King County Executive
Heather Villanueva	SEIU 775
Leslie Walker	Seattle Children's Hospital

Introduction

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, healthy environments, and employment and educational opportunities. Public policy and state government influence these structural factors and therefore affect the opportunities available for all Washingtonians to be healthy. State government has the ability to promote equity and decrease disparities. For the purpose of this guidance, **equity** means "all people have full and equal access to opportunities that enable them to attain their full potential."[vi] **Inequities** are differences that are "not only unnecessary and avoidable but are considered unfair and unjust."[vii] **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 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. While

[vi] This definition of equity is from King County Ordinance 16948
[vii] This definition of inequity is adapted from the Washington State Department of Health's working definition of health inequity

language plays an important role in promoting equity, achieving equity in state government will require a comprehensive approach that uses frameworks and tools to analyze equity impacts. Equity analysis is an intentional process that looks at benefits and burdens and makes adjustments based on that analysis. To provide some examples of the comprehensive and intentional approach needed to achieve equity, this section also highlights integrated frameworks and important considerations to promote equity.

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 populations who are disproportionally 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 3)
- Language requiring engagement and consultation with representatives from diverse populations in decision-making processes (Table 4)
- Language requiring collection, analysis, and/or reporting of disaggregated data (Table 5)
- Inclusive language for policies and programs that can be used to strive for the greatest inclusion possible (Table 6)

Tables 3-5 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 3 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 3. Language for interventions and/or funding for populations impacted by inequity	
Sample Language	**Considerations**
Sample Policy Language The [campaign/funding/intervention/ program/ resources/etc.] shall be culturally and linguistically appropriate and prioritized among [schools/early learning centers/communities/populations 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.]	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 populations so it is important to pair resources with requirements particularly for populations already facing disparities. 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. When deciding which indicator to use (e.g. percent of students on free and reduced price lunch, populations experiencing the largest disparities, etc.) it is important to consider what the best indicator is for the particular policy or program. 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. 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	This example language can be included in RFPs and other solicitation documents. This language

<table>
<tr><td>[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)</td><td rowspan="2">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.</td></tr>
<tr><td>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.</td></tr>
</table>

Table 4. Language requiring engagement and consultation with representatives from diverse populations 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 populations who will be impacted by the policy, particularly those who 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. It is important that these decision-makers facilitate meaningful community engagement with individuals who actually represent communities rather than selecting representatives for political reasons our 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.
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 populations who will be impacted.	

Table 5. Language requiring collection, analysis, and/or reporting of disaggregated data	
Sample Language	**Considerations**
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: (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.	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 populations. 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.

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 (using aggregated years when appropriate) indicates significant differences among categories of individuals as it pertains to the subject of the report.	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) and 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. 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).

Policies that are written to ensure specific populations and groups are included often call for detailed language to describe the targeted group(s). Table 6 provides some descriptive language to help 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 not exhaustive; the best course of action is to connect with members of the population or groups for which policies are written to ensure the language will translate effectively into practice.

Table 6. Inclusive language for policies and programs

Group	Descriptive 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 populations	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
*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. ** 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. *** 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.	

Integrated Frameworks and Important Considerations to Promote Equity

The stakeholders who contributed to this guidance document 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. Cultural competence** is a "set of values, behaviors, attitudes, and practices within a system, organization, program or among individuals and which enables them to work effectively cross culturally. Further, it refers to the ability to honor and respect the beliefs, language, interpersonal styles and behaviors of individuals and families receiving services, as well as staff who are providing such services. Striving to achieve cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment."[viii] **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.[ix] 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 populations who are facing inequities and eliminate 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 of 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, create barriers to voting, or 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 be involved in this process.

- **Ensure all state services and programs are culturally and linguistically appropriate for the diverse populations in 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.

[viii] Denboba, D., U.S. Department of Health and Human Services, Health Services and Resources Administration (1993). *MCHB/DSCSHCN Guidance for Competitive Applications, Maternal and Child Health Improvement Projects for Children with Special Health Care Needs.*

[ix] 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

- **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.[x] Regressive tax systems require the lowest income individuals to pay the largest share of their income in taxes and create an unequitable 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 the language will promote opportunity and equity and not perpetuate disparities.

- **Ensure accountability in the state system.** Establish metrics to track progress toward eliminating disparities and achieving equity in state government.

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.

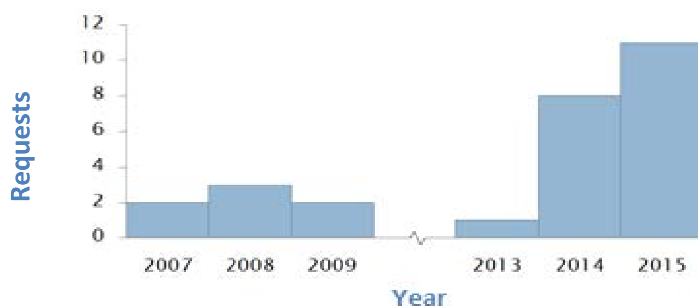
[x] Davis C, Davis K, Gardner M, et al. Who Pays? A Distributional Analysis of the Tax Systems in All 50 States: Fifth Edition. Institute on Taxation and Economic Policy. Available at http://www.itep.org/pdf/whopaysreport.pdf.

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

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 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 7.

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

Table 7: 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 Liias	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 disproportionally 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 disproportionally 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 disproportionally 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. A list of Council Members is included in Table 8.

Table 8: 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[xi]:	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

[xi] 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 in Table 9.

Table 9: 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.
All reports are available on the Council's Web site: HealthEquity.wa.gov	

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