State Policy Action Plan to *Eliminate Health Disparities*

Governor's

Interagency Council on Health Disparities

June 2010

Message from the Chairs

To Governor Gregoire and Members of the Legislature:

On behalf of the Council and all those who have contributed to its work, we are pleased to present the State Policy Action Plan to Eliminate Health Disparities.

Washington's communities of color continue to face a disproportionate burden of disease and death and disparities between men and women also remain for some health outcomes. While the reasons for such inequities are numerous and interrelated, what is clear is that health disparities in our State are persisting, sometimes even growing, and always unjust.

What is also clear is that Washington is becoming increasingly more diverse and the health of its communities of color will soon drive its overall health. Therefore, if Washington is to reach its goal of becoming the healthiest state in the nation, which we believe it can, then we must take action to promote the health of our diverse communities. Eliminating health disparities is a daunting challenge but also essential for our children, our communities, and our State.

This action plan outlines policy recommendations for your consideration aimed at closing the academic achievement gap; increasing health insurance coverage and access to culturally and linguistically appropriate healthcare services; promoting a diverse healthcare workforce; and ensuring all Washingtonians have equal opportunity to access healthy environments, make healthy choices, and manage their health in order to reduce disparities in obesity and diabetes.

We recognize the reality of the State's budget deficit and economic recession. Therefore, in addition to submitting our full list of policy priorities, we have also highlighted several immediate priorities that we believe can be implemented with little or no additional state funds.

We thank you for your ongoing support and commitment.

Sincerely,

Vickie Ybarra, RN, MPH
Chair

Emma Medicine White Crow
Vice Chair

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For persons with disabilities, this document is available on request in other formats.

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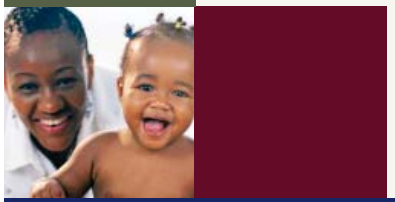
Executive Summary

In Washington State, there are many examples of variations in health behaviors, status, and outcomes by race/ethnicity, as well as by gender. These health disparities are often dramatic and always unjust.

In 2006, with the passage of 2SSB 6197, the Legislature charged the Governor's Interagency Council on Health Disparities with creating an action plan for eliminating health disparities by race/ethnicity and gender. In creating the action plan, the Council was specifically asked to identify five priority health conditions and social determinants of health and to convene advisory committees to help develop recommendations for the plan. The Council was also asked to create recommendations to improve the availability of culturally appropriate health literature and interpretive services and to gather information to understand how the actions of state government work to reduce or contribute to health disparities.



This report serves as the Council's state policy action plan to eliminate health disparities by race/ethnicity and gender. The plan covers each of the Council's five priorities—**education, health insurance coverage, healthcare workforce diversity, obesity, and diabetes**—and also provides recommendations related to language access and promoting equity within state agencies.

All of the recommendations within this plan are priorities for the Council. They were arrived at through careful deliberation and prioritization within advisory committees, input from the public, and finalization by Council members. However, given the reality of the State's budget deficit and economic recession, the Council has highlighted several immediate priorities that it believes can be implemented with little or no additional state funds.

Immediate Priority Recommendations (recommendations are summarized—more detailed language is provided in the full text):

- Ensure the State's schools with the largest academic achievement gaps have access to high-performing teachers and other certificated staff by reallocating funding for National Board Certification stipends and incentivizing training in culturally responsive teaching.
- Create a single, seamless, state-subsidized health insurance plan for public programs that includes options to cover all people in families with incomes below 200% of the federal poverty level and that defines a standard benefit package for all enrollees.
- Ensure all healthcare providers receive the training and resources they need to provide culturally competent care to all patients regardless of race/ethnicity, culture, socioeconomic status, or language through licensure requirements, workplace training, and reporting requirements for health professions education institutions.
- Require postsecondary institutions to set targets to increase enrollment and completion of diverse students in healthcare education programs until diversity reflects the population served and to report annually on progress to the Higher Education Coordinating Board.
- Appoint an endocrinologist and a certified diabetes educator to any statewide panel or policy making body created to address issues related to chronic disease management.

Introduction

The Legislature created the Governor's Interagency Council on Health Disparities (Council) in 2006 and assigned it the primary responsibility of creating an action plan for eliminating health disparities by race/ethnicity and gender. In creating the action plan, the Council was specifically asked to identify five priority health conditions and social determinants of health and to convene advisory committees to help develop recommendations for the plan.

This report is the culmination of that process, which included:

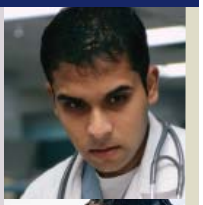
- identifying 32 health topics for consideration in the plan;
- collecting and reviewing data and information on the magnitude of the problem, level of severity, and degree of disparity for each of the 32 health topics;
- completing a first phase of prioritization to narrow the list of 32 health topics to 12 initial priorities;
- conducting targeted environmental scans on the 12 initial priorities to identify activities throughout the state aimed at improving the health of communities, particularly communities of color;
- completing a second phase of prioritization to select five priorities;
- seeking, compiling, and reviewing public input through forums, surveys, and discussions to guide the Council's selection of priorities throughout the two-phase prioritization process;
- convening diverse advisory committees to identify, assess, and propose policy recommendations for the Council's consideration;
- releasing provisional recommendations for public comment; and
- incorporating feedback into this final report.

This report serves as the Council's state policy action plan to eliminate health disparities by race/ethnicity and gender. The Council does not have the authority to implement programs to address disparities. Therefore, this plan outlines policy recommendations for consideration by the Governor and Legislature. The plan covers each of the Council's five priorities—**education, health insurance coverage, healthcare workforce diversity, obesity, and diabetes.**

This report provides a brief overview of health disparities in Washington State followed by key findings and recommendations for each of the Council's priorities. The Legislature also charged the Council with creating recommendations to improve the availability of culturally appropriate health literature and interpretive services and gathering information to understand how the actions of state government work to reduce or contribute to health disparities. Recommendations resulting from these latter responsibilities are also included in the report.

Looking For More Information?

Additional, more detailed information on the Council's prioritization process and advisory committees, including the final reports and recommendations from each committee, is available on the Council's Web site at: HealthEquity.wa.gov.



Definition of Health Disparities:

The difference in incidence, prevalence, mortality, or burden of disease and other adverse health conditions, including lack of access to proven healthcare services that exists between specific population groups in Washington State.

Background

Health Disparities in Washington State

In Washington State, as in the United States overall, there are often dramatic variations in health behaviors, status, and outcomes by race/ethnicity. Here are just some examples:

- **Access to Care**: Hispanic adults are less likely than all other racial/ethnic groups to report having a personal healthcare provider.
- **Smoking**: American Indians/ Alaska Natives have the highest smoking rates (nearly double that of Whites) followed by Hawaiian/ Pacific Islanders and Blacks/African Americans. Smoking rates have declined significantly among Whites but remained relatively stable among other racial/ethnic groups.
- **HIV**: The HIV incidence rate for Blacks is six times higher than the rate for Whites. Similarly, the rates for Hispanics and American Indian/ Alaska Natives are double the rate for non-Hispanic Whites.
- **Hepatitis B**: Nationally, more than half of the 1.3-1.5 million people with chronic Hepatitis B are Asians and Pacific Islanders.
- **Heart Disease**: Coronary heart disease mortality rates are significantly higher for American Indian/Alaska Natives and Blacks than for Whites.
- **Mental Health**: American Indians and Alaska Natives report significantly higher rates of poor mental health than all other racial/ethnic groups.
- **Oral Health**: Children of color have more dental caries and fewer dental sealants than White children.
- **Infant Mortality**: Black and American Indian/Alaska Natives experience twice the infant mortality as other groups.
- **Environmental Health**: There are disproportionately larger numbers of hazardous treatment facilities, landfills, toxic release inventory facilities, and other sites with potential exposures to hazardous chemicals in communities of color.
- **Occupational Health**: Workers of Hispanic origin make up about 5% of the Washington workforce but account for 11% of occupational fatalities.

Washington's Changing Demographics

Washington is becoming more diverse. In 2008, the Office of Financial Management (OFM) estimated that 23.8% of Washingtonians were people of color, up from 20.6% in 2000. Washington's Hispanic population was the fastest growing group, increasing from 7.5% in 2000 to 9.3% in 2008 followed by the Asian and Pacific Islander population, which increased from 5.9% to 6.9% over the same period. In 2008, the Black and American Indian/Alaska Native populations accounted for 3.4% and 1.4% of the total population, respectively.

By 2030, OFM projects Washington's non-Hispanic White population will decline as a share of the total population to 68.4%, while the proportion of people

Use of the Term Race/Ethnicity

Race and ethnicity are social classifications—they are not based on biology and do not reflect innate genetic differences. Throughout this report, we use the single term race/ethnicity to emphasize that race and ethnicity are non-precise and socially constructed. Specific racial/ethnic categories described in this report reflect the language used in the data sources they were drawn from.

of color will increase to 31.6% – nearly one in every three residents. By 2030, the Hispanic population is projected to make up 12.9% of the total population followed by the Asian and Pacific Islander (9.5%), Multiracial (4.4%), Black (3.4%), and American Indian/Alaska Native (1.4%) populations. As Washington becomes more diverse, the need to take action to redress disparities becomes more urgent. Without change, the overall health of the state's population will decline and Washington will slip further away from its goal of becoming the healthiest state in the nation.

Why Do Racial/Ethnic Health Disparities Exist?

While genetics may play a role in some diseases, many health experts agree the overall role is minimal. So, why do racial/ethnic health disparities exist? Communities of color tend to have lower incomes and less education than White communities and this lower socioeconomic status is the major factor contributing to the poorer health experienced by communities of color. Differences in socioeconomic status lead to differential access to resources and conditions that influence health, such as nutritious food, exercise, social networks, safe and healthy environments, and appropriate healthcare services.

Disparities Faced by Other Populations

The Council recognizes there are other populations affected by health inequities, including low-income groups, older adults, rural residents, individuals with disabilities and special healthcare needs, and the LGBT community. However, the Council was given the specific task of addressing disparities by race/ethnicity and gender, and therefore, disparities for other populations are beyond the scope of this plan.

Racial/ethnic health disparities are not entirely explained by the unequal distribution of social and economic resources. There is evidence that disparities persist even when factors such as education and income are taken into account. The added burden of how society treats people of color—both institutional and interpersonal racism—contributes to the many factors that lead to inequities in health. Institutional racism is illustrated by programs and policies that, often unintentionally, manifest in reduced access to goods, services, and opportunities for people of color. In addition, chronic stress resulting from racial discrimination is a known determinant of poor physical and mental health.

Health Disparities by Gender

In creating the Council, the Washington State Legislature recognized that women often experience disparities in income, employment, and other social determinants of health. Therefore, the Legislature charged the Council with considering health disparities by gender in addition to disparities by race/ethnicity. The Agency for Healthcare Research and Quality reports that women are more likely than men to suffer from arthritis, serious mental illness, and other conditions that effect daily function. In addition, the death rate for acute myocardial infarction is higher for women than for men. Overall, women are more likely to report having a usual source of healthcare than men. However, among those who report not having a usual source of care, women are more likely to report financial or insurance barriers as the reason.

Disparities by race/ethnicity were particulary dramatic for each of the Council's priority health areas. As a result, this action plan focuses primarily on disparities by race/ethnicity. The Council's advisory committees, particularly the health insurance committee, considered women's health issues in deliberations and in crafting policy recommendations for the Council's consideration. (References available on page 28)

Education

There is a large body of evidence linking greater educational attainment with better health behaviors, self-reported health, health outcomes, and longer life expectancy. For example, people with college degrees on average live at least five years longer than those with less than a high school education. In addition, infant mortality rates are nearly double for mothers with less than a high school education compared to mothers with a college education. Education influences health through at least three pathways: improved health behaviors, better employment opportunities and higher income, and a greater sense of control and higher levels of social standing and social support.

The Academic Achievement Gap in Washington State

A number of indicators measure the achievement gap, including performance on state assessments, dropout rates, and graduation rates, among others. In general, female students performed better on the state assessment than male students and Asian and White students performed better than American Indian, Pacific Islander, Black, and Hispanic students. On-time and extended graduation rates, as well as drop-out rates vary dramatically by race/ethnicity, with White and Asian students faring better than students from other racial/ethnic groups. It is important to note the tremendous diversity that exists within these broad categories, particularly the category "Asian American." Student achievement varies considerably by racial/ethnic subgroup, with Southeast Asian and Filipino students, in particular, having higher dropout rates and lower passing rates on the state assessment.

Washington's public schools are becoming more diverse. The number and percentage of students of color enrolled in the public school system has increased steadily from 7.5% in 1971 to 17.9% in 1990 to 35.2% in 2008. In addition, projections show that the state will continue to grow more and more diverse and the proportion of students of color in the state's public school system will reach 50% by 2029 (personal communication, December 4, 2009). In 2008, there were 47 school districts in which students of color already made up more than 50% of the student population, including four of the ten largest enrollment districts.

The implications of these data carry great weight. Students of color—those students who suffer the burden of the achievement gap—comprise an ever increasing share of the students in the public school system and their performance will soon drive the performance of the entire system. Closing the achievement gap, therefore, is essential if Washington is to create a world-class education system as well as adequately address health disparities.

The Council's Education Advisory Committee

The Council convened an education advisory committee to assess and recommend policy options for its consideration. The committee defined its purpose as follows: to identify policy recommendations to reduce the academic

"...one of the most effective strategies for reducing health disparities in this country could be to take steps to close the gaps in educational attainment."
—Commission to Build a Healthier America

achievement gap for students of color in grades K-12. Because the committee recognized that the increasing diversity of the public school system will have substantial implications on the overall performance of the educational system and ultimately on the health of the children in it and the adults they will become, throughout its deliberations it sought to focus on institutional changes to make the educational system responsive to students of color. The Council considered committee recommendations along with public comment in offering its policy recommendations.

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Education

Key Findings

- Evidence from education research demonstrates that teachers are one of the most important factors influencing student academic success.
- National board certification may not be the perfect indicator for identifying high performing teachers; nonetheless, current research finds it is one clear way to distinguish more effective teachers from their less effective counterparts with respect to academic achievement.
- The current NBCT stipend structure in Washington is not fully effective at ensuring the state's highest need schools have access to high-performing teachers.
- High-performing teachers may not necessarily perform well in diverse classrooms and more should be done to ensure teachers receive training in culturally responsive teaching.

- There is evidence in the literature that effective school leadership is an important determinant of school and student achievement.
- Currently, indicators for identifying high performing principals are lacking.
- More should be done to ensure principals receive training in cultural competence.

- There is evidence in the education research supporting family, community, school partnerships positive impact on student achievement and other student-level and school-level outcomes.
- Districts that are effective in promoting family, community, and school partnerships have made it a priority and have dedicated resources, often in the form of family engagement offices and/or dedicated family engagement staff.
- Community and family engagement strategies should be culturally responsive and based on best practices and identified standards.

Recommendations

IMMEDIATE PRIORITY: Ensure the state's schools with the largest academic achievement gaps have access to high-performing teachers and other certificated staff. The NBCT stipend that applies broadly to certificated staff should be reduced to $2,500/year, with the saved resources redirected to increase the NBCT stipend for certificated staff serving in schools identified as having the largest academic achievement gaps. The achievement gap stipend should be increased to $7,500/annually and in order to be eligible for the annual stipend, certificated staff should complete initial and ongoing clock hours training in culturally responsive teaching and service delivery in the targeted population, i.e., student groups targeted in the five achievement gap studies: African American, Asian, Latino, Native American, and Pacific Islander students. In addition, programs to provide financial support and mentoring should be provided broadly to teachers and other certificated staff already serving in schools with the largest achievement gaps who wish to work toward their National Board Certification.

Ensure that schools identified as having the largest academic achievement gaps have access to high quality school leadership. As in the case of National Board Certified staff above, stipends should be institutionalized as a public policy tool to incentivize high quality principals to take posts in schools identified as having the largest academic achievement gaps in Washington State.

Include funding in the Basic Education Funding formula to provide Family/Community Engagement Officers in schools identified as having the largest academic achievement gaps. Family/Community Engagement Officers should promote seamless collaboration and culturally relevant and responsive support between local early learning, K-12, family/guardian, faith-based, post-secondary, after school and racial/ethnic community groups. Family/Community Engagement Officers will initiate best practices for family engagement known to produce school success for children that are culturally responsive to the targeted population. The overall Family/Community Engagement efforts should coordinate with OSPI in advocating best practices statewide for family/community engagement. Through collaboration with OSPI, Family/Community engagement officers will have access to resources from OSPI's Office of Civil Rights and Center for the Improvement of Student Learning as well as the Office of the Education Ombudsman, among others.

Key Findings

- There is strong evidence in the literature that publicly funded, center-based, comprehensive early childhood development programs are effective in preventing cognitive developmental delay and increasing readiness to learn.
- Early childhood development programs themselves have direct impacts on health.
- Prioritizing resources to districts in which schools are experiencing the largest achievement gaps is essential to ensure children of color entering the public school system are ready to learn.

- There is strong evidence in the literature, including studies specifically in Washington State, that healthy students are more likely to have academic success.
- Health and education are inextricably linked and therefore a focus on school health is not tangential but rather essential to closing the achievement gap.
- While the Coordinated School Health model has not been rigorously studied in a comprehensive way to measure effects on health or achievement, there are a number of individual school-based health interventions that have been shown to improve both health and academic outcomes.

Recommendations

As OSPI, DEL, and Thrive by Five Washington develop and implement a comprehensive Early Learning Plan, ensure resources are available to provide adequate funding to create a high quality comprehensive early learning system in partnership with community for children birth-5. State funding should prioritize services targeting districts where schools have the largest academic achievement gaps so that children of color are as likely to succeed in school as other students.

Dedicate funds to implement the Coordinated School Health Model in a culturally responsive manner so schools can comply with existing unfunded school health mandates, including fully funding staffing requirements for school nurses, counselors, PE teachers and food preparation staff as described in the Basic Education Financing Task Force recommendations. Ensure prioritization of Coordinated School Health funding for schools identified as having the largest academic achievement gaps. In implementing the Coordinated School Health model, schools receiving funding should prioritize policies and programs to promote safety and civility in all schools, such as violence prevention, gang prevention, and behavioral health programs.




Health Insurance Coverage

There is substantial evidence demonstrating that people without health coverage for needed care have greater problems accessing healthcare because of cost, are less likely to have a regular doctor or a health home, and are less likely to receive healthcare when they need it. Those without health coverage are more likely to receive poor quality care, have worse health outcomes, and have shorter life expectancies than patients with health insurance coverage. Evidence shows that adverse consequences of being uninsured are experienced by those who are uninsured even for short periods of time. To the extent that specific communities of color experience higher rates of uninsurance, we can expect to see greater problems accessing healthcare and subsequent disparities in health among these communities.

Disparities in Health Insurance Coverage in Washington State

In 2008, 12.3% of Washington's population less than 65 years of age were uninsured. Overall, adults were more likely to be uninsured than children (15% vs. 5%) and males were more likely to be uninsured than females (14% vs. 11%). American Indians and Alaska Natives were twice as likely to be uninsured than Whites (23% vs. 12%) and Hispanics were twice as likely to be uninsured than non-Hispanics (21% vs. 11%). American Indians and Alaska Natives were less likely to have employer-based insurance relative to Whites (38% vs. 64%) and Hispanics were less likely to have employer-based insurance than non-Hispanics (37% vs. 67%). Blacks and American Indians/Alaska Natives were more likely to have public insurance (24% and 33%, respectively) relative to Whites (16%). Similarly, Hispanics were more likely to have public insurance than non-Hispanics (35% vs. 14%). According to Washington data from 2000-2006, uninsurance rates were growing the fastest for American Indians and Alaska Natives, non-Hispanic Blacks and Hispanics.

National data from 2004-2006 reveal large variations in health coverage among Asian and Native Hawaiian and Pacific Islander subgroups. Uninsurance rates are particular high for Koreans (31%), Native Hawaiian and Pacific Islanders (24%), Vietnamese (21%), and other South Asians (20%).

According to national data sources, less than half of women (48%) are able to obtain health insurance through their work, compared to 57% of men. Women are more likely than men to have insurance through their spouse's plan and as a result, single women are twice as likely to be uninsured as married women. Lack of insurance is one reason that women report delaying or avoiding needed care because of cost at higher rates than men.

To the extent that communities of color experience higher rates of uninsurance, we can expect to see greater problems accessing health care and subsequent disparities in health.

The Council's Health Insurance Coverage Advisory Committee

The Council convened a health insurance coverage advisory committee to assess and recommend policy options for its consideration. The committee defined its purpose as follows: to identify policy recommendations to improve health insurance coverage rates and access to comprehensive and culturally competent care for communities of color in ways that achieve health equity and eliminate societal health disparities. In an effort to identify policy recommendations, the committee reviewed insurance data, discussed policies and programs, and assessed numerous policy options. The Council considered the committee recommendations along with public comment in offering its policy recommendations.

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Health Insurance Coverage

Key Findings

- 72% of uninsured adults and 78% of uninsured children are potentially eligible for public coverage.
- There are a number of strategies that have been shown to be effective in increasing enrollment in public programs among eligible individuals by reducing administrative barriers, by increasing awareness and by addressing other barriers, such as stigma.
- Communities of color are disproportionately more likely to be low-income and eligible for public insurance.
- Insurance is unaffordable to many.

- Having a health insurance card does not necessarily provide access to timely care if providers are unable or unwilling to accept Medicaid patients.
- Health homes improve coordination of care across care settings in ways that address the needs of the patient.

Recommendations

IMMEDIATE PRIORITY: Create a single, seamless, state-subsidized health insurance plan for public programs.

a. Have a single name with a single point of entry for consumers, i.e., actual enrollment in Medicaid, SCHIP, Basic Health, etc. should be invisible to the consumer and aid in reducing the possible negative stigma associated with certain public insurance plans.
b. Include options to cover all people in families with incomes below 200% FPL.
c. Have a single application, definitions and standardized eligibility criteria across all programs.
d. Define a standardized benefit package that provides comprehensive and culturally competent care to all enrollees.
e. Develop a state health insurance exchange that serves as the single point of entry for the state-subsidized plan as well as other plans.
f. Assure continuity of care for children that move across products when family income changes and families are no longer eligible for Apple Health for Kids by contracting with same plans, or allowing children to remain in Apple Health for Kids with appropriate cost sharing regardless of income.

Ensure that the public plan provides adequate access to comprehensive and culturally competent care.

a. Reimburse providers appropriately in order to ensure there is an adequate supply of healthcare providers willing to accept its patients.
b. All patients have a health home that provides patients with timely, coordinated care, enhanced access to primary care, improves health outcomes and reduces health disparities.




Key Findings	Recommendations
• There is evidence that aggressive outreach, including reaching immigrants and people of color, in combination with policy clarifications, can be effective in increasing enrollment among eligible individuals • Providing language access services, e.g., making renewal notices, forms and information available in multiple languages and having interpreters available is a best practice to improve participation in public insurance programs.	**Fund community-state partnerships to provide outreach to increase enrollment by race/ethnicity and to decrease the churn rate within public insurance plans.** a. Community outreach efforts should be created and conducted by trusted individuals and organizations from within the communities they serve. b. Community outreach resources (e.g., healthcare navigators or Internet resources) help individuals enroll, navigate, and have better experiences with the healthcare system. c. Outreach efforts should be targeted to help address barriers to enrollment, such as cultural, linguistic, or literacy barriers; confusion about procedures; possible negative stigma; fears related to immigration status; hesitancy to provide information about race/ethnicity or language; and specific barriers that women may face (e.g., losing coverage when a spouse retires). d. Funds are allocated based on community need (e.g., greater funding for communities with higher uninsurance rates). e. Individuals receive follow-up to ensure they are able to access their primary care provider for appointments and can navigate the system.
• The collection and use of race/ethnicity and language data enables public reporting of healthcare quality measures stratified to reveal where disparities are occurring and ultimately can improve care for all.	**Require that all health insurance payers, health plans and healthcare providers collect data on race/ethnicity, gender, and primary language.** a. Standardized methods for collecting data are created so they meet both state and federal standards. This process should be conducted in a collaborative way so it receives buy-in from those payers, plans and providers. b. Safeguards (data security, HIPAA compliance, etc) are in place so data are used appropriately. Provide information to consumers to share how information will be used. c. Data are collected in a way that they can be used to identify disparities in care and outcomes and target interventions to improve care and health outcomes and reduce disparities.

* The Council recognizes that many of the Council's health insurance recommendations were included within provisions of the federal Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010; however it maintains the recommendations remain relevant in helping Washington to implement the provisions and encouraging early adoption.

Healthcare Workforce Diversity

Over the years, a number of national panels have concluded that a diverse healthcare workforce is essential in eliminating health and healthcare disparities. The benefits of a diverse healthcare workforce include improved access to care for communities of color, greater patient choice and satisfaction, improved adherence to treatment, better communication between patients and providers, better educational experiences for all students in health professions training programs, and strengthened cultural competence of the health system.

The Diversity of Washington's Healthcare Workforce

Available data in Washington State describing the healthcare workforce by race/ethnicity are limited. The last comprehensive data source on the diversity of the healthcare workforce was the 1999 Washington State professional licensing survey, which has since been discontinued. While those data are now ten years old, they revealed that Washington's communities of color were, for the most part, disproportionately underrepresented in the health professions. In 2007 and 2008, the Department of Health began surveying the health professionals it licenses to collect demographic information, including race/ethnicity data. While those surveys have also been discontinued, researchers from the Center for Health Workforce Studies analyzed data for the nursing professions and found that, with few exceptions, Hispanic and non-White individuals remain disproportionately underrepresented among the nursing professions.

The Council's Healthcare Workforce Diversity Advisory Committee

The Council convened a healthcare workforce diversity advisory committee to assess and recommend policy options for its consideration. The committee defined its purpose as follows: to identify policy recommendations to increase the diversity of the healthcare workforce so that it reflects the diversity of the population it serves and to increase the cultural competence of the healthcare workforce in order to promote equity and reduce health disparities. In an effort to identify policy recommendations, the committee reviewed workforce data, discussed policies and programs, and assessed numerous policy options. The Council considered the committee recommendations along with public comment in offering its policy recommendations.

The Council's Workforce Diversity Advisory Committee also submitted a number of second-tier recommendations for the Council's consideration. These can be found in the committee's final report and recommendations, which is available on the Council's Web site:

HealthEquity.wa.gov.

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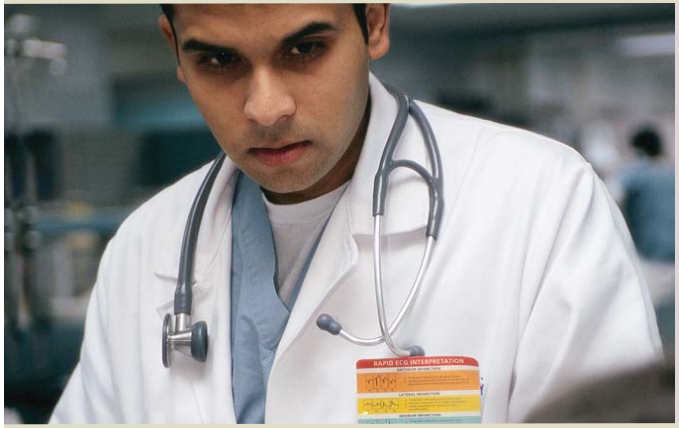

Healthcare Workforce Diversity

Key Findings

- There are numerous examples in the research of improved well-being and health outcomes resulting from culturally competent care.
- Currently, only select healthcare professionals are required to receive cultural competence training as a requirement for initial or license renewal.
- Health professions education institutions are required to offer cultural competence training; however, the degree to which such training is provided and the quality of training is unknown.

- There is evidence to support the belief that a diverse healthcare workforce results in improved access, satisfaction and outcomes, such as adherence to treatment.
- While some health professions education institutions are making great progress to increase enrollment and completion of diverse students, others are not.
- Available data, though limited, reveal that Washington's communities of color are disproportionately underrepresented in the health professions.

Recommendations

IMMEDIATE PRIORITY: Ensuring all healthcare providers receive the training and resources they need to provide culturally competent care to all patients regardless of race/ethnicity, culture, socio-economic status, or language. At a minimum, this can be accomplished by: (1) requiring all licensed healthcare providers to receive cultural competence training as a condition for initial licensure, (2) encouraging healthcare employers to deliver cultural competence training as a part of ongoing staff development, and (3) requiring health professions education institutions to report on the cultural competence training offered and the degree to which the training has integrated existing cultural competency standards.

IMMEDIATE PRIORITY: Requiring postsecondary institutions to set targets to increase enrollment and completion of diverse students in healthcare education programs until diversity reflects the population served and to report annually on progress to the Higher Education Coordinating Board (HECB). Progress can be achieved by encouraging postsecondary institutions to create clear mission statements that recognize the importance of diversity, establish policies regarding the need for culturally competent healthcare and the role of health professions diversity, ensure diversity on faculty recruitment committees, and recognize the role diverse faculty play in the success of diverse students. The HECB could compile data into a "dashboard" for colleges and universities, which could include metrics on diversity of student body, diversity of faculty, graduation rates for students of color, etc. Diversity criteria could also be included in state administered scholarship, grant, and loan repayment programs, such as the opportunity grant program to increase enrollment in high demand career pathway programs, such as healthcare. In addition, should the Legislature move forward with establishing Performance Agreements with public higher education institutions, increased diversity in enrollment, and completion of healthcare education programs could be one deliverable in those agreements.

Key Findings

- A number of expert panels have recommended creating opportunities for K-12 students to participate in career development programs, particularly at younger ages.
- There are a number of health career development and enrichment programs in Washington that have demonstrated success, yet remain chronically underfunded.

- The regular collection and analysis of healthcare workforce demographic data is essential to monitor progress of program interventions and to tailor interventions to areas with shortages of diverse health professionals.
- Washington has not had a systematic, comprehensive data source to collect information on the diversity of the healthcare workforce since 1999.

Recommendations

Providing stable state funding to expand healthcare career exploration, preparation, work-based learning opportunities, mentorships, and early certification programs that have been shown to be effective at increasing the diversity of the healthcare workforce, including funding for outreach and public awareness efforts to recruit diverse students to take advantage of these opportunities.

Providing funding to ensure the regular collection, analysis, and reporting of data on the diversity of the healthcare workforce. This can be done by providing support for the Department of Health to reinstate its demographics survey of health professionals and to include funding to regularly analyze and report on findings. The Department of Health can consider adopting a minimal surcharge on license and facilities fees to support the survey. The Department of Health should consider linking the administration of the survey to online license renewal (when available) and using any savings to fund analysis and dissemination of results.




Obesity & Diabetes

Obesity is the second leading preventable cause of disease in the United States; the first is tobacco use. Obesity is associated with an increased incidence of diabetes, cardiovascular disease, liver disease, certain types of cancer, gall bladder disease, asthma and other respiratory problems, osteoarthritis, sleep apnea, disability, decreased emotional well-being, and mortality. Pregnant women who are obese are at increased risk for complications during pregnancy and delivery.

Diabetes is the seventh leading cause of death in the United States and in Washington. Diabetes is a progressive disease, which can contribute to numerous comorbidities and complications. One in five adults with diabetes has poor vision; some eventually go blind. Diabetes is also the leading cause of end-stage kidney disease. Nervous system damage, and poor circulation are common among people with diabetes and can lead to lower extremity amputations.

Obesity and Diabetes Disparities in Washington State

Data from 2005-2007 showed that Native Americans and Alaska Natives, Blacks, and Hispanics had significantly higher rates of obesity than Whites. The rate remained significantly higher for American Indians and Alaska Natives after adjusting for gender, age, income, and education. Data from the First Steps program found that among Washington women who gave birth in 2003, Pacific Islander woman had the highest rates of overweight and obesity combined (66%) while Asian women had the lowest (24%). Data from King County from 2001-2007 found that while Asians and Pacific Islanders combined were less likely to be obese (11%) than King County adults (18%), Native Hawaiians and Pacific Islanders were more likely to be obese (37%). A review of obesity in the United States reports that among Asian and Pacific Islanders, prevalence of obesity is highest for Native Hawaiians and Samoans, and Asians born in the United States are four times more likely to be obese than foreign-born Asians.

From 2003-2005, the prevalence of diabetes was higher for Blacks, American Indians and Alaska Natives, Hispanics, and Asian and Pacific Islanders than for Whites. After controlling for income, education, age, and gender, Blacks and American Indians and Alaska Natives still had significantly higher prevalence of diabetes than Whites. Mortality rates were also significantly higher among communities of color compared to Whites, with rates among Blacks and American Indians and Alaska Natives approximately two times higher. In King County, data from 2002-2006 revealed the prevalence of diabetes was highest among Pacific Islanders (13.3%), higher than any other racial/ethnic group and 3.2 times higher than for Whites.

Communities of color are more likely to suffer from diabetes-related complications, such as kidney disease, retinopathy, blindness, amputations, and mortality. Rates of complications among certain racial/ethnic groups have been reported at two to four times those seen in Whites and may be due to poorer control of diabetes and comorbidities such as high

Obesity is a leading preventable cause of disease, second only to tobacco use.
Diabetes is the seventh leading cause of death.

blood pressure and cholesterol levels. More importantly, there is substantial evidence that inequities in healthcare quality may be important contributors to disparities in diabetes control and subsequent complications experienced by people of color.

The Council's Obesity & Diabetes Advisory Committee

The Council convened an obesity & diabetes advisory committee to assess and recommend policy options for its consideration. The committee defined its purpose as follows: to identify two sets of policy recommendations for obesity and diabetes, respectively, to increase opportunities for all Washingtonians to access healthy environments, make healthy choices, and manage their health in order to promote equity and reduce disparities in obesity and diabetes.

In an effort to identify policy recommendations, the committee reviewed obesity and diabetes data, discussed policies and programs to address healthy eating, physical activity and diabetes prevention and management, and assessed numerous policy options. The Council considered the committee recommendations along with public comment in offering its policy recommendations.

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Obesity

Key Findings

- Parts of Washington State, both urban and rural, lack access to healthy affordable foods via walking or public transit. These neighborhoods are often in low-income and racially/ethnically diverse communities and in neighborhoods at high risk for food insecurity.
- There is evidence that greater access to full-service supermarkets with healthy affordable foods can reduce the risk of obesity.
- There is a need to expend access to fresh, healthy, affordable foods in underserved areas.

- Students of color are more likely to eat unhealthy snacks at school than White students and greater exposure to sugar-sweetened beverages and unhealthy snacks in school are associated with greater consumption of sugar-sweetened beverages and unhealthy snacks in school.

- Increased physical activity is associated with reduced rates of obesity and improved health outcomes.
- Students of color are more likely to be from low-income families and may have less access to parks and recreational opportunities outside of the school setting.

Recommendations

Create incentives to attract farmer's markets and full-service grocery stores to underserved neighborhoods (e.g., tax credits, grant programs, loans, economic development programs, and other economic incentives).

Create incentive programs for corner stores and food banks in underserved areas to offer healthy, affordable foods (e.g., grant and loan programs to purchase refrigeration equipment, technical assistance with marketing, linkages to wholesale distributors, etc).

Require that all food and beverages offered in schools, including competitive foods, meet nutritional standards. This would include limiting access to sugar-sweetened beverages in schools.

Mandate all schools implement physical education policies and curricula to require all students in grades K-12 to participate in at least 30 minutes of moderate to vigorous physical activity each day through school physical education programs. Provide state funding to help low-income schools implement this policy.




Diabetes

Key Findings	Recommendations
• Support groups, peer education, self-management classes, and case management services have been shown to be effective in increasing knowledge and changing behaviors in diverse communities. Continued support for activities that have proven to be effective at a statewide level could help to reduce diabetes disparities.	Provide sustainable state funding to the Department of Health to create a community grant program for evidence-based, culturally appropriate/tailored diabetes communication, outreach, screening, education, self-management, and case-management efforts within communities of color.
• A large body of evidence exists to support a range of interventions to improve diabetes outcomes. The American Diabetes Association standards of medical care in diabetes are based on a complete review of the relevant literature and updated on a regular basis.	Require that all public health insurance plans cover minimum standards of diabetes care (from American Diabetes Association), which includes reimbursable diabetes education for those with diabetes and pre-diabetes.
• Policy making bodies assigned with addressing issues related to chronic disease management need representatives with a wide range of expertise, including diabetes expertise.	**IMMEDIATE PRIORITY**: Appoint an endocrinologist and a certified diabetes educator to any statewide panel or policy making body created to address issues related to chronic disease management (e.g., heart disease and diabetes).
• Support groups, peer education, self-management classes, and case management services have been shown to be effective in increasing knowledge and changing behaviors in diverse communities.	Support efforts to increase the number of people of color becoming certified diabetes educators and to assist organizations serving communities of color to establish certified diabetes education programs.

Language Access

Language access to health and healthcare is essential. There is a growing body of research that demonstrates limited-English proficiency is associated with less healthcare-seeking, less access to healthcare, lower patient satisfaction, diminished healthcare quality, and poorer health outcomes.

According to data from the U.S. Census, the proportion of Washington residents living in households where a language other than English was spoken increased steadily from 6.9% in 1980 to 9.0% in 1990 to 14.0% in 2000. The most common languages spoken were Spanish, Chinese, Tagalog, Vietnamese, Korean, Russian, and Khmer (Cambodian). Overall, 6.4% of Washington residents reported they spoke English less than "very well."

The Council's health insurance advisory committee created language access recommendations in addition to those related to expanding health insurance coverage. The Council considered the committee recommendations along with public comment in offering its policy recommendations.

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Language Access

Key Findings

- The proportion of Washington residents with limited-English proficiency is growing.
- Bilingual/bicultural healthcare providers are clearly the most efficient approach to improve language access; however, professional interpreters are also associated with improved clinical care and outcomes.
- The provision of meaningful language access services is a protected civil right and requirement of health agencies accepting federal funds underTitle VI of the Civil Rights Act of 1964.
- The current DSHS Interpreter Services program has been a model for other states, yet it can be improved and expanded to assist other state agencies.
- A long term strategy to ensure language services are provided in health and healthcare settings is needed.

Recommendations

Ensure appropriate language access services for healthcare and other state services are available to consumers with limited-English proficiency.

a. Increase funding and expand the scope of DSHS's Language Testing and Certification (LTC) program to serve other state agencies and the private sector.
b. Evaluate other options outside of DSHS to provide language testing and certification including technical colleges and community-based organizations. Explore ways to standardize certification process for medical interpreters.
c. Explore models beyond the current brokerage system to obtain and reimburse for interpretive services.
d. Ensure that qualified interpreters can easily obtain certification—the certification process should not be a barrier to obtaining reimbursement for providing quality interpretive services. This could be done through waiving testing fees, holding workshops to help people prepare for and pass the test and revisiting testing procedures and content.
e. Advertise and encourage state agency use of General Administration's translation contract, telephone contract and interpretive services contract to support access to critical state services by consumers with limited-English proficiency.
f. Provide incentives for healthcare providers to hire certified bilingual staff and/or to use certified medical interpreters and to have translated eligibility forms, notices, and other critical written materials available in encounters with consumers with limited-English proficiency. Consider legislation that would require all insurance carriers to provide or reimburse healthcare providers for interpretive services for their enrollees with limited-English proficiency.

Promoting Equity

One of the Council's responsibilities is to gather information to understand how the actions of state government ameliorate or contribute to health disparities. Toward this goal, the Council has considered models to promote policies, programs, and procedures to ensure equal access to goods, services, and opportunities by people of color so all residents have an equal chance at health.

The Council has been fortunate to be able to monitor and learn from two pioneering initiatives within our own state—King County's Equity and Social Justice Initiative and the city of Seattle's Race and Social Justice Initiative. The two efforts are similar in that they both strive for institutional changes to intentionally promote equity. King County's work aims to promote equity for people of color, low-income residents, and individuals with limited-English proficiency. Seattle's work aims to explicitly eliminate institutional racism. While both efforts strive to promote structural changes at the local level, the Council has been able to gather valuable lessons that can potentially be applied statewide.

In addition, the Council has investigated tools and strategies used by state agencies and private organizations and held forums to obtain suggestions from the public.

Select policies, programs, and procedures investigated by the Council include:

- **Agency Workplans**—Agencies/ Departments within both the city of Seattle and King County are required to create and implement workplans to identify and mitigate social inequities both internally as well as in the provision of services.
- **Coordinating Teams**—Both the city of Seattle and King County have interagency coordinating teams to oversee equity initiative activities.
- **Policy Assessment Tools**—King County has implemented an Equity Impact Assessment and Review Tool to evaluate current and new policies and programs for their impact on communities of color and other targeted populations.
- **Outreach and Public Engagement Policies**—Both the city of Seattle and King County have implemented outreach and public engagement policies to ensure meaningful input by affected communities.
- **Language Access Policies**—The city of Seattle instituted a comprehensive language access policy to ensure appropriate translation and interpretive services are provided for non-English and limited-English speaking customers. Some state and local agencies have also adopted such policies.
- **Workforce and Contracting Policies**—Seattle's Race and Social Justice Initiative includes goals to increase the diversity of city employees and to increase contracting with Women and Minority Business Enterprises.

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Promoting Equity

Key Findings

- Health equity training for state agency management and staff is critical to ensure all state employees, particularly those with decision-making and management roles, have a baseline understanding of health equity terms and concepts and understand the importance of addressing equity issues.
- Success of any statewide effort to ensure state agencies intentionally consider and work to promote equity in all government business is dependent on executive leadership and commitment.
- Health equity champions within the implementing agencies are necessary for ongoing commitment and success.

Recommendations

Develop the capacity for state agencies to create policies, programs, and procedures to ensure equal access to goods, services and opportunities by people of color so all Washingtonians have an equal chance at health. The Council can facilitate capacity building by:

a. Providing technical assistance to state agencies in creating and implementing health equity training for agency staff.
b. Compiling and making available model health equity-related policies, such as language access and public engagement policies.




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