Community Forum on

Health Equities

Summary of Forum Proceedings

May 28, 2008

Hosted by the:

Governor's Interagency Council on Health Disparities

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July 2008

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The Governor's Interagency Council on Health Disparities (the Council) would like to acknowledge and thank all of those who attended and shared their valuable stories, input, and suggestions at the Health Equities Community Forum:

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Community

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Community

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DSHS

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Tacoma Pierce Co Health Dept, Solutions for Humanity, Community and the Environment

Kirsten Blume
Puget Sound Affiliate, Susan G Komen for the Cure

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St John Medical Center

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Thurston County Public Health

Jay Zatzkin, MD
Tacoma Pierce Co Health Dept - ENACCT

The members of the Council would also like to sincerely thank the management and staff of The Evergreen State College/Tacoma Campus for hosting the forum, especially Dr. Artee Young, Bernadette Blakeney, and Jay Cortez.

Council members in attendance at the forum:

- Vickie Ybarra, Chair
- Emma Medicine White Crow, Vice Chair
- Winona Hollins-Hauge
- Gwendolyn M. Shepherd
- Felecia Waddleton-Willis
- Millie Piazza

The Council extended invitations to the forum through electronic distribution contact lists for the Council and the Washington State Board of Health. Personal invitations were also mailed to approximately 100 Pierce County residents and community-based health and minority services organizations, including the Tacoma-Pierce County Health Department, Pierce County Council, the Tacoma City Council, law enforcement officials, and Washington State legislators who represent Pierce County. Invitations were provided in English and in Spanish.

INTRODUCTION

The Governor's Interagency Council on Health Disparities (the Council) held a community forum on May 28, 2008 at the Tacoma Campus of The Evergreen State College in Tacoma, Washington. The Council, in creating a state action plan for eliminating health disparities, wanted to inform community members about current activities. They also wanted to gather information from participants to help guide them in their future activities.

COMMUNITY FORUM PROCEEDINGS

Welcome from the Council

Council Chair, Vickie Ybarra, welcomed forum participants. Representatives were recognized from:

- Private non-profits
- Government agencies
- Pierce County
- Tribal communities
- Grassroots organizations
- Other organizations
- Individuals
- Eastern Washington
- Western Washington

Welcome from the Honorable Senator Rosa Franklin, Senate President Pro Tempore

Senator Franklin, a registered nurse with more than 40 years of health care experience, serves as the Vice-Chair of the Washington State Senate's Health and Long-Term Care Committee. The Senator reviewed the community needs/issues that led to the creation of the Joint Select Committee on Health Disparities. One recommendation from the Committee was the creation of the Governor's Interagency Council on Health Disparities.
(See the committee's final report: http://www1.leg.wa.gov/documents/joint/jshd/2005nov.pdf).

Update on Tacoma-Pierce County Health Equity Summit

Amy Bates, a prevention specialist focusing on health equity issues from the Tacoma-Pierce County Health Department, offered appreciation to the Council and Senator Franklin for their support of health equity work in Pierce County. She provided a demographic snapshot of the diversity of Pierce County communities and gave an overview of issues impacting health equity for all Pierce County citizens. Ms. Bates described a unique *Cross Cultural Collaborative* working together in Pierce County to reduce health disparities for their community members. Activities include promoting awareness of social determinants of health through outreach using the *Unnatural Causes* media campaign. To kick off the campaign, in March 2008, a Health Equity Summit was held on the Tacoma campus of the University of Washington. More than 165 representatives from government agencies, community and non-profit organizations, and private industries, through focus groups and panel discussions, shared their ideas and concerns regarding health equities in Pierce County. Following the summit, a Health Equity Action Committee was convened to begin addressing the issues and implementing the ideas, multi-jurisdictionally. Recognizing disparities exist between racial/ethnic groups, as well as rural/urban communities, the committee will provide opportunities in a variety of locations for residents to participate in developing a county-wide Health Equity Action Plan.

Overview of the Action Plan being developed by the Council and other Council Activities

Chair Ybarra said the Council is in the process of creating a state action plan for eliminating health disparities in Washington State. The plan, which the Council hopes to have completed by 2010, will look at health disparities broadly. It will also specifically address a number of diseases and conditions indentified in the legislation that established the Council. Chair Ybarra briefly described three additional responsibilities of the Council:

- ✓ **Language barriers:** The Council must—after holding hearings and conducting research––issue recommendations for improving the availability of culturally appropriate health literature and interpretive services within public and private health-related agencies.

- ✓ **Communication:** The Council is charged with promoting communication among state agencies and between state agencies and communities of color, the public sector, and the private sector to address health disparities.

- ✓ **Information gathering:** Through public hearings, inquiries, studies, and other efforts at information gathering, the Council will work to understand how the actions of state government ameliorate or contribute to health disparities.

She advised the participants that the Council members were at the forum to request advice from community members to help guide development of statewide health communications capacity to diverse communities. Chair Ybarra noted that the comments provided during the forum discussion would be considered as the Council formulates its policy action plan recommendations for the Washington State Legislature.

Chair Ybarra described the health impact reviews which are also a part of the Council's responsibilities. The Council collaborates with the Washington State Board of Health to complete health impact reviews requested by the Governor or members of the Legislature. A health impact review analyzes the extent to which a proposal for a legislative or budgetary change is likely to have a positive or negative impact on health disparities.

Surveys

Participants were invited by Chair Ybarra to complete written surveys which will be used by the Council to prioritize health issues that will be addressed in its action plan. The surveys will guide the Council in choosing the first five priorities for which Advisory Work Groups will be convened later this year. The groups will make their policy recommendations to the Council in 2009. The surveys were provided to participants in English and in Spanish. Chair Ybarra advised the group that the survey was available in Vietnamese on the Council's Web site. The survey included information about communication challenges and barriers. Council staff will analyze the results of the survey and make them available to the Council and community members by the September 2008 Council meeting.

Community Comments

Chair Ybarra moved forward with the discussion portion of the forum.

Following, is a summary of written and group discussion comments.

> ***"Include all people in the civil/power decision-making process (income and other barriers to be addressed to increase participation)."***

1. What would you like the Council to know, or consider, as it continues its work to prioritize and create the state action plan?

- There is more to inequities and disparity beyond racial groups: rural, unemployed, poor. Consider multiple impacts – and innovative methods.

- Health systems need to be required, not only to provide cultural competency training, but also to enhance their receptiveness to addressing the needs of the underserved.

- Council needs to sell the state action plan. They need to "knock on doors" and break down communication barriers to get the message out. The Council can continue to build relationships with community members and invite/include them into the Council's work groups, sessions, meetings, forums. It is very important to involve community members, not just agency officials or communication organization leaders, in the process of developing and implementing the state action plan. Their information dissemination is not good. Research programs in different counties and help get the word out. Rural residents are systematically excluded from the public policy process. The Council could provide more efforts to get input from non-English speaking or new immigrant communities.

- The Council can advocate for funding the health equity bills and policy action plan. Remember that community groups doing grassroots level work also need more money to stay on track. The Council could recommend policies that would allow health public service announcements to be placed on cable television.

- The Council should advocate for universal health care coverage.

> ***"Please consider moving beyond interventions that seek to ameliorate or buffer inequities as they affect health to include at least some interventions that address root causes of social and economic inequity."***

- Workforce (healthcare) diversity is extremely important. Start early to get students interested. There is a need to increase the pipeline for nursing professions, particularly for students of color. We need to work with these students early on, as early as the 4th grade. MESA (funded through UW) programs needs more funding because MESA helps increase the pipeline for nursing programs. Nurse Camp (in Pierce County for four years) exposes high school students to health care professions. It's a great "pipeline" project for workforce diversity.

- Women's health should be a priority as well – particularly breast cancer.

- Mental health should not be separated from physical health. It's important to listen to the communities and empower them to identify the problems and prevent them.

- There are two priorities: 1) Raise awareness of health issues in rural areas. 2) Raise awareness of providers in/about their communities.

- There are shortage areas for primary care providers, for dentists, and for mental health providers. We need to expand our resources to recruit and retain many other types of providers. Planning is one part of our work but there are current unmet needs in our families and communities. Racism and institutionalized discrimination are real barriers now. What are we doing, or can we do, that is tangible to meet our needs today?

- Effective reduction of health disparities will be either disease or process specific. If you choose disease, focus where disparities are greatest. It is probably, best, however, to focus on social determinants. Identify which are modifiable and address those which will give you the greatest positive change after modification. You're already considering mental health and other social determinants, great! Work on social determinants more than chronic disease issues.

> ***"The health care business model does not reflect health equity for all."***

- War on poverty is the most important issue. We're losing it now – let's get working on it again. Address core social determinants (for example, political, economy). We need to understand each community's definition of "health."

- The "isms" are core undercurrents that perpetuate inequities. Let's work to overcome our own "classism." Nurture grassroots groups' efforts. Include all people in the civil/power decision-making process (income and other barriers to be addressed to increase participation). Remember health inequity affects all. Increased suffering may be experienced at one level but the impact crosses all society. Deep-seated inequities should be addressed pre-disease. Population based health (ecological framework), targeting intended audiences uniquely at each community is the best way to do this. Ask community members how to do this work.

- Environment and health are connected. Prevention is important – trying to protect vulnerable groups from those things in our environment that harm our health, for example, chemicals in our environment that affect you if you live near industries or near freeways.

2. In your experience, do you think community members are well informed about health disparities?

- We need to educate our peers and leaders (even those in health agencies) so they really know what the social determinants of health are. Certainly policy makers and heads of state agencies (and their staffs) are often not educated about social determinants of health. They are not getting the word out to others.

- Current health care system is not working on health disparities for communities of color. There are unreasonable expectations for minority groups around quality and access issues because they are not treated equally.

- Communities of color and low-income communities live these disparities every day. We need to build on the strengths of communities to make their health better by educating and empowering groups with health disparities (not just those groups with money). We should develop grassroots-oriented community mobilization strategies to spread the word to include peer-to-peer models. We could provide grant funds to community providers to inform and involve community members.

- There is a lack of bilingual/bi-cultural outreach; put out free papers in more languages.

- I think people in power need more education about health disparities. The terminology is meaningless. We need to use concrete terms when we talk about health disparities. A very small percentage of health disparities are known – and the causes of those are not made clear. People may know about them but not have passion to deal with it (as they're) trying to keep food on tables.

3. How do you think state government activities perpetuate health disparities? Ideas for possible solutions?

- One solution is health impact assessments, particularly around land use planning (Tacoma-Pierce County Health Department is doing this). The assessments can look at issues like "feeling connected to the community." Planning should be done for both community and economic development. Now, there are a disproportionate number of convenience stores (for example) in lower economic communities. We need to rectify income inequalities. One way to do this is by looking at zoning, access to grocery stores, healthy housing, etc. We also need to look across sectors to increase healthy environments.

- Public resources, such as local government, are underutilized for addressing health and wellness of their communities. The Legislature could broaden the mandate to require local governments to do health impact assessments of their policy decisions. After the assessments are completed, they should invest money in programs (such as workforce diversity building) that show cultural competence. Also, more resources could be used for prevention, rather than responding to problems after they occur. The Governor's focus on early childhood education is a step towards the right direction. We need to continue to allocate more resources towards social determinants and prevention.

- The Legislature is looking into some of these things: community design, physical activity, wellness, and health impact assessments on policies prior to action on a bill to see the positive/negative impact on communities. Access is one point they have taken up. Wellness is a concentration for them. They are putting holes in the government silos.

- It is difficult to capture all these issues in public policy. We need to educate the legislators and work together around identified needs. Efforts have started at national level. We need to build relationships and leadership and have communities involved and testifying, but also need support at the top. You can't have the silos – that's why we have the Council as an interagency group. Improve coordination and capacity to address issues. All state agencies must have a base level of understanding and shared vision to arrive at an integrated coordinated plan for action. All state agencies have a role to play.

- There is legislation and incentives to require an increased number of providers to treat Medicaid patients. There is a huge shortage of primary care physicians, especially in rural communities. By recognizing the need for more medical providers, the government could approve more loan repayment programs as incentives for recruitment.

- There is also an access problem for at-risk youth in the community. There is a need to increase Medicaid enrollment by increasing awareness of eligibility. This is the key to increasing access.

- The cost of health care is a challenge. We need good mental health care (access and resources) at reasonable costs, especially for youth. This could be key in breaking the generational cycle in some families. Use community mobilization as a means of engaging youth.

- Lobby for the underserved. People in power represent dominant interests, control resources, and decision making. Resources are often in "English" only. Programs that serve the majority get "more bang for the buck" so minority programs are cut. Have people of color involved in the authorities with decision making power regarding disparity concerns. Provide outreach to those people who are afraid to come out of their own community. Empowerment is important. Poverty is the greatest in-equalizer. Encourage people to work, living wages, and finish education. Capacity building is also needed. Areas with disproportional impacts often don't get the funding because they lack infrastructure capacity.

- Low income qualifications are too high for men to obtain insurance without having to have children and spouses. This needs to be addressed.

4. What barriers prevent you and your community from getting health information?

- In our society, we talk about diseases. The absence of disease is not health. We need to talk about "health." We also need to train providers to understand health.

- We can empower grassroots groups. We need to help organizations link with others to share information and resources. We can give grassroots groups information about how to get health information to their respective communities, recognizing language and time can be barriers to community members seeking health information.

- School Board controls on curriculum (for example, blocked Academic Content Standards K-12 Education modules) can be a barrier to disseminating health information.

- Lack of community resources, due to English limitations, can prevent us from organizing speakers to present health information.

> ***"Cultural competence of how we access information can be a barrier, especially if you don't have a regular medical provider with whom you can communicate."***

- Health disparities are an outcome of social inequities – so don't forget these.

- People have to want to learn about health information to get through the barriers. They often do not know how to access health information. Medical care providers do not have enough information about prevention, so they give information about treatment. We need a system of health advocates who promote and assist with wellness strategies.

5. Is there a lack of interpretive services? If so, at which points of service? Is there a particular lack in language or dialect? What strategies do you suggest to recruit and retain more interpreters?

- Yes,
  - in our health department, mental health program and others
  - in elementary schools
  - at community health promotion events
- Languages,
  - Cambodian language; contact community leaders in their own communities, such as Cambodian group.
  - Punjabi
  - Sign language
- We need more money to pay live interpreters and reduce frustration with language line services. We should offer educational incentives and pay for certification. We should advocate for higher wages that are not dependent on whether or not the client shows up for the appointment. It's better to have native language educators than interpreters. We should encourage (native language speakers) to go into health care fields. Also, we can recruit interpreters from local communities and promote peer-to-peer strategies.
- Interpreters are available but services need to be prioritized by health system staff who seem to only provide services "if they must." We can also increase the "cultural" literacy of service providers.

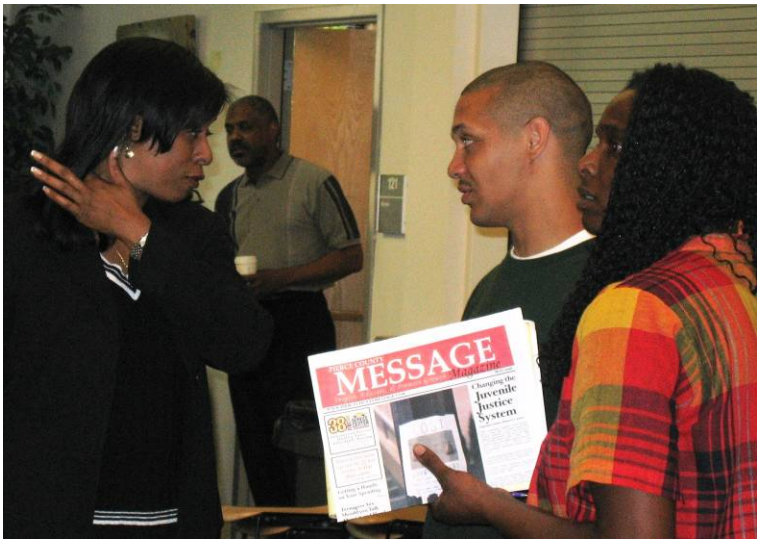
6. Do you have suggestions for improving the quality and availability of health education materials?

- Providers themselves don't necessarily understand the social determinants. A lot of education is needed. Unnatural Causes serves as a good tool to do this education.
- Parents want and need to know what resources/advocacy is available on health resources, topics, for example, updated Web site information plus community-level groups giving feedback on how they want/need to be educated. Think outside the box; for example, develop local public service announcements for targeted audiences at specific times to meet the needs and interests of the community members. Buy health education time in minority media channels (Message magazine, BET, VH1, KDNA, etc.).

- Train community leaders who can speak both English and the native language to educate their own people.

- Identify within each county: hospitals with sliding scale options or charity services; homeless shelters; community health centers and their offerings, drug treatment centers, schools with programs to help assist community health centers in providing healthcare (UW Tacoma Nursing Program, patient navigators, etc). Use this information to develop multi-lingual resource guides with more pictures, less words.

- Look at models that are working with specific types of communities and let local communities choose the best fit for their residents.



7. What type of outreach and communication methods are effective with your community?

- Use health navigators to build capacity in communities. Health navigators and person-to-person are most effective. By talking together around these topics, we are building power in our community. We are rich with creativity in these groups. HC3 has money to provide resources to host community forums. They have done some already, including HIV, youth, and women's health.

- Mentoring – various programs. For example, have health department staff mentor students. Important not just to look at racial/ethnic disparities. Rural/urban, language differences, etc. The minorities are becoming the majority.

- Multi-lingual resource guides with simple language are effective. Translate materials using cultural symbols. Make resources available in Spanish. Have short clips of audio/video about the programs in each group's own language because some people don't know how to read/write even in their own language.

- Group meetings with verbal outreach – no written materials, e.g. pamphlets. Both 1-on-1 and small groups are better than written literature. You can reach some groups through outreach at ethnic festivals. Remember to provide stipends (or incentives) to encourage community members to participate.

> ***"Provide alternative formats for non-literate people. Use TV, radio, and person-to-person communication channels."***

- Visual, community posters, and local service access points which use more DVDs, vignettes, storytelling, workshops, etc. are good.

- Health messages should be sent through minority media, such as radio or local cultural newspapers. The messages should be framed and presented to motivate individual behavior change.

8. Other comments:

- Commission on African American Affairs will be holding community meetings in August (Spokane) and in October (Tacoma). See information on their Web site at: www.caa.wa.gov

- There is power in unity to improve health care. Integrated health care systems provide improved quality in health care and increases overall quality of life for all.

- There are funding partners that could be used as resources to invest in communities that are working on improving wellness, such as the Kellogg Foundation.

- Things that should be done: 1) education at various levels; 2) livable wages; 3) make welfare "workforce;" 4) use mentoring liberally; 5) mental wellness; 6) empowerment that inequities are unacceptable.

- Participants provided information about groups or individuals in their communities who should be contacted by the Council's Outreach Coordinator.

SUMMARY

Key recommendations that were repeated throughout the community forum included the following:

- The Council should focus on the social determinants of health, such as poverty and environmental conditions.

- An emphasis should be placed on training bilingual/bicultural members of the community to provide outreach within their respective communities (e.g., health navigators).

- We should invest more in our communities so they have the capacity and infrastructure to plan and implement programs to address health disparities themselves, as well as to more fully participate in the policymaking process.

- In order to enhance the cultural competency of services and to ensure that state government actions redress and not perpetuate disparities we need to better educate our legislators, agency leaders, and other policymakers, as well as our health care providers, about health disparities and the social determinants of health.

- Organizations, including the Council, should strengthen community outreach activities by holding more forums, providing more information in person (such as at health fairs), and better utilizing minority media (such as through public service announcements on minority-owned television and radio or through inserts in minority press).

- More focus should be placed on improving the quality and accessibility of mental health services and on integrating mental health and physical health services.

- More funding and commitment should be placed on using health impact assessment during policymaking at the local and state levels.

- The Council should consider other groups that are affected by health disparities, such as rural communities and the poor.

APPENDIX

1. Written testimony from Communities of Color Coalition

VISION
A community free of racism and cultural intolerance.

MISSION
The Communities of Color Coalition (C3) is a non-partisan group of citizens who meet on behalf of the peoples of Snohomish County to discuss, problem-solve, and advocate for social justice, cultural and religious respect and human rights, especially for people of color and other under-represented groups. Our major areas of concern include but are not limited to: the elimination of personal and institutional racism; equal access to and opportunities in education; equal access to and opportunities in economic development and employment; and fair and equal treatment under the law and in our society.

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COMMUNITIES of COLOR COALITION C3

Wednesday, May 28, 2008

Vickie Ybarra, RN, MPH, Council Chair
Governor's Interagency Council on Health Disparities
PO Box 47990
Olympia WA 98504-7990

Madam Chair and Esteemed Council Members:

The Communities of Color Coalition (C3) is a non-partisan group of citizens who meet on behalf of the peoples of Snohomish County to discuss, problem-solve, and advocate for social justice, cultural and religious respect and human rights, especially for people of color and other under-represented groups. Our major areas of concern include, but are not limited to: the elimination of personal and institutional racism; equal access to and opportunities in education; equal access to and opportunities in economic development and employment; and fair and equal treatment under the law and in our society.

In 2007, in response to the increasingly recognized importance of health disparities at both federal and state levels, the Communities of Color Coalition began to look for ways to both raise the general public awareness of health disparities and involve the community's own health care providers in a search for effective strategies to address locally identified disparities. Planning began in earnest in November, 2007, when we became aware of Unnatural Causes, the PBS documentary series on socioeconomic and racial disparities in health, scheduled for broadcast in March and April of 2008.

On May 6th, the Communities of Color Coalition (C3) hosted a two-hour community gathering in Everett focused on health disparities. The evening began with a light supper, followed by the screening of "When the Bough Breaks", a 30-minute segment from Unnatural Causes, examining the impact of racism on infant mortality in African Americans. This was followed by facilitated small group discussions.

Sponsors of the event included the Communities of Color Coalition, Providence Everett Medical Centers, Everett Community College, Snohomish County Medical Reserve Corps, Washington State University Snohomish County Extension, Familias Unidas, South Everett Neighborhood Center, Woodburn Company, REI, YMCA of Snohomish County, KSER 90.7 fm, Positive Women's Network, Women's Wellness Center and Everett School District. Endorsers included Snohomish Health District, Everett Clinic, League of Women Voters of Snohomish County, Community Health Center of Snohomish County and NAACP, Snohomish Branch.

Participation at the Everett event totaled at least 80 people, 77 of which were formally signed in. Discussion groups were asked to respond to three questions: (1) what was the most surprising or disturbing aspect of the Unnatural Causes segment; (2) what elements of "unnatural causes" are common in their community; and (3) what local actions addressing health disparities would they suggest? Discussion group comments were recorded and aggregated, with the following results:

Most surprising or disturbing film content
* The impact of racism-induced stress as a factor driving health disparities (36%)
* The existence of health disparities even after socio-economic factors have been accounted for (19%)
* The increase of disparities over time as immigrants settle in to life in the United States (11%)

Most common elements seen in local community
* Chronic racism in everyday activities, often denied or unrecognized, generates stress and fear (32%)
* Housing, health insurance costs and a high-tech oriented labor market are local socio-economic factors that drive health disparities (17%)
* Cultural resources that would support the increasingly diverse population and reduce stress are largely absent (17%)

Most suggested actions to address local disparities
* Enhance understanding through community conversations, improved communication and good information (30%)
* Improve access to care by providing language support, transportation options and insurance coverage (20%)
* Include cultural understanding, race relations and health disparities training in educational curriculum and community information programs (13%)

Evaluation forms were filled out by 48 participants (60%). Demographics collected indicate that 71% were female, 29% male; 46% were people of color; and the average age was 48.5 years old. The majority indicated that their awareness of health disparities was raised (92%), they learned useful information (94%), and their overall opinion of the event was either excellent (67%) or good (31%).

A second event, to be held on June 3rd in Monroe, will feature a showing of the Unnatural Causes segment "Becoming American" in both English and Spanish, and include facilitated discussions with Spanish interpretation. Further events are being planned for other areas of Snohomish County. Action ideas that come out of these discussions will be compiled and presented in a formal report to the community.

The facilitated community discussion approach has so far received broad community support and better than anticipated participation. Community organizations and health care providers have contributed both resources and endorsements that have been vital to the success already achieved. These discussions are expected to help define an ongoing focus in the community on the health disparities experienced by people of color and other underrepresented groups.

Thank you for this opportunity to report on our efforts in Snohomish County.

Sincerely,

Kinuko Noborikawa, Chair

Community Discussion of Health Disparities

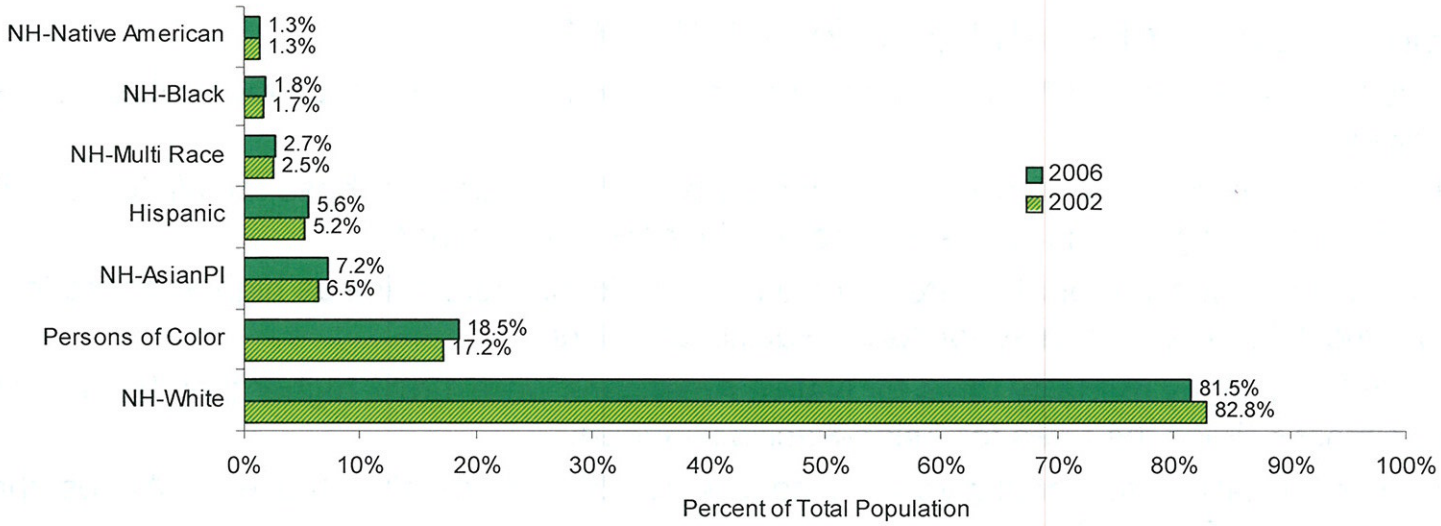
Snohomish County Health Facts for 2002-2006:

- Overall mortality rates for Native Americans were 32% higher than those for Whites; the rates for Blacks were 12% higher.
- Stroke mortality rates for Native Americans were 140% higher than those for Whites; for Blacks they were 75% higher and for Asian-Pacific Islanders, 34% higher.
- Chronic lung disease mortality rates for Native Americans were twice as high as those for Whites and almost 11 times the rates for Asian-Pacific Islanders.
- Unintentional injury mortality rates for Native Americans were 126% higher than those for Whites and almost 5 times the rates for Asian-Pacific Islanders.
- Diabetes mortality rates for Native Americans were 157% higher than those for Whites; the rates for Blacks are 126% higher.
- Chronic liver disease mortality rates for Native Americans were almost 5 times higher than those for Whites.
- Infant mortality rates for Native Americans and Blacks were 49% higher than those for Whites; the rates for Hispanics were 31% higher.

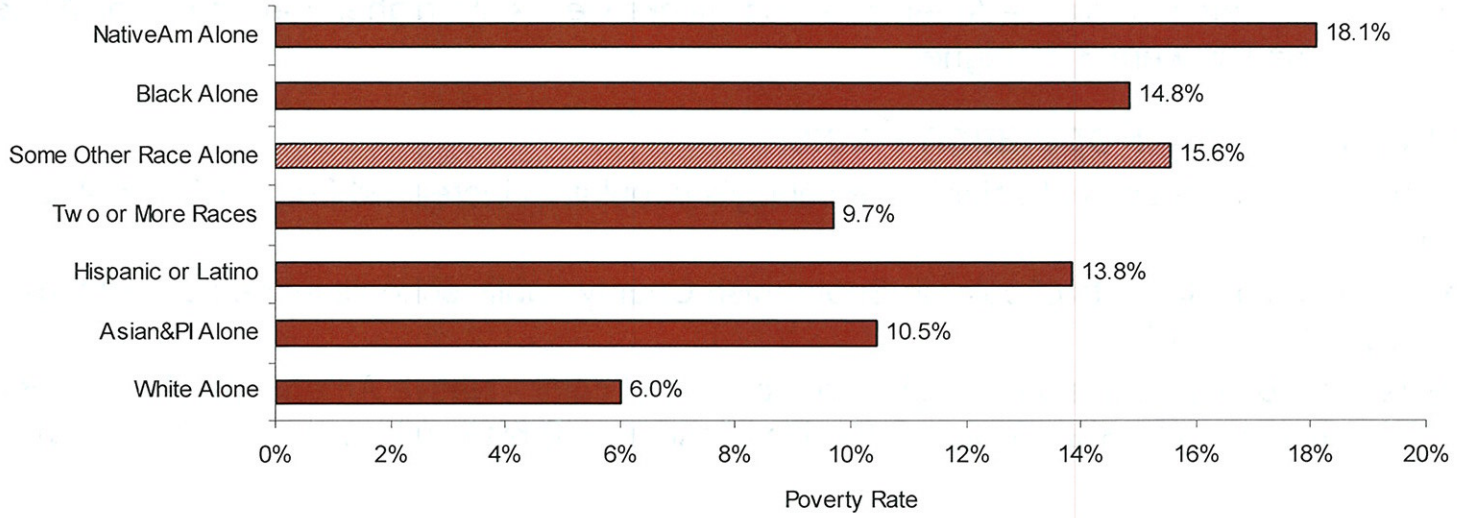
Snohomish County Population Facts:

- The proportion of persons of color in the county's population increased from 17.2% in 2002 to 18.5% in 2006.
- The proportion of students of color in Snohomish County public schools increased from 19.5% in 2002 to 25.4% in 2006.
- Census 2000 poverty rates were higher for persons of color - Native Americans (18.1%); Blacks (14.8%); Hispanics (13.8%); Asians & Pacific Islanders (10.5%) - when compared with Whites (6.0%).

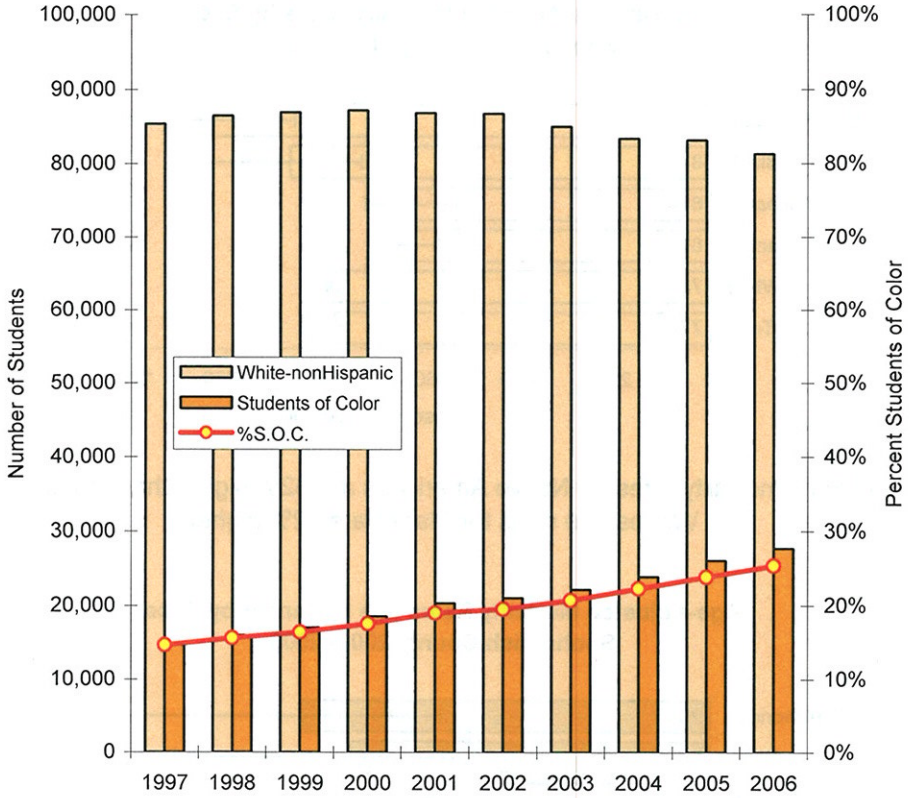
Population By Race & Hispanic Origin: Snohomish County, 2002 & 2006



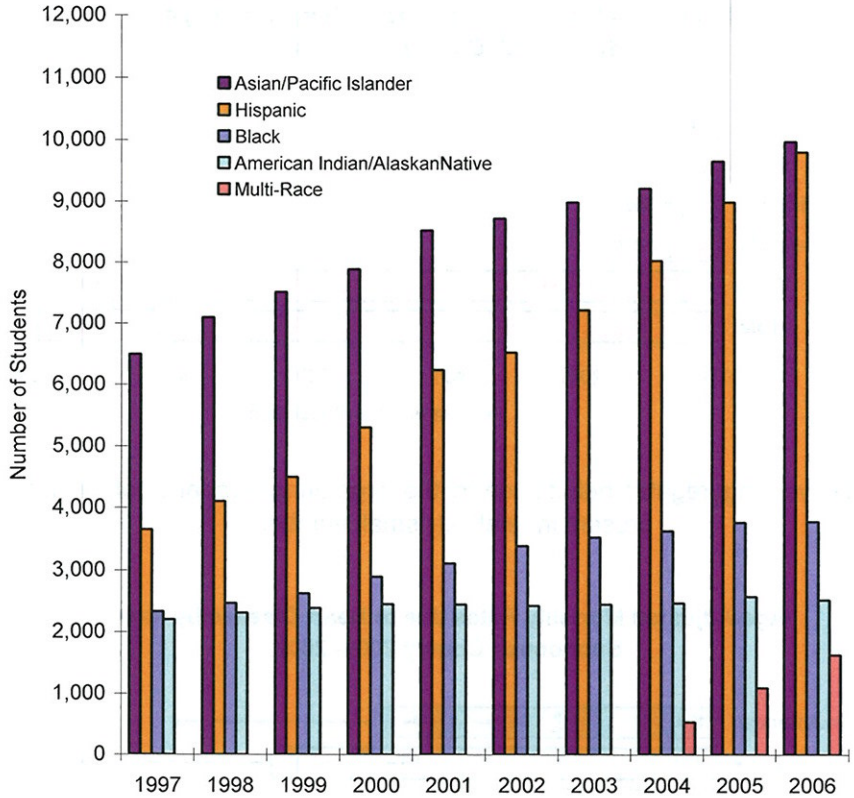
Poverty Rate By Race & Hispanic Origin: Snohomish County, 2000 Census



Sno.Co. School District Enrollment
White-nonHispanic Students & Students of Color



Sno.Co. School District Enrollment
Students of Color by Race/Ethinicity



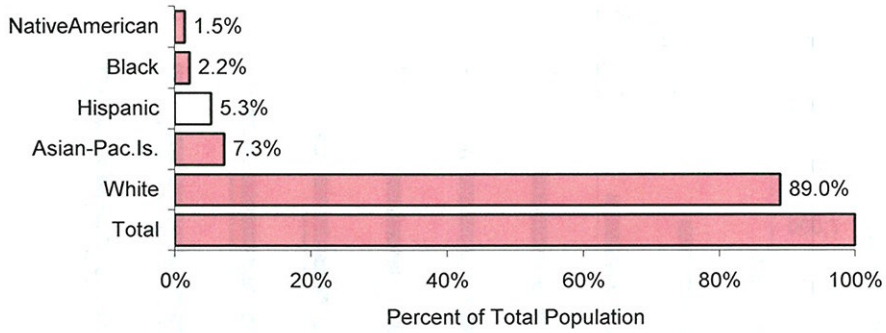
	Total	White-NH	NotProvided	Student of Color	%S.O.C.	Black	Asian/Pac.Is.	AmInd/AKNtv	Hispanic	Multi-Race
1997	100,096	85,403	0	14,693	14.7%	2,337	6,498	2,204	3,654	----
1998	102,481	86,486	0	15,995	15.6%	2,472	7,099	2,317	4,107	----
1999	103,954	86,910	0	17,044	16.4%	2,629	7,521	2,395	4,499	----
2000	105,741	87,193	0	18,548	17.5%	2,897	7,889	2,460	5,302	----
2001	107,150	86,813	0	20,337	19.0%	3,115	8,530	2,453	6,239	----
2002	107,806	86,742	0	21,064	19.5%	3,390	8,721	2,430	6,523	----
2003	107,163	84,973	0	22,190	20.7%	3,527	8,987	2,454	7,222	----
2004	107,273	83,366	31	23,876	22.3%	3,629	9,212	2,476	8,022	537
2005	109,339	83,145	116	26,078	23.9%	3,764	9,655	2,577	8,983	1,099
2006	109,210	81,295	210	27,705	25.4%	3,780	9,969	2,525	9,799	1,632

Note: The revised definitions of race implemented by the 2000 Census were first used by OSPI & school districts in 2004. The Asian and Pacific Islander groups are recombined here for trend line consistency. The "multi-race" category was also new in 2004 but cannot be readily redistributed to the original categories.

Source: "October Enrollment by Building, Gender and Ethnicity From Form P105: 1997-2006", Office of the Superintendent of Public Instruction (http://www.k12.wa.us/dataadmin/).

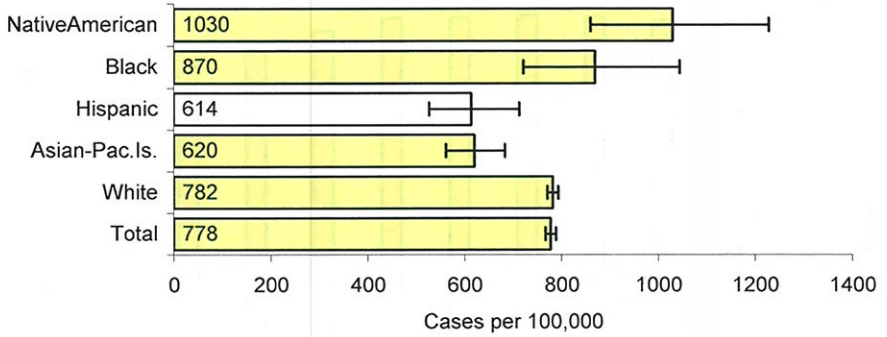
Selected Measures of Mortality by Race and Hispanic Origin: Snohomish County, 2002-2006

Population Distribution by Race & Hispanic Origin
Snohomish County 2002- 2006



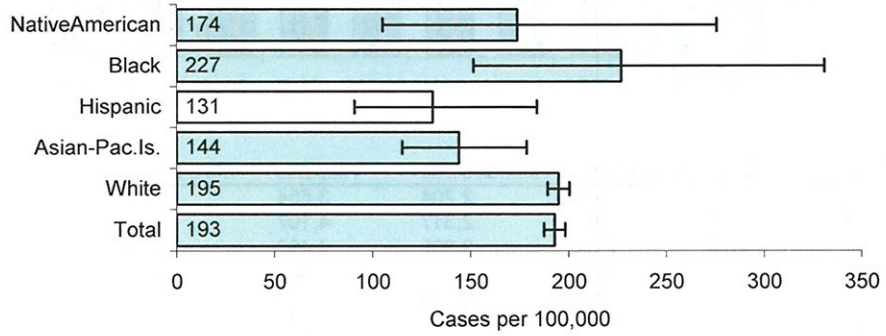
Five year aggregates help to control the large annual variation otherwise present in relatively small numbers.

Overall Age-Adjusted Mortality Rates by Race
Snohomish County 2002- 2006



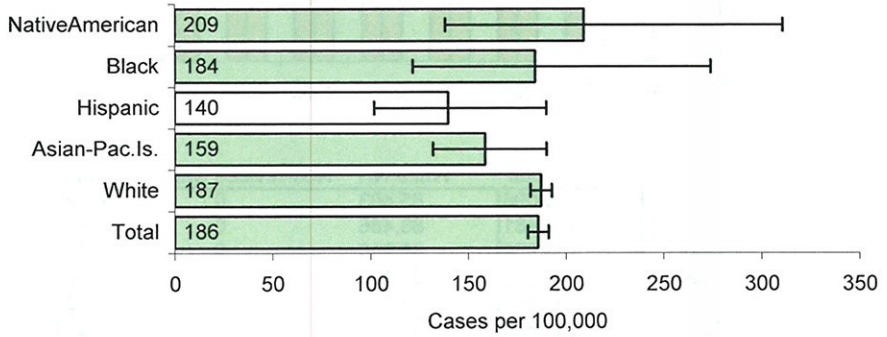
Overall mortality rates for Native Americans are 32% higher than those for Whites; the rates for Blacks are 12% higher.

Age-Adjusted Mortality Rates due to Heart Disease by Race
Snohomish County 2002- 2006



Heart disease mortality rates for Blacks are 16% higher than those for Whites; the rates for Hispanics are 33% lower than Whites.

Age-Adjusted Mortality Rates due to Cancer by Race
Snohomish County 2002- 2006

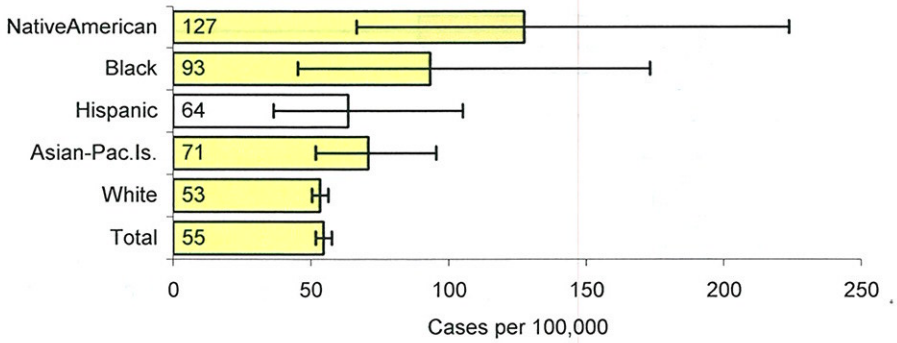


Cancer mortality rates for Native Americans are 12% higher than those for Whites; the rates for Hispanics are 25% lower than Whites.

Note: "Hispanic" describes a cultural heritage group but it is not a "race". Hispanic persons may be of any race and are included in the race groups above.
Source: Data provided by Mark Serafin, Snohomish Health District; 4/16/2008 (see also http://www.snohd.org/snoHealthStats/index.htm).

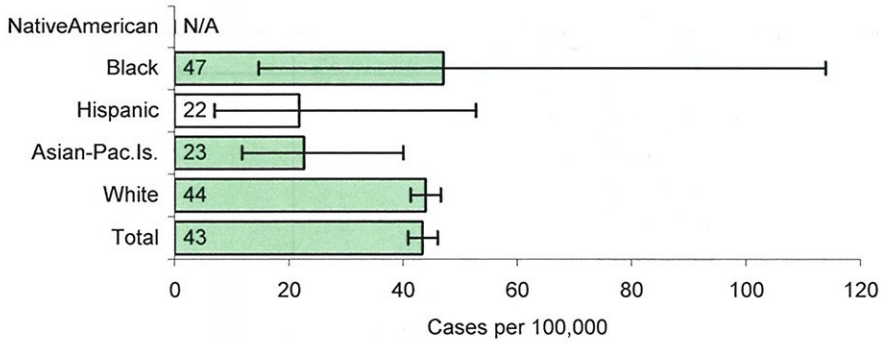
Selected Measures of Mortality by Race and Hispanic Origin: Snohomish County, 2002-2006

Age-Adjusted Mortality Rates due to Stroke by Race Snohomish County 2002- 2006



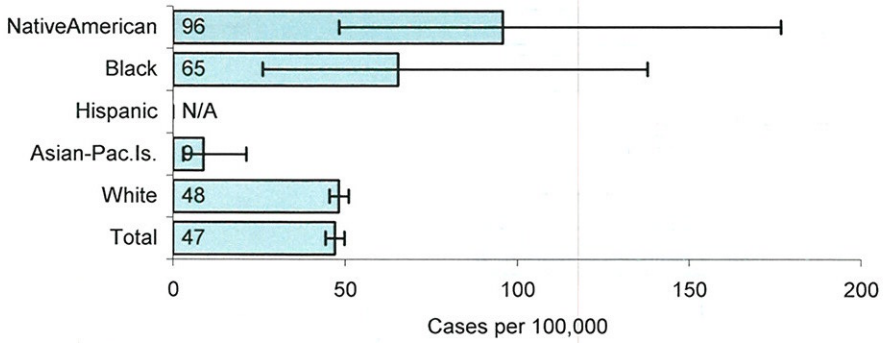
Stroke mortality rates for Native Americans are 140% higher than those for Whites; for Blacks they are 75% higher and for Asian-Pac.Is., 34% higher.

Age-Adjusted Mortality Rates due to Alzheimer's Disease by Race: Snohomish County 2002- 2006



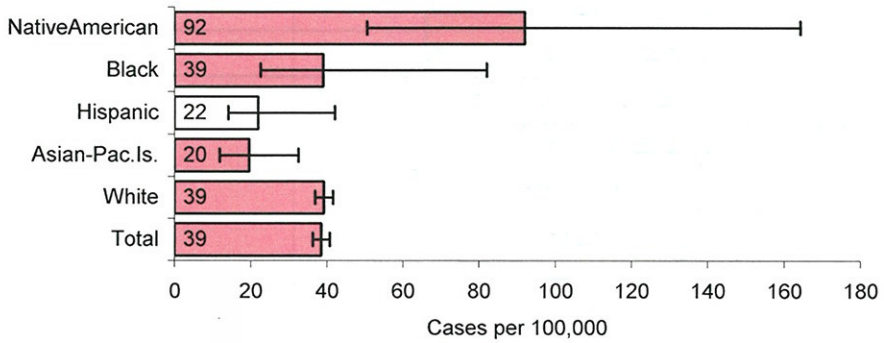
Alzheimer's Disease mortality for Blacks is 7% higher than for Whites; but the rates for Whites are twice as high as Hispanics and Asian-Pac.Is.

Age-Adjusted Mortality Rates due to Chronic Lower Respiratory Disease by Race: Snohomish County 2002- 2006



Chronic lung disease mortality rates for Native Americans are twice as high as those for Whites and almost 11 times the rates for Asian-Pac.Is.

Age-Adjusted Mortality Rates due to Unintentional Injury by Race: Snohomish County 2002- 2006

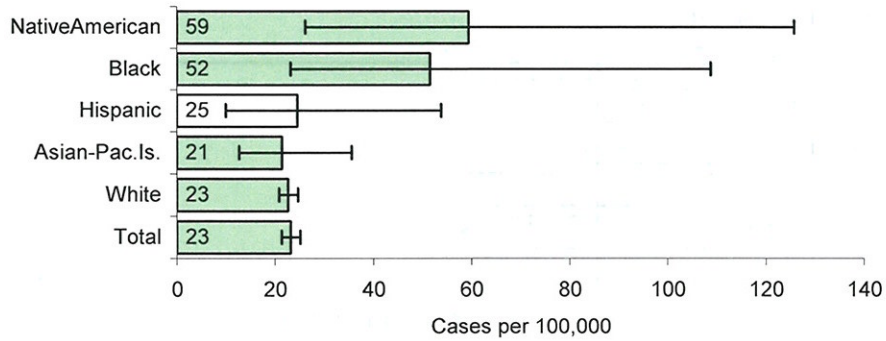


Unintentional injury mortality rates for Native Americans are 126% higher than those for Whites and almost 5 times the rates for Asian-Pac.Is.

Note: "Hispanic" describes a cultural heritage group but it is not a "race". Hispanic persons may be of any race and are included in the race groups above.
Source: Data provided by Mark Serafin, Snohomish Health District; 4/16/2008 (see also http://www.snohd.org/snoHealthStats/index.htm).

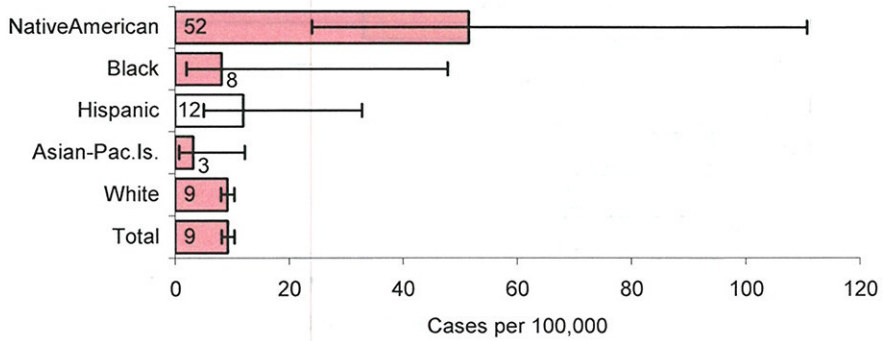
Selected Measures of Mortality by Race and Hispanic Origin: Snohomish County, 2002-2006

Age-Adjusted Mortality Rates due to Diabetes by Race
Snohomish County 2002- 2006



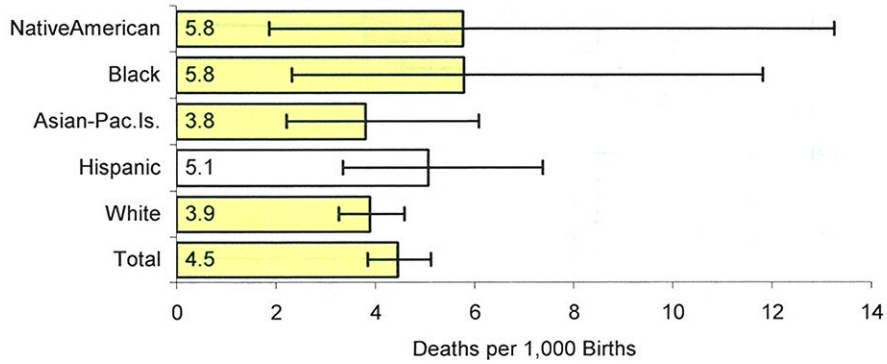
Diabetes mortality rates for Native Americans are 157% higher than those for Whites; the rates for Blacks are 126% higher.

Age-Adjusted Mortality Rates due to Chronic Liver Disease by Race: Snohomish County 2002- 2006



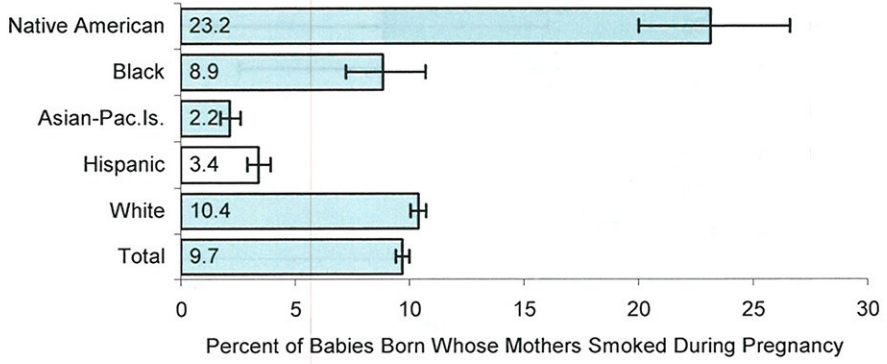
Chronic liver disease mortality rates for Native Americans are almost 5 times higher than those for Whites.

Infant Mortality Rates due to All Causes by Race
Snohomish County 2002- 2006



Infant mortality rates for Native Americans and Blacks are 49% higher than those for Whites; the rates for Hispanics are 31% higher.

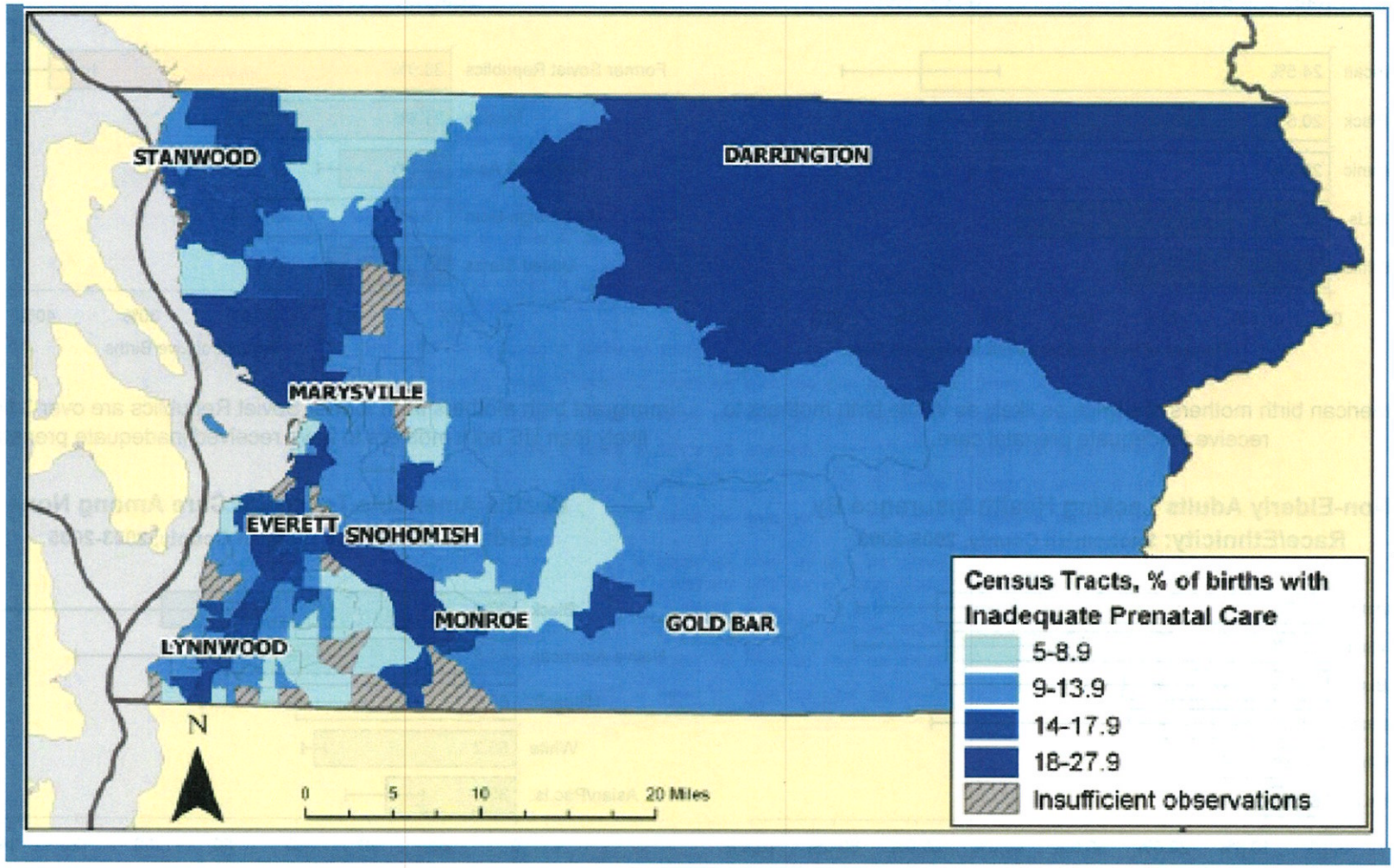
Smoking During Pregnancy By Race/Ethnicity:
Snohomish County, 2002-2006



Smoking rates during pregnancy are more than 10 times higher for Native American birth mothers than for Asian-Pacific Islander birth mothers.

Note: "Hispanic" describes a cultural heritage group but it is not a "race". Hispanic persons may be of any race and are included in the race groups above.
Source: Data provided by Mark Serafin, Snohomish Health District; 5/5/2008 (see also http://www.snohd.org/snoHealthStats/index.htm).

Percent of Women Receiving Inadequate Prenatal Care by Census Tract, 2003-2005

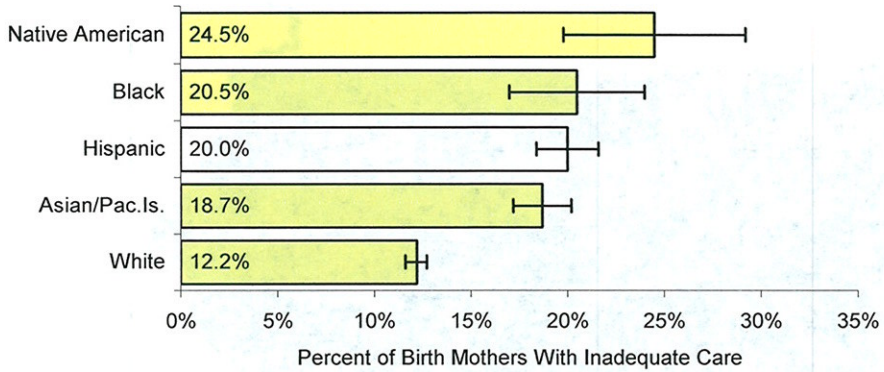


Data source: Washington State Birth Certificates (2003-2005)

Source: Access To Health Care In Snohomish County, Snohomish Health District, March 2008.
http://www.snohd.org/snoHealthStats/accessReport.htm

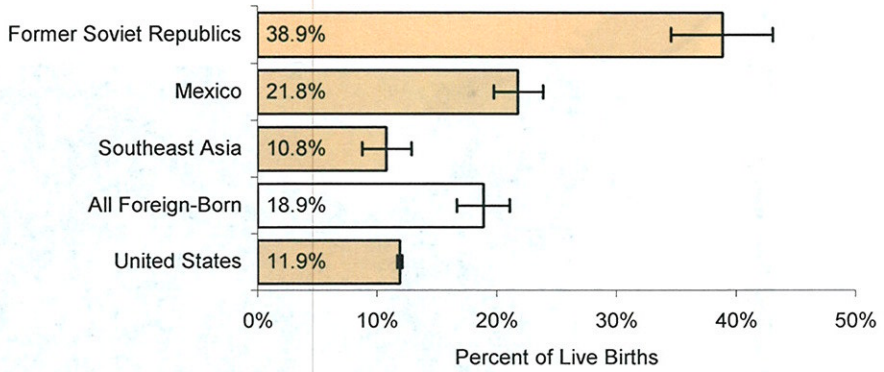
Selected Measures of Access to Health Care by Race/Ethnicity: Snohomish County, 2003-2005

Birth Mothers Receiving Inadequate Prenatal Care By Maternal Race and Ethnicity: Snohomish County 2003-2005



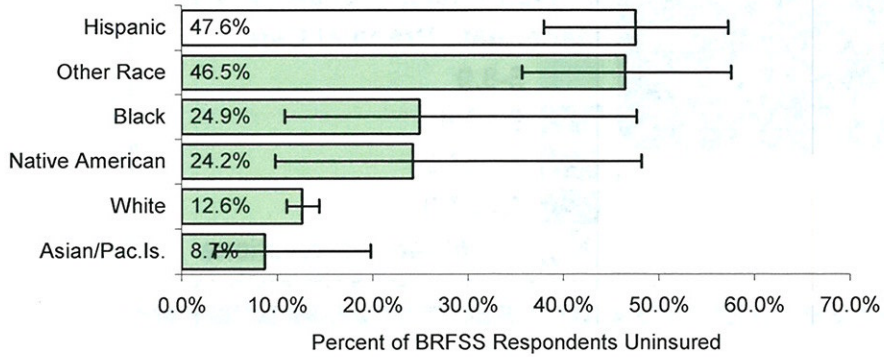
Native American birth mothers are twice as likely as White birth mothers to receive inadequate prenatal care.

Birth Mothers Receiving Inadequate Prenatal Care By Maternal Birthplace: Snohomish County, 2003-2005



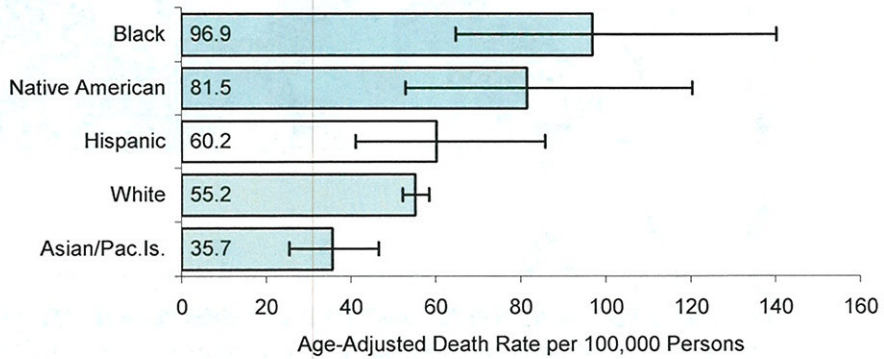
Immigrant birth mothers from former Soviet Republics are over 3 times more likely than US born mothers to have received inadequate prenatal care.

Non-Elderly Adults Lacking Health Insurance By Race/Ethnicity: Snohomish County, 2005-2006



Hispanic non-elderly adults are almost four times more likely than White adults to not have health insurance.

Deaths Amenable To Health Care Among Non-Elderly Adults: Snohomish County, 2003-2005



Black non-elderly adults are 175% more likely than White adults and almost 3 times more likely than Asian/Pac.Is. adults to die from a treatable disease.

Source: Access To Health Care In Snohomish County, Snohomish Health District, March 2008.
http://www.snohd.org/snoHealthStats/accessReport.htm