

Summary of Public Input Surveys

Submitted to the Governor's Interagency Council on Health Disparities

August 2008

BACKGROUND

The Governor's Interagency Council on Health Disparities (Council) is responsible for developing a state action plan to eliminate health disparities by race/ethnicity and sex and for creating language access recommendations to improve the availability of culturally appropriate health literature and interpretive services. Further, the Council has the responsibility under Revised Code of Washington 43.20.275 to "promote and facilitate communication, coordination, and collaboration among relevant state agencies and communities of color, and the private sector and public sector, to address health disparities." Engaging communities of color in its work is a responsibility that the Council takes seriously. The Council is committed to seeking public input and feedback, particularly from communities of color, as it performs its work.

The Council interacts with and solicits input and feedback from the public in a number of ways. All meetings of the Council are open to the public and time for public comment is included on each agenda. The Council maintains an interested parties' e-mail distribution list, which it uses to announce meetings, send out draft and final agendas, and solicit input, comment and feedback on specific topics. The Council has also organized and/or participated in public forums and meetings to obtain information about community health needs, concerns and possible solutions. Council members and staff have also disseminated public input surveys at a variety of meetings and events, particularly those with a focus on the health of communities of color. This document summarizes information learned from surveys that the Council has received to date.

RESULTS

Survey Respondents

As of August 15, 2008, the Council received 451 completed or partially completed surveys. A large proportion of respondents (73%) were female. Of the 448 respondents who supplied their race/ethnicity, 181 (40%) were Black or African American, 112 (25%) were White or Caucasian, 58 (13%) were Asian, 33 (7%) were Hispanic or Latino, 16 (4%) were American Indian/Alaska Native, 6 (1%) were Native Hawaiian or other Pacific Islander, 35 (8%) selected more than one racial/ethnic category, and 7 (2%) indicated that they identified with another race/ethnicity.

Among the 35 respondents who selected more than one category, 25 selected White or Caucasian, 18 selected Black or African American, 17 selected American Indian/Alaska Native, 7 selected Asian, 6 selected Hispanic or Latino, 2 selected Native Hawaiian or other Pacific Islander, and 3 selected "Other."

Thirty-one of 441 respondents (7%) said they preferred to discuss health-related concerns in a language other than English. The Spanish language version of the survey was completed and turned in by nine respondents.

Input on Priorities for State Action Plan

Respondents were asked to choose five priorities that the Council should focus on in its plan to eliminate health disparities. Among the 451 total survey respondents, 437 provided input on their priorities.

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Included in this section, is a series of tables for different demographic groups, which provide the number and percentage of respondents who chose the specified health condition or social determinant of health as one of their five priorities.

The top five priorities selected by all respondents and by respondents from communities of color were: diabetes, education, obesity, health insurance coverage, and heart disease. The top five priorities for each racial/ethnic group were largely the same, with diabetes occurring in every priority list, education and obesity occurring in six of the seven lists, and health insurance coverage and heart disease/stroke occurring in five of the seven lists. In addition, health literacy showed up among the top-five priorities for Asians, Hispanics/Latinos, and Native Hawaiian and Pacific Islanders. HIV/AIDS was a top priority for African Americans/Blacks and Native Hawaiian and other Pacific Islanders and substance abuse was a priority for American Indians and Alaska Natives.

Please note that because the number of surveys were small for some groups, particularly for the Native Hawaiian and other Pacific Islander group (only eight respondents, including two respondents who selected multiple racial/ethnic categories), results should be interpreted with caution.

Table 1: Public Input into Council Priorities – All Respondents, n=437

Health Condition / Social Determinant of Health	Number	Percentage
Diabetes	206	47%
Education	204	47%
Health Insurance Coverage	191	44%
Obesity	188	43%
Heart Disease & Stroke	141	32%
Health Literacy	128	29%
HIV/AIDS	118	27%
Substance Abuse	115	26%
Health Care Provider Diversity	102	23%
Smoking Rates	66	15%
Environmental Hazards	62	14%
Chronic Kidney Disease	46	11%

Note: Some individuals chose fewer than five priorities others chose more than five priorities.

Among the 339 respondents who selected racial/ethnic categories indicating that they were persons of color, 330 provided input on their priorities. Table 2 provides information on priority health topics for those 330 respondents from communities of color.

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Table 2: Public Input into Council Priorities – Persons of Color, n=330

Health Condition / Social Determinant of Health	Number	Percentage
Diabetes	159	48%
Education	159	48%
Health Insurance Coverage	132	40%
Obesity	127	38%
Heart Disease & Stroke	117	35%
HIV/AIDS	109	33%
Substance Abuse	93	28%
Health Literacy	89	27%
Health Care Provider Diversity	85	26%
Smoking Rates	45	14%
Environmental Hazards	44	13%
Chronic Kidney Disease	43	13%

Note: Some individuals chose fewer than five priorities and others chose more than five priorities.

Among the 181 respondents who indicated that they were African American or Black, 177 provided input on their priorities. Table 3 provides information on priority health topics for those 177 African American or Black respondents.

Table 3: Public Input into Council Priorities – African American or Black, n=177

Health Condition / Social Determinant of Health	Number	Percentage
Education	98	55%
Diabetes	94	53%
Obesity	84	48%
HIV/AIDS	78	44%
Heart Disease & Stroke	74	42%
Health Insurance Coverage	64	36%
Substance Abuse	55	31%
Health Care Provider Diversity	49	28%
Health Literacy	40	23%
Chronic Kidney Disease	35	20%
Smoking Rates	24	14%
Environmental Hazards	18	10%

Note: Some individuals chose fewer than five priorities and others chose more than five priorities.

Among the 58 respondents who indicated that they were Asian, 56 provided input on their priorities. Table 4 provides information on priority health topics for those 56 Asian respondents.

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Table 4: Public Input into Council Priorities – Asian, n=56

Health Condition / Social Determinant of Health	Number	Percentage
Diabetes	22	39%
Health Insurance Coverage	20	36%
Heart Disease & Stroke	20	36%
Education	17	30%
Health Literacy	16	29%
Health Care Provider Diversity	15	27%
Obesity	9	16%
Environmental Hazards	8	14%
Smoking Rates	7	13%
Substance Abuse	7	13%
Chronic Kidney Disease	4	7%
HIV/AIDS	4	7%

Note: Some individuals chose fewer than five priorities and others chose more than five priorities.

Thirty-three respondents indicated that they were Hispanic or Latino and another 6 respondents who selected multiple racial/ethnic categories selected Hispanic or Latino as one of those categories. Due to small numbers, these groups were combined for analysis. Among the 39 respondents who indicated that they were at least partly Hispanic or Latino, 38 provided input on their priorities. Table 5 provides information on priority health topics for those 38 respondents.

Table 5: Public Input into Council Priorities – Hispanic or Latino (including those selecting multiple races), n=38

Health Condition / Social Determinant of Health	Number	Percentage
Education	26	68%
Health Insurance Coverage	22	58%
Diabetes	16	42%
Obesity	15	39%
Health Literacy	14	37%
Health Care Provider Diversity	13	34%
HIV/AIDS	13	34%
Environmental Hazards	12	32%
Substance Abuse	12	32%
Smoking Rates	8	21%
Heart Disease & Stroke	7	18%
Chronic Kidney Disease	0	0%

Notes: Some individuals chose fewer than five priorities and others chose more than five priorities. Due to small numbers, individuals selecting multiple racial/ethnic groups, including Hispanic or Latino, are included.

Sixteen respondents indicated that they were American Indian/Alaska Native and another 17 respondents who selected multiple racial/ethnic categories selected American Indian/Alaska Native as one of those categories. Due to small numbers, these groups were combined for

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analysis. All 33 respondents who indicated that they were at least partly American Indian or Alaska Native provided input on their priorities (see Table 6).

Table 6: Public Input into Council Priorities – American Indian or Alaska Native (including those selecting multiple races), n=33

Health Condition / Social Determinant of Health	Number	Percentage
Diabetes	18	55%
Health Insurance Coverage	17	52%
Substance Abuse	15	45%
Obesity	14	42%
Heart Disease & Stroke	12	36%
Education	10	30%
Health Literacy	9	27%
HIV/AIDS	9	27%
Environmental Hazards	4	12%
Smoking Rates	4	12%
Health Care Provider Diversity	2	6%
Chronic Kidney Disease	1	3%

Notes: Some individuals chose fewer than five priorities and others chose more than five priorities. Due to small numbers, individuals selecting multiple racial/ethnic groups, including American Indian/Alaska Native, are included.

Eight respondents indicated that they were at least partly Native Hawaiian or Pacific Islander, including two who selected multiple racial/ethnic categories. Due to small numbers, these groups were combined for analysis. All 8 respondents provided input on their priorities (see Table 7).

Table 7: Public Input into Council Priorities – Native Hawaiian or Pacific Islander (including those selecting multiple races), n=8

Health Condition / Social Determinant of Health	Number	Percentage
Diabetes	3	38%
Education	3	38%
Health Literacy	3	38%
Obesity	3	38%
HIV/AIDS	2	25%
Substance Abuse	2	25%
Chronic Kidney Disease	1	13%
Health Care Provider Diversity	1	13%
Health Insurance Coverage	1	13%
Heart Disease & Stroke	1	13%
Environmental Hazards	0	0%
Smoking Rates	0	0%

Notes: Some individuals chose fewer than five priorities and others chose more than five priorities. Due to small numbers, individuals selecting multiple racial/ethnic groups, including Native Hawaiian or other Pacific Islander, are included. **Due to small numbers, results should be interpreted with caution.**

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Input on Language Access Recommendations

142 of 426 respondents (33%) indicated that they have had trouble understanding or talking to a health care provider (see Box 1). A total of 121 respondents provided suggestions for what could have been done to improve communication. The majority of suggestions fell into the following six themes:

- 1. Time:** Patients would like more time with their physicians and other health care providers to explain their symptoms and concerns and to ensure that they understand their diagnoses and treatment options. In addition, patients want their health care providers to listen to them and care for them and suggest that longer appointment times could assist with this.
- 2. Cultural Competence:** Providers should always treat their patients with respect and understand how to communicate with individuals from diverse cultures.
- 3. Consumer Education and Self-Advocacy:** Health care consumers need more educational resources and access to information to help them better advocate for themselves in the health care setting.
- 4. Technical Language:** Health care providers need to use less technical language when discussing health matters with their patients.
- 5. Navigators and Interpreters:** There is a need for more patient navigators and health care interpreters and patients need to be informed that interpreters are available.
- 6. Provider Education:** Physicians should receive ongoing training in a variety of topics, (e.g., how to serve patients of diverse backgrounds, talking about sexual/gender minority issues, etc).

Box 1: Examples of Communication Problems in Health Care

"When we finally did see [the provider], it was apparent he hadn't even read her chart. We have lost trust in his medical care."

"HCPs are too busy, so they want to address their own agenda with limited to no opportunities for questions."

"The doctor prejudged my situation."

"Provider should not assume that I understand what is being said. Sometimes I do not like to disagree with the doctor."

"I understood him and felt belittled that he was talking down to me."

"The health care provider needed training in how to talk with a Native American. A huge misunderstanding occurred because of not understanding how to communicate and understand the language of symbolism."

Other suggestions for how communication could be improved included encouraging providers to become more involved in community services, ensuring that health care organization policies and protocols are followed, providing patients with written instructions to manage their health, and ensuring a bilingual and bicultural workforce.

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Input on Community Outreach Mechanisms

Survey respondents were then asked how likely they would be to use a Web site, e-mail lists, or an electronic newsletter to obtain information on health disparities. Respondents were asked to score their response using a Likert scale. Table 8 provides the number and percentage of respondents who selected each category. Overall, more than half of all respondents indicated that they were very likely to extremely likely to use the different information sources. Conversely, about 15-20% indicated that they were not at all or not very likely to use the different sources. Several individuals included comments that everyone did not have access to computers or the skills to use such technology.

Table 8: Respondents Likelihood to Use Various Sources for Information on Minority Health and Health Disparities

	Not At All Likely	Not Very Likely	Somewhat Likely	Very Likely	Extremely Likely
Web site (n = 413)	32 (8%)	28 (7%)	79 (19%)	131 (32%)	143 (35%)
E-mail lists (n = 398)	39 (10%)	43 (11%)	93 (23%)	122 (31%)	101 (25%)
Electronic newsletter (n = 377)	40 (11%)	39 (10%)	83 (22%)	116 (31%)	99 (26%)

Ninety-eight respondents provided additional suggestions for reaching communities with information on multicultural health and health disparities. By far, the two most frequently mentioned suggestions were: (1) to organize more forums, workshops, community meetings, and classes and (2) to mail out printed materials (e.g., brochures, flyers, newsletters) or to distribute them in doctor's offices, community centers, churches and other locations where community members meet. Many respondents also suggested using television, radio, newspaper, or magazine advertisements and announcements, particularly in minority-owned or local sources. Additional suggestions for electronic information sharing included blogs, webinars, my space or face book advertisements, text messages, and Web site improvements.

Other Input

Finally, survey participants were encouraged to provide additional comments that they would like to share with the Council. Fifty-eight individuals provided additional comments. Many suggested other health conditions and topics that the Council should prioritize; cancer, poverty, literacy, and upstream social determinants of health were mentioned multiple times. Other suggestions ranged from suggestions for health systems changes and/or services that require more funding, suggestions to improve the public input survey design, and requests for additional training, information and tools, such as cultural competency assessment tools and training on advocacy and becoming involved in the policymaking process. Note, in addition to this summary of the public input surveys, all Council members will receive a complete list of all comments received from the public input surveys