

# **RECOMMENDATIONS**

## **FROM THE**

### **JOINT SELECT**

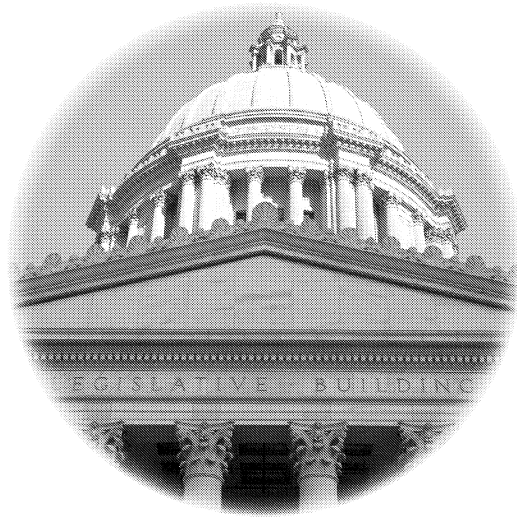
#### **COMMITTEE ON**

##### **HEALTH DISPARITIES**



November 1, 2005  
Washington State Legislature  
Olympia, Washington





## **RECOMMENDATIONS FROM THE JOINT SELECT COMMITTEE ON HEALTH DISPARITIES**

### **Joint Select Committee Members:**

Sen. Rosa Franklin, Co-Chair

Sen. Tracey Eide

Sen. Linda Evans Parlette

Sen. Dave Schmidt

Rep. Dawn Morrell, Co-Chair

Rep. Sharon Tomiko Santos

Rep. Mary Skinner

### **Staff:**

Christopher Blake, Counsel, House Health Care Committee

Sharon Swanson, Counsel, Senate Health and Long Term Care Committee

Beth Herzog, Committee Assistant, House Health Care Committee

Randi Schaff, Committee Assistant, Senate Health and Long Term Care Committee



# **INTRODUCTION**



## HEALTH DISPARITIES IN AMERICA

In recent years, the issue of health disparities between different racial and ethnic populations in American society has been the subject of countless articles and reports by academic institutions, private foundations, and government entities. The National Institutes of Health have defined the concept of “health disparities” as “the differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.” Studies continue to demonstrate such differences in the health status of different racial and ethnic populations, as well as between men and women. Across a range of diseases and health conditions such as cancer, heart disease, asthma, infant mortality, HIV/AIDS, and diabetes, statistics show that different racial and ethnic populations have markedly different experiences in the incidence, prevalence, mortality, and burden of diseases. Data from the United States Centers for Disease Control and Prevention provide some examples of these disparities.

Cardiovascular Disease: In 2000, the death rates for African Americans from both heart disease and strokes were 29% and 40% higher than the white population, respectively.<sup>1</sup>

Cancers: In 2001, prostate cancer incidence rates in Washington State were 172.2 per 100,000 for white males compared with 256.9 for African Americans, while the mortality rates for prostate cancer for these

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<sup>1</sup> Centers for Disease Control and Prevention, *Eliminating Racial and Ethnic Health Disparities*. <http://www.cdc.gov/omh/AboutUS/disparities.htm>. [accessed October 6, 2005]

populations were 27.7 and 62, respectively.<sup>2</sup> While the Asian American population as a whole has significantly lower death rates than the white population, the incidence of cervical cancer in Vietnamese women in the United States is five times higher than in white women.<sup>3</sup>

Diabetes: The prevalence of diabetes is 70% higher for the African American population and 100% higher for the Hispanic population than for whites.<sup>4</sup>

Asthma: Survey data from 2002 show asthma prevalence to be 11.6% among American Indians and Alaska Natives and 9.3% among African Americans, while only 5.0% for Hispanics and 2.9% for Asian Americans.<sup>5</sup>

HIV/AIDS: In 2001, more than half of the new AIDS cases in the United States came from the African American and Hispanic populations.<sup>6</sup>

Infant Mortality: The death rate for African American infants in the United States is 2.3 times higher than for white infants.<sup>7</sup> In Washington the rate for American Indian and Alaska Natives is 8.9 and for African

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<sup>2</sup> Centers for Disease Control and Prevention, *2001 Top 10 Cancers by State*.  
<http://apps.nccd.cdc.gov/uscs/GraphV.asp?group=3f&Year=2001&Gender=MAL&Var1=Washington&TableType=INCI>. [accessed October 10, 2005]

<sup>3</sup> Centers for Disease Control and Prevention, *Chronic Disease Overview*.  
<http://www.cdc.gov/nccdphp/overview.htm>. [accessed May 5, 2004]

<sup>4</sup> *Id.*

<sup>5</sup> Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, *Asthma Prevalence and Control Characteristics by Race/Ethnicity – United States, 2002*, February 27, 2004.

<sup>6</sup> Centers for Disease Control and Prevention, *Eliminate Disparities in HIV and AIDS*.  
<http://www.cdc.gov/omh/AMH/factsheets/hiv.htm>. [accessed October 6, 2005]

<sup>7</sup> *Supra*, note 3.



Americans it is 11.2 compared with 4.9 to 5.2 for Asians and Pacific Islanders, Hispanics, and non-Hispanic whites.<sup>8</sup>

Generally, non-Hispanic white populations fare better than racial and ethnic minority populations, although this is not always the case. For example, the American Journal of Preventive Medicine noted in 2003 that the Latino population has a 35% lower mortality rate for heart disease, 43% lower mortality rate for cancers, and 25% lower mortality rate for stroke compared to the non-Hispanic white population.<sup>9</sup> There are similar instances where the Asian American population also fares better than the non-Hispanic white population. This paradox highlights the complex interaction of all of the components that determine the health of an individual and a community. It moves the debate on health disparities beyond the basic conclusion that poverty is the only influence on health status, and it demands a closer examination of the influences of culture, the environment, and the health care delivery system on the health of racial and ethnic minority populations.

#### POLICY INITIATIVES CONCERNING HEALTH DISPARITIES

For policy makers, the issue of health disparities addresses both immediate and future health concerns. Policy makers must face the current discrepancies in health care status that leave people needing care today, while also preparing Washington state for a more diverse population in the coming decades. As our nation better understands the discrepancies between the health status of different racial and ethnic populations and the factors that determine the health of each group, policy makers must ensure that there is a health care system capable of adapting to the needs of our changing society.

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<sup>8</sup> Centers for Disease Control and Prevention. *Racial/Ethnic Disparities in Infant Mortality – United States, 1995-2002*. Morbidity and Mortality Weekly Report, 2005; 54: 553-556.

<sup>9</sup> David E. Hayes-Bautista, Ph.D., “Research on Culturally Competent Healthcare Systems” *American Journal of Preventive Medicine*, April 2003, pg. 9.

Projections predict that Washington state, like the rest of the country, will become more diverse in its population over the next several decades. It is estimated that the composition of the population of the United States will change from approximately 69% non-Latino white in 2000 to 53% in 2050, 12% Latino in 2000 to 24% in 2050, 12% non-Latino African American in 2000 to 13% in 2050, 4% Asian/Pacific Islander in 2000 to 9% in 2050, and 0.7% American Indian in 2000 to 0.8% in 2050.<sup>10</sup> As of 2000, the non-Hispanic white population of Washington state represented almost 79% of the total population, while Hispanics represented 7.5%, non-Hispanic African Americans represented 3.1%, non-Hispanic Asians represented 5.4% and non-Hispanic American Indians and Alaska Natives represented 1.4%.<sup>11</sup> The 7.5% Hispanic population is an increase from 2.9% in 1980 and 4.4% in 1990.<sup>12</sup> Data also show that the percentage of people in Washington living in homes where a language other than English is spoken increased from 6.9% in 1980 to 9.0% in 1990 to 14.0% in 2000.<sup>13</sup> It is estimated that the entire racial and ethnic minority population of Washington state will grow to 25% by 2010.<sup>14</sup>

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<sup>10</sup> The Henry J. Kaiser Family Foundation, *Key Facts: Race, Ethnicity & Medical Care – Update June 2003*, pg. 4.

<sup>11</sup> Washington State Office of Financial Management, *2003 Washington State Data Book, Population by Race and Hispanic Origin, Federal Census 2000*. <http://www.ofm.wa.gov/databook/population/pt07.htm>. [accessed October 10, 2005]

<sup>12</sup> Washington State Office of Financial Management, *Washington Trends, Population of Hispanic/Latino Origin*. <http://www.ofm.wa.gov/trends/htm/pr/fig306p.htm>. [accessed September 16, 2004]

<sup>13</sup> Washington State Office of Financial Management, *Washington Trends, Language Spoken at Home*. <http://www.ofm.wa.gov/trends/htm/pr/fig207p.htm>. [accessed September 16, 2004]

<sup>14</sup> Washington State Board of Health, *Final Report State Board of Health Priority: Health Disparities*, May 2001, pg. 11.

In the face of these demographic changes, the topic of health disparities occupies the agenda of federal, state, and local government agencies; private organizations; health care providers and facilities; and educational institutions.

Federal Government: The United States Department of Health and Human Services' public health planning initiative, *Healthy People 2010*, identifies more than 400 objectives in 28 focus areas which support two primary goals: (1) increasing life expectancy and quality of life and (2) eliminating health disparities among segments of the population. There are several federal programs supporting these goals, including the CDC's Racial and Ethnic Approaches to Community Health (REACH) 2010 which funds local programs to eliminate disparities in six priority areas.

State Government: In 2001, the Washington State Board of Health released the report and recommendations of its Committee on Health Disparities which had studied policy options for creating a more diverse and culturally competent workforce. The Washington State Department of Health conducts many activities related to reducing health disparities, including Project HOPE, which works to bring more people from rural and minority populations into the health care workforce, and the Diabetes Collaborative, which works with health plans to provide evidence-based, patient-centered care for patients with diabetes.

Local Government: The Seattle-King County REACH Coalition works within the African American, Asian American, Pacific Islander American, and Hispanic/Latino communities in King County to provide education,

support groups, self-management, and case coordination services to individuals living with diabetes. Several communities are also providing prenatal and infancy home visits by nurses to first-time mothers to improve early childhood outcomes by improving health behaviors, promoting parental responsibility, and encouraging life planning.

#### CREATION OF THE JOINT SELECT COMMITTEE ON HEALTH DISPARITIES

For quite some time, communities of color have been voicing concerns about health disparities. Out of these concerns and policy makers' sensitivity to the issue, Senate Concurrent Resolution 8419 was introduced and passed by the Legislature in 2004 creating the Joint Select Committee on Health Disparities (Committee). The Committee is composed of members of the standing committees with jurisdiction over health care and education from the Senate and the House of Representatives. These members are:

- Senator Rosa Franklin (Senate Health and Long-Term Care Committee), co-chair
- Representative Dawn Morrell (House Health Care Committee), co-chair
- Senator Tracey Eide (Senate Education Committee)
- Senator Linda Parlette (Senate Health and Long-Term Care Committee)
- Representative Sharon Tomiko Santos (House Education Committee)
- Senator Dave Schmidt (Senate Education Committee)
- Representative Mary Skinner (House Health Care Committee)

SCR 8419 directs the Committee to identify ways to improve health care status and address health disparities among women and in communities of color. Specifically, the Committee must do four things:

- Consider the impact of early childhood development programs on reducing disparities and review the sources of such interventions (eg., family resources, child care, education, community organizations, social determinants – places where interventions may occur);
- Address barriers to gender-appropriate and culturally- and linguistically-appropriate health care and health education materials, including increasing the number of female and minority health care providers through career ladders, expanded recruiting, education, and retention programs;
- Address ways to encourage review of the gender, racial, and ethnic composition of the health workforce and health care training programs; and
- Evaluate the impact of reductions in health care expenditures on women and communities of color.

The Committee's work began the summer of 2004 and was completed in the fall of 2005. During that time the Committee held one public hearing, five work sessions, and two recommendation development meetings. As required by SCR 8419, prior to submitting the recommendations that follow, the Committee requested input from the American Indian Health Commission; the Commission on African-American Affairs; the Commission on Asian-Pacific American Affairs; and the Commission on Hispanic Affairs. The Committee submitted its proposed recommendations to each of these entities with the exception of the American Indian Health Commission. Out of respect for the sovereignty of each tribe, rather than requesting comments from the American Indian Health Commission to speak on behalf of all of the tribes located in Washington state, the Committee sent its proposed recommendations to each of the 29 tribes within

the state. The Committee then considered these comments before adopting its final recommendations.

### FRAMING THE ISSUE OF HEALTH DISPARITIES

Establishing an appropriate framework for considering a topic as broad and complex as health disparities which touches upon so many different aspects of society is a crucial first step in the deliberations of a statewide policymaking body. With the amount of evidence documenting these disparities, one approach to the issue is to provide strategies for reducing disparities as they pertain to specified diseases and health conditions. This approach to the issue is the most direct way of identifying health disparities and tailoring solutions to resolve them. The Committee decided, however, that addressing the issue from such a perspective would not be the optimal approach for a statewide policymaking organization for several reasons. The Legislature is neither organized to respond quickly to the emerging data on health disparities, nor does it possess the expertise to assess appropriate interventions for each disease or health condition. Most importantly, however, a disease-by-disease approach does not lend itself to addressing the underlying causes of health disparities that are common to all diseases.

The Committee decided that approaching its work by targeting the social determinants of health – those environmental, behavioral, and institutional forces that determine the health of communities – would benefit all Washingtonians regardless of disease or health condition and regardless of gender, race, or ethnicity. The Washington State Department of Health has defined the social determinants of health as those “societal conditions that affect health and that potentially can be altered by informed action.” These conditions range from healthy behaviors (dietary habits, smoking, physical exercise, substance

abuse) to employment (job security, safe workplace) and from healthy environment (safe neighborhoods, affordable housing, environmental hazards) to health care (workforce diversity, cultural awareness in the workforce, discrimination, access to care). These are areas where a statewide policymaking entity can have the greatest influence on changing the health status of individuals and communities. In addition, a social determinants approach to the problem of health disparities promotes partnerships and communication across races and ethnicity as well as diseases and health conditions.

There are numerous factors that determine the health of a population, and they interact in unique and complex ways in each community. The Committee focused its energies on those determinants of health that were most closely related to the jurisdiction of the standing committees that comprised the Committee: health care and education. The Committee held working sessions to discuss diversity and cultural competence in the health care workforce, early childhood development programs, and the effects of reductions in health care expenditures on disparities. Through the presentations of dozens of individuals working in partnerships to reduce the prevalence of health disparities in Washington state, the Committee learned that there are many programs that are achieving tangible results. Among the lessons learned from the work of these groups is that well-coordinated efforts between state and local stakeholders are the most effective methods for improving the health status of all racial and ethnic populations. As the state explores its role in reducing health disparities, one natural function that it can perform is to assist the current efforts to form partnerships and eliminate the silos that impede the efforts of many organizations.

Recognizing what studies have shown, including the federal report on health disparities, as well as listening to the voices of the minority and tribal communities, and hearing from consumers, providers and those knowledgeable about the issue and its impact on communities of color, it is appropriate that the state take an active leadership role in working with the public and private sector to build partnerships in order to close the gap and eventually eradicate health disparities in communities of color and women. To that end, the Joint Select Committee on Health Disparities makes the following recommendations.



# RECOMMENDATIONS



**RECOMMENDATIONS TO THE LEGISLATURE OF THE JOINT SELECT  
COMMITTEE ON HEALTH DISPARITIES**

In striving to become the healthiest state in the nation, it shall be the policy of the State of Washington to address health disparities in communities of color and among women by creating an action plan and statewide policy to include, but not limited to, the following recommendations.

1. At a minimum, the action plan shall include health impact statements that measure and address other social determinants of health that lead to disparities (lack of emphasis on early childhood development, housing, violence, employment, poverty, etc.) as well as the contributing factors of health that can have broad impacts on improving status, health literacy, physical activity, and nutrition. The action plan shall recognize the need for flexibility.
2. Develop a workforce that is representative of the diversity of the State's population.
3. Identify and collecting relevant and accurate data on health care professionals, students in the health care professions, and recipients of health services.
4. Develop the knowledge, attitudes, and practice skills of health professionals and those working with diverse populations to achieve a greater understanding of the relationship between culture and health.
5. Ensure the availability of appropriate age, gender, cultural, and linguistic health literature and interpretive services.
6. Create an interagency coordinating council under the direction of the Governor to promote and facilitate communication, collaboration, and cooperation among state

agencies and programs in the communities, including public health and health care providers.

7. Encourage the Department of Health to continue focusing statewide disease-specific plans and community education (e.g., asthma, diabetes, smoking cessation, HIV/AIDS, immunization, Sudden Infant Death Syndrome (SIDS), and mental health) to address racial, ethnic and gender disparities related to the disease.
8. Establish for all Washingtonians, beginning with children and expectant and new parents a “health home” that encompasses at least an ongoing relationship with a primary care provider and a source of core health information for each person.
9. Designate a member of the State Board of Health to represent American Indian and Alaska Native populations.
10. Develop tools and information based on desegregated data that systematically review key policies as they are developed to learn “up front” how they might ameliorate or exacerbate the root causes of health disparities.

# APPENDICES



# APPENDIX A





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**SENATE CONCURRENT RESOLUTION 8419**

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AS AMENDED BY THE HOUSE

Passed Legislature - 2004 Regular Session

**State of Washington                      58th Legislature                      2004 Regular Session**

**By** Senators Franklin, Deccio, Thibaudeau, Keiser, T. Sheldon,  
McAuliffe and Kohl-Welles

Read first time 01/19/2004. Referred to Committee on Health &  
Long-Term Care.

WHEREAS, A disproportionate burden of disease, disability, and death exists among women and people of color in the state; and

WHEREAS, Infant mortality for American Indians and African-Americans is more than double the rate for non-Hispanic whites; and

WHEREAS, African-Americans are more than three times as likely, American Indians and Alaska Natives more than twice as likely, and Hispanics 1.5 times as likely as non-Hispanic whites to die from diabetes; and

WHEREAS, Women may express signs and symptoms of diseases, including heart disease, differently than men, and until recently, little attention has been given to the detection, treatment, and prevention of diseases specifically related to the unique needs and experiences of women; and

WHEREAS, The foundations for personal health, academic success, and professional achievement begin in early childhood; and

WHEREAS, Comprehensive early childhood development programs foster healthy physical, cognitive, and social development; and

WHEREAS, Long-term benefits include improved high school graduation rates, decreases in teen pregnancy, decreased delinquency, and higher rates of employment;

NOW, THEREFORE, BE IT RESOLVED, By the Senate of the state of Washington, the House of Representatives concurring, That a joint select committee on health disparities be created to identify opportunities for improving health care status and addressing health disparities among women and in communities of color; and

BE IT FURTHER RESOLVED, That the committee consist of eight members from committees with jurisdiction over health and committees with jurisdiction over education: Four members of the Senate to be appointed by the President of the Senate, including two members of the majority party and two members of the minority party; and four members of the House of Representatives to be appointed by the Speaker of the House of Representatives, including two members from the majority party and two members of the minority party; and

BE IT FURTHER RESOLVED, That the committee shall:

(1) Consider the impact of early childhood development programs on reducing health disparities among women and in communities of color, including a review of information about the sources of critical childhood interventions that impact health disparities such as family resources, child care, education, community organizations, social determinants, and others;

(2) Consider opportunities to improve health status of women and people of color by addressing barriers to gender-appropriate and culturally and linguistically appropriate health care and health education materials and practices, including a review of opportunities to increase the number of female and minority health providers in the state through development of career ladder, expanded recruiting, education, and retention programs, so consumers have more choice among health care providers;

(3) Address ways to encourage review of the gender, racial, and ethnic composition of the health work force and health career training, education, and career ladder programs;

(4) Evaluate the impact of reductions in health care expenditures on women and communities of color;

(5) Request input from the American Indian Health Commission, the Commission on African-American Affairs, the Commission on Asian Pacific American Affairs, and the Commission on Hispanic Affairs prior to submitting final review and recommendations to the Legislature; and

(6) Complete its review and submit its recommendations to the appropriate policy and fiscal committees of the Legislature by November 1, 2005.

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# APPENDIX B



## **Joint Select Committee on Health Disparities**

Following document is organized by meeting dates to include the agenda and summary per meeting.

Meetings held to date include: September 22, 2004; December 1, 2004; January 21, 2005; May 17, 2005; and June 21, 2005.

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### **September 22, 2004**

#### **AGENDA**

##### **Joint Select Committee on Health Disparities**

Wednesday

September 22, 2004

5:30 pm

Senate Hearing Rm 4  
J. A. Cherberg Bldg  
Olympia, WA

#### **WORK SESSION:**

1. Introduction of members - selection of Co-Chairs.
2. Overview of current health disparity issues.  
Staff overview of SCR 8419  
Staff overview of briefing materials
3. Public comment.
4. Discussion of future agenda and timelines.

#### **SUMMARY**

The September 22, 2004 meeting of the Joint Select Committee on Health Disparities provided an overview of the enabling legislation and the topic of health disparities by staff and an opportunity for public comment on the issue.

##### **I. Staff Presentation**

Staff provided an overview of SCR 8419 and the briefing book that had been assembled for the committee. The National Institutes of Health define health disparities as “differences in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups in the United States.” Issues determining health include access to health care, employment, social norms, housing, and early childhood education. There are several ways to approach the issue of health disparities including social determinants of health, health disparities (disease and condition specific), and health care disparities.

## **II. Public Testimony**

### **Dr. Toni Russell, African American Mental Health Professionals of Western Washington (AAMHPWW)**

The African American population has not had proportionate access to mental health programs. There are differences in how this population is able to access these services and AAMHPWW has a strategic plan for helping to provide culturally competent health care services through community partnerships. The organization conducts research and provides services in the communities.

### **Dr. Juliet Van Eenwyk, Washington State Department of Health**

The Department is interested in looking at the social determinants of health and how they result in economic, educational, and racial/ethnic disparities. While access to care is important to maintaining healthy populations, social problems (e.g., housing) must also be addressed. Changes in individual behavior cannot be considered outside of the overall social context. The committee should look broadly at health. The Legislature should look at issues of housing, education, transportation, and taxation issues and how they impact health. African American lung cancer rates are disproportionately high compared to their smoking rate indicating that there are other issues impacting these rates including a lesser standard of care and living in industrial areas where there are environmental pollutants.

### **Becky Johnston, American Indian Health Commission of Washington State (AIHC)**

The AIHC has the goal of improving the health status of American Indians and Alaska Natives through the promotion of tribal-state collaboration. American Indians and Alaska Native people have lower health status and inadequate health care compared to other Americans. There is less government spending on American Indians and Alaska Natives than other American populations.

### **Maria Gardipee, Washington State Department of Health**

The national class standards help organizations develop services to improve outcomes, ensure that people receive equitable services and treatment, and assist in the implementation of cultural competence efforts. The Department of Health has a cultural competence plan for the agency.

### **Kim Moore, Health Workforce Diversity Network (HWDN)**

The HWDN is an organization consisting of representatives of agencies, health professionals, community clinics, hospitals, higher education, and public health. Diversity improves access to care, communication between patients and providers, patient satisfaction, and educational experiences for health professions students. The HWDN forms partnerships to enumerate the workforce, serves as a clearinghouse of diversity efforts, and identifies gaps in health careers pathways. The Workforce Training and Education Coordinating Board and the Area Health Education Centers are members of the HWDN so that they can all coordinate their efforts.

Dr. C.A. Horne, J.J. Jones, and Eddie Rye, Mental Health and Health Care Coalition for Communities of Color (Coalition)

The Committee should accept a broad reach in its activities. State agencies should clarify in their reports how they define “cultural competency.” The Coalition’s goals are to bridge health care gaps, increase awareness through forums, integrate policy recommendations into state agency missions and programs, connect people of color in disparity programs, and foster partnerships. The Coalition has published a report of recommendations for addressing disparity issues in health care. The poor are more likely to have a mental disorder than the wealthy. There must be a reexamination of how funds are distributed. Local governments do not have a connection to the minority populations in their communities.

The relationship between some agencies and the African American community is nonexistent. Examples of this are in tobacco awareness and long-term care. Existing funds are not getting to where they can do the most good. There should be a board to oversee how funds are distributed.

Vickie Ybarra, Yakima Valley Farm Workers Clinic

It is imperative to create a diverse health care workforce. Disparities in health treatment and health status exist in Washington. Diversity in the health care workforce leads to increased access to health care for communities of color as well as improved satisfaction and health outcomes. Increasing the number of women in the health professions has helped address women’s health issues; similar results for minority populations can be achieved by increasing the number of minorities in the health professions. Increased diversity can transform health education, cultural competence, responsiveness to the needs of communities of color, and research resources.

There are many valuable resources in the state. The University of Washington has two centers for health disparities research at the School of Nursing and the School of Dentistry. The Health Care Personnel Task Force is also working on diversity issues. The University of Washington has the Center for Health Workforce Studies which reviews trends in the health professions in Washington. This Center should be commissioned to conduct a study of the impact of Initiative 200 on admissions, matriculation, and graduation in health profession education programs.

There is a lot of activity addressing disparities in Washington, but outcomes must be the yardstick of programs working to diversify health education and the health professions. “Cultural competence” can be defined as the knowledge, attitudes, and practice skills that everybody needs to work in cross-cultural situations. “Diversity” speaks to the composition of the profession. A profession probably needs to be diverse in order to be culturally competent, but many people can be culturally competent (as individuals).



**December 1, 2004**

**AGENDA**

**Joint Select Committee on Health Disparities**

Wednesday  
December 1, 2004  
5:30 pm

Senate Hearing Rm 4  
J. A. Cherberg Bldg  
Olympia, WA

**WORK SESSION:**

1. Approaches to Health Disparities Reduction Programs.  
Sheela Choppala, Washington State University, Vancouver
2. Cultural Competency in Contracting/Briefing on Tobacco Programs in Washington State.  
Eloise Gray, Snohomish County Health Department  
David Harrelson, Washington State Department of Health  
Deborah Parker, Tulalip Tribe
3. Diabetes Collaborative.  
Jan Norman, Washington State Department of Health
4. Initiatives in Pierce County.  
Ethlyn Gibson, RN, MSN, MultiCare Health System  
LTC Carl A. Gibson, MD, FACP, Madigan Army Medical Center  
Angel Ortiz-Hernandez, Community Health Care

**SUMMARY**

The December 1, 2004 meeting was a work session with four points of discussion. The following is a summary of the session.

**I. Approaches to Health Disparities Reduction Programs**

Sheela Choppala, Washington State University, Vancouver

Three hundred articles per month are published on the issue of Health Disparities. The first step in understanding the issue is to understand the difference between individual health and population health and to accurately define health disparities. Health disparities are differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.

Individual health is the health of a person who is impacted by their immediate surroundings and behaviors. Individual health relates to individual determinants. Population health refers to the aggregate health of a collection of people grouped together



because they share distinguishing features such as race, ethnicity, gender, age, social class, a common social environment, or residence.

Next, we must look at social determinants of health as defined by the World Health Organization:

- |                      |                     |
|----------------------|---------------------|
| 1) Social gradient   | 6) Unemployment     |
| 2) Stress            | 7) Social support   |
| 3) Early life issues | 8) Addiction        |
| 4) Social exclusion  | 9) Food / nutrition |
| 5) Work situation    | 10) Transportation  |

There are many determinants of health. Two of the most important are a person's access to health care and the quality of the care provided. The impact of unconscious bias cannot be overstated.

## **II. Cultural Competency in Contracting / Briefing on Tobacco Programs in Washington State**

Eloise Gray, Snohomish County Health Department

David Harrelson, Washington State Department of Health

Deborah Parker, Tulalip Tribe

Prior to determining how to spend the tobacco settlement money, Mr. Harrelson worked with the various communities to come up with a plan to assess their needs. Any improvement in outreach and access must come from within the target communities. Trust and respect were key to developing outreach. Several key elements were examined, including: the policies currently in place; hiring decisions; realizing 'best practices' were not developed with communities of color in mind; developing culturally appropriate materials for consumers and providers.

During the information gathering stage of the plan development, it became apparent that people in the target communities were concerned primarily with their need for food, housing and health care, not tobacco education. Consequently, the tribes decide how to address the issues within their communities. DOH contracts with 27 of the 29 federally recognized tribes in Washington.

## **III. Diabetes collaborative**

Jan Norman, Washington State Department of Health

There is a great deal of disparity between the instances of diabetes and heart disease in communities of color. The Washington State Collaborative (WSC) is working to improve the quality of care given to specific groups of people. The goal is to provide improved quality of care in a cost effective manner based on evidence based care. WSC delivers population based medicine.

WSC seeks to provide the same quality of care and quality of treatment to all people, with care givers accountable for outcomes. A collaborative is a year-long process of enrolling clinical practices in a quality improvement initiative. The process begins with

baseline practice data. The collaborative measures improvement within the pilot population over the course of one year. The collaborative educates providers on how to shift their care from one of acute care to chronic care. The analogy given is that your pets and car get chronic care. We all receive reminders in the mail to service the car or take the cat in for shots. Why not people? Currently, WSC is working to have co-pays waived for preventative health visits.

How can policy makers change the system? Four suggestions:

- 1) Assess potential for realigning payment system to drive improved outcomes.
- 2) Provide support to develop more sophisticated tools to measure quality improvements.
- 3) Invest in information technology to drive better data collection and analysis of evidence based practices.
- 4) Continue to support evidence based effectiveness research.

Many plans and providers indicate a willingness to pursue such changes but their effort will depend on the support and commitment of the ultimate financiers of health care - government and private employers.

#### **IV. Initiatives in Pierce County - MultiCare Health System**

Ethlyn Gibson, MultiCare Health System

LTC Carl A. Gibson, MD, FACP, Madigan Army Medical Center

Angel Ortiz-Hernandez, Community Health Care

Everyone talks about partnering with different entities. We decided to partner with consumers. Our efforts are directed at educating the public with examples of people who live in the community. Information is presented in the language of the community. We pick high profile members of the community to place on the fliers. We use mediums that are most likely to reach the target population, i.e. radio in poorer communities, bill boards, churches and places of worship in communities of faith. Free screenings are available at Ethnic Fest or other community based events.

MultiCare has a four pronged approach to this partnership:

- 1) Increase community awareness
- 2) Develop partnerships
- 3) Research (early detection, prevention)
- 4) Cultural competency promotion within health community

**January 21, 2005**

**AGENDA**

**Joint Select Committee on Health Disparities**

Friday  
January 21, 2005  
3:30 pm

Senate Hearing Rm 4  
J. A. Cherberg Bldg  
Olympia, WA

**WORK SESSION: HEALTH CARE WORKFORCE DIVERSITY.**

**PANEL 1: ConneX Program**

Maria Benavides, Yakima Valley Farm Workers Clinic  
Vickie Ybarra, Yakima Valley Farm Workers Clinic

**PANEL 2: Tacoma Pierce County Employment and Training Consortium**

Colin Conant, Tacoma Pierce County Employment and Training Consortium  
Madeleine Thompson, Workforce Training and Education Coordinating Board  
Frankie Manning, Washington State Board of Health

**PANEL 3: Area Health Education Centers**

Steve Meltzer, Eastern Washington Area Health Education Center  
Laurie Wylie, Western Washington Area Health Education Center

**PANEL 4: Initiatives in Higher Education**

Michelle Andreas, Washington State Board of Community and Technical Colleges  
Pat Ward, Washington State Board of Community and Technical Colleges  
Helen Kuebel, Lower Columbia College  
Kathy McVay, Higher Education Coordinating Board

Other business.

**SUMMARY**

The following is a brief overview of the panel presentations from the Health Disparities hearing held on January 21, 2005. The focus was on Health Care Work Force Diversity.

**I. ConneX Program**

**Yakima Valley Farm Workers Clinic**

The focus is on connecting students with health care careers. ConneX serves the Yakima Valley. YVFWC received a grant through DHHS. The focus is on getting young people from the community interested in medical careers with an emphasis on pharmacy, dentistry, nursing, and dieticians. The students participate in a one week placement with a professional from their area of interest. The students attend Saturday academies for twelve weeks at a time. The goal is to have the students pursue their education after high school and return to their community after graduation. The program is 4 years old.

Currently, there are 30 mid school, 55 high school and 25 college level students. The program is partnered with 9 school districts and 4 higher education institutions.

## **II. Tacoma Workforce Board**

Working towards connecting industry and education. Health care professionals want to hire a workforce that reflects their patient base. Very hard to do because they need employees with the necessary training and skills. They are working with minority populations to attract individuals to these fields. Some examples of what they are doing are: conducting health care occupation workshops across the state; presenting materials about health care careers in different languages; hiring retention specialists to assist employers in creating support systems for minorities and their families once they are hired.

## **III. Area Health Education Centers**

The Eastern Washington representative gave a very detailed breakdown of the ethnic makeup for Washington State. She highlighted a few programs that assist minority students with entering the health work force.

Project Hope – is a summer internship program for 11/12 grade minority students. The preference is for 1<sup>st</sup> generation college students to work with health providers. Six week, 20 hours per week program.

Health Career Ambassadors – health care professionals are available to teach or mentor students interested in health care careers.

## **IV. Initiatives in Higher Education**

Focus their efforts on recruitment, curriculum, and retention and graduation success. Emphasis on attracting and training a diverse student body as well as training the faculty in cultural and gender competency.

Schools focus on assistance with financial assistance, loan repayment, internships for lower income students. First generation college students receive assistance with community support. Many lack the education background of higher income students. Target to receive tutoring help when needed.

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**May 17, 2005**

**AGENDA**

**Joint Select Committee on Health Disparities**

Tuesday

May 17, 2005

9:00 a.m. - 12:00 p.m.

Senate Hearing Rm 4

J. A. Cherberg Bldg

Olympia, WA

**WORK SESSION:**

9:00 am

**Introduction of Washington's Minority Affairs Commissions.**

Rebecca Johnston, Director, American Indian Health Commission

Leo Gaeta, Chair, Commission on Hispanic Affairs

Zelma Jackson, Chair, Commission on African American Affairs

Ellen Abellera, Chair, Commission on Asian Pacific American Affairs

Brief Break

10:30 am

**Creating a culturally competent health care workforce through training opportunities for existing health care professionals.**

Panel:

Nancy Nash, Mid Valley Hospital

Dr. Carey Jackson, Harborview Medical Center

11:00 am

**Creating a culturally competent health care workforce through training new health care professionals.**

Panel:

Pat Ward, State Board for Community and Technical Colleges

Joane Mocerri, Pierce College

Shirley Mohsenian, Yakima Valley Community College

Carol Schneider, Yakima Valley Community College

11:30 am

Member discussion of previous and future topics

**SUMMARY**

The May 17, 2005 meeting of the Joint Select Committee on Health Disparities served two purposes. First, the directors for Washington's Minority Affairs Commissions each made a brief presentation. Second, several speakers addressed the issue of creating a

culturally competent health care workforce through training new health care professionals. A brief summary of the presentations given follows:

### **I. Introduction of Washington's Minority Affairs Commissions**

#### **Becky Johnston - American Indian Health Commission**

Twenty-nine tribes in Washington, twenty-six participate with the commission. Created in 1994 to work collaboratively with state officials to, "build bridges and disseminate information" to the tribes. The major problem facing the commission is the limited access to adequate, culturally competent health care for native Americans. Approximately 2 billion dollars is spent in federal funds towards Indian Health Services (IHS) but the need is closer to 10 billion. IHS receives 60% less in funding for health care than what is spent on prisoners. Currently, IHS contracts with private health services to meet the need.

Ideas: Exempt tribal members from co-pays. Give the tribes a seat on the Board of Health. Allow for government to government communication when working on state health policy.

#### **Leo Gaeta - Commission on Hispanic Affairs**

Primary purpose is to provide input to state and local government entities on issues that affect Latinos. Main problems facing Latinos in regard to health care is lack of insurance, housing and worker safety. Latino community in Washington is a transitory, migrant population. Very hard to provide follow up health care to a community that does not have regular doctor or home. Very limited income, education and cultural competency are huge barriers.

Ideas: Address access issues regarding medical services and insurance concerns for community.

Develop a stronger presence in healthcare workforce to address specific concerns facing Latino community. There needs to be one entity that will collect, maintain and study data regarding issues that are ongoing in the Latino community. For example, diabetes has become a larger problem. Consistent data would assist in tracking and understanding this phenomena.

Cultural competence does not just mean an interpreter. Understanding the language is only one aspect of competency. There needs to be a greater understanding of dialects, communities and a sensitivity to the culture as a whole before there can be compliance. Compliance by a patient is critical to successful treatment.

#### **Zelma Jackson - Commission on African American Affairs**

Created in 1989. Nine commissioners to advise Governor on issues relating to African Americans. Issues facing this community include low income housing, lack of access to health care, the basic health plan is not enough. Heart disease is the number one killer for African Americans. There needs to be a greater understanding in the medical community as to health concerns facing our community. New immigrants into our community become "Americanized" and face the same health concerns (poor eating habits, stress,

low income, violence). Efforts to educate our community are not working with regards to health.

Ideas: Promote healthy living not just health care. Work towards a social transformation in American medicine toward healthier living. Put the money towards that, rather than treating people who are at crises mode.

Ellen Abellera - Commission on Asian Pacific American Affairs

Ms. Abellera spoke at length about the Health Care Summit on September 30, 2005 in Sea-Tac. A formal invitation will be sent to all members.

Ideas: Have each commissioner have equal representation on the disparities task force. Have health and social data collected, stored and analyzed about each ethnic group. Enhance the education outreach within each community through community based organizations. Churches, community centers and schools can each assist with this.

**II. Creating a Culturally Competent Health Care Workforce**

Nancy Nash - Mid Valley Hospital

Cultural competency in the medical field is key to the survival of patients. America is too diverse for cultural competency to be an option for medical schools and hospitals. Mid Valley is a bilingual, bi-cultural medical facility. Their stated goal is health equity for all.

Ideas: Share the committee findings statewide. Make cultural competency part of the accrediting process for providers and facilities. Increase the awareness of the importance of trained cultural brokers. Make access to culturally competent health care a statewide goal.

Dr. Carey Jackson, Harborview Medical Center

Harborview has 45 interpreters on staff covering 70 linguistic groups. Cultural competency requires more than an understanding of language. Harborview has a website that was created to deal with the issue of cultural competency, <http://www.ethnomed.org/> This site generates 50,000 hits per week, worldwide.

Ethnomed.org provides a brief overview of clinical issues and assists medical staff with sensitivity towards other cultures and concerns. The site also provides patient education in native languages. There is audio in the particular language to avoid issues of illiteracy in any language.

Panel:

Pat Ward, State Board for Community and Technical Colleges

Joane Mocerri, Pierce College

Shirley Mohsenian, Yakima Valley Community College

Carol Schneider, Yakima Valley Community College

The main question when dealing with cultural competency is not how you would like to be treated. The question is, "how can I treat this person as he/she wishes to be treated?"

The community college approach has been to concentrate on middle and high school students. Utilizing outreach to attract young people from diverse cultural backgrounds to participate in a medical career.

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**June 21, 2005**

**AGENDA**

**Joint Select Committee on Health Disparities**

Tuesday

June 21, 2005

1:30 pm

House Hearing Rm B

J. L. O'Brien Building

Olympia, WA

**LIVE TVW**

**WORK SESSION: EARLY CHILDHOOD DEVELOPMENT**

1:30 pm

Kathy Carson, Program Administrator,  
Parent-Child Health, Public Health - Seattle & King County

Lois Schipper, Public Health Nurse, Program Manager,  
Parent-Child Health, Public Health - Seattle & King County

2:15 pm

Dr. Ben S. Danielson, Medical Director, Odessa Brown Children's Clinic

3:00 pm

Member discussion

**SUMMARY**

The June 21, 2005 hearing addressed the subject of Early Childhood Development. The following is a short summary of the presenters with highlights of their remarks. Audio of the hearing can be accessed at <http://www.tvw.org>.

**I. Early Childhood Development**

Kathy Carson, Seattle & King County Public Health

Lois Schipper, Seattle & King County Public Health

New mothers of infants who require NICU (Neo-Natal Intensive Care Unit) services are given a questionnaire in an effort to determine what environmental factors they have in common. The study indicates that women living in lower economic neighborhoods suffer from prolonged chronic stress and are at a higher risk to give birth to low birth



weight babies. Minority women are more likely to live in low income areas. Common stressors for these women are: high rates of crime, domestic violence and substance abuse; inadequate resources, fatigue, a need to work, limited support structures, higher single partner births, and depression. Women who suffer from depression have a more difficult time bonding with their infants. Children who do not receive appropriate nurturing in their early years are more likely to have less empathy as they grow older.

A greater emphasis on healthy women is key. Pre-natal care is important but a physically and mentally healthy mother is the most important factor for a healthy, full-term birth.

The Nurse Family Partnership is a program in Seattle-King County that sends nurses into the homes of low-income, teenage first time mothers. Home visits begin during pregnancy and continue until the child reaches the age of 2. The program has three main goals: 1) improve pregnancy outcomes; 2) improve the health and development of the child; and 3) stabilize the family economic situation. The program was previously introduced in New York, Tennessee and Colorado. Participants were monitored over 15 years and results indicate the participants had higher IQ's, better language development and fewer mental health issues than non-participants. Currently, the Washington program is active in 6 counties and serves 550 women.

Dr. Ben Danielson, Odessa Brown Children's Clinic

A major area of emphasis that must be addressed by this committee: the need to aggregate resources and data.

Health care providers have racial biases because people have racial biases. In many instances, negative racial attitudes exist on a subconscious level. Awareness of racial bias is the first step to addressing the institutional racism minorities face everyday. An increased emphasis on clinical practice guidelines for culturally diverse populations, diversity in the workforce, cross cultural training, and research among different ethnic groups is critical. Mentoring at all levels of education is critical. Requiring cultural awareness courses in medical school is a good first step.

Cultural competency is a misleading term. This term creates a presumption that people can be made competent in all the various cultures that exist. Perhaps we should be talking about achieving cultural sensitivity, cultural respect or cultural awareness.

We must learn how to tap into the genius of the community to navigate the cultural maze. By example: A study was conducted to determine why Navajo parents were not placing their newborn children into car seats. Car seats were purchased and given to the parents but still, the parents refused to place the children in them. Finally, medical staff met with tribal elders and determined that

placing a newborn child into a plastic, synthetic covered seat went against the beliefs of the parents. Parents were afraid that their children would be 1) physically unsafe and 2) spiritually damaged by the materials. The situation was resolved when tribal elders provided blankets created by tribal members to wrap the baby in prior to placing the child in the seat.

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# Washington State Legislature

## Joint Select Committee on Health Disparities

**Tuesday  
July 19, 2005  
9:00 am**

**House Hearing Rm E  
J. L. O'Brien Building  
Olympia, WA**

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**WORK SESSION:** Effect of reductions in health care expenditures.

**Washington Health Foundation**

Greg Vigdor, President and CEO, Washington Health Foundation

**Community Health Clinics**

Ben Flores, CEO, Washington Association of Community and Migrant Health Centers

Dr. Evan Oakes, Clinical Programs Manager, Community Health Centers of King County

David Flentge, CEO, Community Health Care of Pierce County

**Department of Social and Health Services - Medical Assistance Administration**

Dr. Nancy Anderson, MD, Director, Family Services Section



# SUMMARY

**DATE:** October 13, 2005  
**TO:** Joint Select Committee on Health Disparities Members  
**FROM:** Sharon Swanson  
**SUBJECT:** **Summary of July 19, 2005 Work Session**

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The subject for the July 19, 2005 work session was the, "Effect of reductions in health care expenditures." The following is a summary of the issues addressed. Audio of the hearing can be accessed through [www.tvw.org](http://www.tvw.org).

**I. Washington Health Foundation**, Greg Vigdor, President and CEO, Washington Health Foundation (WHF).

WHF is attempting to address the fundamental inequities in health care expenditures. WHF believes this is the core problem facing the national health care system. Currently, Washington is ranked 15<sup>th</sup> in the nation. Washington will not become the healthiest state in the nation unless we deal with the issue of health disparities.

Prescriptions for future success:

- 1) Understanding / visibility: Health disparities needs to be a 'top of the radar' issue. Washington should have a report card for the state with each area of health care receiving a separate analysis or grade. Creating an Office of Minority Health, having a health care ombudsman, preparing health disparities impact statements are all ideas this committee can consider.
- 2) Symptoms of Problems: there is a huge disparity between the numbers of minority health care workers and the numbers of minority patients. The need for cultural competency cannot be overstated. Government programs and private organizations should be utilized to address the shortage of workers and the lack of competency. Greater support of community outreach programs and addressing cultural barriers in early learning will help address this concern.
- 3) Systematic Answers: Health disparities should be addressed by addressing the social determinants of health, ie housing.

**II. Community Health Clinics**, Ben Flores, CEO Washington Association of Community and Migrant Health Centers; Dr. Evan Oakes, Clinical Programs Manager, Community Health Centers of King County; David Flentge, CEO, Community Health Care of Pierce County.

Currently, 23 community health center organizations operate 139 different clinic sites in 33 of the 39 counties in Washington State. Health centers target low-income under served populations in both urban and rural areas who might otherwise have difficulty accessing primary care

services. Patients cannot be turned away because of their inability to pay. Evidence suggests that access to the type of primary care that health centers specialize in can mitigate the impact of racial and income inequality on health status. The culturally appropriate community health center model has shown remarkable success in reducing, and in some cases eliminating, some of the most persistent disparities in health status.

To maintain current levels of services, community health centers are dependent upon stable funding from the state for both the Basic Health Plan and Medicaid Programs, along with community health grants to support capacity and to provide services to the uninsured. When these programs are cut, the challenges to maintain access to services for under served populations becomes even more difficult. Patients will not be directly denied services but their appointments may be pushed out several weeks. Often, patients resort to emergency room care greatly increasing the cost to the state.

**III. Department of Social and Health Services - Medical Assistance Administration, Dr. Nancy Anderson, MD, Director, Family Services Section**

The biology of race is non-existent. The social construct of race is the issue. Health disparities boils down to inadequate access.

Focus on three preventable conditions and look at the cost to the state.

1) Low birth weight for minority births: the majority of minority births are financed by the government. Low birth weight occurs 50% more to women of color than white women. Many factors are considered in determining why this happens. Access to prenatal care, stress pollution, diet, drug and alcohol abuse all contribute. If the low birth rate for African American infants were the same for that of white infants, this would result in a yearly savings of about \$2.5 million in medical costs during the first year of life for Medicaid infants.

2) Obesity: Many chronic health conditions are tied to obesity. Minority populations have a higher prevalence of obesity than whites. Women suffer more from obesity. Studies have shown that the longer people reside in this country, the more they suffer from obesity. Life style, diet and environmental issues factor in. If a person lives in a poor neighborhood that is unsafe to walk in or the parks are not maintained, this will impact their ability to be healthy and combat obesity. Preventing this condition is far easier and less expensive than treating it. It is very hard to lose weight as an adult. The conditions resulting from chronic obesity are very expensive and deadly.

3) Asthma: Asthma is a chronic disease. The prevalence of asthma has increased in the past twenty-five years. Minorities suffer more than whites in terms of severity of the disease. The determinants of asthma include the access to health care, the environment, health behaviors and genetics. Asthma can be exacerbated by environment, mold, pets, pollution, smoking, housekeeping. Environment is as critical as access to health care in the treatment of asthma.

Ideas for this committee to consider are:

- 1) Collect information on race-ethnicity of medicaid patients.
- 2) Collaborate with community-based organizations and academic researchers who can help find out more about disparities in patients and how to eliminate them.
- 3) Use contractual agreement with health plans to measure and eliminate disparities.
  - \* Include in the quality improvement aspect of contracts.





# APPENDIX C



## COMMENT 1

Developing a statewide policy and action plan to ~~minimize~~ eliminate health disparities in the State of Washington. These shall include the following recommendations:

1. At a minimum, the action plan shall include health disparity impact statements that measure and address other social determinants of health that lead to disparities (lack of emphasis on early childhood development, housing, violence, employment, poverty, etc.) as well as the contributing factors of health that can have broad impacts on improving status, health literacy, physical activity, and nutrition. The action plan shall recognize the need for flexibility.
2. ~~Developing~~ a workforce that is representative of the diversity of the State's population.
3. ~~Identifying~~ and ~~collecting~~ relevant and accurate data on health care professionals, students in the health care professions, and recipients of health services.
4. ~~Developing~~ the knowledge, attitudes, and practice skills of health professionals and those working with diverse populations to achieve a greater understanding of the relationship between culture and health.
5. Ensuring the availability of ~~appropriate age, gender, cultural, and linguistic~~ health literature and interpretive services that are appropriate for age, gender, culture and linguistics of the client(s).
6. ~~Create~~ Creating an interagency coordinating council under the direction of the Governor to promote and facilitate communication, collaboration, and cooperation between State agencies and programs in the communities, including public health and health care providers.
7. Encouraging the Department of Health to continue focusing statewide disease-specific plans (e.g., asthma, diabetes, smoking cessation, HIV/AIDS, immunization, Sudden Infant Death Syndrome (SIDS), and mental health) to address racial, ethnic and gender disparities related to the disease.
8. ~~Striveing~~ to establish a medical home for all Washingtonians, beginning with children and expectant and new parents.
9. ~~Designateing~~ a member of the State Board of Health to represent American Indian and Alaska Native populations.
10. Develop tools that systematically review key policies as they are developed to learn "up front" how they might ameliorate or exacerbate the root causes of health disparities.

Attached is my response to the recommendations. Most are just editing, but the biggest is the first statement. I believe that we should work toward elimination of health disparities, not just minimalization. Minimalization can have a number of views of success, which may or may not reflect real improvements in the health of those in need. Elimination is easily measured.

Laurie Wylie, MA, SNP, RN  
Executive Director  
Western Washington Area Health Education Center  
2033 Sixth Ave., Suite 310  
Seattle, WA 98121  
Phone 206-441-7137 Fax 206-441-7158

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## COMMENT 2

Greetings,

Thank you for soliciting input on your draft recommendations to address health disparities in Washington State. I believe you have very sound and valid recommendations in the list provided for input.

A aspect of healthcare that I believe is missing, has to do with a sector of the Latino population (mostly farmworkers that arrived in the last 20-30 years to the US) that places a great deal of confidence in natural path medicine and therapy-also referred to as alternative medicine. This may include herbal medicines or home prepared remedies and even massage therapy. The faith and confidence in this alternative medicine by many Latinos is often reinforced when individuals experience "unfavorable experiences" with traditional healthcare providers. Good or bad, natural path "practitioners" are huge influencers among this sector of the Latino population. Natural medicine/therapies are very commonly provided by mothers who learned these remedies from previous generations. It is often an inexpensive, convenient and culturally accepted way alleviating health problems. Of course, we also know that often some of these "home prepared" remedies can represent serious health risks and some work has been done to inform this community of the dangers.

A question worth considering is...What helpful role can natural path medicine and the practitioners of natural path medicine play in influencing healthier living, healthier eating and preventive healthcare among the Latino Communities in our state?

I am not a healthcare provider but have worked in the healthcare arena for over four years doing healthcare outreach and education in North Central Washinton. In addition, we work with six regional hospitals and a number of clinics introducing health information technology and other support services. I am also part of that population sector of Latinos that arrived in the US in the last 30 years...1979 to be exact. And natural

medicine was practiced by my grandmother, my mother and at least my oldest sister still does on some level. Natural medicine is deeply rooted in the beliefs, traditions and way of life of many Mexican and Central American Latinos in the state. If we are more effective at engaging this population sector through their beliefs and traditions about health, we may be able to gradually introduce healthier living and health promotion where needed in a proactive way. Of course the tough part is figuring out "how" to accomplish this effectively.

These are some of my thoughts and input for your consideration.

Regards,  
Jesus

**Jesús Hernández**  
**Director of Programs & Marketing**  
**Community Choice Healthcare Network**  
620 N. Emerson Suite 303  
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PH: 509-665-8478 \* FAX: 509-665-7672

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### **COMMENT 3**

After working most of my life in some form of education service or another in South, Central, and North America, I believe education can not be stressed enough when considering the issue of health disparities. I work at Outreach coordinator for Columbia Valley Community Health in Wenatchee, WA. I have a promotora program where I employ 5 promotoras (lay health educators) to work as community health advisors in our community and with our migrant farm workers. We are working with a population in Eastern Washington who are quite adept at pretending to be literate. We also encounter many traditional beliefs that range between very helpful to very harmful. It is not just a case of providing literature aimed at a 6<sup>th</sup> grade reading level. I believe there is a need in the Latino community to educate illiterate adults in a culturally competent manner that can bring their level of understanding out of a fear based mentality to one of adult competency. There is a cultural need to understand how to communicate in our system. By that I mean how to prepare for a doctors visit, how to be proactive and how to take responsibility for their own health. Many of the Latino community are coming from a medical understanding that we had in our culture fifty years ago where the doctor took care of everything and the patients trusted them to do that.

I had the experience of suffering a car accident when there was only a group of largely uneducated people available. The first reaction was panic on their part. As a group they tried to pull me out of the car window although the other side of the car was perfectly fine. When I asked them not to do that they started piling on blankets until I could barely breathe. No one there knew to call 911 and certainly not how to stay on the line, give info etc.

I think especially in the wake of Katrina, we would like to know we can count on people to respond to our emergency needs in a way that will help us. Education is paramount to limiting health disparities.

I find the verbiage in the both the letter and the legislation to be woefully inadequate regarding education.

Thank you,

**Carol McCormick**  
**Outreach Coordinator**  
**Columbia Valley Community Health**  
Wenatchee, WA 98801  
509-661-3623  
[cmccormick@cvch.org](mailto:cmccormick@cvch.org)

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#### **COMMENT 4**

I just have two brief comments. Perhaps the work *education* could be added after the word "collaboration" under #6.  
Also regarding #8... what does medical home mean? This might be explained or written with more detail for those who are not health or policy savvy. Thank you for all the hard work you are doing. This looks like an excellent proposal.

Sincerely, **Mary Jo Ybarra-Vega M.S.**  
Quincy Community Health Center.

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#### **COMMENT 5**

**From:** Iniguez, Uriel (CHA) [mailto:UIniguez@cha.wa.gov]  
**Sent:** Tuesday, September 27, 2005 12:07 PM  
**Subject:** Proposed Disparities Recommendations for Comment 8-053.doc

I received some input on the recommendations- people were mostly pleased with them with some concern that they were kind of weak.  
Suggest that we delete the words Encourage, striving, ensuring- to something that it is measurable.

- 2- develop a workforce
- 5. ensure the availability
- 7. The Department of Health will focus
- 8. Establish a medical home
- 9. Designate a member

Just some thoughts.

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## COMMENT 6



STATE OF WASHINGTON  
COMMISSION ON AFRICAN AMERICAN AFFAIRS  
210 11th Ave. SW, Olympia, Washington 98504-0926 (360) 725-5663  
[www.caa.wa.com](http://www.caa.wa.com)

September 26, 2005

### MEMORANDUM

From: Rosalund Jenkins, Executive Director  
Washington State Commission on African American Affairs

Re: Comments on recommendations of the Joint Select Committee on Health Disparities

Attached please find detailed comments on the committee's draft recommendations submitted by Commissioner Karen Johnson. I'm also summarizing below comments received during four Town Hall meetings conducted by the African American Legislative Day Planning Team. Those meetings provided a forum for community members to discuss a draft legislative agenda and the work of the Joint Select Committee. Lastly, I'm including other anecdotal feedback I received from various doctors and my ethnic commission counterparts with whom I discussed the work of the Joint Select Committee.

Overall, the participants in our town halls were quite pleased to hear about the work of the committee. Across they board they supported the work and plans to address the issue through legislation. Also, they did voice concerns about drug coverage and access to costly diagnostic tests and treatments for people who are receiving publicly-funded care. Of special concern was a perception that Medicaid patients, public employees and others served through managed care systems received a lower standard of care and restricted access to name-brand prescription drugs. This has serious implications for people of color, given that we receive publicly-funded care in disproportionately large numbers.

During discussions with physicians and my counterparts on staff with the other ethnic commissions, there's a sense that our involvement in the discussion of health disparities can and should be expanded as you go forward. We want to assist Sen. Franklin and the other committee members in every way as they pursue solutions. That might require some coordinated public engagement facilitated through House and Senate staff and the ethnic commissions. We also should consider doing some coordinated public education and media relations work to continue broadening public awareness and involvement on this issue. Lastly, we are eager to see the Intercultural Networks that arise from this week's Diversity Health Summit substantively involved as work begins on framing policy issues and drafting legislation.

Thank you for the opportunity to comment.

**COMMENT 6 (Continued)**

**JOINT SELECT COMMITTEE ON HEALTH DISPARITIES  
PROPOSED RECOMMENDATIONS FOR COMMENT**

Developing a statewide policy and action plan to [change "minimize" - to "eliminate"] health [add "and healthcare"] disparities in the State of Washington. These shall include the following recommendations:

1. At a minimum, the action plan shall include health disparity impact statements that measure and address other social determinants of health that lead to disparities (lack of emphasis on early childhood development, housing, violence, employment, poverty, etc.) as well as the contributing factors of health that can have broad impacts on improving status, health literacy, physical activity, and nutrition. The action plan shall recognize the need for flexibility.
2. Developing a workforce that is representative of the diversity of the State's population.
3. Identifying and collecting relevant and accurate [add "disaggregated racial/ethnic"] data on health care professionals, students in the health care professions, and recipients of health services.
4. Developing the knowledge, attitudes, and practice skills of health professionals and those working with diverse populations to achieve a greater understanding of the relationship between culture and health.
5. Ensuring the availability of appropriate age, gender, cultural, and linguistic health literature and interpretive services.
6. Creating [add "a subagency or"] an interagency coordinating council [add "with appropriate accountability and oversight authority and responsibility -" ] under the direction of the Governor [add "-" ] to promote and facilitate communication, collaboration, and cooperation between State agencies and programs in the communities, including public health and health care providers.
7. Encouraging the Department of Health to continue focusing statewide disease-specific plans (e.g., asthma, diabetes, smoking cessation, HIV/AIDS, immunization, Sudden Infant Death Syndrome (SIDS), and mental health) to address racial, ethnic and gender disparities related to the disease.



8. [Delete "Striving to" and begin with "Establish"] a medical home for all Washingtonians, beginning with children [add "(especially children of incarcerated parents),"] and expectant and new parents.
9. Designating a member of the State Board of Health to represent American Indian and Alaska Native populations.

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10. Develop tools that systematically review key policies as they are developed to learn "up front" how they might ameliorate or exacerbate the root causes of health disparities.

ADD:

11. Developing and implementing strategies to increase general public and physician awareness of the extent of racial and ethnic health and healthcare disparities in Washington State.
12. Developing and implementing wide-range strategies aimed at ensuring equal access to quality primary and specialty care for all ethnic people groups.
13. Incent the establishment of Washington State elementary and middle school partnerships with Historically Black Colleges and Universities (HBCUs) and the Hispanic Association of Colleges and Universities (HACUs) to attract students of color to the field of medicine and healthcare professions.
14. Requiring (or Encouraging) statewide academic medical centers, medical schools and hospitals to launch as comprehensive strategic plan to increase the institution's emphasis on racial and ethnic people groups, ensuring the inclusion of racial/ethnic health issues in all aspects of research and education.
15. Establish a healthcare system that is responsive to, and reflects the realities of, Washington's racial and ethnic people groups.

Respectfully Submitted by Commissioner Karen A. Johnson, Ph.D.

9/23/05 9:01:05 AM