



Toward a State Action Plan to  
**E**liminate  
Health **D**isparities

2008 Progress Report

Governor's Interagency Council on  
Health Disparities

DRAFT

This document has not been reviewed or approved  
by the Office of Financial Management



STATE OF WASHINGTON  
GOVERNOR'S INTERAGENCY COUNCIL ON HEALTH DISPARITIES  
Washington State Board of Health  
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January 15, 2008

To the Governor and Members of the Legislature:

Washington's communities of color continue to face a disproportionate burden of disease and death. Disparities between men and women also remain for some health outcomes. The reasons for such inequities are numerous, interrelated, and complex. Women and people of color often have lower socioeconomic position, power, and prestige and are more likely to experience discrimination and exclusion. Thus, these populations may have limited resources, substandard working and living conditions, fewer opportunities to make healthy choices, and less favorable experiences with the health care system. As examples, communities of color often have higher exposures to toxics in their home and work environments, have higher rates of smoking and substance abuse, and may be less likely to have health insurance coverage. Moreover, a lack of racial/ethnic and cultural diversity in the health care workforce may contribute to disparities in health care received by people of color.

In 2005, the Joint Select Committee on Health Disparities published recommendations that were turned into a suite of bills that the Washington State Legislature passed in 2006 and Governor Gregoire subsequently signed. Among those bills was Second Substitute Senate Bill 6197, which created the Governor's Interagency Council on Health Disparities and charged the Council with developing a statewide action plan to eliminate health disparities by race/ethnicity and sex.

This report summarizes the Council's progress toward creating a state action plan and describes other activities the Council has initiated or participated in that contribute to the goal of improving the health and well-being of communities of color in Washington State.

We thank you for your ongoing support and commitment to this important work.

Sincerely,

Vickie Ybarra, RN, MPH  
Chair

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## I. EXECUTIVE SUMMARY

The Governor's Interagency Council on Health Disparities is responsible for creating an action plan to eliminate health disparities by race/ethnicity and sex. This report describes the Council's progress toward creating the action plan and highlights accompanying activities that the Council has initiated or participated in that contribute toward the goal of improving the health and well-being of Washingtonians, particularly communities of color.

### *State Action Plan Progress*

The Council has made considerable progress toward creating an action plan and anticipates completion of the first version by 2010, two years ahead of schedule. In response to the broad legislative mandate to address social determinants of health in addition to specific conditions and indicators, one of the Council's first tasks was to consider possible additions to the existing list of 16 health topics specified in statute. The Council received significant public input and voted to add sixteen additional health topics. The Council received briefings on the prevalence, severity, and disparity of each and completed a prioritization process to narrow the list to the following twelve current priorities:

#### *Social Determinants of Health*

- Health Workforce Diversity
- Substance Abuse
- Health Insurance Coverage
- Education
- Health Literacy
- Environmental Exposures
- Smoking Rates

#### *Health Conditions*

- Overweight & Obesity
- Diabetes
- HIV/AIDS
- Chronic Kidney Disease
- Heart Disease & Stroke

### *Other Highlights*

The Council completed an assessment of the availability of culturally and linguistically appropriate health education materials through a contract with a non-profit organization. It held community meetings and organized the Public Forum on Language, Culture, and Health Care to solicit public input on language access barriers and solutions to obtaining quality health care. The Council will use this information and conduct further research to create recommendations for improving the availability of culturally and linguistically appropriate health education materials and interpretive services.

The Council consulted with the State Board of Health on two health impact reviews to assess the impacts of education policy on health disparities. The Council was awarded a federal grant from the Office of Minority Health to expand its capacity to engage communities of color in its work and to more effectively reach affected communities with information on health and health disparities. The Council has fostered increased coordination and collaboration among state agencies, private organizations, and community groups. One example was the Each Student Successful Summit, co-sponsored by the Council and eleven other partners to discuss a whole-child approach to addressing health disparities and the academic achievement gap.

## II. INTRODUCTION

The Governor's Interagency Council on Health Disparities (i.e., the Council) was created in 2006 when the Legislature passed and the Governor signed Second Substitute Senate Bill 6197. According to resulting statutory language:

*“The council shall consider in its deliberations and by 2012, create an action plan for eliminating health disparities.”*

*“The council shall report its progress with the action plan to the governor and the legislature no later than January 15, 2008.”*

The purpose of this report is to detail the Council's progress toward creating a state action plan to eliminate health disparities by race/ethnicity and sex. This report will also provide an overview of the Council, its membership, and its responsibilities. Finally, this report will highlight accompanying activities that the Council has initiated or participated in that contribute toward the goal of improving the health and well-being of Washingtonians, particularly communities of color.

## III. ABOUT THE COUNCIL

In accordance with Section 43.20.275 of the Revised Code of Washington (RCW), the Council has 17 members: a chair appointed by the Governor; representatives of 14 state agencies, boards, and commissions; and two members of the public who represent the interests of health care consumers. A list of current and former Council members is provided in Box 1.

The Council is charged with the following responsibilities:

- By 2012, the Council must create a state action plan for eliminating health disparities in Washington State.
- To help with its work, the Council is required to establish advisory committees to address specific issues.
- The council must hold hearings and conduct research in order to make recommendations for improving the availability of culturally appropriate health literature and interpretive services within public and private health-related agencies.
- The Council is charged with promoting communication and collaboration among state agencies, communities of color, and the public and private sectors to address health disparities.
- The Council is responsible for gathering information through public hearings, inquiries, studies, and other efforts to understand how the actions of state government ameliorate or contribute to health disparities.

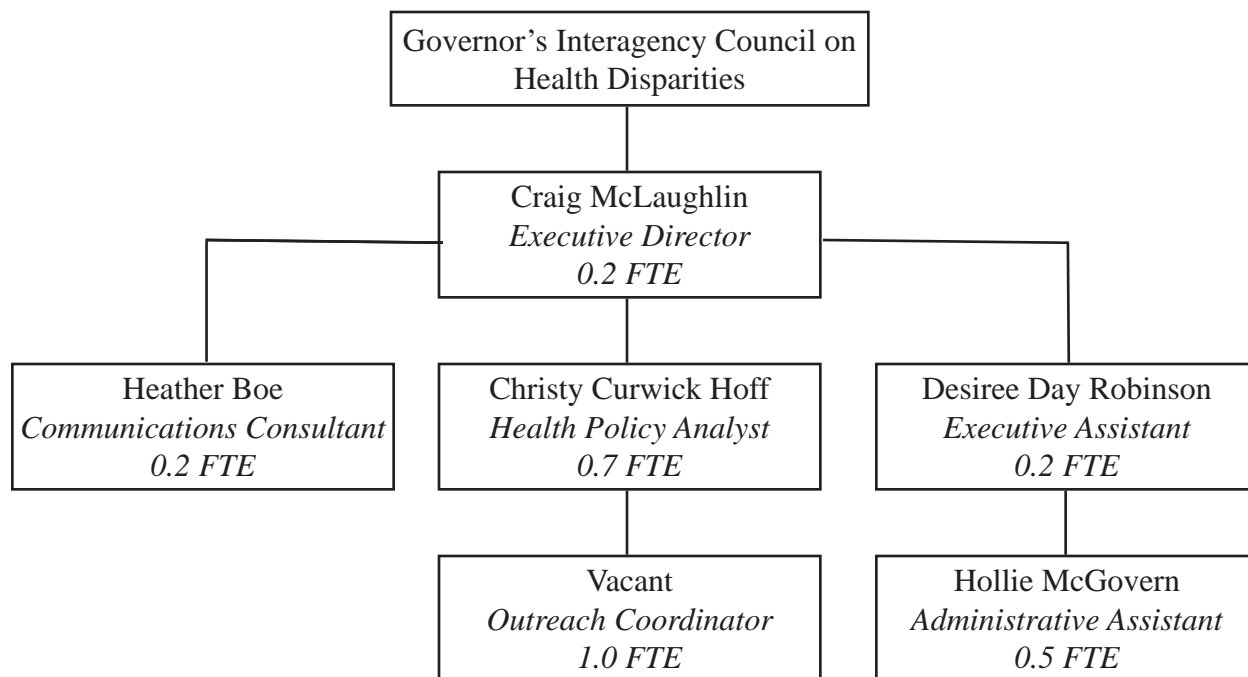
- The Council must collaborate with the State Board of Health to develop health impact reviews requested by the Governor or the Legislature. A health impact review is a review of a proposal for a legislative or budgetary change to determine the extent to which the proposal would exacerbate or ameliorate health disparities.
- The Council must update the Governor and the Legislature on its progress in 2008, 2010 and 2012.

<b>Box 1: Governor's Interagency Council on Health Disparities Membership</b>	
Governor's Representative and Council Chair:	Vickie Ybarra, RN, MPH
Consumer Representative and Council Vice Chair:	Emma Medicine White Crow
Consumer Representative:	Gwendolyn Shepherd
Commission on African American Affairs:	Winona Hollins-Hauge, MSW, LICSW
Commission on Asian Pacific American Affairs:	Ellen Abellera
Commission on Hispanic Affairs:	Lourdes Portillo Salazar Yvonne Lopez-Morton (former member)
Department of Agriculture:	Eric Hurlburt
Department of Community, Trade & Economic Development:	Annie Conant
Department of Early Learning:	Felecia Waddleton-Willis, DO
Department of Ecology:	Millie Piazza John Ridgway (alternate) Joy St. Germain (former member)
Department of Health:	Sofia Aragon, JD, RN
Department of Social and Health Services:	MaryAnne Lindeblad
Governor's Office of Indian Affairs:	Martha Holliday Danette Ives (alternate) Craig Bill (former member)
Health Care Authority	Nancy Fisher, RN, MD, MPH
Office of Superintendent of Public Instruction	Martin Mueller
State Board of Health:	Frankie T. Manning, MN, RN
Workforce Training and Education Coordinating Board:	Madeleine Thompson

The Council receives staff support from the State Board of Health. With the creation of the Council, staff at the State Board of Health underwent reorganization and hired additional staff to support the Council (see Figure 1).

Under RCW 43.03.220, the Council is a Class 1 group, which is defined as “any part-time board, commission, council, committee or other similar group which is established by the executive, legislative, or judicial branch to participate in state government and which functions primarily in an advisory, coordinating, or planning capacity.”

**Figure 1:  
Staff Support for the Governor’s Interagency Council on Health Disparities**



All meetings of the Council are open to the public as required by the Open Public Meetings Act, Chapter 42.30 RCW. The Council maintains an electronic-mail distribution list of interested members of the public, which it uses to announce meetings, distribute draft and final meeting agendas, and solicit input and feedback to guide its work.

In addition, the Council maintains a Web site, which it uses to supply information about the Council, announce upcoming meetings, and post meeting agendas, minutes, and materials. Contact information for Council members and staff, Council bylaws, press releases, and other information can be found on the Web site.

Governor’s Interagency Council on Health Disparities  Web site:  <a href="http://www.sboh.wa.gov/hdcouncil">www.sboh.wa.gov/hdcouncil</a>
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Funding for the Council became available in July 2006. By October 2006, the Governor’s office had appointed the chair and two public members, all agency representatives were appointed, and the State Board of Health had hired additional staff to support the Council. The Council held its first meeting and public forum on October 20, 2006 in conjunction with the *Fifth National Conference on Quality Health Care for Culturally Diverse Populations*. To date, the Council has held seven public meetings. Council meeting minutes are available on its Web site.

## IV. STATE ACTION PLAN TO ELIMINATE HEALTH DISPARITIES

### *Identifying Additional Health Conditions, Indicators of Health, and Social Determinants of Health for Consideration in the Action Plan*

Section 43.20.280 RCW, states that the Council's action plan to eliminate health disparities,

*"...must address, but is not limited to, the following diseases, conditions, and health indicators: Diabetes, asthma, infant mortality, HIV/AIDS, heart disease, strokes, breast cancer, cervical cancer, prostate cancer, chronic kidney disease, sudden infant death syndrome (SIDS), mental health, women's health issues, smoking cessation, oral disease, and immunization rates of children and senior citizens."*

Further, according to section 43.20.270 RCW:

*"The legislature finds that women and people of color experience significant disparities from men and the general population in education, employment, healthful living conditions, access to health care, and other social determinants of health."*

*"It is the intent of the Washington state legislature to create the healthiest state in the nation by striving to eliminate health disparities in people of color and between men and women. In meeting the intent of chapter 239, Laws of 2006, the legislature creates the governor's interagency coordinating council on health disparities. This council shall create an action plan and statewide policy to include health impact reviews that measure and address other social determinants of health that lead to disparities as well as the contributing factors of health that can have broad impacts on improving status, health literacy, physical activity, and nutrition."*

In response to the broad legislative mandate to address social determinants of health in addition to specific conditions and indicators, one of the Council's first tasks was to consider possible additions to the existing list of 16 health topics specified in statute. On March 21, 2007, the Council sent out a request, through its interested parties' distribution list, for public input into additional health topics that the Council should consider in its action plan. In response, the Council received more than 50 suggestions from dozens of experts, advocates, and other interested members of the public.

Council members reviewed the suggestions submitted by the public and put forward their own proposals for discussion and vote at the May 23, 2007 Council meeting. At that meeting, Council members adopted a motion to add a number of social determinants of health and health indicators proposed by Council members, as well as three additional health conditions. Thus, in addition to the 16 health conditions and indicators of health already listed in statute, the Council agreed to expand the list to include 16 new health topics. The expanded list of health conditions, indicators of health, and social determinants of health approved for consideration by the Council at its May 23, 2007 meeting is provided in Box 2.

**Box 2: Health Conditions, Indicators of Health, and Social Determinants of Health Under Consideration by the Governor's Interagency Council on Health Disparities  
May 23, 2007**

*Health Topics Listed in RCW 43.20.280*

- Asthma
- Cervical Cancer
- Diabetes
- HIV/AIDS
- Infant Mortality
- Oral Disease
- Smoking Cessation
- Stroke
- Breast Cancer
- Chronic Kidney Disease
- Heart Disease
- Immunization Rates
- Mental Health
- Prostate Cancer
- Sudden Infant Death Syndrome
- Women's Health Issues

*Health Topics Added by the Council*

- Access to Nutritious Food
- Colorectal Cancer
- Education
- Health Insurance Coverage
- Income
- Obesity
- Social Support Systems
- Supportive Parenting & Childcare Systems
- Access to Opportunities for Physical Activity
- Culturally & Linguistically Appropriate Healthcare
- Exposure to Environmental Hazards
- Health Literacy
- Lupus
- Preventive Services Utilization
- Substance Abuse
- Workforce Diversity

\* Note: Topics presented are in alphabetical order

***Prioritizing Health Conditions, Indicators of Health, and Social Determinants of Health***

In accordance with Section 43.20.280 RCW:

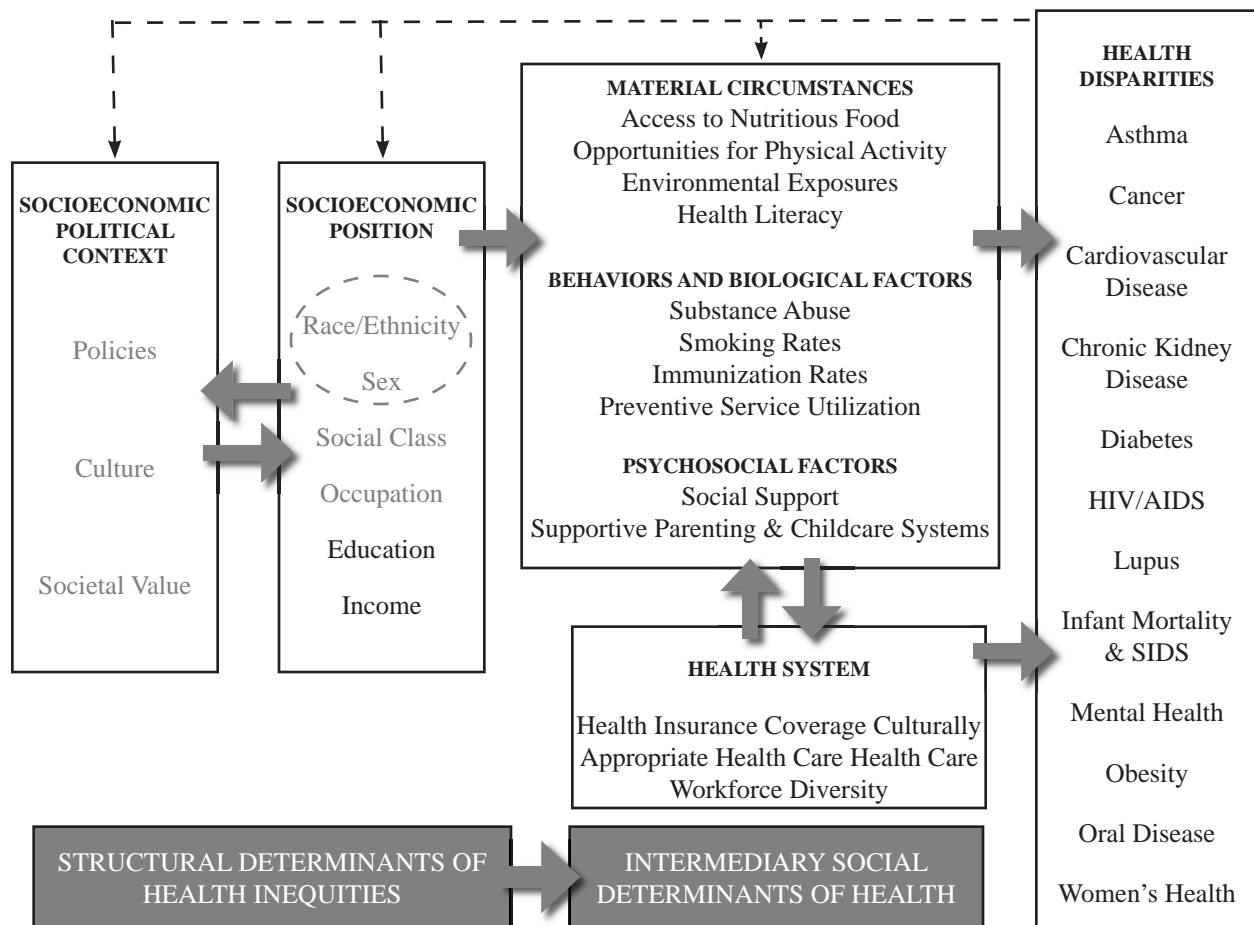
*“The council shall prioritize the diseases, conditions, and health indicators according to prevalence and severity of the health disparity. The council shall address these priorities on an incremental basis by adding no more than five of the diseases, conditions, and health indicators to each update or revised version of the action plan.”*

For the Council to prioritize the health topics listed in Box 2, it had to first become familiar with the epidemiologic data available for each topic. At its May 23 and September 20 meetings, the Council received one-page briefing documents for each of the health topics, which outlined available data for three criteria: (1) the magnitude of the problem, (2) the severity of the health condition or the degree to which the social determinant of health results in adverse health outcomes, and (3) the level of disparity. Briefing documents for each of the health topics listed in Box 2 are provided as Appendix A. Council staff prepared the briefing documents using previously published data and information.

Council members also expressed an interest in seeing the relationships between the social determinants of health and health outcomes. At its September 20 meeting, the Council approved a framework linking the social determinants of health to the health outcomes under consideration, see Figure 2. The model was adapted from a framework developed for the Commission on Social Determinants of Health<sup>1</sup>. The model shows how social, economic, and political mechanisms stratify populations by socioeconomic position, power, and prestige, for which race/ethnicity, sex, social class, education, occupation, and income are often indirect indicators. This stratification results in some populations having less favorable material circumstances, health behaviors, psychosocial factors, and experiences with the health system. The unequal distribution of these social determinants of health constitutes the mechanism by which socioeconomic position, power, prestige and discrimination generate health disparities.

The health conditions, indicators of health, and social determinants of health under consideration by the Council are included in the conceptual framework. Education and income, two determinants under consideration by the Council, are depicted as structural determinants of health inequities according to the framework. Race/ethnicity and sex are circled in the model to

**Figure 2: Framework Linking the Social Determinants of Health with Health Disparities**



Note: Conditions listed in “Health Disparities” column are presented in alphabetical order

1 Commission on Social Determinants of Health. A Conceptual Framework for Action on the Social Determinants of Health . Draft. April 2007. [http://www.who.int/social\\_determinants/resources/csdh\\_framework\\_action\\_05\\_07.pdf](http://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf). Accessed July 23, 2007.

indicate that the Council has been charged with the elimination of disparities by race/ethnicity and sex. Other structural determinants of health inequities, shown in gray text, were not identified by the Council for consideration, but are included to provide context to the model.

In addition, the Council approved prioritization criteria and a process for scoring the health conditions and social determinants of health (see Appendix B). At its September 20, 2007 meeting, the Council held a work session for members to complete their individual scoring sheets. Following the meeting, Council staff compiled the scores.

Tables 1 and 2 provide the total score, average score, standard deviation, and range of scores for the health conditions and social determinants of health, respectively. The standard deviation measures the amount of dispersion in the scores, with a lower standard deviation indicating less dispersion (i.e., the scores are clustered closely around the average score) and a higher standard deviation indicating higher dispersion.

Consistent with previous guidance provided by the Council, staff averaged the scores for breast, cervical, prostate, and colorectal cancers into a composite score for these cancers. Similarly, scores for infant mortality and SIDS were averaged into a single score. The broken out scores for breast cancer, prostate cancer, colorectal cancer, cervical cancer, infant mortality, and SIDS are provided in Table 1 for reference and indicated by italicized gray text.

**Table 1: Prioritized List of Health Conditions**

<b>Health Condition</b>	<b>Total Score</b>	<b>Average Score</b>	<b>Standard Deviation</b>	<b>Score Range</b>
Overweight & Obesity	245	17.5	2.0	13-20
Diabetes	241	17.2	2.0	14-20
HIV/AIDS	228	16.3	2.1	13-20
Chronic Kidney Disease	226	16.1	2.4	13-20
<i>SIDS</i>	<i>214</i>	<i>15.3</i>	<i>2.7</i>	<i>12-20</i>
Mental Health	213	15.2	2.5	11-20
Asthma	210	15.0	2.1	12-20
Women's Health	208	14.9	2.6	11-20
Infant Mortality & SIDS	207	14.8	2.2	12-20
<i>Prostate Cancer</i>	<i>207</i>	<i>14.8</i>	<i>3.4</i>	<i>8-20</i>
<i>Breast Cancer</i>	<i>201</i>	<i>14.4</i>	<i>3.0</i>	<i>10-20</i>
Heart Disease & Stroke	200	14.3	2.8	10-20
<i>Infant Mortality</i>	<i>199</i>	<i>14.2</i>	<i>2.2</i>	<i>11-20</i>
Lupus	195	13.9	3.8	7-20
<i>Colorectal Cancer</i>	<i>183</i>	<i>13.1</i>	<i>3.5</i>	<i>9-20</i>
Cancer (breast, cervical, prostate, colorectal)	181	12.9	3.0	9-20
Oral Disease	161	11.5	3.2	7-20
<i>Cervical Cancer</i>	<i>132</i>	<i>9.4</i>	<i>3.7</i>	<i>6-20</i>

**Table 2: Prioritized List of Social Determinants of Health**

<b>Social Determinant of Health</b>	<b>Total Score</b>	<b>Average Score</b>	<b>Standard Deviation</b>	<b>Score Range</b>
Health Care Workforce Diversity	251	17.9	2.2	14-20
Substance Abuse	248	17.7	2.2	13-20
Health Insurance	247	17.6	2.3	12-20
Education	243	17.4	3.2	11-20
Health Literacy	231	16.5	2.4	13-20
Culturally & Linguistically Appropriate Health Care	231	16.5	2.7	12-20
Environmental Exposures	229	16.4	2.9	11-20
Smoking Rates	218	15.6	3.2	9-20
Income	216	15.4	2.2	13-20
Supportive Parenting & Childcare Systems	201	14.4	3.5	8-20
Preventive Services Utilization	179	12.8	3.1	8-20
Social Support	173	12.4	4.2	7-20
Access to Nutritious Food	162	11.6	3.5	6-20
Immunization Rates	161	11.5	3.4	6-20
Opportunities for Physical Activity	161	11.5	3.5	5-20

The Council met on October 22, 2007 to review the results of the scoring and discuss next steps. At that meeting, Council members noted that, when looking at the tables together, there was a natural break in the total scores between chronic kidney disease, which had a total score of 226, and smoking rates, which had the next highest total score of 218.

Council members then discussed and agreed that smoking rates and heart disease/stroke, which both had total scores below 226 were sufficiently important public health priorities with significant disparities by race/ethnicity and sex to be retained as priorities for future consideration. Council members also discussed that they had a separate mandate to develop recommendations for improving the availability of culturally and linguistically appropriate health literature and interpretive services. They agreed that since health care workforce diversity would move forward as a priority, and since the Council would be addressing health literature and interpretive services under a separate charge, there was no need to retain culturally and linguistically appropriate health care on the prioritized list.

The Council approved a motion to shorten its list of priorities to twelve health conditions and social determinants of health. Box 3 provides a list of the Council's current priorities for consideration in the state action plan. Items that did not make the short list may be considered for future iterations of the plan.

Of note, the health topics presented in Box 3 are categorized as social determinants of health or health conditions based on how they fit into the logic model framework presented in Figure 2. The Council recognizes that there is much overlap in these categories. For example, one can argue that overweight and obesity should be categorized as a social determinant of health, as it is a known contributor to health outcomes such as diabetes, heart disease, and stroke. Similarly, one can equally argue that substance abuse is not a determinant of health, but a health condition.

<b>Box 3: Current Priorities for Consideration in the State Action Plan</b>	
<b>October 22, 2007</b>	
<i>Social Determinants of Health</i>	<i>Health Conditions</i>
<ul style="list-style-type: none"> <li>• Health Workforce Diversity</li> <li>• Substance Abuse</li> <li>• Health Insurance Coverage</li> <li>• Education</li> <li>• Health Literacy</li> <li>• Environmental Exposures</li> <li>• Smoking Rates</li> </ul>	<ul style="list-style-type: none"> <li>• Overweight &amp; Obesity</li> <li>• Diabetes</li> <li>• HIV/AIDS</li> <li>• Chronic Kidney Disease</li> <li>• Heart Disease &amp; Stroke</li> </ul>
<p>Notes: The social determinants of health and health conditions are listed in rank order according to the total score received during the prioritization process. Health topics are categorized as social determinants of health or health conditions based on where they fit in the logic model framework depicted in Figure 2.</p>	

***Next Steps toward Developing a State Action Plan***

At its October 22, 2007 meeting, Council members agreed that they wanted more information before identifying the top five priorities for the first version of the action plan. Specifically, the Council wants to gather more information about initiatives that are ongoing in the state, either by government agencies or community organizations, to address the twelve priority health conditions and social determinants of health. The Council does not want to duplicate efforts already underway. Further, there may be excellent work going on in the state to address one or more of the twelve priorities, but gaps may exist where the Council can lend its support. Therefore, Council staff will conduct focused environmental scans to identify activities ongoing in the state that aim to address the twelve priority health conditions and social determinants of health. This information will be presented to the Council at upcoming meetings.

Once the Council identifies its top five priorities, it will organize and convene advisory committees for each priority. The advisory committees will be tasked with identifying policy options for addressing each priority. The Council, in collaboration with the advisory committees, will develop the goals, objectives, and strategies for the first version of the action plan which is expected to be completed in 2010, two years ahead of schedule.

## V. ADDITIONAL COUNCIL ACTIVITIES

### *Culturally and Linguistically Appropriate Health Literature and Interpretive Services*

In accordance with subsection 3 of RCW 43.20.275:

*“The council with assistance from the state board, shall assess through public hearings, review of existing data, and other means, and recommend initiatives for improving the availability of culturally appropriate health literature and interpretive services within public and private health-related agencies.”*

In January 2007, the State Board of Health, on behalf of the Council, released a request for proposals for projects aimed at assessing the availability of culturally and linguistically appropriate health education materials and interpretive services and providing guidance on recommendations to improve such materials and services and increase their effective use. As a result, the Cross Cultural Health Care Program (CCHCP) was awarded a contract to: (1) identify and describe notable sources and current organization of health education materials in Washington State and to make recommendations to improve their availability and dissemination and (2) to identify barriers and solutions to navigating the health care system by underserved communities. CCHCP completed these assessments and submitted its final reports in June 2007. The reports, “Culturally and Linguistically Appropriate Health Education Materials: Access, Networks, and Initiatives for the Future and “Barriers to Health and Effective Utilization of Existing Resources” are available on the Council’s Web site.

In brief, CCHCP conducted focus groups and key informant interviews with individuals whose work involves improving access to care for underserved communities. As examples, participants’ experience included the provision of interpreter services, training of service providers, community outreach, and the development of culturally and linguistically appropriate health promotion and patient education materials. During focus groups and interviews, CCHCP gathered information related to the following:

- Characteristics of an ideal information system
- Organizations and programs that are successful in connecting service providers and members of the public with appropriate health information
- Key factors for ensuring the quality of health education materials
- Gaps in currently available translated health materials
- Barriers to making access to health materials more widely available
- Existing infrastructures that could be strengthened to improve widespread availability of materials
- Standards and conventions for producing and organizing health information

- Key stakeholders involved in the production and organization of health information
- Potential funding sources for improving the organization and availability of health education materials

In addition, CCHCP held a series of focus groups with cultural navigators to obtain their perceptions on the barriers faced by their clients while trying to access the health care system. Cultural navigators help to facilitate their clients' access to and understanding of available health and social services in a manner that fosters deep respect for and understanding of their clients' cultures. A number of barriers and potential solutions were identified during the focus group discussions and are detailed in the final report. CCHCP presented its results to the Council at its September 20, 2007 meeting.

In addition to the assessment described above, the Council also held a Public Forum on Language, Culture, and Health Care on September 19, 2007. Twenty-five members of the public participated in the forum and provided input on how to improve the quality and availability of culturally and linguistically appropriate health education materials and interpretive services. Also present were ten Council members, Council staff, and three interpreters hired to provide Spanish, Vietnamese, and Korean language interpretive services. Proceedings from the forum are available on the Council's Web site.

Key recommendations from the public forum were to:

- Attract more interpreters into the profession with better working conditions, higher and more stable pay, and improved benefits.
- Work with community members and community-based organizations from the beginning to identify needed health education topics, develop appropriate health messages, and use relevant media and dissemination strategies.
- Improve the participation of people of color in the health care professions by addressing the cost of education.

Further, Council staff helped a graduate student from The Evergreen State College organize a community meeting as a part of the student's Capstone project. The community meeting was held at the La Aldea de Betania Church in Tacoma. There were 20 participants. All participants were Latino, originally from Mexico or El Salvador, and all were Spanish-speaking with limited English proficiency. The graduate student facilitated the meeting in Spanish. Overall, participants expressed concerns about feeling ignored or treated rudely by their medical providers, and by the receptionists that check them in for appointments and handle the billing. Participants recommended that clinic receptionists should be required to attend cultural competency training, in addition to general customer service skills training. Participants also discussed differences between in-house and contracted interpreters, with many participants indicating that they perceived in-house interpreters to be friendlier, more caring and more trusted.

The Council will continue to gather and review information on improving interpretive services and language access in health care in its effort to formulate recommendations. For example, CHOICE Regional Health Network prepared an excellent report in 2006, as a part of a grant from the Robert Wood Johnson Foundation, titled, "Quality Assurance Recommendations for Health Care Interpreting in Washington State," which outlines a number of recommendations for ensuring the quality of health care interpreting and interpretive service delivery methods. It is also considering additional forums. These information-gathering efforts will lead to formal recommendations from the Council.

### ***Health Impact Reviews***

RCW 43.20.285 states:

*"The state board shall, to the extent that funds are available expressly for this purpose, complete health impact reviews, in collaboration with the council, and with assistance that shall be provided by any state agency of which the board makes a request."*

Subsection (1) specifically requires the Council to propose forms and procedures for initiating health impact reviews for approval by the State Board of Health. At its December 5, 2006 meeting, the Council reviewed and discussed a draft health impact review request form and draft procedures for requesting and completing health impact reviews. It passed a motion to approve both documents with minimal changes and submit them to the State Board of Health. The Board approved the form and procedures at its December 13, 2006 meeting.

On January 5, 2007, Senator Rosa Franklin submitted requests to the State Board of Health for health impact reviews on two budget proposals from the Office of Superintendent of Public Instruction. One request was for a review of the Building Bridges for Dropout Reductions Program and the second was for a review of the Financial Incentives to Attract Excellent Teachers for Hard-to-Staff Schools and Subjects Program. Board of Health staff released both reviews on February 1, 2007. The budget proposal for Building Bridges became House Bill 1573 and Senate Bill 5497. Second Substitute House Bill 1573 was signed by the Governor. Pieces of the Financial Incentives proposal were passed in the state operating budget for 2007-2009 (HB 1128). Provisions similar to those in the Financial Incentives proposal were passed in Second Substitute House Bill 1906.

Solicitations for input and feedback on both health impact reviews were sent to all Council members. Several Council members provided comments, including significant input from the Council Chair, which was used to help guide and focus the research for both reviews.

Following the 2006 legislative session, staff from the Board of Health conducted interviews with three Representatives, two Senators, legislative staff, and representatives from a state agency and a non-profit organization. The purpose of the interviews was to evaluate the process, content, and impact of the first two health impact reviews in order to identify whether changes needed to be made prior to the 2007 legislative session.

Overall, both health impact reviews were very well-received; however, the reviews did not appear to be used during legislative committee deliberations. Interviewees suggested that the primary reason why more health impact reviews were not requested during the 2006 legislative session was because Legislators are unaware of or lack familiarity and comfort with the health impact review process. Other suggestions from interviewees included shortening the reviews and executive summaries to make them more quickly accessible and linking them to the fiscal note, either by providing a reference in the fiscal note or providing a link to the health impact review from the fiscal note section of the Legislature's Web site.

The two health impact reviews completed to date, as well as the request form and procedures document can be found on the State Board of Health's Web site at: [www.sboh.wa.gov/HIR](http://www.sboh.wa.gov/HIR).

### ***National Association of State Offices of Minority Health***

The Council, while not an office of minority health *per se*, meets the federal definition of a state and territorial office of minority health, as it is an entity formally established in statute to improve the health of racial and ethnic populations. As such, the Council applied for and was accepted into the National Association of State Offices of Minority Health (NASOMH).

NASOMH is an organization dedicated to protecting and promoting the health and well-being of racial and ethnic minority communities, tribal organizations and nations in all fifty states and territories. Its aims are to:

- Inform and advance the national discussion on minority health, cultural competence, and the elimination of racial and ethnic disparities in health and health care.
- Inform state and local governments of policies, rules and regulations to ensure capacity building, viability, and efficacy of State Offices of Minority Health.
- Implement, monitor and evaluate training, research, community outreach, information dissemination, practice and policy development to improve the health of racial and minority communities, tribal organizations and nations in all fifty states and U.S. territories.

As a member of NASOMH, the Council will be more connected and informed about activities in other states and at the national level to eliminate racial and ethnic health disparities so that it can more effectively complete its work.

### ***Office of Minority Health State Partnership Grant***

As an entity which meets the federal definition of a state or territorial office of minority health, the Council applied for and received a state partnership grant from the U.S. Department of Health and Human Services' Office of Minority Health. The Council was awarded \$125,000 per year for three years to hire an Outreach Coordinator to improve the Council's capacity to engage communities of color in its work.

The Council believes that eliminating disparities will require increased awareness of health disparities among affected populations, and it recognizes that one way to combat disparities is to

reach affected communities with targeted, effective, and culturally appropriate health messages. Washington's December 2006 windstorms—which resulted in widespread power outages and subsequently an epidemic of carbon monoxide poisonings and deaths, primarily among immigrant populations—highlighted the need to improve our ability to communicate with hard-to-reach populations in emergencies. It drove home for Washington, just as Hurricane Katrina had for the nation, the link between health disparities and emergency preparedness and response.

A variety of activities designed to increase capacity to communicate with hard-to-reach communities are underway in Washington State. Targeted populations include racial/ethnic communities, the disabled, and other vulnerable populations, which also may experience health disparities. Many of these efforts are not coordinated and integrated to a significant degree. The state partnership grant will allow the Council to hire an Outreach Coordinator to identify, learn from, and document existing efforts in order to create an effective outreach communication strategy to promote engagement in its own work. Moreover, the grant will enable the Council to see that these efforts are coordinated and integrated in a fashion that promotes linkages across organizations and intra-organizational silos; leverages expertise, resources and information; identifies and seeks to address gaps; and recommends ways that current efforts might be sustained. Grant objectives are aligned with the Council's statutory charge.

More specifically, the state partnership grant has the following objectives:

- The Council will convene and staff an interagency workgroup to coordinate statewide efforts aimed at improving the capacity to communicate effectively with communities of color.
- The Council will create a health communications directory with information regarding where racial/ethnic communities reside, community organizations and other trusted sources that can serve as information conduits, and specific cultural and linguistic needs of the communities.
- The Council will create a health communications improvement plan to document communications gaps, recommend strategies for filling those gaps, identify best practices, and suggest ways that existing resources for reaching communities of color might be maintained and the information they contain kept current.
- The Council will begin using and evaluating the newly identified communications channels to reach communities of color to increase awareness of health disparities and to seek input into the Council's work.
- The Council will develop and disseminate a final report to the U.S. Department of Health and Human Services' Office of Minority Health that highlights project successes and barriers, lessons learned, and practical recommendations for other states to use in their efforts to reach and communicate with communities of color.

Activities implemented under the state partnership grant will help further the Council's efforts to improve communication, collaboration, and coordination among agencies, organizations, and communities of color to address health disparities.

### ***Public Input into the Council's Work***

Engaging communities of color in its work is a responsibility that the Council takes very seriously. The Council has been and remains committed to seeking public input and feedback, particularly from communities of color, as it proceeds with 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 e-mail distribution list for interested members of the public, which it uses to announce meetings, send out draft and final meeting agendas, and solicit input, comment and feedback on specific topics. The Council, individual Council members and staff have organized, sponsored and/or participated in a number of public forums and meetings in order to obtain information about community health needs, concerns and solutions to guide its work. Some examples follow:

- Presentation and open discussion at the Joint Conference on Health on October 16, 2006 in Yakima.
- Community forum in conjunction with the first meeting of the Council and the *Fifth National Conference on Quality Health Care for Culturally Diverse Populations* held on October 20, 2006 in Seattle.
- Community conversation breakout session during the African American Legislative Day events on February 12, 2007 in Olympia.
- Meeting of the Cross Cultural Collaborative of Pierce County Steering Committee on April 9, 2007 in Tacoma.
- Community meeting at the La Aldea de Betania Church in May 2007 in Tacoma.
- Meeting of the Commission on Asian Pacific American Affairs and a community forum on health disparities on August 18, 2007 in Spokane.
- Public Forum on Language, Culture and Health Care held on September 19, 2007 in Tumwater.
- African American Health and Legislation Forum held in conjunction with a meeting of the Washington State Association of Black Professionals in Health Care on October 23, 2007 in Seattle.
- Community forum on emergency preparedness and minority populations held on October 25, 2007 in Seattle.

- Lecture on medical self-advocacy and health disparities held on November 5, 2007 at Gilda's Club in Seattle.

Council members and staff have also disseminated public input surveys at a variety of meetings and events, including many of those listed above. As of November 19, 2007, the Council had received 201 completed or partially completed public input surveys. A summary of the public input received from these surveys is available on the Council's Web site. The Council recognizes that the findings from the surveys are not necessarily representative of the views of the general population of Washington State or of communities of color. Nonetheless, the Council uses and will continue to use input from public surveys along with other sources of public input in its deliberations to help guide its work.

In brief, the top five priorities that survey respondents believe the Council should focus on in its plan to eliminate health disparities are diabetes, preventive care, obesity, health insurance coverage and education. All but one of which are included in the prioritized list of 12 health topics currently under consideration for inclusion in the Council's first action plan. Thirty-one percent of respondents indicated that they have had trouble understanding or talking to a health care provider. Many of these individuals provided suggestions for what could have been done to improve communication. The majority of suggestions fell into the following five themes:

- Patients require 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, etc.
- Health care providers need to use less technical language when discussing health matters with their patients.
- Patients need to feel like their health care providers truly listen to them and care for them.
- Providers should always treat their patients with respect, regardless of their cultural background.
- Health care consumers need more information to help them better advocate for themselves in the health care setting.

More than half of all respondents indicated that they were very likely to extremely likely to use Web sites, e-mail lists, and electronic newsletters to obtain information on health for communities of color and health disparities. Other suggestions for reaching communities of color with health information included organizing forums, workshops, community meetings, and classes; mailing printed materials (e.g., brochures, flyers) or distributing them in doctor's offices, community centers, and other locations; and publishing information in newsletters, magazines, and journals.

The Council will continue to hold forums, participate in community meetings and events, take oral and written public testimony, and distribute public input surveys in order to obtain public input into its work.

***Fostering Communication, Coordination and Collaboration***

The Council has the responsibility under Subsection 2 of RCW 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.”*

In addition to engaging communities of color in its work, the Council is also dedicated to fostering a coordinated and collaborative approach to addressing health disparities throughout Washington State. The Council, itself, serves as a vehicle for facilitating such collaboration, as its members represent 14 key agencies, boards, and commissions, as well as the Governor's office and health care consumers. Each meeting of the Council includes time for Council member comments and updates. This provides a chance for members to share information about relevant activities, initiatives and events so that opportunities for collaboration and resource sharing can be discussed. As examples, the representative from the Department of Social and Health Services provides regular updates on her agency's efforts to implement patient navigator pilot projects and the representative from the Health Care Authority keeps the Council informed on the development of a plan to address health literacy. Between meetings, announcements about upcoming meetings and events of interest to the Council are shared via email.

The public meetings of the Council also facilitate communication and collaboration with the private sector, particularly community-based organizations. Representatives from community groups and organizations attend Council meetings on a regular basis. Meetings provide an opportunity for formal information sharing, through organized presentations and briefings to the Council and through public testimony, as well as informal networking among guests and Council members.

Just a few examples of ways in which the Council has helped to foster communication, coordination and collaboration to address health disparities follow:

- On May 18, 2007, the Council co-sponsored a summit titled, *Each Student Successful: Exploring Policies to Address Health Disparities and the Academic Achievement Gap*, along with eleven other state agencies, commissions, community organizations and private partners. Six Council members served on the Summit's Advisory Committee and the summit was facilitated by the Council's chair. The summit brought together educators, public health professionals, parents, students, policy makers, academic experts, and advocates to discuss a whole-child policy approach to addressing the health and academic needs of students impacted by health disparities and the academic achievement gap.
- The Washington State Department of Health, in collaboration with the Workforce Training and Education Coordinating Board, is currently surveying health care professionals in

an effort to collect race/ethnicity and other demographic data. Such demographic data is of critical importance in the development, implementation and evaluation of programs to increase the diversity of the health care workforce. Council members representing the Department of Health and the Workforce Training and Education Coordinating Board, along with other program staff, provide regular updates to the Council on the survey and the Council serves as a forum for other interested members and/or their organizations to provide input into this valuable work.

- The Washington State Department of Social and Health Services is leading efforts to develop performance indicators to link quality improvement measures with provider reimbursement rate increases. The Department of Social and Health Services' representative on the Council serves as the Council's representative on a stakeholder workgroup which is developing performance measures. Quality improvement efforts can reduce health disparities and Council representation in the workgroup will reduce the risk that pay-for-performance programs recommended will have unintended consequences that increase disparities.
- The Health Care Personnel Shortage Task Force publishes an annual report to monitor progress on outcomes, strategies, and goals listed in its strategic plan to address shortages in health care personnel in Washington State. The Workforce Training and Education Coordinating Board's representative on the Council staffs the task force and another Council member is a task force member. Through these relationships, the Council will provide input into and review of the task force's progress reports, particularly sections related to increasing the racial/ethnic and cultural diversity of the health care workforce. Similarly, the Council will be able to use recommendations from the task force to guide its work.
- On October 23, 2007, the Council co-hosted the *African American Health and Legislation Forum* along with the Commission on African American Affairs, the Washington State Association of Black Professionals in Health Care and a number of other community partners. Council members and staff served as organizers, facilitators, presenters, and participants in the community conversation about African American health, health disparities, and health priorities. This forum provided a chance for members of the African American community, including medical and public health professionals and the general public, to learn about the Council and its work to develop a state action plan to eliminate racial/ethnic health disparities. Further, the forum provided a wonderful opportunity for the Council to obtain input from the African American community. All attendees received public input surveys and networking opportunities allowed members of the public to share their health concerns and solutions with Council members in attendance.
- The Bremerton chapter of the NAACP was honored with a Selecky Award for its work to organize a community training on second hand smoke prevention titled, "Not in MaMa's Kitchen". Council members worked closely with NAACP youth, adult activists, the Kitsap County Health District and the Tobacco Prevention and Control Program to ensure the training's success. This collaborative work has enabled NAACP chapter members to provide input into the Council's work.

- The Washington State Department of Health is establishing an ongoing multicultural health awareness and education program for health care professionals. The Department anticipates having a training tool available on its Web site for all health professionals by July 2008. The Council recognizes the importance of this work, as improving the cultural competence of the health care system is one strategy for reducing health care disparities. Therefore, the Council is following the Department of Health's progress and will continue to serve as a forum for individual Council members and other interested members of the public and organizations to provide input into this important work.

Future activities implemented under the state partnership grant will also help to directly fulfill the Council's responsibility to improve communication, collaboration, and coordination among agencies, organizations, and communities of color to address health disparities. Specifically, the Council's Outreach Coordinator hired to work on the grant project will convene an interagency workgroup to coordinate statewide efforts aimed at improving the capacity to communicate effectively with communities of color and other hard-to-reach populations. Moreover, the Council will use its improved communication capacity to more effectively engage communities of color in its work and assist with efforts to disseminate health education messages.

## **VI. APPENDICES**

Appendix A: Briefing Documents

Appendix B: Scoring Criteria

# Appendix A: Briefing Documents

**Access to Nutritious Food Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Nutrition** refers to the process of absorbing nutrients from the food we eat and processing them in the body in order to maintain health and grow. Two measures of **access to nutritious food** include intake of fruits and vegetables and food insecurity rates.

**CRITERION #1: MAGNITUDE**

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- In 2005, 26% of Washington adults reported eating fruits and vegetables five or more times a day; this rate has remained relatively constant from 1994-2005.
- In 2003, 5% of Washington adults reported that they went hungry or did not eat because of not having enough money for food, 15% reported that they ran out of food before the end of the month, and 9% cut meal sizes or skipped meals in the past 12 months because there was not enough money for food.

**CRITERION #2: ASSOCIATION TO HEALTH OUTCOMES**

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- Poor diet, along with low levels of physical activity, was the second leading cause of death in the United States, accounting for 400,000 deaths in the year 2000 (16.6%).
- Evidence suggests that consumption of fruits and vegetables within recommended levels might protect against obesity, prevent certain types of cancer, reduce the risk of coronary heart disease, stroke, and hypertension, promote respiratory health, prevent diverticulosis, and prevent the formation of cataracts.
- Food insecurity can lead to malnutrition, elevated risk for chronic diseases, poor management of diabetes and other chronic diseases, psychosocial dysfunction, anxiety, depression, lower overall health status, and decreased quality of life. Food insecurity is associated with being overweight among women and in reduced consumption of fruits and vegetables.

**CRITERION #3: DISPARITY**

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- In Washington, data from 2003 and 2005 found that Asians and Pacific Islanders were most likely to eat fruit and vegetables five or more times per day (30.3%), followed by American Indian/Alaska Natives (24.2%) whites (24.1%), blacks (21.0%), and Hispanics (20.6%) for an Index of Disparity of not meeting fruit and vegetable guidelines of 11%.\*
- Washington data from 2003 and 2005 combined found that women were more likely to report eating fruits and vegetables at least five times a day, 29% relative to 19%, respectively.

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004.*

*\*Consistent with Keppel et al., (2004), fruit and vegetable consumption rates were transformed to rates for not meeting the fruit and vegetable consumption guidelines for purposes of calculating the Index of Disparity.*

Sources: (1) Preliminary data from: Washington State Department of Health (2007). Health of Washington State. 2007. Olympia, WA. *In press.* (2) The Report of the Dietary Guidelines Advisory Committee on Dietary Guidelines for Americans, 2005. Accessed at <http://www.health.gov/dietaryguidelines/dga2005/default.htm> on August 9, 2007.

**Asthma Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Asthma** is a chronic inflammatory disorder of the airways that makes it hard to breathe. Breathing becomes difficult because the airways tighten, thicken, become inflamed, and fill with mucus. Symptoms of asthma can include wheezing, shortness of breath, chest tightness, and cough.

**CRITERION #1: PREVALENCE / INCIDENCE**

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- The prevalence of current asthma among Washington adults has increased from 7.0% in 1999 to 9.5% in 2005, an increase of 36%. There were an estimated 416,100 adults with asthma in 2005.
- In 2004, 8.7% of Washington youth (6<sup>th</sup> - 12<sup>th</sup> graders) reported having current asthma.
- The proportion of Washington adults reporting that at least one child in their household currently had asthma increased from 10.0% in 1999 to 11.5% in 2003.
- The prevalence of asthma is greater in Washington than it is nationally, and has been reported as one of the highest in the nation.

**CRITERION #2: SEVERITY**

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- Deaths from asthma are rare, affecting about 86 Washington residents per year. The asthma death rate declined from 1.9 to 1.4 deaths per 100,000 from 1990 to 2001 and has remained stable since then.
- Between 2000 and 2004, there were about 5,200 hospitalizations for asthma each year.
- In 2002, the estimated costs for medical care due to asthma were almost \$240 million.
- Adults and youth with asthma report having symptoms frequently, often have trouble sleeping, and miss work and school.

**CRITERION #3: DISPARITY**

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- For 2003-2005, asthma prevalence among Washington adults by race and ethnicity was as follows: Native Americans (14%), blacks (11%), non-Hispanic whites (9%), Asians and Pacific Islanders (7%), and Hispanics (7%); for an Index of Disparity of 47%.
- For 2002 and 2004 combined, asthma prevalence among youth was as follows: blacks (10.6%), Native Americans (9.8%), non-Hispanic whites (9.2%), Pacific Islanders (8.0%), Asians (5.9%) and Hispanics (5.8%); with an Index of Disparity of 50.0%.
- Asthma death rates for 1992-2001 combined were significantly higher among blacks (3.6 per 100,000), Native Americans (3.1 per 100,000) and Asians/Pacific Islanders (2.6 per 100,000) than for whites (1.8 per 100,000). Hispanics had a death rate of 1.3%. The Index of Disparity for asthma mortality rates was 113.5%.
- Wide variations exist for Hispanic subgroups, with higher prevalence found among Puerto Ricans. Washington's Hispanic population originates largely from Mexico.
- Among young children, asthma prevalence is higher for boys than girls. By high school and through adulthood these differences reverse and women have higher prevalence than men. From 2003-2005, the prevalence among women (11%) was nearly twice that of men (7%).

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004*

Sources: (1) Dilley JA, Pizacani BP, Macdonald SM, Bardin J. The Burden of Asthma in Washington State. Washington State Department of Health. Olympia, WA. June 2005. DOH Pub No. 345-201. (2) Preliminary data from: Washington State Department of Health (2007). Health of Washington State. 2007. Olympia, WA. *In press.*

**Cervical Cancer Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Cervical cancer** is characterized by an uncontrolled growth of cancer cells in the cervix of the uterus, which have the potential to spread to other areas of the body.

**CRITERION #1: PREVALENCE / INCIDENCE**

- From 1992-2004, there was a decline in the incidence rate of invasive cervical cancer.
- In 2004, 215 women were diagnosed with invasive cervical cancer, for an age-adjusted incidence rate of 6.8 per 100,000.

**CRITERION #2: SEVERITY**

- Deaths from cervical cancer are rare.
- In 2005, there were 63 deaths from invasive cervical cancer in Washington for an age-death of 2 per 100,000 women.
- Washington's age-adjusted mortality rate from cervical cancer has declined from 1980 to 2005.

**CRITERION #3: DISPARITY**

- In the years 1999-2001 combined, the age-adjusted incidence rate for cervical cancer in Washington was significantly higher for Hispanics (14.7 per 100,000) than for Non-Hispanics (7.0 per 100,000). The rate among Asian/Pacific Islander women (10.5 per 100,000) was significantly higher than the rate for white women (7.0 per 100,000). The rates for American Indian/Alaska Natives and blacks were 7.3 and 8.3 per 100,000, respectively.
- The index of disparity for incidence by race and ethnicity was 45.8% for the years 1999-2001 combined.
- From 2002-2004, the incidence rate remained higher for Hispanic women (11.6 per 100,000) than for non-Hispanic white women (6.5 per 100,000). The rate for Asian/Pacific Islander women was 9.0 per 100,000 and two few cases of invasive cervical cancer (less than 20) were diagnosed in the African American and American Indian and Alaska Native groups during that period.
- In the U.S., the incidence rate for cervical cancer among Vietnamese women is four times higher compared to all other Asian/Pacific Islander groups combined.
- It is difficult to compare mortality rates for cervical cancer between racial and ethnic groups because the numbers of deaths are very small. However, Washington data from 2000-2002 combined indicate that Asian and Pacific Islander women have higher death rates than white women.
- In 2004, Hispanic women were less likely to report having a Pap test in the last three years than non-Hispanic whites (73% and 81% respectively), though the difference was not observed after adjusting for age, income, and education.

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004*

Sources: (1) Department of Health, Washington State Cancer Registry. Available at <http://www3.doh.wa.gov/WSCR/>. (2) Washington State Department of Health (2004). Invasive Cervical Cancer In: The Health of Washington State, 2004 Supplement. (3) Preliminary data from: Washington State Department of Health (2007). Health of Washington State. 2007. Olympia, WA. *In press*

**Colorectal Cancer Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Colorectal cancer**, or cancer of the colon or rectum, is characterized by an uncontrolled growth of neoplastic (abnormal) cells in the lower segment of the digestive tract, with potential to invade and spread to other sites.

**CRITERION #1: PREVALENCE / INCIDENCE**

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- The age-adjusted incidence rate for colorectal cancer in Washington decreased from 57 cases per 100,000 in 1992 to 47 cases per 100,000 in 2004.
- In 2004, there were 2,775 new cases of colorectal cancer, making colorectal cancer the fourth leading cause of cancer in Washington State.
- According to data from 2006, 32% of Washington residents ages 50 and older received a fecal occult blood test in the previous two years and 64% reported ever having a sigmoidoscopy or colonoscopy.

**CRITERION #2: SEVERITY**

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- In 2005, 946 Washington residents died of colorectal cancer, for an age-adjusted death rate of 15 per 100,000.
- Since 1992, mortality rates for colorectal cancer in Washington have decreased steadily, averaging a decline of 2.6% per year.
- Colorectal cancer is the second leading cause of cancer death in Washington.

**CRITERION #3: DISPARITY**

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- In the years 2003-2005 combined, the age-adjusted incidence rates (per 100,000 residents) for colorectal cancer in Washington was significantly higher for American Indian and Alaska Natives (59) and blacks (57) than for whites (47), Asians and Pacific Islanders (41), and Hispanics (31), for an Index of Disparity of 64%.
- From 2003-2005, the age-adjusted mortality rate (per 100,000 population) for colorectal cancer in Washington was 29 for American Indian/Alaska Natives, 25 for blacks, 17 for Hispanics, 16 for whites and 15 for Asian/Pacific Islanders, for an index of disparity of 45%.
- In Washington, blacks are 70% less likely to report having received screening for colorectal cancer than whites. Hispanics and individuals in other racial groups had screening rates that were comparable to whites.
- From 2002-2004, age-adjusted incidence rates for colorectal cancer were higher for Washington men (55 cases per 100,000) than for women (43 cases were 100,000).
- In 2004, the death rate was higher for Washington men (19.0 deaths per 100,000) than for women (14.4 deaths per 100,000).

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004*

Sources: (1) Preliminary data from: Washington State Department of Health (2007). Health of Washington State. 2007. Olympia, WA. *In press*. (2) Washington State Department of Health. 2004. Washington State Cancer Registry Report. Accessed at: <http://www3.doh.wa.gov/WSCR/html/WSCR2004rpt.shtm> on 8/3/2007.

**Chronic Kidney Disease Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Chronic kidney disease** is a broad term that includes all conditions that damage the kidneys, decreasing their ability to remove waste and fluid from the body, regulate the levels of water and chemicals in the blood, remove drugs and other toxins from the body, and release needed hormones into the bloodstream. The two main causes of chronic kidney disease are diabetes and high blood pressure. Chronic kidney disease can eventually lead to end-stage renal disease, or kidney failure, which requires dialysis or kidney transplantation.

**CRITERION #1: PREVALENCE / INCIDENCE**

- According to national data, the prevalence of chronic kidney disease among adults from 1999-2004 was 16.8%. Since prevalence data are not available in Washington State, using the national prevalence of 16.8% would translate to an estimated 735,000 Washington adults with chronic kidney disease.
- Nationally incidence rates for end-stage renal disease have increased from 8.6 to 34.2 per 100,000 population from 1980 to 2004. Since 1999; however, incidence rates have been relatively stable.
- In Washington, incidence rates for end-stage renal disease have followed a similar trend, yet have remained lower than national rates. The incidence rate increased from 8.4 to 28.1 per 100,000 from 1980-2004.
- In Washington, the prevalence of chronic kidney failure increased 84%, from 55.7 per 100,000 individuals in 1990 to 102.7 per 100,000 in 2001.

**CRITERION #2: SEVERITY**

- In Washington, the age-adjusted death rate for kidney failure was 7 per 100,000 in 2005.
- Nationally, in 2004, there were 60,393 individuals on the donor kidney transplant waiting list, and of those, 10,228 kidney transplants were performed.
- In 2003, 324,826 U.S. residents with end-stage renal disease received dialysis.
- In 2003, there were 82,588 deaths among U.S. patients with end-stage renal disease.
- In the U.S., costs associated with end-stage renal disease exceeded \$27 billion in 2003.

**CRITERION #3: DISPARITY**

- According to national data from 1999-2004, the prevalence for chronic kidney disease was significantly higher for non-Hispanic blacks (19.9%) and Mexican-Americans (18.7%) than for non-Hispanic whites (16.1%). The prevalence was similar for men and women.
- According to national data from 2004, the rates (per 100,000) for end-stage renal disease were 26.3 for whites, 34.1 for Asians and Pacific Islanders, 48.5 for Hispanics, 52.4 for American Indians and Alaska Natives, and 96.8 for blacks, for an Index of Disparity of 120%.
- In 2005, Washington age-adjusted death rates for kidney failure were 7.7 deaths per 100,000 for males and 6.7 deaths per 100,000 for females.

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004*

Sources: (1) CDC. Prevalence of Chronic Kidney Disease and Associated Risk Factors – United State, 1999-2004. MMWR; 2007;56(8):161-165. (2) CDC. State-Specific Trends in Chronic Kidney Failure – United States, 1990-2001. MMWR; 2004; 53(39):918-920. (3) U.S. Renal Data System, USRDS 2006 Annual Data Report: Atlas of End-Stage Renal Disease in the United States, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2006. (4) Washington State Department of Health, Center for Health Statistics. Death Data Tables, 2005. Accessed from [http://www.doh.wa.gov/ehsphl/chs/chs-data/death/dea\\_VD.htm](http://www.doh.wa.gov/ehsphl/chs/chs-data/death/dea_VD.htm) on 4/26/2007. (5) National Institutes of Health. Kidney and Urologic Diseases Statistics for the United States. NIH Publication No. 06-3895. April 2006.

**Culturally and Linguistically Appropriate Healthcare Briefing Document  
Presented to the Governor's Interagency Council on Health Disparities  
September 20, 2007**

**Culturally and linguistically appropriate healthcare** refers to health care services that are respectful of and responsive to the health beliefs and practices and cultural and linguistic needs of diverse patient populations. This briefing document highlights selected findings from a survey of 60 hospitals across the nation. Thirty of the surveyed hospitals were hand-selected for already employing promising practices in the area of cultural and linguistic services, while the other thirty hospitals were selected by a stratified random sample. Therefore, results presented in this briefing document likely overestimate the extent to which hospitals have addressed language and cultural issues.

**CRITERION #1: MAGNITUDE**

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- 43% of hospitals do not have designated executives with direct responsibility for cultural and linguistic competency.
- 70% of hospitals do not stratify quality improvement measures by patient demographics.
- 45% of hospitals do not have plans to recruit and retain a diverse workforce.
- 68% of hospitals do not have new employee orientation programs for physicians that address the provision of culturally and linguistically appropriate care – 23% do not have such programs for other clinical staff, 24% do not have programs for senior management and 57% lack programs for residents and students. Ongoing training was even less frequent.
- 40% of hospitals do not have written policies and procedures that address the provision of culturally and linguistically appropriate patient care services.
- 43% of hospitals do not have competency assessments for interpreters and bilingual staff.

**CRITERION #2: ASSOCIATION TO HEALTH OUTCOMES**

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- Cultural and linguistic competence in healthcare is associated with improved access, utilization, and quality of care.
- Culturally competent cancer prevention and screening patient education programs have been shown to improve positive health behaviors and cancer screening rates.
- A tobacco cessation counseling program that was adapted to be culturally competent was shown to increase quit attempts and resulted in higher quit rates.
- Culturally appropriate diabetes self-management programs have been shown to result in improved indicators of diabetes control and diabetes knowledge.
- Healthcare facilities with cultural competence policies were shown to result in improved asthma management and higher patient satisfaction with care received.

**CRITERION #3: DISPARITY**

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- Data from 1999 in King County revealed that 16% of African Americans, 7% of Asians and Pacific Islanders, 4% of whites, and 2% of Hispanic/Latinos felt that they had been discriminated against while obtaining medical care.
- Data from 1995-1996 in King County found that 29% of African Americans felt that they had ever experienced discrimination while seeking medical care because of their race/ethnicity/color, compared to 1% for white residents. Proportions for other races/ethnicities were 12% for Hispanics/Latinos, 15% for Filipinos, 15% for Koreans, 8% for Chinese, 5% for Japanese and 5% for Vietnamese residents.

Sources: (1) The Joint Commission (2007). Hospitals, Language, and Culture: A Snapshot of the Nation. Accessed at: <http://www.jointcommission.org/PatientSafety/HLC/> on 9/5/2007. (2) Public Health – Seattle & King County (2001). Racial and Ethnic Discrimination in Health Care Settings. Accessed at: <http://www.metrokc.gov/health/reports/ethnicity.htm> on 9/5/07. (3) The Commonwealth Fund (2006). The Evidence Base for Culturally and Linguistic Competency in Health Care. Accessed at: [http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=413821&](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=413821&) on 9/5/07.

**Diabetes Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Diabetes** is a disease in which glucose builds up in the blood and the body has trouble turning food into energy. Normally, our bodies break down food into glucose, and the hormone insulin helps glucose enter cells so our body can use it for energy. Diabetes prevents the body from making enough insulin or from using it properly. In Type 1 diabetes, the immune system destroys the cells in the pancreas that make insulin. In Type 2, the body's cells are not receptive enough to insulin or the pancreas doesn't make enough insulin, or both. Type 2 diabetes accounts for 90-95% of all cases and is caused, in part, by obesity and lack of physical activity.

**CRITERION #1: PREVALENCE / INCIDENCE**

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- Diabetes prevalence has increased from 4.1% in 1994 to 6.3% in 2005, an increase of 54%.
- In 2005, over 300,000 Washington residents had diabetes.

**CRITERION #2: SEVERITY**

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- Diabetes is the seventh leading cause of death in Washington. In 2005, 1,549 Washington residents died from diabetes and 3,317 more deaths listed diabetes as contributory.
- Washington adults with diabetes are 3.2 times more likely to have high blood pressure and 3.7 times more likely to have heart disease than adults without diabetes.
- One in five adults with diabetes has poor vision; some eventually go blind.
- Diabetes is the leading cause of end-stage kidney disease.
- In 2003, almost 1,000 Washington residents had a lower extremity amputation as a result of poor circulation and nervous-system damage caused by their diabetes.
- In 2004, there were 76,732 hospitalizations resulting from diabetes-related complications, totaling more than \$1.5 billion.

**CRITERION #3: DISPARITY**

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- From 2003-2005, diabetes prevalence was significantly higher for non-Hispanic blacks (13.7%), non-Hispanic American Indians and Alaska Natives (12.0%), Hispanics (8.8%), and Asian/Pacific Islanders (8.7%) than for non-Hispanic whites (6.1%).
- The Index of Disparity for diabetes prevalence was 77%.
- Diabetes mortality rates (per 100,000) for 2003-2005 combined were significantly higher for non-Hispanic blacks (176), non-Hispanic American Indians and Alaska Natives (142), Hispanics (118), and Asians and Pacific Islanders (85) than for non-Hispanic whites (75).
- The Index of Disparity for diabetes mortality was 74%.
- Diabetes mortality rates for non-Hispanic Asians and Pacific Islanders increased by about 10% per year between 1994 and 2002, higher than for any other group.
- Data from King County showed that the prevalence of diabetes among Pacific Islanders was 13.3%, higher than any other racial or ethnic group.
- For 2003-2005, diabetes prevalence was higher among men (6.9%) than women (6.1%).
- From 2002-2004, women were more likely to be hospitalized for diabetes than males at younger ages (5-44), while at ages 45 and older, hospitalization rates were higher for men.

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004*

Sources: (1) Washington State Department of Health (2006). Washington State Diabetes Disparities Report. *In Press*. (2) Washington State Department of Health (2004). Diabetes. In: The Health of Washington State 2004 Supplement. (3) Public Health Seattle & King County, Diabetes in King County. Public Health Data Watch, vol 9(1), April 2007. (4) Preliminary data from: Washington State Department of Health (2007). Health of Washington State. 2007. Olympia, WA. *In press*.

**Education Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Education**, along with income and occupation, are common measures of socioeconomic position. For the purposes of this briefing document, education is measured by college graduation rates and on-time high school graduation rates.

**CRITERION #1: PREVALENCE / INCIDENCE**

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- In 2006, 36.2% of Washington adults had completed at least four years of college, 31.4% had completed some college, 24.3% were high-school graduates, and 8.1% had less than a high-school education.
- Data from the 2004-2005 school year revealed that 74% of Washington students graduated on-time (i.e., within four years).

**CRITERION #2: SEVERITY**

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- Washington adults with lower levels of education are more likely to smoke, binge drink, be obese, and eat fewer fruits and vegetables, than adults with more education.
- Populations with less education have lower levels of health literacy, are less likely to have health insurance, and are less likely to use medical services, particularly preventive health services, than populations with more education.
- In Washington, lower levels of education are associated with higher rates of diabetes, drug-induced deaths, and deaths from breast cancer, heart disease, stroke and suicide.
- There is substantial evidence documenting higher mortality rates among people with lower levels of education compared to those with higher educational levels.

**CRITERION #3: DISPARITY**

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- In Washington, from 2003-2005, the proportion of residents with a college education was lowest for Hispanics (16%), followed by American Indian/Alaska Natives (18%), blacks (28%), whites (42%), and Asians and Pacific Islanders (59%).
- The Index of Disparity for not having a college education was 81%.
- On-time high-school graduation rates were lowest for American Indian and Alaska Native students (55%) and Hispanic students (60%), and highest for Asian and Pacific Islander students (80%) and white students (78%).
- In 2006, women in Washington were less likely to have completed at least four years of college (34.6%) than men (37.9%).

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004.*

*\*Consistent with Keppel et al., (2004), college education rates were transformed to rates for not having a college education for purposes of calculating the Index of Disparity.*

Sources: Preliminary data from: Washington State Department of Health (2007). Health of Washington State. 2007. Olympia, WA. *In press.* (2) Centers for Disease Control and Prevention. Washington 2006 Demographics: Prevalence Data. Accessed at: <http://apps.nccd.cdc.gov/brfss/page.asp?cat=DE&yr=2006&state=WA#DE> on 9/10/07.

**Environmental Health Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Environmental health** refers to the ways that the environment can affect our health, including chemicals and microorganisms in the food and water we consume and particles in the air we breathe. Environmental health measures can include the levels of hazards in the environment, the effectiveness of prevention programs in controlling environmental hazards, the levels of chemicals and other agents in our bodies, and the incidence or prevalence of diseases associated with environmental factors. The relationships between levels of pollutants in the environment, exposures to individuals, and subsequent illnesses are extremely complex. Because of this complexity, health outcome data for environmentally-related diseases are rarely available and information on disparities by race/ethnicity and sex are also scarce. This document contains data and information on outdoor air quality and pesticide-related illness, two areas where some information on disparities exists.

**CRITERION #1: MAGNITUDE**

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- In 2002, the majority of outdoor air pollution sources in Washington (an estimated 59%) came from highway vehicles, followed by non-road vehicles and equipment (20%), woodstoves and fireplaces (13%), large industry (4%), and open burning (2%).
- In Washington State, an estimated 4.2 million people live near major urban roadways and are, therefore, exposed to higher levels of diesel exhaust and other air pollutants caused by highway vehicles.
- In Washington State, from 2000-2005, there were 359 reported cases of occupational pesticide-related illnesses that occurred in the agricultural industry, for an average of 59 reported cases per year.

**CRITERION #2: ASSOCIATION TO HEALTH OUTCOMES**

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- Outdoor air pollution can worsen asthma, heart disease, stroke, and lung diseases and can decrease immunity.
- Diesel exhaust can cause cardiovascular disease, respiratory disease, changes in the immune system, and cancers of the lung and bladder.
- Pesticides exposures can sometimes lead to pesticide poisoning, which is characterized by symptoms of eye irritation, visual disturbances, headache, dizziness, nausea, vomiting, numbness, skin irritation, and rash.
- Depending on the route, magnitude, and/or duration of exposure as well as the toxicity of the pesticide, health problems can vary from flu-like symptoms to serious systemic effects, including death.

**CRITERION #3: DISPARITY**

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- Populations living in urban areas are more likely to be exposed to diesel exhaust and other outdoor air pollutants caused by highway vehicles compared to people living in rural areas. As higher proportions of some minority populations, including Asians and blacks, are more likely to live in urban areas, they may be disproportionately exposed to outdoor air pollution.
- Hispanics comprise a large majority of the farm worker population in Washington State, and are therefore, at a higher risk for occupational pesticide-related illness.
- Native Americans and those from Asian Pacific Islander communities are more likely to be exposed to toxicants such as mercury, PCBs and arsenic because of their traditional diets which include relatively frequent consumption of fish.

Sources: (1) Preliminary data and information from: Washington State Department of Health (2007). Health of Washington State. 2007. Olympia, WA. *In press*.

**Female Breast Cancer Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Female breast cancer** is characterized by an uncontrolled growth of neoplastic (abnormal) cells in a woman's breast that have the potential to spread to other parts of her body.

**CRITERION #1: PREVALENCE / INCIDENCE**

- The incidence rate for breast cancer in Washington increased somewhat steadily from 154.2 in 1992 to 186.7 in 1999. More recently, rates appear to be decreasing with rates of 170.1 in 2003 and 164.5 in 2004.
- In 2004, there were 5,401 new cases of female breast cancer in Washington, making breast cancer the most frequently diagnosed cancer among Washington women.
- In 2004, 73% of Washington women ages 40 and older reported having a mammogram within the past two years, exceeding the *Healthy People 2010* goal of 70%.

**CRITERION #2: SEVERITY**

- In 2005, 791 women died of breast cancer in Washington State, for an overall age-adjusted death rate of 23 per 100,000 women.
- Since 1989, mortality rates for breast cancer in Washington have decreased.
- Breast cancer is the leading cause of cancer death among Washington women.

**CRITERION #3: DISPARITY**

- In the years 2000-2004 combined, the age-adjusted incidence rate for breast cancer in Washington was significantly higher for whites (175 per 100,000) than for any other race except Native Americans/Alaska Natives (152.3 per 100,000). Blacks had the next highest rate (146.8 per 100,000), followed by Asian/Pacific Islanders (119 per 100,000) and Hispanics (111.9 per 100,000).
- The index of disparity for incidence by race and ethnicity was 32.5% in the years 2000-2004.
- From 2003-2005 combined, the age-adjusted mortality rate (per 100,000 population) for breast cancer in Washington was 39.0 for American Indian/Alaska Natives, 26.8 for blacks, 23.9 for whites, 17.1 for Hispanics, and 14.7 for Asian/Pacific Islander women, for an index of disparity of 81.6%.
- In Washington, the disparity in death rates between white women and African American women is increasing as the death rate decreases for whites but not for African Americans.
- Washington cancer data are not available for subgroups of the Asian and Pacific Islander category; however, national research has found foreign born Asian and Pacific Islander women are more likely to be diagnosed with later-stage disease than U.S born women.
- Washington data on mammography screening by race/ethnicity are not available; however, national data suggest that African American women may be less likely to be screened adequately or have appropriate follow-up.
- For 2002-2004, African American and American Indian and Alaska Native women were less likely to be diagnosed with localized (or *in situ*) disease than white or Asian Pacific Islander women.

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004*

Sources: (1) Department of Health, Washington State Cancer Registry. Available at <http://www3.doh.wa.gov/WSCR/>. (2) Washington State Department of Health (2004). Female Breast Cancer In: The Health of Washington State, 2004 Supplement. (3). Preliminary data from: Washington State Department of Health (2007). Health of Washington State. 2007. Olympia, WA. *In press*

**Healthcare Workforce Diversity Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Healthcare workforce diversity** refers to a healthcare workforce that reflects the diversity of the population it serves.

**CRITERION #1: MAGNITUDE**

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- In 2006, 76.8% of Washington residents were white, 8.9% were Hispanic, 6.8% were Asian/Pacific Islander, 3.4% were black, and 1.4% were American Indian/Alaska Native.
- While Hispanics make up 8.9% of Washington's population, preliminary estimates from a 2007 survey\* of registered nurses (RNs), licensed practical nurses (LPNs), and dental hygienists revealed that only 1.9% of RNs, 3.3% of LPNs, and 2.1% of dental hygienists were Hispanic.
- Similarly, Asians and Pacific Islanders comprise 6.8% of Washington's population, yet make up only 4.0% of RNs, 4.3% of LPNs, and 3.5% of dental hygienists.
- While 3.4% of Washington residents are black, only 0.8% of RNs and 0.2%\*\* of dental hygienists are black. Four percent of LPNs are black—this is the only example where the proportion of healthcare providers in a racial/ethnic group exceeded the proportion in the general population.
- American Indian and Alaska Native residents comprise 1.4% of Washington's population, yet make up only 0.4% of RNs, 1.0% of LPNs, and 0.1%\*\* of dental hygienists.
- In 2005, 78% of medical school graduates in Washington were white, 13% Asian, 2% black, 2% Hispanic, and 1% Native American.

**CRITERION #2: ASSOCIATION TO HEALTH OUTCOMES**

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- Racial and ethnic minority health care professionals are more likely to serve minority communities; therefore improving access to care for racial and ethnic minority patients.
- Health workforce diversity is associated with improved patient satisfaction, improved patient-provider communication, increased patient participation in care processes, greater adherence to treatment, and increased minority patient utilization of needed health services.
- Improving the diversity of the health professions is consistently recommended as a strategy for eliminating health and healthcare disparities among racial/ethnic minorities.

**CRITERION #3: DISPARITY**

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- In order for the RN workforce to reflect the diversity of Washington State's population, the proportions of Hispanic, Asian and Pacific Islander, black, and American Indian and Alaska Native RNs would need to increase by 368%, 70%, 325%, and 250%, respectively.
- In order for the LPN workforce to reflect the diversity of Washington State's population, the proportions of Hispanic, Asian and Pacific Islander, and American Indian and Alaska Native LPNs would need to increase by 170%, 58%, and 40%, respectively.
- In order for the dental hygienist workforce to reflect the diversity of Washington's population, the proportions of Hispanic, Asian and Pacific Islander, black, and American Indian and Alaska Native RNs would need to increase by 324%, 94%, 1,600%\*\* , and 1,300%\*\* , respectively.
- Women made up 92.4% of RNs, 89.2% of LPNs, and 97.6% of dental hygienists in Washington.
- In 2006, only 28% of Washington nonfederal physicians were women.

\*Response rates for the 2007 surveys of licensed RNs, LPNs, and dental hygienists were 29.3%, 20.5%, and 34.5%, respectively.

\*\*Estimates should be interpreted with caution due to small numbers.

Sources: (1) Washington State Department of Health (2007). 2007 Health Professions Workforce Survey. Pre-release of public use datasets, obtained August 27, 2007. (2) Washington State Board of Health (2001). State Board of Health Priority: Health Disparities. Olympia, Washington. (3) Institute of Medicine (2004). In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce. National Academy of Science. National Academies Press: Washington, DC. (4) Kaiser Family Foundation. Distribution of Medical School Graduates by Race/Ethnicity, 2005. (5). Kaiser Family Foundation. Distribution of Nonfederal Physicians by Gender, 2006. (5) Office of Financial Management. Summary Tables of Population Estimates by Age, Gender, and Race/Ethnicity: State of Washington and Its Counties – 2000 & 2006. Accessed at: <http://www.ofm.wa.gov/pop/race/summarytables.asp> on 9/5/07.

**Health Insurance Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Health insurance** is a mechanism that distributes the costs and risks associated with healthcare, thereby providing financial access to needed healthcare services. Health insurance is purchased by individuals, their employers, and through state and federal government programs such as Medicare and Medicaid.

**CRITERION #1: MAGNITUDE**

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- In 2006, an estimated 593,000 Washington residents were uninsured.
- The proportion of Washington residents without health insurance coverage in 2006 (9.3%) was not significantly different from 2004 (9.9%). From 2000 to 2004; however, there was a 27% increase in the proportion of uninsured residents.

**CRITERION #2: ASSOCIATION TO HEALTH OUTCOMES**

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- Uninsured adults are more likely to go without medical care than insured adults. In 2004, 48% of Washington adults without health insurance reported that they were unable to see a doctor when needed due to cost in the past 12 months compared to 9% of insured adults.
- In 2004, 16% of Washington adults without health insurance reported being in poor or fair health status, compared to 10% of those with health insurance coverage.
- Uninsured adults are less likely to receive preventive services. For example, in Washington State in 2004, 59% uninsured women ages 40-64 had not had a mammogram in the past two years, compared to 25% of insured women in the same age group. Similar disparities exist for cervical, prostate, and breast cancer screenings.
- Populations without health insurance are more likely to be diagnosed with later-stage cancer.
- Women who are uninsured receive prenatal care later in their pregnancies and their children have a greater risk for adverse physical outcomes.
- Uninsured children are more likely to receive care late in the development of health problems, and therefore, are more likely to be hospitalized for conditions that could have been treated with outpatient care.

**CRITERION #3: DISPARITY**

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- In 2006, 22% of American Indian/Alaska Native residents in Washington under the age of 65 were uninsured, significantly higher than the uninsured rate among white residents (11%). Rates of uninsured were 13% for blacks, 9% for Native Hawaiians and Pacific Islanders, and 5% for Asians. Hispanic residents were more likely to be uninsured (23%) relative to non-Hispanic residents (9%).
- The Index of Disparity for being uninsured by race was 175%.
- In 2006, Washington males were more likely to be uninsured than females, with 12% of men uninsured compared to 9% of women.

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004.*

Sources: (1) Washington State Office of Financial Management (2006). The Uninsured Population in Washington State – Research Brief No. 39 (Revised). Olympia, Washington. (2) Washington State Office of Financial Management (2007). Health Insurance by Race/Ethnicity – Research Brief No. 42. Olympia, Washington. (3) State Health Access Data Assistance Center for the Robert Wood Johnson Foundation (2006). The Coverage Gap: A State-by-State Report on Access to Care. (4) Washington State Department of Health (2002). Health Insurance Coverage In: The Health of Washington State. Olympia, Washington. (5) Governor Gregoire's Cover all Children by 2010 Workgroup (2005). Cover all Children – Why? Washington State Planning Grant on Access to Health Insurance.

**Health Literacy Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Health literacy** is the extent to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate health decisions. For this briefing document, health literacy measures are drawn from the 2003 National Assessment of Adult Literacy Survey, which uses four literacy levels: below basic, basic, intermediate and proficient.

**CRITERION #1: MAGNITUDE**

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- In 2003, 14% of U.S. adults had below basic health literacy, 22% had basic health literacy, 53% had intermediate health literacy, and 12% had proficient health literacy.

**CRITERION #2: ASSOCIATION TO HEALTH OUTCOMES**

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- Low literacy can affect communication between patients and their health care providers and can inadvertently lead to substandard medical care.
- Increases in health literacy are associated with improvements in self-reported overall health.
- Populations with low levels of health literacy are less likely to obtain screenings for sexually transmitted diseases, cancer screenings, and immunizations, relative to populations with adequate literacy levels.
- Studies have found a significant association between literacy level and knowledge of health issues, such as HIV, diabetes, asthma, and hypertension.
- Low literacy has been shown to be associated with increased smoking rates and decreased rates of breastfeeding.
- Low literacy has been associated with adverse outcomes in diabetes management.
- Some evidence suggests that low literacy may be associated with depression.

**CRITERION #3: DISPARITY**

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- The percentage of adults with below basic health literacy was as follows: 9% for whites, 9% for the multiracial group, 13% for Asians and Pacific Islanders, 24% for blacks, 25% for American Indian and Alaska Natives, and 41% for Hispanics, for an Index of Disparity of 149%.
- Women had higher average health literacy than men; 12% of women had below basic health literacy compared to 16% of men.

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004.*

Sources: (1) Kutner M, Greenberg E, Jin Y, and Paulsen C (2006). The Health Literacy of America's Adults: Results From the 2003 National Assessment of Adult Literacy (NCES 2006-483). U.S. Department of Education. Washington, DC: National Center for Education Statistics. (2) Berkman ND, DeWalt DA, Pignone MP et al. (2004). Literacy and Health Outcomes. Summary, Evidence Report/Technology Assessment No. 87. AHRQ Publication No. 04-E007-1. Rockville, MD: Agency for Healthcare Research and Quality. (3) Committee on Health Literacy (2004). Health Literacy: A Prescription to End Confusion. Report Brief. Washington, DC: National Academies Press.

**Heart Disease and Stroke Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Heart disease** is a broad term that includes coronary heart disease, myocardial infarction (or heart attack) and other serious conditions. Coronary heart disease, the most common type of heart disease, occurs when the arteries that supply blood to the heart become hardened and narrowed due to plaque buildup. Coronary heart disease can lead to a myocardial infarction. Angina, or chest pain, can also occur. **Stroke**, also known as cerebrovascular disease, is the interruption of blood supply to the brain. In an ischemic stroke, the most common type of stroke, an artery that supplies blood and oxygen to the brain becomes blocked, either by a blood clot or by a narrowing of the artery. In a hemorrhagic stroke, an artery in the brain ruptures.

**CRITERION #1: PREVALENCE / INCIDENCE**

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- In 2005, 6% of Washington adults (over 260,000) reported that they had heart disease, angina or had survived a heart attack and 2.4% (over 100,000) reported that they had survived a stroke.

**CRITERION #2: SEVERITY**

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- In 2005, coronary heart disease and stroke were the second and third leading causes of death in Washington State, causing 7,734 and 3,167 deaths, respectively.
- Since 1980, mortality rates for both heart disease and stroke have been declining steadily.
- Mortality rates for heart disease are lower in Washington than in the nation; however, stroke mortality rates are higher in Washington than in the nation. In 2003, Washington's death rate for stroke ranked 13<sup>th</sup> highest in the U.S.
- In 2005, there were 77,959 and 26,612 hospitalizations in Washington that included coronary heart disease and stroke among the listed diagnoses, respectively.
- Heart disease and stroke are leading causes of long-term disability.

**CRITERION #3: DISPARITY**

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- For the years 2003-2005, coronary heart disease mortality rates (per 100,000) were significantly higher for American Indian/Alaska Natives (186) and blacks (163) than for whites (132). Rates for Hispanics and Asians/Pacific Islanders were 103 and 95, respectively. The Index of Disparity for coronary heart disease mortality was 54%.
- From 2003-2005, stroke mortality rates (per 100,000) were 70.6 for blacks, 68.1 for American Indian/Alaska Natives, 55.9 for Asian/Pacific Islanders, 55.0 for whites, and 51.6 for Hispanics for an Index of Disparity of 21%.
- Heart disease prevalence, hospitalization rates, and mortality rates are all significantly higher for Washington males than for females.
- Prevalence of stroke and hospitalization rates for stroke were higher for Washington males than females. Men ages 65-74 had higher stroke mortality rates than women, but women ages 85 and older had higher mortality rates from stroke than men.

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004*

Sources: (1) Washington State Department of Health (2004). The Burden of Heart Disease and Stroke in Washington State. December 2004. (2) Washington State Department of Health (2004). Coronary Heart Disease. In: The Health of Washington State, 2004 Supplement. (3) Centers for Disease Control and Prevention (2007). Prevalence of Heart Disease – United State, 2005. MMWR. 56(6):113-118. (4) Preliminary data from: Washington State Department of Health (2007). Health of Washington State. 2007. Olympia, WA. *In press.*

**HIV/AIDS Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

A person is **HIV** positive if he or she is infected with the human immunodeficiency virus. HIV infection is usually fatal after the virus damages the body's immune system so that it can no longer fight infections and certain types of cancers. During the course of HIV infection, most people experience a gradual decline in their CD4+ T cell count, which impacts the immune system. The term **AIDS** applies to the most advanced stages of HIV infection. The CDC definition of AIDS includes those with fewer than 200 CD4+ T cells per cubic millimeter of blood or the presence of one or more of 26 opportunistic infections.

**CRITERION #1: PREVALENCE / INCIDENCE**

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- There are at least 10,500 people living with HIV/AIDS in Washington State.
- As people continue to live longer with HIV/AIDS, the number living with the disease has increased 5% per year.
- In 2005, there were 575 newly diagnosed cases of HIV in Washington (including cases diagnosed with both HIV and AIDS), for a crude incidence rate of 9.1 cases per 100,000.
- From 2001 to 2005, the rate of newly diagnosed HIV cases dropped 2.5% per year.

**CRITERION #2: SEVERITY**

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- In 2005, among Washington residents ages 35-44, HIV was the fifth leading cause of death for men (5% of deaths) and the ninth leading cause of death for women (2% of deaths).
- From 2001 -2005, there was an average of 114 deaths per year associated with HIV/AIDS.
- Average estimated lifetime costs for health care associated with HIV exceed \$500,000 per person.

**CRITERION #3: DISPARITY**

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- In Washington State, from 2003-2005 HIV rates were more than six times higher among blacks (46.5 per 100,000) than whites (7.1 per 100,000), while rates among American Indian/Alaska Native, Hispanic, and Asian/Pacific Islander residents were 13.6, 13.1, and 5.2 per 100,000, respectively.
- The Index of Disparity for HIV rates was 286%.
- Blacks make up only 3% of the state's population, yet account for 15% of all male HIV diagnoses and 40% of all HIV diagnoses among women.
- HIV infection rates are higher among foreign-born blacks than among blacks born in the U.S.
- From 2003-2005, HIV rates were significantly higher among men than in women for all age groups.
- From 2001-2005, 72% of all new HIV diagnoses in Washington State were among men who have sex with men.

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004*

Sources: (1) Preliminary data from: Washington State Department of Health (2007). Health of Washington State. 2007. Olympia, WA. *In press*

**Immunization Rates Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Immunization rates** for children and senior citizens is listed in RCW 43.20.280 as one of the indicators of health that the Governor's Interagency Council on Health Disparities must address in its plan to eliminate health disparities. This document provides data on the 4-3-1-3-3-1 immunization series, which is four or more doses of diphtheria, tetanus, and pertussis; three or more doses of poliovirus vaccine; one or more doses of measles, mumps, rubella; three or more doses of haemophilus influenza B; three or more doses of hepatitis B vaccine, and one dose of varicella vaccine. Indicators of adult immunization rates include influenza (flu) and pneumococcal vaccination rates.

**CRITERION #1: MAGNITUDE**

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- In 2005, the percentage of Washington children age 19-35 months who received the 4-3-1-3-3-1 vaccination series was 66%, up nearly 15% from the 2002 rate of 52%.
- Washington rates have remained consistently lower than U.S. rates.
- In 2005, 67.8% of Washington adults age 65 and over reported having a flu shot within the past year, while the percentage who have ever had pneumococcal vaccine was 66.9%.
- From 1995-1999, the rates of pneumococcal vaccination increased significantly among Washington adults 65 years and older, while flu vaccination rates remained relatively stable over the same period.

**CRITERION #2: ASSOCIATION TO HEALTH OUTCOMES**

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- Vaccine preventable diseases are often highly contagious, and can cause serious symptoms, complications, and even death. Since the introduction of immunizations, rates of vaccine-preventable disease have decreased by 95-100%. As one example, prior to the introduction of the measles vaccine in 1963, an average of 503,282 cases and 432 deaths from measles were reported each year in the U.S. In 1998 there were 89 reported cases.
- In 2005, influenza and pneumonia combined was the 8<sup>th</sup> leading cause of death in Washington State.

**CRITERION #3: DISPARITY**

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- From 2003-2005, the percentages of Washington children age 19-35 months who received the 4-3-1-3-3-1 vaccination series were 69.1% for Hispanics, 61.8% for whites, 60.6% for blacks, and 60.0% among the "other" race/ethnicity category.
- From 2003-2005, the Index of Disparity for not receiving the 4-3-1-3-3-1 series was 26.8%\*.
- In Washington from 2003-2005, blacks ages 65 and older had the lowest rate of influenza vaccine (55.8%) compared to Asians and Pacific Islanders (67.3%), Hispanics (67.4%), whites (70.0%) and American Indians and Alaska Natives (71.1%), for an Index of Disparity for not receiving the influenza vaccine was 21%.

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004.*

*\*Consistent with Keppel et al., (2004), immunization rates were transformed to non-immunization coverage for purposes of calculating the Index of Disparity.*

Sources: (1) Washington State Department of Health. Childhood Immunization Coverage for Washington State 2003-2005. December 2006. (2) Kaiser Family Foundation. State Health Facts. Accessed at: <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Washington&category=Health+Status&subcategory=Adult+Immunizations> on May 1, 2007. (3) CDC BRFSS Data Tables. Access at: <http://www.cdc.gov/nip/coverage/default.htm#BRFSS> on May 1, 2007. (4) CDC. Impact of Vaccines Universally Recommended for Children -- United States, 1990-1998. MMWR, 1999, 48(12):243-248. (5) Preliminary data from: Washington State Department of Health (2007). Health of Washington State. 2007. Olympia, WA. *In press.*

**Income Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Income**, along with education and occupation, are common measures of socioeconomic position. For the purposes of this briefing document, data on annual household income are provided.

**CRITERION #1: PREVALENCE / INCIDENCE**

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- In 2005, the median household income in Washington was \$49,262. This was higher than the U.S. median household income of \$46,242.
- In 2005, 10% of Washington State residents had household incomes below the federal poverty level of \$19,806, compared to 13% for the U.S. as a whole.

**CRITERION #2: SEVERITY**

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- Populations with lower incomes have lower overall health and life expectancies than populations with higher incomes.
- In Washington, populations with lower incomes are more likely to smoke, binge drink, be obese, and less likely to meet guidelines for physical activity and nutrition, than populations with higher incomes.
- Populations with lower incomes have lower levels of health literacy, are less likely to have health insurance, and are less likely to use medical services, particularly preventive health services, than populations with higher incomes.
- In Washington, lower incomes are associated with higher rates of asthma and diabetes.
- Lower maternal income is associated with higher infant mortality rates.
- There is substantial evidence documenting higher mortality rates among populations with lower incomes compared to those with higher incomes.

**CRITERION #3: DISPARITY**

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- In Washington, from 2003-2005, 33% of Hispanic adults lived in households with annual incomes less than \$20,000, followed by 24% among blacks, 22% among American Indian and Alaska Natives, 14% among Asians and Pacific Islanders, and 12% among whites.
- The Index of Disparity for living in a household with an annual income less than \$20,000 was 94%.

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004.*

Sources: Preliminary data from: Washington State Department of Health (2007). Health of Washington State. 2007. Olympia, WA. *In press*.

**Infant Mortality Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Infant mortality** is defined as deaths of children less than one year of age. From 2003-2005, the top three causes of infant mortality in Washington State were birth defects (27%), sudden infant death syndrome (11%), and preterm birth (10%).

**CRITERION #1: PREVALENCE / INCIDENCE**

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- In 2005, 420 infants died in their first year of life in Washington State; the infant mortality rate was 5.1 deaths per 1,000 live births.
- The infant mortality rate in Washington decreased significantly from 11.8 deaths per 1,000 live births in 1980 to 5.8 in 1995. Since then, the rate of decline has slowed.
- The infant mortality rate has been consistently lower in Washington than in the U.S.

**CRITERION #2: SEVERITY**

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- As a measure of mortality, by definition, infant mortality is severe.

**CRITERION #3: DISPARITY**

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- Infant mortality rates (per 1,000 live births) by race and ethnicity for 2003-2005 combined were about twice as high for American Indians/Alaska Natives (9.7) and blacks (8.9) as for whites (4.7). The rates for Hispanics and Asians and Pacific Islanders were 4.8 and 3.8, respectively. The Index of Disparity was 85%.
- While the infant mortality rate is lower in Washington State than in the nation, the rate for American Indians in Washington is higher than the rate for American Indians nationwide.
- In 2004, the rate for Pacific Islanders (8.9) was nearly double the rate for Asians (4.6).
- Among Hispanics, national data reveal that the infant mortality rate among Puerto Rican mothers (8.2) was higher than among women of Mexican origin (5.5), Central and South American origin (5.0) and Cuban origin (4.6)
- The infant mortality rate due to prematurity (one of the top three causes of infant mortality) is three times higher among African Americans than the rate for non-Hispanic whites. African American women have twice the prevalence of very low birthweight babies; which comprise less than 1% of all births but account for 44% of all infant deaths.
- African American and American Indian women experience greater risk factors for infant mortality, such as smoking, obesity, and high stress, and therefore, begin pregnancy less healthy than other groups.

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004*

Sources: (1) Washington State Department of Health (2006). Infant Mortality. In: MCH Data Report 2006. (2) Matthews et al., 2006. Infant Mortality Statistics from the 2003 Period Linked Birth/Infant Death Data Set. National Vital Statistics Reports, Volume 54, Number 16. National Center for Health Statistics. (3) Infant Death Data. Center for Health Statistics, Washington State Department of Health. Accessed from [http://www.doh.wa.gov/ehsphi/chs/chs-data/infdeath/inf\\_VD.htm](http://www.doh.wa.gov/ehsphi/chs/chs-data/infdeath/inf_VD.htm) on 4/2/2007. (4) Wasserman, 2006. Race/Ethnic Disparities in Infant Mortality. Presentation to Washington State Board of Health, December 13, 2006. (5) Preliminary data from: Washington State Department of Health (2007). Health of Washington State. 2007. Olympia, WA. *In press*

**Lupus Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Lupus**, or systemic lupus erythematosus (SLE), is a chronic inflammatory disease that can target the joints, skin, brain, kidneys, heart, lungs, and blood vessels. Lupus is an autoimmune disease, which means that the immune system attacks its own body's tissues and organs. Lupus is classified as a rheumatic disease, because it affects connective tissues and often manifests with painful joints and arthritis.

**CRITERION #1: PREVALENCE / INCIDENCE**

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- There is a lack of epidemiological information on lupus, and therefore, the exact number of people with lupus is unknown.
- The Lupus Foundation of America estimates that approximately 1.5 million Americans have a form of lupus. The Office of Minority Health at the Center for Disease Control and Prevention reports a much more conservative estimate of 239,000 people in the U.S. being affected by lupus.

**CRITERION #2: SEVERITY**

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- From 1979 to 1998, the annual number of deaths in the U.S. from lupus increased from 879 to 1,406.
- From 1979 to 1998 the crude death rate from lupus increased from 3.9 to 5.4 deaths per 100,000 U.S. population.
- The average cost to provide medical treatment for a lupus patient is estimated between \$6,000 and \$10,000 per year.
- One out of every three patients with lupus is temporarily disabled by the disease; while one in four is currently receiving disability payments.

**CRITERION #3: DISPARITY**

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- From 1979 to 1998, crude death rates were over three times higher among blacks than among whites in the U.S.
- From 1979 to 1998 the death rate from lupus among black women in the U.S. increased by about 70%.
- According to the National Institutes of Health, one in every 250 black women has lupus.
- Lupus is three times more common in black women than in white women. Lupus is also more common among Hispanic, Asian, and American Indian women.
- From 1979-1998 crude death rates were five times higher among U.S. women than men.
- In 1998, there were 1,214 deaths from lupus among U.S. women and 192 deaths among men.
- The Lupus Foundation of America reports that women comprise 90% of lupus diagnoses.
- According to research from the Lupus in Minorities: Nature Versus Nurture (LUMINA) study, African American and Hispanic lupus patients develop lupus earlier in life and experience more severe disease than white patients.

Sources: (1) Centers for Disease Control and Prevention. 2002. Trends in Deaths from Systemic Lupus Erythematosus – United States, 1979-1998. MMWR 51(17):371-374. (2) National Women's Health Information Center. Lupus – Frequently Asked Questions. Accessed at: <http://www.4women.gov/faq/lupus.htm> on 8/7/07. (3) Lupus Foundation of America. Lupus Statistics. Accessed at: [http://www.lupus.org/webmodules/webarticlesnet/templates/new\\_newsroom.aspx?articleid=247&zoneid=60](http://www.lupus.org/webmodules/webarticlesnet/templates/new_newsroom.aspx?articleid=247&zoneid=60) on 8/7/2007. (4) Centers for Disease Control and Prevention. Eliminate Disparities in Lupus: Fact Sheet. Accessed at: <http://www.cdc.gov/omh/AMH/factsheets/lupus.htm> on 8/7/2007. (5) Lupus Research Institute. Who Gets Lupus? Accessed at: [http://www.lupusresearchinstitute.org/print.php?id=who\\_gets\\_lupus](http://www.lupusresearchinstitute.org/print.php?id=who_gets_lupus) on 8/7/2007.

**Mental Health Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Mental health** means healthy mental function, which is characterized by the ability to perform productive activities, to have fulfilling relationships with other people, to adapt to change, and to cope with adversity. **Mental illness** refers to conditions generally characterized by alterations in thinking, mood, or behavior that are associated with distress or impaired function.

**CRITERION #1: PREVALENCE / INCIDENCE**

- From 2001-2005 combined, 69,264 Washington adults (9.6%) reported having 14 or more mentally unhealthy days (frequent mental distress).
- The Healthy Youth Survey 2004 shows that 29% of eighth graders, 32% of tenth graders, and 32% of twelfth graders reported having experienced symptoms of depression.

**CRITERION #2: SEVERITY**

- In 2005, 814 Washington residents committed suicide for an age-adjusted rate of 13 per 100,000. Suicide is the eighth leading cause of death for all residents and the second leading cause of death among youth 15-24 years old in Washington.
- From 1998-2000, mental illness was the leading cause of hospitalization among school-aged children and adolescents in Washington.
- In established market economies such as the U.S., mental illness is the second leading cause of disability and premature mortality.

**CRITERION #3: DISPARITY**

- From 2001-2005 combined, the prevalence of frequent mental distress was significantly lower among Asians/Pacific Islanders (6.7%) and significantly higher among Native Americans/Alaska Natives (14.5%) and those in the "other non-Hispanic" group (16.8%) than among whites (9.4%). The prevalence among blacks was 8.5% and among Hispanics was 9.2%. The Index of Disparity for frequent mental distress was 74.3%.
- In the years 2003-2005 combined, age-adjusted suicide rates (per 100,000) were highest for American Indian/Alaska Natives (14) and whites (14) followed by Asians and Pacific Islanders (8), blacks (8) and Hispanics (6), for an Index of Disparity of 83%.
- A report of the U.S. Surgeon General found that African Americans and Asians have about the same prevalence of mental health problems as whites, with variations in rates among subpopulations of these two groups. However, these two groups utilize mental health services at lower rates than whites. American Indians and Alaska Natives are likely to have a disproportionately high burden of mental health problems. The report found that different groups of Latinos have very different rates of mental health problems.
- Minority populations have a disproportionately high burden of unmet need for mental health services, partially due to a severe shortage of culturally appropriate mental health services.
- From 2001-2005 combined, Washington women reported having frequent mental distress at a significantly higher rate than Washington men, 11.7% relative to 7.6%, respectively.
- From 2003-2005, Washington males committed suicide at significantly higher rates than women at all ages; 79% of all completed suicides were committed by men. The highest rate of suicide occurred among men 75 years old and older.

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004*

Sources: (1) Washington State Department of Health (2004). Suicide In: The Health of Washington State, 2004 Supplement. (2) Healthy People 2010, Mental Health and Mental Disorders. (3) Washington State Department of Health (2006). Children's Mental Health in Washington State. (4) Centers for Disease Control (2004). MMWR Self-Reported Frequent Mental Distress among Adults—United States, 1993-2001. (5) Preliminary data from: Washington State Department of Health (2007). Health of Washington State. 2007. Olympia, WA. *In press*. (6) CDC, Health-related Quality of Life, Washington Trend data, accessed at <http://apps.nccd.cdc.gov/HRQOL> on 7/30/2007. (7) Department of Health and Human Services (2001). Mental Health: Culture, Race, and Ethnicity, A supplement to Mental Health: A Report of the Surgeon General. (8) Department of Health and Human Services. (1999). Mental Health: A Report of the Surgeon General.

**Oral Disease Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Oral disease**, defined broadly, includes dental and periodontal infections, mucosal disorders, oral and throat cancers, developmental disorders, injuries, and other chronic and disabling conditions. The most common oral diseases are dental caries (tooth decay) and periodontal diseases.

**CRITERION #1: PREVALENCE / INCIDENCE**

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- Dental caries is the most common disease among children.
- In 2005, 59% of Washington's 2<sup>nd</sup> - 3<sup>rd</sup> graders had dental caries; 20% had untreated decay.
- The prevalence of dental caries and untreated decay remained stable from 2000 and 2005.
- Data from 2004 revealed that 70% of Washington adults age 18 years and older visited a dentist in the past year; while 69.3% had their teeth cleaned in the past year.
- In 2004, 39.1% of adults age 65 and older had lost six or more of their natural teeth due to tooth decay or gum disease and 16.1% had lost all their teeth.
- In 2004, 733 Washington residents were diagnosed with oral and throat cancer; the incidence rate was 11.9 per 100,000.
- From 1992-2004, the incidence rate for oral and throat cancer decreased by 1.1% per year.

**CRITERION #2: SEVERITY**

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- In 2004, there were 171 deaths among Washington residents from oral and throat cancer for a mortality rate of 3.1 deaths per 100,000.
- The oral and throat cancer mortality rate has remained level from 1992-2004.

**CRITERION #3: DISPARITY**

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- Dental caries prevalence among 2<sup>nd</sup> - 3<sup>rd</sup> graders was significantly higher among Native Americans (77.3%), Hispanics (72.2%), and Asians (67.9%) than for whites (55.0%). The prevalence for African American children was 59.5%. The prevalence of untreated decay were significantly higher for all minority groups relative to white children, with the highest prevalence among Native American children at 37.0%, more than double the prevalence of 16.3% among white children.
- The Index of Disparity for dental caries prevalence among 2<sup>nd</sup> - 3<sup>rd</sup> graders was 25.9%.
- The incidence rates for oral and throat cancer were 14.6 per 100,000 for American Indian/Alaska Natives, 11.3 for whites, 10.3 for blacks, and 8.0 for Asians/Pacific Islanders.
- The Index of Disparity for oral and throat cancer rates was 50.9%.
- Non-Hispanics had a higher incidence rate for oral and throat cancer than Hispanics.
- Mortality rates for oral and throat cancer did not vary by race/ethnicity.
- The incidence rate and mortality rate for oral and throat cancer was higher for Washington males than for females.

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004*

Sources: (1) Washington State Department of Health (2006). Smile Survey 2005 – The Oral Health of Washington's Children. March 2006. (2) Washington State Department of Health (2007). 2004 Cancer in Washington – Annual Report of the Washington State Cancer Registry. August 2006. (3) US Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General. 2000. (4) National Oral Health Surveillance System. Accessed at: <http://www.cdc.gov/nohss/index.htm> on April 4, 2007.

**Overweight and Obesity Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Overweight and obesity** refer to ranges of weight that are generally considered unhealthy for a given height. For adults, the body mass index (BMI) is used to determine overweight and obesity ranges, because it correlates well with body fat percentage. BMI is calculated by dividing weight in kilograms by height in meters squared. **Overweight** is defined by having a BMI between 25.0 and 29.9 and **obesity** is defined by having a BMI greater than 30. For children and adolescents, overweight is generally defined as being above the 95<sup>th</sup> percentile for BMI, while children between the 85<sup>th</sup> and 95<sup>th</sup> percentile are classified as being at risk for overweight.

**CRITERION #1: PREVALENCE / INCIDENCE**

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- In 2005, 23% of Washington adults were obese and another 36% were overweight; this translates to more than 2.5 million Washington adults.
- The age-adjusted obesity rates increased sharply from 10% in 1994 to 23% in 2005, a relative increase of 130%.
- Results from the 2004 Healthy Youth Survey found that 10% of Washington tenth graders were overweight and 13% were at risk of being overweight.
- From 2003-2005, 22% of Washington women who gave birth were obese prior to pregnancy and 49% of all women gained more weight during pregnancy than recommended.

**CRITERION #2: SEVERITY**

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- Obesity is associated with many adverse health outcomes, including diabetes; colon, uterine, and breast cancer; respiratory problems; hypertension; elevated blood cholesterol; heart disease; stroke; and gall bladder disease, liver disease, osteoarthritis, sleep apnea, and decreased emotional well-being.
- Excessive weight gain during pregnancy increases the risk of obstetrical complications, giving birth to a high birth weight infant, hyperglycemia in the infant, and weight retention after pregnancy.

**CRITERION #3: DISPARITY**

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- In Washington, from 2003-2005, American Indian and Alaska Natives and Blacks had the highest prevalence of obesity at 31.8% and 29.7%, respectively, followed by Hispanics (24.3%), whites (22%), and Asians and Pacific Islanders (11.5%). The Index of Disparity for obesity prevalence was 134%.
- From 2003-2005, there was no difference in obesity prevalence between Washington men and women.

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004*

Sources: Preliminary data from: Washington State Department of Health (2007). Health of Washington State. 2007. Olympia, WA. *In press*.

**Physical Activity Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Physical activity** is bodily movement that expends energy. The Centers for Disease Control and Prevention (CDC) recommends that adults engage in moderate physical activity (e.g., brisk walking or bicycling) for at least 30 minutes a day, five days a week or engage in vigorous activity (e.g., running or aerobics) for at least 20 minutes a day, least three days a week.

**CRITERION #1: MAGNITUDE**

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- In 2005, 64% of Washington adults met the CDC guidelines for physical activity (see definition in box above). This proportion is the same as in 2001 and 2003.
- In the 2004-2005 school year, 34% of Washington youth in grades 9-12 participated in moderate physical activity and 68% participated in vigorous physical activity for at least 30 minutes a day, five days a week

**CRITERION #2: ASSOCIATION TO HEALTH OUTCOMES**

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- Physical activity reduces the risk for high blood pressure, cardiovascular disease, diabetes, colon cancer, and falls and fractures among older adults.
- Physical activity helps to maintain healthy body weight, reduces problems with osteoarthritis and low back pain, reduces symptoms of depression and anxiety, and improves overall quality of life.

**CRITERION #3: DISPARITY**

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- In Washington, data from 2003 and 2005, found that Asians and Pacific Islanders were least likely to meet guidelines for physical activity (54%), followed by blacks (59%), Hispanics (61%), American Indian/Alaska Natives (63%) and whites (64%).
- The Index of Disparity for not meeting physical activity guidelines was 13.2%.
- Washington data from 2003 and 2005 combined found that men reported meeting the physical activity guidelines more often than women.

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004.*

*\*Consistent with Keppel et al., (2004), physical activity rates were transformed to rates for not meeting the physical activity guidelines for purposes of calculating the Index of Disparity.*

Sources: Preliminary data from: Washington State Department of Health (2007). Health of Washington State. 2007. Olympia, WA. *In press.*

**Preventive Services Utilization Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Preventive services utilization** refers to the use of services such as immunizations, disease screenings, and counseling services, which are provided to patients in order to prevent the onset of disease or to initiate early treatment for conditions that are not yet apparent. Separate briefing documents provide information on immunization rates and cancer screening rates; therefore, this document highlights data on prenatal care and cholesterol screening, in addition to providing general information on preventive care.

**CRITERION #1: MAGNITUDE**

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- For the years 2001-2003 combined, 83% of Washington women reported receiving prenatal care during the first trimester of their pregnancies.
- In 2005, 76% of Washington adults reported that they had their cholesterol checked at least once during their lives, with 63% reporting having been screened during the last year.
- From 1991-2003, the percentage of Washington adults who reported having had their cholesterol checked during the preceding five years remained unchanged.

**CRITERION #2: ASSOCIATION TO HEALTH OUTCOMES**

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- Increasing the use of preventive services, by definition, will result in decreased morbidity and mortality from diseases that could have been prevented or identified at an earlier stage.
- Use of proven preventive services could result in fewer cases of and deaths due to infectious diseases and chronic diseases, such as cancer, cardiovascular disease and diabetes.
- The Partnership for Prevention estimated that increasing the use of just 5 preventive services (counseling about aspirin use and smoking, screening for colorectal and breast cancers, and immunization against influenza) would save more than 100,000 lives each year in the U.S.

**CRITERION #3: DISPARITY**

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- From 2001-2003, the percentage of Washington women receiving prenatal care in their first trimester was highest for whites (83.3%) and Asians (83.1%), followed by blacks (76.6%), American Indian and Alaska Native women (70.8%), and Native Hawaiian and Pacific Islander women (65.4%). Non-Hispanics were more likely to have prenatal care during their first trimester than Hispanic women (84.4% relative to 73.2%), for an Index of Disparity for not receiving prenatal care during the first trimester was 56%\*.
- According to U.S. data from 2003, the percentage of adults age 20 or older reporting that they had their cholesterol checked during the previous 5 years was 75.0% for non-Hispanic blacks, 74.7% for American Indian/Alaska Natives, 74.2% for non-Hispanic whites, 69.6% for Asians/Pacific Islanders, and 65.5% for Hispanics, for an Index of Disparity for not having cholesterol screening of 16%.
- According to U.S. data from 2003, 74.4% of women compared to 71.3% of men reported having their cholesterol checked during the previous 5 years.

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004.*

*\*Consistent with Keppel et al., (2004), preventive care rates were transformed to not having the preventive care for purposes of calculating the Index of Disparity.*

Sources: (1) Preliminary data from: Washington State Department of Health (2007). Health of Washington State. 2007. Olympia, WA. *In press.* (2) Centers for Disease Control and Prevention (2005). Trends in Cholesterol Screening and Awareness of High Blood Cholesterol – United States, 1991-2003. MMWR 54(35):865-870. (3) Washington State Department of Health 2006. Prenatal Care In: MCH Data Report 2006. Olympia, Washington (4) Partnership for Prevention (2007). Preventive Care: A National Profile on Use, Disparities, and Health Benefits. Washington, DC.

**Prostate Cancer Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Prostate cancer** is a cancer that forms in the tissues of the prostate. The prostate is a gland in the male reproductive system found below the bladder and in front of the rectum.

**CRITERION #1: PREVALENCE / INCIDENCE**

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- In 2004, the overall age-adjusted incidence rate for prostate cancer in Washington was 163.0 per 100,000.
- The 2004 incidence rate for prostate cancer in Washington was significantly lower than the rate in 1992.
- In 2004, prostate cancer was the most common cancer among Washington men and the second leading cause of cancer overall with 4,428 cases.

**CRITERION #2: SEVERITY**

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- In 2004, the overall age-adjusted death rate in Washington from prostate cancer was 25.8 per 100,000 people.
- In 2004, 590 men died from prostate cancer in Washington. Prostate cancer is the second leading cause of cancer mortality in men in Washington.
- The trend in the age-adjusted mortality rate for prostate cancer in Washington has declined from 1992 to 2001.

**CRITERION #3: DISPARITY**

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- In the years 2000-2004 combined, blacks had a significantly higher rate of prostate cancer (252.9 per 100,000) than all other races and ethnicities. Whites had the next highest rate (168.1 per 100,000), followed by Hispanics (134.4 per 100,000), American Indians/Alaska Natives (121.2 per 100,000), and Asian/Pacific Islanders (98.8 per 100,000).
- The Index of Disparity for incidence by race and ethnicity was 71.2%.
- One study found disparity between African American men and white men in the treatment of nonmetastatic prostate cancer in the U.S. between 1991-1999.
- In the years 2000-2004 combined, the age-adjusted mortality rate for prostate cancer was significantly higher for blacks (46.2 per 100,000) than for all other races and ethnicities. Whites had the next highest rate (27.7 per 100,000), followed by Hispanics (18.6 per 100,000) American Indians/Alaska Natives (17.4 per 100,000), and Asian/Pacific Islanders (12.8 per 100,000).
- The index of disparity for mortality by race and ethnicity was 114.4%.

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004*

Sources: (1) Department of Health, Washington State Cancer Registry. Available at <http://www3.doh.wa.gov/WSCR/>. (2) *Comprehensive Cancer Control Plan*, Washington State Department of Health, 2004-2008. (3) Comprehensive Cancer Control Program, Prostate Cancer Fact Sheet, Washington State Department of Health. (4) Zeliadt, S, Potosky, A, Etzioni, R., et. al. Racial Disparity in Primary and Adjuvant Treatment for Nonmetastatic Prostate Cancer: Seer-Medicare Trends 1991-1999. *Urology* 64 (6), 2004.

**Smoking Rates Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Smoking cessation**, or quitting smoking, is listed in RCW 43.20.280 as one of the indicators of health that the Governor's Interagency Council on Health Disparities must address in its plan to eliminate health disparities. However, this briefing document provides data on **smoking rates**, which are more commonly collected and reported and consistent with Healthy People 2010.

**CRITERION #1: MAGNITUDE**

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- In 2006, the smoking rate among Washington adults was 17%; the rate has been declining since 2001.
- From 1998 to 2006, youth smoking has declined; however, since 2004 smoking rates among high school students have stalled. In 2006, the smoking rates among 6<sup>th</sup>, 8<sup>th</sup>, 10<sup>th</sup>, and 12<sup>th</sup> graders were 2%, 6%, 15%, and 20%, respectively.
- Secondhand smoke exposure in the home decreased from 19% in 2000 to 11% in 2005.
- In 2005, Washington had the fifth lowest state smoking rate in the U.S.

**CRITERION #2: ASSOCIATION TO HEALTH OUTCOMES**

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- Smoking is the single most preventable cause of disease and death in Washington and in the U.S.
- Smoking causes heart disease, several kinds of cancer (lung, larynx, esophagus, pharynx, mouth, and bladder), and chronic lung disease. Smoking during pregnancy is associated with miscarriage, premature birth, low birthweight and sudden infant death syndrome.
- An estimated 8,000 Washington residents die from smoking-related causes each year.
- In Washington State, annual healthcare costs associated with tobacco use are an estimated \$1.5 billion.

**CRITERION #3: DISPARITY**

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- For the years, 2003-2005, smoking rates were higher among American Indians and Alaska Natives (37%), Hawaiians and Pacific Islanders (27%) and African Americans (25%), relative to Hispanics (17%), whites (19%) and Asians (12%).
- The Index of Disparity was 108.3%.
- The smoking rates for whites have decreased from 1999 to 2005, but have remained relatively stable among all other racial and ethnic groups.
- Data from King County revealed that certain Asian subgroups, such as Korean and Vietnamese men, have particularly high rates of smoking, at 29% and 38%, respectively.
- Washington men smoke at a higher rate than women, 20% versus 17%, respectively.
- Among Asians, Hawaiians and Pacific Islanders, and Hispanics, men smoked at significantly higher rates than women.

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004*

Sources: (1) Washington State Department of Health (2007). Adult Smoking Rates in Washington: A Report on Current Disparities. (2) Washington State Department of Health (2007). Tobacco Prevention and Control Program Progress Report. (3) Smyser M, Krieger J, and Solet D. 1998. The King County Ethnicity and Health Survey. Public Health-Seattle and King County. Seattle, WA. (4) Preliminary data from: Washington State Department of Health (2007). Health of Washington State. 2007. Olympia, WA. *In press*.

**Social Support Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Social support** refers to both the social networks that individuals and groups maintain as well as the functional aspects of support. Social networks refer to the number of contacts and the frequency of contacts, while the functional aspects of support refer to the quality and type of support (e.g., emotional support, practical support, negative interaction).

**CRITERION #1: MAGNITUDE**

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- In Washington State in 2006, almost 84% of adults reported always or usually getting the emotional support they needed.

**CRITERION #2: ASSOCIATION TO HEALTH OUTCOMES**

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- Populations with greater levels of social support have reduced mortality from disease, have better survival outcomes after heart attack and stroke, recover more quickly from disease, and cope better with chronic illness.
- There is some evidence that social support may even be protective against disease onset, such as heart disease.
- Social support has also been shown to reduce the risk of mental illness.
- In Missouri, social support characteristics, such as visiting with friends and relatives, having close friends for emotional support, and the perception of having help available when sick or disabled, was associated with health related quality of life among adults ages 60 years and older.

**CRITERION #3: DISPARITY**

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- In 2006, the proportion of Washington adults who reported always or usually getting the emotional support they needed was highest for whites (86%), followed by individuals of multiple races/ethnicities (79%), blacks (72%), and Hispanics (70%). The proportion of individuals grouped into the "other" race/ethnicity category reporting that they always or usually received the emotional support they needed was 74%.
- In 2006, 82% of Washington men and 85% of women reported always or usually getting the emotional support they needed.

Sources: (1) Stansfield SA (2006). Social Support and Social Cohesion. In: Marmot M and Wilkinson RG (Eds.), *Social Determinants of Health*, Second Edition. Oxford: Oxford University Press. (2) Preliminary data from: Washington State Department of Health (2007). Health of Washington State. 2007. Olympia, WA. *In press*. Olympia, Washington. (3) Centers for Disease Control and Prevention (2005). Social Support and Health-Related Quality of Life Among Older Adults – Missouri, 2000. *MMWR*,54(17):433-437. (4) Washington State Department of Health. Washington 2006 BRFSS Core Variables Report. Accessed at: [http://www.doh.wa.gov/EHSPHL/CHS/CHS-Data/brfss/brfss\\_tables.htm](http://www.doh.wa.gov/EHSPHL/CHS/CHS-Data/brfss/brfss_tables.htm) on 9/11/07.

**Substance Abuse Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Substance abuse** is a recurring pattern of alcohol or other drug use which impairs a person's functioning. For the purposes of this brief document, the rate of binge drinking (i.e., drinking more than five drinks on at least one occasion) is used as an indicator of alcohol abuse and the rate of drug-induced deaths (i.e., intentional and unintentional poisonings) is used as an indicator of drug abuse.

**CRITERION #1: MAGNITUDE**

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- In 2005, 14% of Washington adults reported binge drinking during the past month; this rate has remained relatively constant from 1990-2005.
- In 2005, there were 921 drug-induced deaths, 139 of which were suicides, and another 8,128 deaths where drugs contributed to the death.
- From 1990 to 2005, the age-adjusted rate of drug-induced deaths in Washington increased from 5 per 100,000 to 14 per 100,000.

**CRITERION #2: ASSOCIATION TO HEALTH OUTCOMES**

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- Alcohol abuse can lead to liver disease, such as fatty liver, alcohol-induced hepatitis, and cirrhosis of the liver, and can increase the risk of osteoporosis, pancreatitis, cancer, and infections. Alcohol use is also associated with injuries and deaths related to motor vehicle crashes, falls, drowning, fires, and violence.
- Alcohol abuse during pregnancy is associated with fetal alcohol spectrum disorders.
- Long term effects from drug abuse can result in damage to the heart, lungs, liver, kidneys, and can suppress the immune system. Injection drug use increases the risk for blood-borne diseases such as AIDS and hepatitis B and C.
- Drug use during pregnancy is associated with low birth weight, prematurity, and congenital malformations.

**CRITERION #3: DISPARITY**

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- In Washington from 2003-2005, the prevalence of binge drinking was highest among American Indian/Alaska Natives (17%), followed by whites (15%), blacks (14%), Hispanics (11%), and Asians/pacific Islanders (9%), for an Index of Disparity of 58%.
- From 2003-2005, drug-induced death rates (per 100,000) in Washington were highest for American Indians and Alaska Natives (35), followed by blacks (20), whites (14), Hispanics (8), and Asians and Pacific Islanders (3), for an Index of Disparity of 542%.
- In Washington, men had higher rates of binge drinking and drug-induced deaths than women.

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004.*

Sources: (1). Preliminary data from: Washington State Department of Health (2007). Health of Washington State. 2007. Olympia, WA. *In press.* (2) Washington State Department of Health. Alcohol Abuse and Dependence In: The Health of Washington State 2007. Olympia, Washington.

**Sudden Infant Death Syndrome Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Sudden infant death syndrome (SIDS)** is defined as sudden deaths of children under one year of age that remain unexplained after an investigation, which includes a complete autopsy, examination of the death scene, and review of the medical history.

**CRITERION #1: PREVALENCE / INCIDENCE**

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- The rate of SIDS in Washington State has declined from 0.9 deaths per 1,000 live births in 1999 to 0.5 deaths per 1,000 live births in 2005.
- In 2005, 42 infants died from SIDS, accounting for 10% of all infant mortality.
- In 2005, SIDS was the second leading cause of infant mortality.

**CRITERION #2: SEVERITY**

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- As a measure of infant mortality, by definition, SIDS is severe.

**CRITERION #3: DISPARITY**

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- Washington data from 2000-2004 combined, revealed that the rate of SIDS was higher among American Indians (1.9 deaths per 1,000 live births) and African Americans (1.3) compared to non-Hispanic whites, Asians and Pacific Islanders and Hispanics (all three groups had a rate of 0.8).
- The index of disparity for SIDS was 100.0%.

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004*

Sources: (1) Wasserman, 2006. Race/Ethnic Disparities in Infant Mortality. Presentation to Washington State Board of Health, December 13, 2006. (2) Washington State Department of Health. Sudden Infant Death Syndrome (SIDS) Fact Sheet. Accessed from <http://www.doh.wa.gov/Topics/SIDS.htm> on 4/2/2007. (3) Infant Death Data. Center for Health Statistics, Washington State Department of Health. Accessed from [http://www.doh.wa.gov/ehsphi/chs/chs-data/infdeath/inf\\_VD.htm](http://www.doh.wa.gov/ehsphi/chs/chs-data/infdeath/inf_VD.htm) on 7/30/2007.

**Supportive Parenting and Childcare Systems Briefing Document  
Presented to the Governor's Interagency Council on Health Disparities  
September 20, 2007**

Early childhood is a time of immense physical, social, emotional, and intellectual growth of children – all critical elements of school readiness and success later in life. Moreover, the importance of early childhood development for health has been well-documented. **Supportive parenting and childcare systems** are key factors in promoting optimal child development. Common measures of supportive parenting include reading to young children and regular bedtime and mealtime. Indicators of quality child care include learning environments, nurturing adult/child interactions, and teacher-child ratios. Data are not available for these indicators in Washington.

**CRITERION #1: MAGNITUDE**

- In the U.S. in 2005, 60.3% of children ages 3-5 who had not yet entered kindergarten were read to daily by a family member.
- According to national data from 2000, 58% of children between the ages of 4 months and 35 months had both a regular meal time and a regular bed time.
- According to the perceptions of kindergarten teachers in Washington State, 44% of the incoming students in 2004 were not prepared for kindergarten.
- In 2005, there were about 175,000 children enrolled in 7,771 licensed childcare facilities in Washington State.

**CRITERION #2: ASSOCIATION TO HEALTH OUTCOMES**

- Reading to young children has been shown to promote language development and reading comprehension, which in turn relates to later success in school. The link between education and health outcomes has been well-documented.
- Regular mealtimes with children provide opportunities for parents and children to interact and allow parents to model healthy eating behaviors. Regular bedtimes help to ensure that children receive proper rest and reduce sleep problems, which have been shown to hinder performance in elementary school. A lack of a regular bedtime has also been associated with mental health risks.
- High quality child care is associated with better cognitive, language and social development in children.

**CRITERION #3: DISPARITY**

- According to national data in 2005, the proportion of children ages 3-5 who had not yet entered kindergarten who were read to daily was highest for non-Hispanic white children (67.7%), followed by Asians (65.6%), non-Hispanic blacks (49.7%), and Hispanic children (44.7%), for an index of disparity of not being read to daily of 44.5%.
- In 2000, the proportion of U.S. children between the ages of four months and 35 months who had both the same mealtime and bedtime every day was highest for non-Hispanic whites (63%), compared with 47% of non-Hispanic black children and 53% of Hispanic children of the same age.

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the “best” rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004.*

*\*Consistent with Keppel et al., (2004), rates were transformed to rates for not being read to daily for purposes of calculating the Index of Disparity.*

Sources: (1) Federal Interagency Forum on Child and Family Statistics (2007). America's Children: Key National Indicators of Well-Being 2007. Federal Interagency Forum on Child and Family Statistics, Washington, DC: U.S. Government Printing Office. (2) The Commonwealth Fund (2004). Early Child Development in Social Context: A Chartbook. New York. (3) The Office of Superintendent of Public Instruction (2005). Student Readiness for Kindergarten: A Survey of Kindergarten Teachers in Washington State. Olympia, Washington. (4) Public Health Improvement Partnership (2005). Report Card on Health in Washington 2005. Olympia, Washington. (5) Washington State Child Care Resource and Referral Network (2006). Child Care in Washington State 2006. Olympia, Washington.

**Women's Health Issues Briefing Document**  
**Presented to the Governor's Interagency Council on Health Disparities**  
**September 20, 2007**

**Women's health issues** is listed in RCW 43.20.280 as one of the indicators of health that the Governor's Interagency Council on Health Disparities must address in its plan to eliminate health disparities. Women's health issues encompass mental and physical health and wellness, as well as the activities, behaviors, and other factors that influence health throughout all stages of a woman's life. Many key health issues for women were listed independently in RCW 43.20.280, including but not limited to, heart disease, stroke, and breast cancer. This briefing document highlights two additional health issues faced by women – pregnancy and birth rates among teens and intimate partner violence.

**CRITERION #1: PREVALENCE / INCIDENCE**

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- The rate of pregnancy among Washington 15-17 year-olds has decreased from 59 pregnancies per 1,000 in 1989 to 28 per 1,000 in 2005.
- The birth rate among Washington 15-17 year-olds has declined from 33 births per 1,000 in 1992 to 15 births per 1,000 in 2005.
- In 2005, 28% of women reported experiencing physical violence or unwanted sex from an intimate partner in their lifetimes and 10% reported ever being injured by an intimate partner.

**CRITERION #2: SEVERITY**

---

- Children of teen mothers are more likely to be born prematurely, to be low birthweight and to die during their first year of life than children born to non-teen mothers.
- Teens who give birth are less likely to finish high school and therefore, more likely to have low earnings.
- Women who are victims of intimate partner violence have poorer physical and mental health and use health services more than other women.
- From 2004-2006, 48 Washington women were killed by their current or former male partners.

**CRITERION #3: DISPARITY**

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- In Washington, for 2003-2005 combined, the birth rate for 15-17 year-olds was significantly higher among Hispanics (56 per 1,000), American Indian and Alaska Natives (35 per 1,000) and African Americans (19 per 1,000) than among whites (9 per 1,000) and Asians and Pacific Islanders (6 per 1,000).
- The Index of Disparity for birth rates among 15-17 year-olds was 366%.
- Washington data on intimate partner violence are not available. National data indicate that domestic violence rates were higher for American Indian and black women than for white women; however these differences did not persist after adjusting for income in at least one study.

**The Index of Disparity** is the average of the difference in rates between the racial/ethnic group with the "best" rate and all other racial/ethnic groups.

*Keppel KG et al., Measuring progress in healthy people 2010. Statistical Notes, no 25. NCHS, 2004*

Sources: (1) Preliminary data from: Washington State Department of Health (2007). Health of Washington State. 2007. Olympia, WA. *In press*. (2) Washington State Department of Health (2002). Domestic Violence. In: The Health of Washington State. (3) Washington State Coalition Against Domestic Violence. (2006). If I had One More Day: Findings and Recommendations from the Washington State Domestic Violence Fatality Review.



# Appendix B: Scoring Criteria

## PRIORITIZATION OF HEALTH CONDITIONS: PHASE I

<b>CRITERION #1: PREVALENCE / INCIDENCE</b>				
<ol style="list-style-type: none"> <li>1. The prevalence/incidence of the condition is low and has been decreasing or staying the same over time.</li> <li>2. The prevalence/incidence is low, but has been increasing over time.</li> <li>3. The prevalence/incidence is moderate.</li> <li>4. The prevalence/incidence is high, but has been decreasing over time.</li> <li>5. The prevalence/incidence is high and has been increasing or staying the same over time.</li> </ol>				
<b>CRITERION #2: SEVERITY</b>				
<ol style="list-style-type: none"> <li>1. The condition is not at all likely to result in death or long term disability.</li> <li>2. The condition is not very likely to result in death or long term disability.</li> <li>3. The condition is somewhat likely to result in death or long term disability.</li> <li>4. The condition is very likely to result in death or long term disability.</li> <li>5. The condition is extremely likely to result in death or long term disability.</li> </ol>				
<b>CRITERION #3: DISPARITY</b>				
<ol style="list-style-type: none"> <li>1. The disparity in prevalence/incidence and/or severity by race, ethnicity, and/or sex is very low.</li> <li>2. The disparity in prevalence/incidence and/or severity by race, ethnicity, and/or sex is somewhat low.</li> <li>3. The disparity in prevalence/incidence and/or severity by race, ethnicity, and/or sex is moderate.</li> <li>4. The disparity in prevalence/incidence and/or severity by race, ethnicity, and/or sex is somewhat high.</li> <li>5. The disparity in prevalence/incidence and/or severity by race, ethnicity, and/or sex is very high.</li> </ol>				
HEALTH CONDITION	For each health condition, score each criterion from 1 to 5. Multiply the score by the assigned weight and enter into the appropriate cell. Add the weighted criterion scores to obtain the total score.			Total Score for the Health Condition
	Weight:	Criterion #1 1	Criterion #2 1	
1. Asthma				
2. Cancer, Breast				
3. Cancer, Cervical				
4. Cancer, Prostate				
5. Cancer, Colorectal				
6. Chronic Kidney Disease				
7. Diabetes				
8. HIV/AIDS				
9. Heart Disease & Stroke				
10. Infant Mortality				
11. Lupus				

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## PRIORITIZATION OF HEALTH CONDITIONS: PHASE I

<b>CRITERION #1: PREVALENCE / INCIDENCE</b>				
<ol style="list-style-type: none"> <li>1. The prevalence/incidence of the condition is low and has been decreasing or staying the same over time.</li> <li>2. The prevalence/incidence is low, but has been increasing over time.</li> <li>3. The prevalence/incidence is moderate.</li> <li>4. The prevalence/incidence is high, but has been decreasing over time.</li> <li>5. The prevalence/incidence is high and has been increasing or staying the same over time.</li> </ol>				
<b>CRITERION #2: SEVERITY</b>				
<ol style="list-style-type: none"> <li>1. The condition is not at all likely to result in death or long term disability.</li> <li>2. The condition is not very likely to result in death or long term disability.</li> <li>3. The condition is somewhat likely to result in death or long term disability.</li> <li>4. The condition is very likely to result in death or long term disability.</li> <li>5. The condition is extremely likely to result in death or long term disability.</li> </ol>				
<b>CRITERION #3: DISPARITY</b>				
<ol style="list-style-type: none"> <li>1. The disparity in prevalence/incidence and/or severity by race, ethnicity, and/or sex is very low.</li> <li>2. The disparity in prevalence/incidence and/or severity by race, ethnicity, and/or sex is somewhat low.</li> <li>3. The disparity in prevalence/incidence and/or severity by race, ethnicity, and/or sex is moderate.</li> <li>4. The disparity in prevalence/incidence and/or severity by race, ethnicity, and/or sex is somewhat high.</li> <li>5. The disparity in prevalence/incidence and/or severity by race, ethnicity, and/or sex is very high.</li> </ol>				
<b>HEALTH CONDITION</b>	<b>For each health condition, score each criterion from 1 to 5. Multiply the score by the assigned weight and enter into the appropriate cell. Add the weighted criterion scores to obtain the total score.</b>			<b>Total Score for the Health Condition</b>
	<b>Weight:</b>	<b>Criterion #1</b>	<b>Criterion #2</b>	<b>Criterion #3</b>
12. Mental Health	1	1	2	
13. Overweight and Obesity				
14. Oral Disease				
15. Sudden Infant Death Syndrome (SIDS)				
16. Women's Health Issues				

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## PRIORITIZATION OF SOCIAL DETERMINANTS OF HEALTH: PHASE I

<b>CRITERION #1: MAGNITUDE</b>				
<ol style="list-style-type: none"> <li>1. The magnitude of the problem is low and has been decreasing or staying the same over time.</li> <li>2. The magnitude of the problem is low but has been increasing over time.</li> <li>3. The magnitude of the problem is moderate.</li> <li>4. The magnitude of the problem is high but has been decreasing over time.</li> <li>5. The magnitude of the problem is high and has been increasing or staying the same over time.</li> </ol>				
<b>CRITERION #2: ASSOCIATION TO HEALTH OUTCOMES</b>				
<ol style="list-style-type: none"> <li>1. The social determinant of health is associated with a very low number of health outcomes.</li> <li>2. The social determinant of health is associated with a somewhat low number of health outcomes.</li> <li>3. The social determinant of health is associated with a moderate number of health outcomes.</li> <li>4. The social determinant of health is associated with a somewhat high number of health outcomes.</li> <li>5. The social determinant of health is associated with a very high number of health outcomes.</li> </ol>				
<b>CRITERION #3: DISPARITY</b>				
<ol style="list-style-type: none"> <li>1. The disparity in the magnitude of the problem by race, ethnicity, and/or sex is very low.</li> <li>2. The disparity in the magnitude of the problem by race, ethnicity, and/or sex is somewhat low.</li> <li>3. The disparity in the magnitude of the problem by race, ethnicity, and/or sex is moderate.</li> <li>4. The disparity in the magnitude of the problem by race, ethnicity, and/or sex is somewhat high.</li> <li>5. The disparity in the magnitude of the problem by race, ethnicity, and/or sex is very high.</li> </ol>				
<b>SOCIAL DETERMINANT OF HEALTH</b>	<b>For each determinant, score each criterion from 1 to 5. Multiply the score by the assigned weight and enter into the appropriate cell. Add the weighted criterion scores to obtain the total score.</b>			<b>Total Score for the Social Determinant of Health</b>
<b>Weight:</b>	<b>Criterion #1</b>	<b>Criterion #2</b>	<b>Criterion #3</b>	
	1	1	2	
1. Access to Nutritious Food				
2. Culturally and Linguistically Appropriate Healthcare				
3. Education				
4. Environmental Exposures				
5. Health Insurance Coverage				
6. Health Literacy				
7. Healthcare Workforce Diversity				
8. Immunization Rates				
9. Income				
10. Opportunities for Physical Activity				
11. Preventive Service Utilization				

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## PRIORITIZATION OF SOCIAL DETERMINANTS OF HEALTH: PHASE I

<b>CRITERION #1: MAGNITUDE</b>										
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<ol style="list-style-type: none"> <li>1. The disparity in the magnitude of the problem by race, ethnicity, and/or sex is very low.</li> <li>2. The disparity in the magnitude of the problem by race, ethnicity, and/or sex is somewhat low.</li> <li>3. The disparity in the magnitude of the problem by race, ethnicity, and/or sex is moderate.</li> <li>4. The disparity in the magnitude of the problem by race, ethnicity, and/or sex is somewhat high.</li> <li>5. The disparity in the magnitude of the problem by race, ethnicity, and/or sex is very high.</li> </ol>										
SOCIAL DETERMINANT OF HEALTH	For each determinant, score each criterion from 1 to 5. Multiply the score by the assigned weight and enter into the appropriate cell. Add the weighted criterion scores to obtain the total score.	Total Score for the Social Determinant of Health								
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; padding: 2px;">Weight:</th> <th style="text-align: center; padding: 2px;">Criterion #1</th> <th style="text-align: center; padding: 2px;">Criterion #2</th> <th style="text-align: center; padding: 2px;">Criterion #3</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;"></td> <td style="text-align: center; padding: 2px;">1</td> <td style="text-align: center; padding: 2px;">1</td> <td style="text-align: center; padding: 2px;">2</td> </tr> </tbody> </table>	Weight:	Criterion #1	Criterion #2	Criterion #3		1	1	2	
Weight:	Criterion #1	Criterion #2	Criterion #3							
	1	1	2							
12. Smoking Rates										
13. Social Support										
14. Substance Abuse										
15. Supportive Parenting & Childcare Systems										

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