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2013-2014

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# Washington State Latino/Hispanic Assessment Report

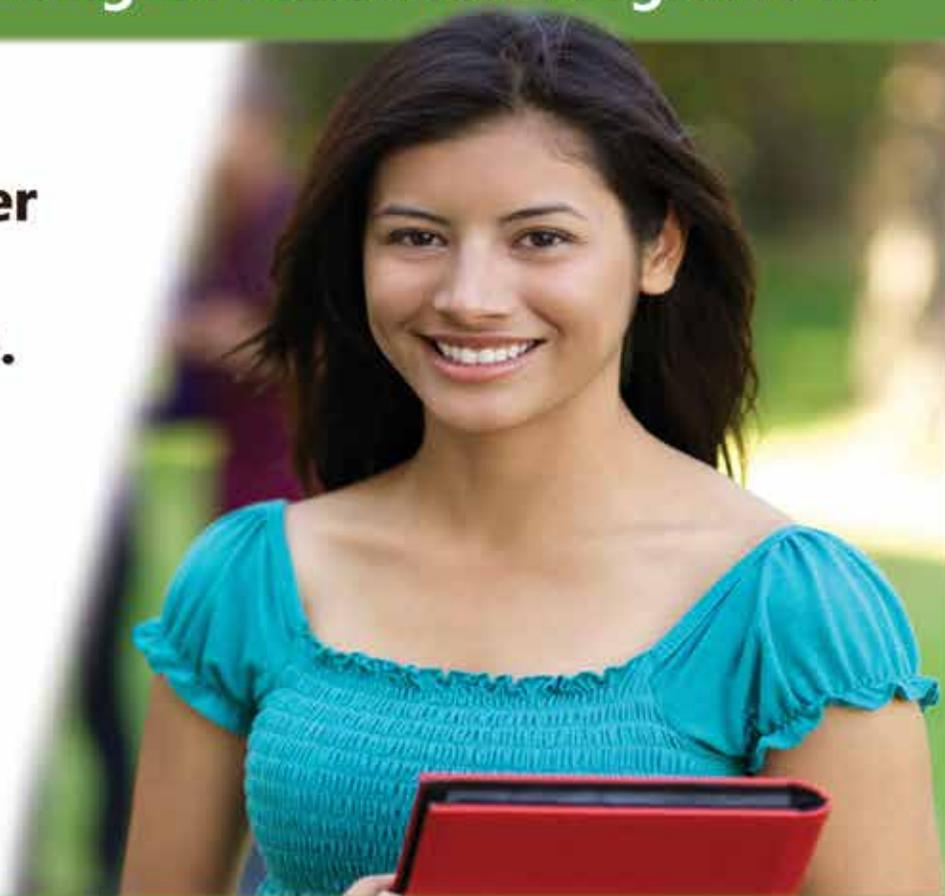


Washington State Commission on Hispanic Affairs

*All children in Washington State have the right to a public education, grades kindergarten to 12, up through age 21.*

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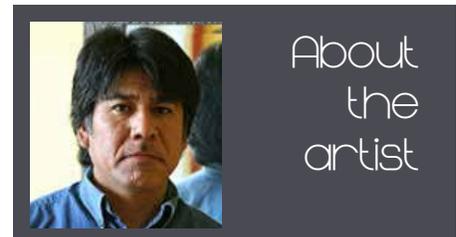
- ✓ *Complete all the forms you are given when you enroll your child in school. The school will use your responses to determine if your child qualifies for additional services. Remember, you have the right to request an interpreter if you need one.*
- ✓ *Attend school meetings and respond to requests for your opinion. Your ideas will improve services for your child and your family.*



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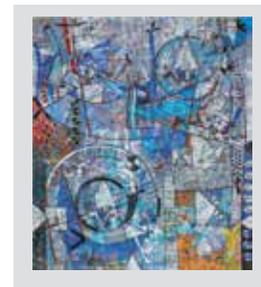
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Fulgencio Lazo was born in 1966 in Oaxaca, Mexico. He studied under Shinzaburo Takeda at the Fine Arts School in Oaxaca, graduating in 1989. Trained as a print maker, Lazo works predominately with acrylics on canvas in his studios in Seattle and Oaxaca. He has had over 40 solo shows throughout the US, Mexico, Japan and France, and has numerous pieces in public collections. He enjoys community celebrations of Day of the Dead and has participated in many, including installations for the Seattle Art Museum, Tacoma Art Museum, and the National Museum of Mexican Art.



"Poetas en los viajes" (Travelling Poets)



"Gozona infantil" (A Child's Reciprocity)

<http://fulgenciolazo.blogspot.com>

*DISCLAIMER: We thank all the contributors to this report for their time and effort and unless otherwise indicated, the views and opinions expressed in their articles are those of the authors and do not necessarily reflect the official policy or position of the Commission on Hispanic Affairs.*

## II. ACKNOWLEDGMENTS

**Our achievements would not have been possible without strong partnerships with organizations, individuals, institutions, legislators, state agencies, and our interns and volunteers over the past two years.**

We'd like to acknowledge our partners who have worked with us over the past two years, particularly Ricardo Sanchez from LEAP (Latino/a Education Achievement Project), Frances Contreras, Associate Professor in the Department of Education Studies at the University of San Diego, who contributed in producing a report called Project GRADUATE (Gathering Rich, Accurate Data & Understanding Assessment, Tracking, and Engagement) that gave the Commission valuable data to use in advocating for our community. We'd also like to thank our other strong partnerships with the Washington State Coalition for Language Access (WASCLA), Esparza Plus, Everett School District, Hispanic Roundtable, Latino Community Fund, Office of the Education Ombudsman, State Farm, Washington State Court Appointed Special Advocates (CASA), National Association of Latino Elected Officials (NALEO), Washington STEM, and Latino Civic Alliance.

We also would like to thank one pioneer who spent the majority of his life fighting to improve the lives of the Latino community, Tomas Villanueva. He was a tireless advocate for the Latinos who suffered discrimination and unfair labor practices. He was an outspoken person who believed in action. Villanueva was a co-founder of the Commission on Hispanic Affairs in the 1970s and will be missed by many. We thank him for his diligent efforts for the Hispanic community.

Thanks also to our radio stations: Radio Luz 1680AM, La Nueva 103.3FM, and Radio KDNA 91.9FM. As well as our state agency partnerships: the Office of the Governor, the Dept. of Social and Health Services, the Office of Minority and Women's Business Enterprises, the Office of the Attorney General, the Dept. of Labor & Industries, the Human Rights Commission, the Dept. of Revenue, the Dept. of Financial Institutions, the students from the S.I.F.E. program at Heritage University, the Office of Superintendent of Public Instruction, the Office of the Insurance Commissioner, the Dept. of Ecology, the Dept. of Licensing, the Dept. of Services for the Blind, and the Office of the Secretary of State. We'd also like to thank Washington State University.

Special thanks to Commissioner Nora Coronado for all her hard work in spearheading the production of this year's report. She not only recruited and coordinated many of the authors but also was an integral part in the quality of content produced.

Lastly but not least, our thanks and gratitude to the Commissioners that we bid farewell during 2012-2014: Lillian Ortiz-Self who served as the Chair for four years; Ty Cordova who served on the Commission for over 6 years was essential in the development of our assessment reports; Sharonne Navas is well known for her work on education issues; as well as Ana Ruiz Peralta, Ana Maria Diaz Martinez, Jennifer Ramirez Robson, Cynthia De Victoria and Rosalba Pitkin who served since 2006. We appreciate all the work and effort that has been done on behalf of Commission by these volunteer Commissioners. Thank you for your dedication and advocacy for our communities.

### Thanks to our Sponsors/Advertisers:

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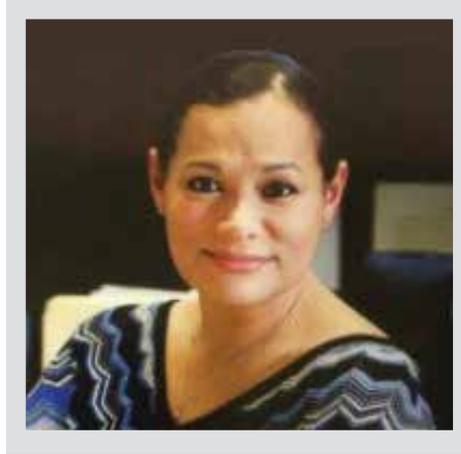


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Special thanks to the Department of Enterprise Services (DES) for their partnership and help printing this year's report!



I have had the privilege of serving on the Commission of Hispanic Affairs (CHA) the past two years and the honor of serving as Chair the past year. CHA continues to work on building a Commission that represents the diverse Latino community of Washington State insuring that we have both geographical representation as well as Commissioners who possess the subject matter expertise, education and experience needed to address issues in our communities such as education, immigration reform, health, economic development, resource accessibility, environmental health, civic engagement, criminal justice and public safety among others.



I am proud of the work that CHA has accomplished the past two years and honored to work alongside my fellow Commissioners who give of their time and talent to making our communities a better place to live and ones that are inclusive of all Washingtonians. CHA strives to build collaborative working relationships with state agencies, non-profit advocacy groups, elected officials and Latino community leaders in addressing issues that impact the Latino community.

These working relationships, partnerships and opportunities to share our perspectives and counsel as Commissioners to legislators and policy makers have contributed to successes for our community. The passing of the REAL Hope Act, which allows undocumented students to apply and compete for state need grants to help pay for college, will provide additional funding and make higher education accessible for a sector of our community.

Another success is evident by the recent decision by Federal Court Judge Rice regarding Yakima's election system for City Council that was found to not be equally open to participation by members of the Latino minority and in violation of the Voting Rights Act. According to U.S. Census Bureau and the Pew Research Hispanic Trends Project, population estimates as of 2013 state there are roughly 54 million Hispanics living in the United

States representing approximately 16.9% of the U.S. total population, making people of Hispanic origin the nation's largest ethnic or race minority. The U.S. Hispanic population for July 1, 2050 is estimated to reach 132.8 million, constituting approximately 30% of the U.S. population by that date. We believe this decision is a positive step in the right direction towards the passing of a Voting Rights Act that is inclusive of all Washingtonians

and insures our government is representative of our community.

The Commission has developed community priorities patterned around Governor Inslee's Results Washington with a focus on issues that impact the Latino community and provide a framework for the work we do in our community. All five areas: education, economic development, environmental, public safety and civic involvement in our government have an impact on health and the critical importance of building healthy communities. A healthy community is one that promotes healthy people by ensuring access to safe and nutritious foods; safe places to walk, run, or bike; living wages; clean air and water; adequate and accessible health care systems; safe and affordable housing and other healthy enablers. This assessment is focused on health impacts in the Latino community and the direct connection advancing social justice reform has in building healthy communities for all Washingtonians.

We would like to thank all of our community partners for their collaboration and partnership in making our work possible. We could not do this work without your support.

A handwritten signature in black ink, appearing to read 'Gloria Ochoa'. The signature is fluid and cursive.

Gloria Ochoa

Chair, Washington State Commission on Hispanic Affairs

# IV. COMMISSIONERS & STAFF



**GLORIA OCHOA**  
CHAIR, 1st Term Expires 8/01/15

She commenced her legal career as a Deputy Prosecuting Attorney for Benton County, she is now currently in private practice and admitted to both State and Federal Courts. She teaches Law Practice Management at Gonzaga University School of Law. She holds a judicial services contract with the Spokane Tribe of Indians and serves as Chief Judge for Spokane Tribal Court. Gloria is a member of the Hispanic Business Professionals Association and a member of the Inland Northwest Chamber of Commerce. She is a member of the Latina/o Bar Association's Judicial Evaluation Committee, the Spokane County Bar Association's Diversity Committee and Indian Law Section, and the Washington State Bar Association Lawyer's Fund for Client Protection Board. Gloria is on the Board of Directors for the Little Spokane River Estates Homeowner's Association.



**FRANK LEMOS**  
1st Term expires 8/01/15

Founder and CEO of LDC, Inc. is a successful businessman in the Pacific Northwest. He has over 24 years' experience in the professional construction consulting industry, twelve of which were spent working for, or consulting to, large regional and national engineering firms. Mr. Lemos started LDC, Inc. in 2003. In less than four years, Mr. Lemos has successfully grown LDC by 300%. Mr. Lemos is known for this expertise in client service and management team building, and it was through his expertise that this effort was successful. Additionally, Mr. Lemos is known for his ties to his community; he is always available to fellow enterprises and business owners for support and alliance building. He is active in the business community, holding several committee positions and he is a known advocate for policies and community action that support job creation and business opportunity for firms in the Pacific Northwest.



**JOSE MANUEL RETA**  
2nd Term Expires 08/01/16

He is a decorated Vietnam War veteran, and was also part of the bicentennial color guard for the Wagon Train in 1976. He attended Nooksack Valley high school, then Bellingham Technical Institution and Whatcom Community College. Mr. Reta has experience working in agriculture and in the dairy business. He is currently the owner of "Colima Design," a clothing design and alteration company. He has been an active member on the Bellingham Herald Advisory Committee, the F.D.A. board, the D.V. Commission, and the Washington Hispanic Chamber of Commerce Board member association. Manuel has been the president of the Northwest Washington Hispanic Chamber of Commerce since 2007. He has won several awards, including the Top Ten Whatcom County Most Giving Award in 2009 and the Whatcom county peace builder cross-cultural award in 2009.



**ANDRÉS MANTILLA**  
VICE CHAIR  
2nd Term expires 8/01/17

Senior Vice President for Ceis, Bayne, East Strategic designing and implementing creative community outreach and engagement strategy. Prior to joining CBE strategic, Mr. Mantilla served as Business Services Manager and Strategic Advisor to the City of Seattle's Office of Economic Development. He served on Mayor Greg Nickels' Community Outreach Team working on policy and engagement in Seattle's immigrant businesses and communities of color. Mr. Mantilla serves as the Vice-Chair for the Washington State Commission on Hispanic Affairs. He also serves of the Board of Directors for King County Conservation Voters, NARAL Pro-Choice Washington and on the Neighbor 2 Neighbor Board for The Seattle Foundation. He holds a degree from the University of California, Santa Barbara in Latin American Studies.



**RAQUEL FERRELL CROWLEY**  
2nd Term Expires 8/01/17

She has earned her Masters of School Administration and her Bachelors of Sciences in Education through Central Washington University. Her Bachelors of Sciences Degrees are in Career and Technology Education (CTE), Family and Consumer Sciences Education (FACSE), Work Based Learning Coordinator (WBLC), Spanish and her English as a Second Language (ELL) endorsement. She has been recognized nationally for her efforts in Consumer Management and Financial Fitness. Raquel participates in numerous capacities including advisory roles for Kittitas County 4-H, Emergency Management team, Youth in Kittitas County. She is currently a member of the Washington State Principal Association (AWSP), Washington State Association of Career and Technology Education (WA-ACTE), National Association of Professional Women, and a member of Washington Association of Family and Consumer Sciences Educators (WA-FACSE).



**ANITA AHUMADA**  
2nd Term Expires 8/01/17

Originally from Chile she acquired her formal education at the Universidad de Chile. She worked as a Social Worker in her native country until she moved to the U.S. in 1970. She worked for the Department of Corrections and served as a Court Interpreter. Anita was the first state employee to obtain Interpreter Certification granted by the Washington State Supreme Court. She co-founded the Language Interpreters Services and Translations (LIST) Office, a nationally recognized program which pioneered equal access to government programs for LEPs. She has also participated in providing language services for numerous Minority and Justice Community Forums under the leadership and guidance of Supreme Court Justice Charles Smith. Anita co-founded the Hispanic Coalition of Snohomish County where she served as Executive Secretary and Co-Director. Anita collaboratively coordinated sports clinics for Hispanic children; she also worked in securing subsidized housing for minority seniors, Hispanic women's health education, ESL classes, literacy programs, and voting education.



**NORA CORONADO**  
1st Term expires 8/01/15

She is the Director of Community Partnership and Development in the Center of Health Equity, Diversity and Inclusion (CEDI). Her responsibilities include developing and strengthening partnerships throughout the WWAMI (Washington, Wyoming, Alaska, Montana, and Idaho) region which includes the Schools of Medicine, community based organizations and clinics and other strategic partners. She also partners with student organizations and professional groups to collaborate in developing mentoring and educational opportunities across our campuses. She is also developing connections with our alumni. Nora is of Mexican origin. Her father and his family immigrated into this country from Mexico as migrant farmworkers. She was born and raised in Eastern Washington where her family settled. She was the first in her family to obtain a college education. Nora also works with the University of Washington Latino Center for Health as the Coordinator of Community Partnerships, with the goal of growing research opportunities for those interested in Latino Health issues throughout the WWAMI region. For further information see [Latinocenterforhealth.org](http://Latinocenterforhealth.org). As a Commissioner for the Washington State Commission on Hispanic Affairs Nora's area of interest is in health inclusive of mental, physical and environmental health. Because of this role, she currently participates on the Governor's Interagency Council on Health Disparities; the Speaker of the House Task Force on Mental Health; and the Governor's Council on the Healthiest Next Generation. Nora has an MSW from the University of Washington and has completed her coursework for an MPH with an emphasis on maternal and child health, as well as coursework towards a PhD in social welfare. Being on the commission seemed a natural fit





**DANIEL VILLO**  
1st Term Expires 08/01/17

Currently the Labor Equity Manager for the City of Seattle where he directs the City's efforts to ensure access generated by its public expenditures. Daniel leads policy and compliance design efforts directly related to program workforce shaping, evaluation criteria in contractor participation and stakeholder education around supplier diversity, targeted hire and apprenticeship access. Daniel currently serves as the Chair of the U.S. Department of Labor Advisory Committee on Apprenticeship at the behest of US Secretary of Labor. Formally the Director of the California Construction Academy at the UCLA Labor Center he directed research and analysis of issues facing the construction industry in the new green economy. A recognized subject matter expert he authored a nationally recognized book on workforce development in the sector and speaks regularly at industry leading events. Daniel has decades of experience in building alliances with building trades unions, local and municipal governments and workforce development agencies. His commitment to access at all levels materializes in the role he plays as the National Secretary for ALPFA, the largest Latino professional membership organization in the country. Daniel holds a BSBA and an M.B.A. and serves on a variety of additional boards and committees.



**EUISEO JOHN JUÁREZ**  
1st Term Expires 8/01/16

He is the Political Director for Progressive Majority Washington and an independent scholar working to examine barriers to civic engagement for marginalized communities. He is the founding Director of Central Washington Progress, serves on the Board of the Washington Bus, an organization that engages tomorrow's leaders on their own terms, and empowers them through education, civic and cultural engagement, and hands-on democracy. He also is on the Board of Directors for Seattle Education Access. After a stint with the US Peace Corps in the Kingdom of Cambodia and then organizing with SEIU Healthcare 1199NW in the South Puget Sound region, EJ now works providing innovative multi-platform communications strategies for Washington State's largest anti-poverty organization, the Statewide Poverty Action Network. EJ holds a Master's degree in Cultural Studies from the University of Washington where he was a Civic Engagement Fellow and a Bachelor's degree in Community Services from Saint Martin's University in Lacey, WA.



**DAVID MORALES**  
1st Term Expires 8/01/17

He is a legal aid attorney in Yakima focusing on farmworker clients. He practices primarily employment rights and civil rights law. David has previous experience in immigrant rights, voting rights, and prisoner rights, having worked for Latino Justice, the Southern Poverty Law Center, the Mexican American Legal Defense and Education Fund, and Catholic Charities of San Antonio Immigration Services. David was appointed in August of 2014 to serve on the Commission. Aside from his work on the Commission for Hispanic Affairs, David is involved in various organizations dedicated to the betterment of the Yakima valley. He volunteers for the United Way of Central Washington. Further, he teaches for La Casa Hogar, a non-profit that aims to serve the Latino Community through education, health and civic programs. Additionally, he continues to be an active participant in the Yakima Valley Dream Team, a grass roots group created to advocate immigrant rights in Yakima. David moved to Yakima after graduating from Columbia Law School in 2012. He is a 2008 graduate of the University of California, Berkeley and spent a year with the Jesuit Volunteer Corps in San Antonio, Texas.



**RICARDO ESPINOZA**  
1st Term Expires 8/01/16

He was appointed to the Commission in 2013. He graduated from Pasco High School. He went to Columbia Basin College and earned a Bachelor's degree in Accounting from The Washington State University-TC. A veteran, Ricardo served in the United States Marine Corp for seven years. He is currently employed by the Department of Corrections where he provides accounting services. Mr. Espinoza served his community as an elected School Board Member for almost 10 years. During that time, he was selected by to represent southeastern Washington on the Board of Directors for the School Directors Association and later, was elected Vice President to the state wide association. Mr. Espinoza contributes his critical thinking skillset and his ability to examine challenges to work towards solving core issues. "My focus is the education of our youth and civic engagement; the two go hand in hand to me in order to better prepare young people to lead in our communities."

## STAFF



**URIEL ÑIGUEZ**  
Executive Director

An immigrant from Mexico; he was first appointed by Governor Christine Gregoire as Executive Director of the Commission on Hispanic Affairs in June 2005. Uriel was reappointed by Governor Insee in January 2014 and also appointed to the Eastern Washington University Board of Trustees. Prior to his appointment as Executive Director, he worked for the Department of Corrections, and served as volunteer Commissioner for the Commission on Hispanic Affairs. During his tenure in the Department of Corrections, he held the positions of Community Corrections Officer, Prison Counselor, Regional Correctional Manager, Associate Superintendent, Field Administrator, and Management Services Chief. Mr. Ñiguez holds a BA in Human Resources Management from Eastern Washington University and a Master's degree in Public Administration from City University. Since his appointment as Director, Mr. Ñiguez has been instrumental in: Organizing the Healthcare, Economic and Educational Diversity Summits, Organizing the Hispanic/Latino Education Forum, Establishing a state wide Spanish radio program, Publishing four Hispanic/Latino Assessments in Spanish and English, Reinstating the Hispanic/Latino Legislative Day, Founder of the Latino Civic Alliance Organization, Developing a Parent training Educational Manual, Developing Parent Training Institutes on our Educational System, and, Developing a Latino Business Directory.



**JESSICA BABCOCK**  
Executive Assistant

Originally from Southern California, Jessica has a M.A. in Conflict Transformation and a B.A. in International Studies and Spanish with a minor in Religious studies. Throughout her education Jessica was involved with cross-cultural experiences in Ecuador, Spain, Turkey and Nepal. Since Jessica began working with the Commission on Hispanic Affairs, she feels a connection between her bi-cultural background and the work the Commission does. Jessica wants to continue to work towards social justice and cultural awareness in the community.



# Washington State Commission on Hispanic Affairs (CHA)



### *Introduction*

The Washington State Commission on Hispanic Affairs ("CHA" or "the Commission") was created by a Governor's Executive Order and established in statute in 1971. As mandated by the state legislature, the Commission's functions are to improve public policy development and the delivery of government services to the Hispanic community through the following means:

1. Identifying and defining issues concerning the rights and needs of Washington State's Hispanic Community;
2. Advising the Governor and state agencies on the development of relevant policies, plans and programs that affect Hispanics;
3. Advising the legislature on issues of concern to the state's Hispanic community;
4. Establishing relationships with state agencies, local governments, and members of the private sector.

The Commission strives to improve public policy development and the delivery of government services to the Latino community and it is to this end that the Commission and its 11 Commissioners spend a significant amount of time collaborating with agencies,

servicing on committees, advising educational agencies, and advising the legislature on identifying and establishing policies that meet and/or address the needs of the Latino community.

The following report will highlight the activities of the Commission over the past two years, identify the Commission's priorities, specifically in the area of Health, and speak to the work and dedication of CHA's volunteer Commissioners and our partners within the Latino community.

### *History of CHA*

The Commission began in 1971 as a strong grassroots movement to improve the conditions for Latinos in the state of Washington. A substantial amount of community action leading to the creation of CHA rose out of the Yakima Valley as well as other areas with high farm worker populations. During this time, a group of Latino community advocates saw the need to take their concerns to the state in order to advocate and lobby for community development. The official creation of CHA was part of a larger history of the Chicano movement that peaked in Washington in the late 60s and early 70s.

The Director of CHA has generally been identified as the official public figure of CHA. Uriel Iñiguez is the fourteenth CHA Director, and has been serving as Director since 2005. He is, to a great extent, the spokesperson or the reference point.

The eleven volunteer Commissioners make up the official CHA board. They are appointed by the Governor with the goal of achieving a balanced representation of the Latino community of the state. The Commissioners represent their designated regions, interests, and expertise. The Commissioners select a Chair and Vice-Chair who have the authority to speak for CHA as a whole.

The current make-up of the Commission reflects a wide range of interests, generations, and ethnic backgrounds. CHA has 11 Commissioners who specialize in a variety of areas, especially higher education and K-12 education, economic development, health and human services, and civic engagement. Some Commissioners are first generation immigrants, others are second or third generation. We have a commissioner from Chile and others are of Mexican descent or first generation Mexican.

The different backgrounds of our Commissioners bring different strengths to the table, and make for a dynamic team that draws upon those strengths to help one another effect change and to improve services to the Latino community.

### *CHA Priorities 2015-2018*

As part of Governor Inslee's "New Strategic Framework," an overall campaign called Results Washington to improve the lives of all Washingtonians was devised through education and innovation. The Commission has aligned its own priorities with the goals set forth by Executive Order 13-04. These goals are: (1) World-Class Education, (2) Prosperous Economy, (3) Sustainable Energy and a Clean Environment, (4) Healthy and Safe Communities, and (5) Effective, Efficient, and Accountable Government.

The Commission has dedicated itself to these goals and has worked to create its own tasks within each of these priorities in order to specifically support and create a positive impact on the Latino communities of Washington State. Commissioners continue to build relationships with the legislature, community and state leadership, government and non-profit agencies and organizations, and local and state educational systems as part of this new agenda in an effort to be more efficient and effective.

### World-Class Education

With the success of our previous projects, the Commission has continued to make huge strides towards closing the educational opportunity gap and improving parent involvement in schools. *The Leading Change Through Advocacy* project, which concluded in 2012, contributed immensely to the success within the Hispanic community in giving Latino students 21st century skills. CHA continues to advocate for education by many other ways.

Achieving equal access, opportunity, and success in post-secondary education is another priority of the Commission as we continue to work towards closing the opportunity gap, ensuring that prevention services are provided and ensuring that parents are engaged and well informed. A large step towards achieving this goal has already begun with the passing of the REAL Hope Act. On February 26th 2014, Governor Jay Inslee signed the initiative which stands for "Realizing Educational Access, Changing Lives." This new law added \$5 million dollars to the state need grant. Now, undocumented students who have received a high school diploma or equivalent are able to receive financial aid to assist in furthering their education.

CHA Commissioners continue to be involved in the fight towards educational equality by working on a variety of committees including the Eastern Washington Disproportionality Committee, the OSPI School Discipline Taskforce Committee, the Educational Opportunity Gap Oversight and Accountability Committee, Migrant Advisory Committee, the Para Educators Committee, Department of Early Learning, Trio and Gear Up Programs.

### Prosperous Economy

Economic Development continues to be a top priority for the Commission. Increasing access to job opportunities, workforce development programs and education as well as access to culturally relevant business resources are some of our goals. We are also striving towards more equitable fair lending access and consumer debt protection as many Latino owned businesses are struggling to obtain contracts and grants for their businesses.

The online Latino Business Directory is continuing to achieve success as we have grown to over 1,000 Latino businesses that are registered and receiving assistance in obtaining access to state government contracts. This initiative was

created in 2011 in connection with the Office of Minority and Women's Business Enterprises (OMWBE) and the Washington Hispanic Media Association (WAHMA), a group of Hispanic leaders working towards developing and sustaining professional development of the Latino community. The purpose of the project is to not only increase access to government contracts but to bring awareness of the benefits of OMWBE certification and the process of obtaining it for Hispanic businesses. As a result of these efforts, CHA assisted in creating a state agency OMWBE Participation Plan (RCW 39.19.060) template of certified Women and Minority business on state contacts (procurement).

CHA Commissioners are also working towards creating a new Washington State non-profit Minority Business Advisory Council to build leadership capacity within the state of Minority Business advocates. There is continued collaboration with the Office of the Attorney General to increase communication and outreach to the Latino community on issues such as fraud and consumer protection. In December 2013, CHA attended a Pre-Summit Community Forum from the Governor's Minority Business Policy to become informed of resources to share with the Hispanic Community. In January 2014, the Commission met with the Office of Financial Management in regards to the support for the inclusion of women and minority owned services. Other efforts include Small Business Liaison Team with the Governor's Office for Regulatory Innovation and Assistance, Career Technology Education, Workforce Development Council and working in an advisory role to multiple Chambers of Commerce.

### Sustainable Energy and a Clean Environment

It is also important to the Commission that we strive to create a safe and healthy environment for our future generations to inhabit. Engaging Latinos in shaping our environmental and sustainability policy is thus a priority for the Commission as we work towards improving air quality in Latino communities and working towards inclusion in the growth of green jobs for Latinos. It is important to have protection from unsafe pesticide use as well as reducing the exposure to industrial toxins. This is particularly relevant when it comes to our Latino farmers. The Commission is working to create an Action Plan with Farm Worker Groups on Pesticides to reduce the number of pesticide-related illnesses.

CHA Commissioners are actively involved with their work on several committees including the Farm Worker Coalition, Washington Environmental Council, Sanitation Board in the Department of Health, the Department of Ecology, and the Environmental Health Department. The Commission will continue to encourage legislators to request Health Impact Statements on all ground water related legislation. The Commission will also identify legislation champions from key Latino areas to champion request for Health Impact Statements.

### Healthy and Safe Communities

Since the last assessment report, CHA has continued to work towards creating more healthy and safe communities for all Latinos. As the majority of this report is focused around Health and the Latino community it will not be discussed at length in this section, however, the Commission will continue to work towards their goals within the Results Washington framework which include equitable access to services, reducing racial disproportionality in the justice system, ensuring safe and healthy housing, increasing healthcare quality and delivery and reducing the obesity in Latino communities.

In order to achieve these goals the Commission continues to work with agencies such as the Department of Social and Health Services, the Department of Health, Department of Licensing, Health Care Authority, Healthy Washington Coalition, Anencephaly Committee, Diabetes Taskforce, the Latino Center for Health at the University of Washington, the Governor's Interagency Council on Health Disparities, The Speaker of the House Task Force on Mental Health and the Governor's Council on the Healthiest Next Generation.

### Effective, Efficient, and Accountable Government

The Commission continues to work to increase full and equitable participation by Latinos in government. It is important that we as a Commission work to increase hiring and inclusion of Latinos in middle/senior level management as well as increase civic engagement and participation among the Hispanic Community. We continue to hear from our community about incidents concerning racial profiling and harassment, which we are constantly working to eliminate through education and creating more culturally and linguistically accessible resources and services. An example would be our Commissioners'

involvement in the Voting Rights Act and with youth vote tables to get Latino youth more involved and engaged. Commissioners are collaborating with the Racial Equity Team and Win-Win Network and also serve on advisory committees with Results Washington, working with DSHS on internships and the Law and Justice Council.

The Commission on Hispanic Affairs has built many other strong partnerships over the past few years. These include Washington State Coalition for Language Access (WASCLA), Esparza Plus, Everett School District, Hispanic Roundtable, Latino Community Fund, Office of the Education Ombudsman, State Farm, Washington State Court Appointed Special Advocates (CASA), National Association of Latino Elected Officials (NALEO), Washington STEM, Latino Civic Alliance, and the Latino Achievement Project (LEAP).

### *CHA Legislative Activities and Session Review 2013-2014*

The past two years the Commission has seen legislative transition. Following some tough sessions in both 2011 and 2012 with many budget difficulties, a new governor was elected. His tenure began January 16, 2013 and resulted in various administrative changes.

The 63rd Legislative Session of 2014 began January 13th and continued through March 13th. During this session budget issues were the main priority. The legislature failed to create a fiscal budget plan and Governor Inslee was forced to call two special sessions in order to complete the budget. After passing their own budgets, the House and Senate were finally able to agree on one budget in June 2013 which comprised of \$33.6 billion. It was the first time in 20 years that the legislature reached a budget so late in the year.

The Commission as a group was involved in several meetings with legislators to share with them issues within the Hispanic community. The Commission offered assistance to the legislature by providing outreach and advocacy to the Hispanic community in order to meet mutually beneficial goals. The Commission worked to identify legislation, drafted talking points and met with specific legislators.

The highlight of the 2014 session was the passing of the Dream Act which changed its name after its initial passing in the House on February 18th. On February 26th

2014, Governor Jay Inslee signed the "REAL Hope Act", which stands for "Realizing Educational Access, Changing Lives." This new law added \$5 million dollars to the state need grant. Now, undocumented students who have received a high school diploma or equivalent are able to receive financial aid to assist in furthering their education. Many of our Commissioners had direct involvement in seeing this bill pushed through, whether reaching out the Governor himself or testifying on the Educational Committee.

Other important legislature included several bills on Interpreters (HB 1709, HB 1815). The first bill required a study to develop a state foreign language education interpreter training program. The second was to assure that education-related information is appropriately provided to parents with diverse cultural and linguistic backgrounds. Work also continued on the Educational Opportunity Gap (Bill 1680). As well as, the Voter Rights Act (House Bill 1413) which addresses local community government and looks at issues around polarized voting. District voting prevents certain communities from being represented, particularly the Hispanic Community making it a priority of the Commission. Finally, the Commission worked with OMBWBE to pass the Accountability Bill (HB 1674) that gives the minority-contracting agency more support in eliminating fraud and mismanagement.

### *"Conozca su Gobierno con Uriel Iñiguez"*

In 2010 the Commission started the Conozca Su Gobierno (Know Your Government) radio program which currently airs on Tuesdays from 11 a.m. - 12 p.m. on Radio Luz KTNS 1680 AM (Seattle and Puget Sound and streamed by Radio KDNA 91.9 FM (Yakima Valley) and KSVR 91.7 FM (Skagit). Our Wednesday programs are from 10:30 - 11:00 a.m. with El Radio Rey (1360 AM Seattle). Thursdays air from 10 - 11 a.m. on Radio La Nueva 103.3 FM and 92.1 FM (Wenatchee). The radio program has now expanded its broadcasting range over 5 different frequencies, covering about 70% of the state including online streaming. On the show, Executive Director, Uriel Iñiguez interviews different state agency representatives to discuss important issues such as taxes, loans, car purchasing, driver's licenses, homeownership, consumer protection, educational and health issues and other subjects relevant for primarily Spanish-speaking Washington residents.

## V. THE COMMISSION AND ITS ACTIVITIES

The purpose of the program is to assist other state agencies in their outreach to the Latino community. Agencies each have 1/2 hour to discuss a topic of concern to the Spanish-speaking community. CHA staff moderate by asking clarifying questions and providing phone numbers and other resources for the listening audience. In continuing our efforts to connect the community to the Commission, the 2014-2015 Radio Program has welcomed our current Commissioners on the air once a month to help facilitate conversation, generate new learnings and build relationships. The Commission encourages community members to call in with questions or concerns.

With our recent expansion, we have increased the number of agency sponsors from 14 to 21. The following agencies or partners are new to the program: Eastern Washington University, Department of Enterprise Services, Department of Services for the Blind, Washington State Employment Security Department, Attorney General's Office, and the Washington State Achievement Council. We are very happy to congratulate our Gold Level sponsors for their continued support in this program: Department of Financial Institutions, Washington State University, the Attorney General's Office, and one of our new sponsors Eastern Washington University.

### *CHA Community Meetings*

The CHA Director and Commissioners holds an average of 300 meetings per year with many different agency heads, community members and leaders, non-profit organizations, legislators, and other elected officials.

In order for the Washington State Commission on Hispanic Affairs to meet its mandate, it is imperative that the Commission understand the needs and issues of the Latino communities of Washington. One of the best ways to carry out this mandate is to meet with Latinos through public community meetings. These forums provide Commissioners an opportunity to identify issues or concerns, such as equitable access to community and state services, community safety issues including pesticide and worker safety and water runoff, areas concerning disproportionate educational services, and any other issue pertinent to the Latinos in that area. Community meetings are conducted in areas represented by one of the Commission's 11 Commissioners. Local Commissioners bring in community leaders, state and federal agencies, local organizations and educational service districts to address concerns or issues previously identified at the public community meetings.

Due to budget cuts, the Commission has decided to only hold 4 public meetings per year. CHA works on publicizing each meeting as much as possible in order to garner the highest possible attendance. In each meeting the Commission attempts to address as many issues as possible to try to meet the needs of each Latino community. Commissioners also follow up individually with their community members to work towards resolving these issues.

Several community meetings at the beginning of 2013 took place. The first was in March in Olympia with several representatives present including John Bash, Deputy Superintendent of North Thurston Public Schools; Sandra Romero, Thurston County Commissioner; Sharon Ortiz, Director of Human Rights Commission; Terry Jeffreys, Mason County Commissioner; Dick Cvitanich, Superintendent of Olympia School District; and Sharon Gilbert, DSHS Children's Services. The meeting addressed concerns around public safety, housing and education. Information on local Latino demographics was also provided. There was animated conversation about equitable access and the barriers to numerous services due to lack of interpreters and translators especially in schools and also in terms of lack of parent engagement. It was determined that there was a need for greater effort to empower parent's to voice their opinions on various issues within the education system. The Commissioners in attendance walked away more aware of these issues and are actively seeking to develop strategies to reach out to the Latino community in order to increase access. Part of this effort includes attempts to increase Spanish-speaking staff to disseminate information to the Latino community, an ongoing struggle in the state.

Shortly thereafter another meeting was held in Mattawa around similar issues - lack of safe and affordable housing, labor & industry issues with the farmworker community, and the opportunity gap in education and language access. Some panelists included: Silvia Barajas, Mattawa City Council; Cindy Carter, Grant County Commissioner; Jerry Yorgesen, Wahluke School Board Member; Steven Saxe, Dept. of Health Representative; Pedro Serrano, L&I representative; John Turley, Mattawa Police Chief; and Sharon Ortiz, Executive Director of the Human Rights Commission.

The Commission held a 3rd meeting with a student population in Cheney, WA on the campus of EWU. The focus was on post-secondary education and included panelists: President Dr. Rodolfo Arévalo from Eastern

Washington University, Ms. Cynthia Vigil from Spokane Falls Community College, Dr. Shelley Redinger who is the Superintendent at School District 81 and Dr. Mary Jo Buckingham, Director of Special Programs at Central Valley School District. Dreamers in attendance had questions clarified on 1079 status.

On October 18th, 2013 the Commission held its fourth meeting in the Bellingham community. The Commission met with law enforcement to talk to them about Latinos being sent to detention centers after being pulled over, community fears of deportation if they needed to call 911. Law Enforcement recognized a tangible need for Spanish-speaking officers. They agreed that a partnership with the Commission to increase recruitment would be helpful. Among this issue, the Commission was interested in talking about health issues within the community and issues with providing information to Latinos. The Commission also brought in Steve Neugembauer, Hydrologist at Whatcom County and Kyle Dodd, Water Quality Specialist in Whatcom County to talk about water quality in the Bellingham area. The Commission will continue to prioritize civic engagement with the Hispanic community.

With the implementation of the Affordable Care Act (ACA) by Executive Order 13-05, the landscape of health care has changed for the better by providing access to quality and affordable health care to the majority of people residing in the United States. In the State of Washington there is still much work to be done. The Commission has decided to take a closer look at some of the topics within health care to provide information about some of the issues affecting the Latino population. Linguistically and culturally appropriate services have been lacking in both physical and mental health services in the state. For example, several of our Commissioners were involved in the translation of our materials that the Health Benefits Exchange used to sign up the community to a health plan. There are many other efforts to improve mental health, provide safe and quality housing, and improve the health of young Latinos, all of which will be discussed in the articles that follow.

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### *Activities in the Health Area*

As mentioned earlier, the Commission continues to work towards creating more healthy and safe communities for all Latinos. The Commission has been active in working towards these efforts by collaborating with other state agencies such as the Department of Social and Health Services, the Department of Health, Department of Licensing, Health Care Authority, Healthy Washington Coalition, Anencephaly Committee, Diabetes Taskforce, and the Latino Center for Health at the University of Washington.



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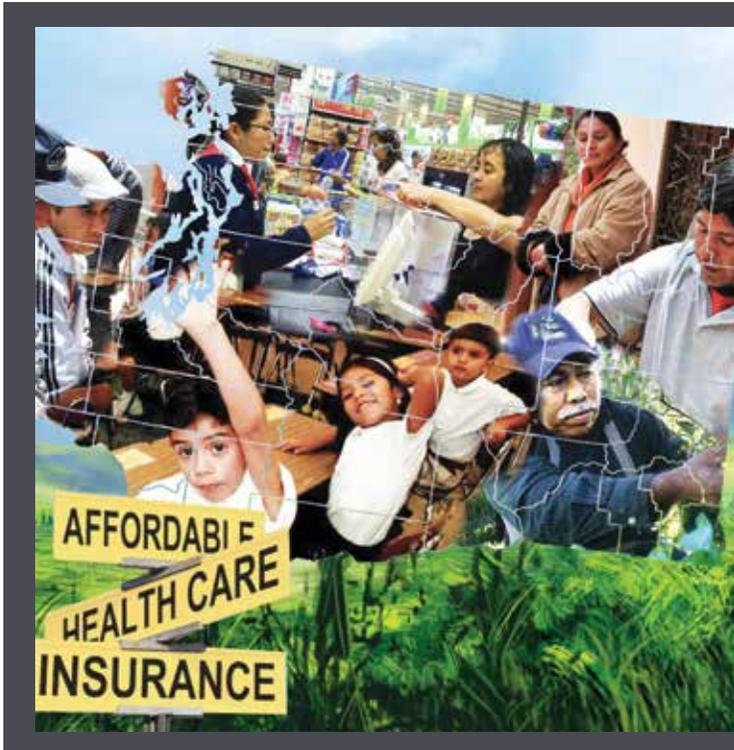


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## The Latino Health in Washington State: Longevity, Disparities and Inequities

Jerry García, PhD

As of 2014 the Latino<sup>1</sup> population in the United States has reached 53 million and is projected to reach 86 million by 2030 and 133 million by 2050. The Latino population in Washington State has reached 807,998 or 11.7 percent of the overall population ranking 12th in the nation. The growth of the Latino population in Washington has mirrored the national trend since 2000. For example, from 2000-2012 the Latino population in Washington State has grown by 363,280 individuals or 81.7 percent.<sup>2</sup> Additionally, immigration coupled with a large youthful demographic and reinforced by a higher fertility rate make Latinos the fastest growing population in the state of Washington. The Latino population in Washington is predicted to grow rapidly within the next couple of decades reaching over one million by 2030. However, the delivery of healthcare to Latinos has not kept pace with the growing population. Indeed, growing disparities continue to be the norm for the Latino population in Washington State. The Centers for Disease Control and Prevention has cited some of the leading causes of illness and death among Latinos, which include heart disease, cancer, unintentional injuries (accidents), stroke, and diabetes. Some other health conditions and risk factors that significantly affect Latinos are: asthma, chronic obstructive pulmonary disease, HIV/AIDS, obesity, suicide, and liver disease. Certainly there is a national and state crisis regarding Latinos and health. What has the

state of Washington implemented to narrow health care disparities and eliminate inequities? How will the national Affordable Care Act impact Latinos and healthcare? (See Table 1)

In his campaign for governor of Washington State [Governor] Jay Inslee made health care a top priority. On April 4, 2014 Governor Inslee signed into law several bills that continue Washington's push to improve quality of health care delivered in the state and reduce costs. According to the Governor's office Washington's State Health Care Innovation Plan has three major components: Building healthier communities, including prevention and early mitigation of disease; Paying for health outcomes rather than the volume of office visits, tests and procedures; Coordinating the care patients receive, including bringing together mental health and substance abuse with primary medical care.<sup>3</sup> Governor Inslee's health initiatives and the national Affordable Care Act (ACA) come at a time when Latinos suffer from some of the largest health disparities in the nation.

The weakest link regarding Latino health in Washington State is the lack of health insurance. The growing Latino population nationally and at the state level requires immediate attention with regards to health insurance coverage. There is substantial evidence demonstrating that people

TABLE 1  
Changes in the Characteristics of the US Hispanic Population by Origin, 2000 and 2010

	Median Age		Less than high school <sup>1</sup>		High school diploma only <sup>1</sup>		Bachelor's degree or more <sup>1</sup>		Proficient in English <sup>2</sup>		U.S. citizens <sup>3</sup>		Poverty <sup>4</sup>		Home Owners <sup>5</sup>	
	2000 - 2010 years	2000 - 2010 (%)	2000 - 2010 (%)	2000 - 2010 (%)	2000 - 2010 (%)	2000 - 2010 (%)	2000 - 2010 (%)	2000 - 2010 (%)	2000 - 2010 (%)	2000 - 2010 (%)	2000 - 2010 (%)	2000 - 2010 (%)	2000 - 2010 (%)	2000 - 2010 (%)	2000 - 2010 (%)	
All Hispanics	25	27	48	38	22	26	10	13	59	65	71	74	23	25	46	46
Mexicans	24	25	54	43	21	26	7	9	57	64	68	73	23	27	48	50
Puerto Ricans	27	27	37	25	26	30	12	16	73	82	99	99	26	27	34	38
Cubans	40	40	37	24	20	29	21	24	54	58	73	74	14	18	58	57
Salvadorians	28	29	64	53	17	24	5	7	38	46	43	55	20	20	32	42
Dominicans	29	29	49	34	21	26	11	15	46	55	57	70	28	26	20	24
Guatemalans	27	27	61	54	17	22	7	8	36	41	38	49	22	26	27	30
Columbians	33	34	26	15	25	27	23	32	50	59	54	66	17	13	41	49
Hondurans	28	28	55	47	21	26	9	10	39	42	40	47	26	27	24	29
Ecuadorians	31	31	36	30	25	26	14	18	45	50	49	60	17	18	31	39
Peruvians	33	34	18	11	27	27	25	30	53	59	50	62	12	14	42	49

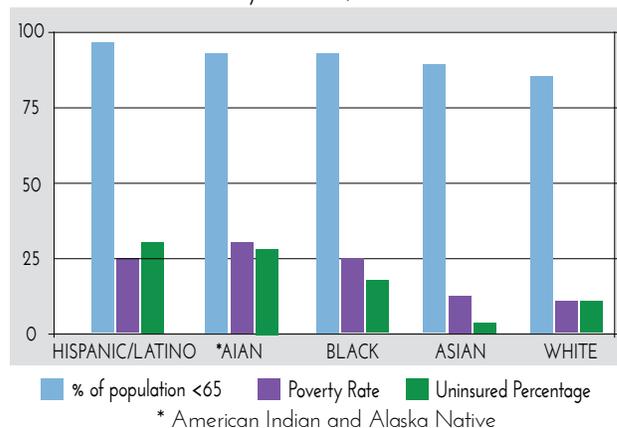
<sup>1</sup>Based on adults ages 25 and older. <sup>2</sup>Based on population ages 5 and older and includes those who speak English at home or speak English very well. <sup>3</sup>Includes U.S. citizens by birth or naturalization. <sup>4</sup>Poverty status is determined for individuals in housing units and non-institutional group quarters. The poverty universe excludes children under age 15 who are not related to the householder, people living in institutional group quarters and people living in college dormitories or military barracks. For detailed information on how poverty status is determined see <http://u.s.a.ipums.org/usa-action/variables/POVERTY=description...tab>. Due Bureau. <sup>5</sup>Includes household heads living in owner-occupied homes. The household population excludes persons living in institutions, group quarters, college dormitories and other group quarters. Source: Pew Hispanic Center tabulations of the 2010 ACS (1% IPUMS) and the 2000 Census 5% IPUMS) PEW RESEARCH CENTER

without health coverage for needed care have greater problems accessing healthcare because of cost, are less likely to have a regular doctor and are less likely to receive healthcare when they need it. In 2009-2011, 16 percent (or 49.1 million) of the overall national population had no health insurance coverage. Of all racial/ethnic groups, Latinos are the less likely to have health insurance coverage. Most Latinos who lack a provider are male (69 percent). According to the Pew Hispanic Center, "more than one-fourth of Hispanic adults in the United States lack a usual health care provider, and a similar proportion report obtaining no health care information from medical personnel..."<sup>4</sup> Nearly one in three (30.7%) people uninsured in the U.S. is Latino. Latinos are nearly three times more likely than Whites to be uninsured. Uninsurance is generally lower among children than adults, but Latino children are still more than two times more likely than White children to be uninsured.

According to the Washington State Office of the Insurance Commissioner, "Heading into 2014, the number of uninsured and underinsured people and the amount of uncompensated care remain critical in Washington State."<sup>5</sup>

By the end of 2012 there approximately 990,000 uninsured Washingtonians or 14.5 percent of the state. The uninsured are primarily adults of working age (between 18-64). These adults have fewer options than children and older adults. Latinos in Washington State were nearly three times as likely to be uninsured than non-Hispanics (30% vs. 11%). Lower economic status and income gaps also play a pivotal role in health disparities.

FIGURE 1  
Washington State: Higher poverty rates lead to insurance disparities by ethnicities, 2014.



Racial and ethnic minorities are more likely than non-Hispanic Whites to be poor or near poor. For example, the median income for Latinos in 2012 was \$39,005 compared to Whites at \$57,009.<sup>6</sup> Another measure is to examine the percentage of Latinos in poverty. Based on 2012 census data 25.6 percent (13.3 million) of Latinos lived in poverty compared to 9.7 percent for non-Hispanic Whites. Health disparities among Latinos in Washington State are often due to the levels of poverty. Groups with average household incomes below \$50,000 are most likely to lack insurance. Latinos have one of the highest family poverty rates in the state (26%). Communities of color tend to have lower incomes and less education than White communities and this lower socioeconomic status are the major factor contributing to the poorer health experienced by the Latino population.<sup>7</sup> Latinos with low educational attainment comprise a large proportion of those lacking a provider; 47 percent report having less than a high school diploma. The vast majority of those with no usual place for health care are of Mexican origin (69 percent), and additional 11 percent are of Central American origin.<sup>8</sup>

Even when income and education are taken into account, disparities for Latinos persist. Institutional and interpersonal racism have an impact with the inequities in health. Institutional racism occurs when programs and policies manifest in reduced access to goods, services, and opportunities for Latinos. Furthermore, Latino health is often shaped by factors such as immigration status, language/cultural barriers, lack of access to preventive care, and the lack of health insurance. Washingtonians who are not U.S. citizens are far more likely to be uninsured than other state residents. For example, 40.7 percent of immigrants who are not U.S. citizens are uninsured, compared to 17.2 percent of immigrants who have become citizens through the naturalization process.

However, the general health for Latinos varies from generation-to-generation. Researchers have known that many first generation Latinos come to the United States with a more favorable health status considering their circumstances that has become known as the “epidemiologic paradox,” which indicates an association between residency in the U.S. and increasingly adverse risk factors and poorer health status.<sup>9</sup> Obesity and diabetes are excellent examples of the increased risk factors associated with long-term residency in the United States for Latinos.

Obesity is associated with an increased incidence of diabetes, cardiovascular disease, liver disease, certain types of cancer, gall bladder disease, asthma and other respiratory problems. In general, Latinos have a higher rate of obesity than non-Latino Whites. According to the Office of Minority Health, 73% of Mexican American women are overweight or obese, compared to only 61.6% of the general female population. In 2009, Latinos were 1.2 times as likely to be obese than non-Latino Whites and Mexican American children were 1.4 times more likely to be overweight as non-Latino White children.

Yet, one anomaly that continues to perplex medical personnel is the life expectancy for Latinos. Racial and ethnic differences in life expectancy at birth, an overall indicator of health in the population, continued among both males and females in 2010. From 1940 to 2010, life expectancy at birth in the United States increased from 60.8 years to 76.2 years for males and from 65.2 years to 81.0 years for females. Latinos, for reasons that are not clearly understood, have longer life expectancy at birth than non-Latino White or non-Latino Black males and females. As of 2011, life expectancy at birth for Latino males was 78.9 years and 83.7 years for Latinos.<sup>10</sup>

TABLE 2  
Life Expectancy at Birth, by Race/Ethnicity and Gender,  
United States, 2010

	BOTH SEXES	MALE	FEMALE									
2006	77.8	75.2	80.3	80.3	77.5	82.9	78.2	75.7	80.6	73.1	69.5	76.4
2007	78.1	75.5	80.6	80.7	77.8	83.2	78.4	75.9	80.8	73.5	69.9	76.7
2008	78.2	75.6	80.6	80.8	78.0	83.3	78.4	76.0	80.7	73.9	70.5	77.0
2009	78.5	76.0	80.9	81.1	78.4	83.5	78.7	76.3	81.1	74.3	70.9	77.4
2010	78.7	76.2	81.0	81.2	78.5	83.8	78.8	76.4	81.1	74.7	71.4	77.7
2011	78.7	76.3	81.1	81.4	78.9	83.7	78.8	76.4	81.1	74.8	71.6	77.8

Sources: Table 7. National Vital Statistics Reports, 61 (4). 2013 Table 6. National Vital Statistics Reports, 61 (6). 2012. Note: 2011 data are preliminary.

Nevertheless, Latinos in Washington remain severely uninsured, which results in a multitude of health disparities. The implementation of the Affordable Care Act (ACA) on January 1, 2014 has the potential to remedy and alleviate some of these disparities.

Although too early to examine data on Latinos and ACA, it is possible to make some comments based potential outcomes. For Latinos, ACA is billed as a major push towards providing health insurance for Latinos and eliminating health care disparities and inequities. According to

the U.S. Department of Health & Human Services (HHS) the implementation of ACA, for Latinos, like other ethnic minorities, addresses inequities in access to quality, affordable health coverage. As previously mentioned Latinos suffer from some of the highest rates of chronic illness and disease, while simultaneously one of America's most disproportionately uninsured populations. HHS estimates that 10.2 million uninsured Latinos have new opportunities for affordable health insurance coverage. ACA promises Latinos greater control over their own health care by ensuring Latinos have access to free preventive services, management of chronic diseases, ensure that all Latinos have access to a primary care doctor, fight health disparities, overall lower health insurance cost for families, financial relief in the form of tax credits and discounts on brand name drugs.<sup>11</sup>

### *Strategies and Tools to Help Latino families Overcome Barriers to Coverage and Care*

- Community Outreach through health and wellness messages that resonate with the Latino community
- Continuing education and training for physicians, nurses and other health providers that build cultural awareness and develop skills to address cultural differences
- Enhancing linguistic skills of staff and community partners to provide high-quality interpreting services
- Educating families about coverage options and enrollment process (ACA)
- Evidence-based research and analysis as well as initiatives that partner with academia and community organizations to improve the health of the community
- Providing families with a list of required documents and identifying alternative options
- Create a single, state subsidized health insurance plan for public programs that includes options to cover all in families with incomes below 200% of the federal poverty line
- There is a large body of evidence linking greater educational attainment with better health behaviors, self-reported health, health outcomes, and a longer life expectancy. The educational attainment gap for Latinos must be closed

At the state level between October 1 and November 7, more than 77,000 Washington State residents enrolled in ACA coverage. A small snapshot of the impact of ACA is available for Seattle and King county. According to Seattle and King County Public Health approximately 85 percent of King County's uninsured became eligible for public or subsidized health insurance under ACA. The highest concentration of newly eligible adults lives in south King County. On average, one in 12 adults in SeaTac, Des Moines, Federal Way, Kent, Auburn, Burien and Renton qualified under ACA. While ACA will significantly expand insurance coverage in King County, some people will remain uninsured in 2014 and beyond. Lawfully present immigrants are not eligible for the Medicaid expansion if they have lived in the U.S. for less than five years, and undocumented immigrants are ineligible regardless of how long they have been in the U.S.. According to U.S. Census Bureau, there are at least 5,800 uninsured immigrants in King County living at or below 138% of the federal poverty level (fpl) with a severe undercount of people who are undocumented. However, they will not qualify for Medicaid expansion, lawfully present immigrants who have lived in the U.S. for less than five years will be able to purchase coverage through Washington Healthplanfinder and those with incomes below 400% fpl may be eligible for subsidies.<sup>12</sup>

At the national level the U.S. government has struggled to get Latinos enrolled into ACA. Many critics point to a language barrier for the low enrollment of Latinos in places such as California. For example, initially California did not offer applications in Spanish and the numbers overwhelmed offices with few counselors to handle the volume.<sup>13</sup> The state of Washington has had a similar experience. One of the leading organizations in Washington that provides healthcare to Latinos is Sea Mar Community Health Centers. In 2012 Sea Mar Clinics treated 53,000 uninsured patients for medical reasons. According to Rudy Vasquez, the managed-care operations director at Sea Mar, the clinic has struggled to get information about ACA to the most in-need communities. According to Sea Mar a number of hurdles have negatively impacted the enrollment of Latinos. These obstacles include technical issues such as limiting the characters one can enter for a last name and the constant changes and delays of ACA, which has caused credibility issues, something very important to the Latino community. Just as important to Latinos is

the government' potential crack down on undocumented immigration, thereby causing hesitation by mixed family members, who fear data collected by the ACA could be used for nefarious purposes.<sup>14</sup>

In summary, the data clearly demonstrate a strong need to address the multitude of disparities and inequities regarding Latinos and the health care system in Washington State. Most studies reveal that Latinos experience poorer health than non-Latino Whites. The high level of uninsured and underinsured Latinos in Washington State must be addressed and made a priority. While having insurance does not guarantee timely access to high quality health care, research shows health coverage often equals access to health care on a more consistent basis. There is hope that the Affordable Care Act will alleviate some of the disparities and inequities that currently exist. However, many of the inequities that affect racial/ethnic groups are based on preconceived views and ideas that hinder or block access to health care. Nonetheless, the initiatives and bills implemented by the Governor and the Washington State Legislature in 2014 brings optimism to Latinos and the health care system in the state.

1. Throughout this report the label Latino or Latina is used rather than Hispanic in order to be more inclusive. Hispanic is used only in regards to government reports.
2. Pew Research Center's Hispanic Trends Project tabulations of 2000 Census and 2012 American Community Survey.
3. "Governor Inslee signs significant bills to improve health care and reduce costs." April 4, 2014, Washington Governor Jay Inslee. Accessed at <http://www.governor.wa.gov/news/releases/article.aspx?id=234>. May 31, 2014.
4. Livingston, Gretchen, Susan Minushkin, and D'Vera Cohn. "Hispanics and Health Care in the United States: Access, Information and Knowledge." A Joint Pew Hispanic Center and Robert Wood Johnson Foundation Research Report.
5. "The state of the uninsured and underinsured 2010-2014: A baseline report on health insurance before the Affordable Care Act." Washington State Office of the Insurance Commissioner, January 30, 2014, 2.
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7. "State Policy Action Plan to Eliminate Health Disparities." Governors Interagency Council on Health Disparities, June 2010.
8. Livingston, Gretchen, Susan Minushkin and D'Vera Cohn. "Hispanics and Health Care in the United States: Access, Information and Knowledge." A Joint Pew Hispanic Center and Robert Wood Johnson Foundation Report, 19.
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10. Jean Kayitsinga, "A Comparison of Latinos and Other Racial/Ethnic Groups on Key Health Indicators." NEXO Vol. XVII, No., Fall 2013, Julian Samora Research Institute, Michigan State University.
11. "Health Reforms for Latinos: The Affordable Care Act Gives Latinos Greater Control Over Their Health Care." The White House, [http://www.whitehouse.gov/files/documents/health\\_reform\\_for\\_latinos.pdf](http://www.whitehouse.gov/files/documents/health_reform_for_latinos.pdf)
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## Latino Health and Politics in Washington State

Vickie Ybarra, PhC, MPH, RN

There are three important dimensions to the intersection of health and politics for Latinos in our state: the impact of immigration status on health coverage, the social determinants of health, and political representation. Without addressing each of these three, gaps in the health of Latinos in Washington will likely remain.

### *Immigration Status and Access to Public Healthcare Coverage*

Publicly funded healthcare coverage remains a complex interaction of laws and politics between the federal and state governments, and immigration status makes it even more complex. The good news is that Washington State has long been on the forefront of providing access to publicly-funded coverage for low-income pregnant women, children and working adults, regardless of immigrant status. The bad news is that state budget pressures and federal Affordable Care Act (ACA) have forced changes that may erode the coverage.

A great example of the importance of federal-state cooperation is in public coverage for low-income pregnant women who are legal immigrants under the 5-year bar<sup>1</sup> and undocumented immigrants. Washington was among the first states in the nation to cover prenatal care for these women with state-only funds, dating back to the 1980s,

recognizing that prenatal care resulted in better birth outcomes and avoided potential Medicaid costs associated with the higher rates of infant health problems with no or late prenatal care. In 2003, the state transitioned that program to a shared state/federal program established during the Bush administration, which to this day continues coverage for Washington's low-income pregnant women who are legal immigrants under the 5-year bar and undocumented immigrants.

Up until 2011, Washington allowed low-income immigrants who were otherwise not eligible for Medicaid to participate in the state-subsidized Basic Health Plan. Then in 2011, in preparation for implementation of federal ACA, eligibility for those immigrants ended, and the whole state Basic Health Plan ended in 2013. Today low-income adults in Washington who are legal immigrants under the 5-year bar and undocumented immigrant remain ineligible for publicly-subsidized insurance by federal law (ACA); they are not eligible for newly expanded Medicaid, nor are they eligible to purchase either subsidized or non-subsidized private insurance on the healthcare exchange. There is a ray of hope for low-income legal immigrants under the 5-year bar—the federal ACA provided a federal Basic Health Program option for low-income adults not eligible for Medicaid.<sup>2</sup>

Currently the state is considering submitting a federal Basic Health Option that if approved by the federal government would provide access to subsidized health coverage for low income legal immigrants who have been here less than 5 years. Because the federal government has only just released the final rules governing these programs, the earliest Washington's federal Basic Health Option could be in place would be 2015.

Even with a federal Basic Health Option though, Washington's low-income adults who are undocumented immigrants will still be left without access to publicly subsidized health insurance coverage.

### Social Determinants of Health

As important as healthcare is, we know that healthcare is just a piece of the puzzle in achieving good health for Latinos and others. Behavior is important of course - exercising, avoiding tobacco, and maintaining a normal weight all involve choices we make in our daily lives. But while individual behavior and responsibility are necessary for good health, we also know that it is not as simple as that. The choices we make are limited by the choices we have, and we live in a society that does not distribute opportunity for positive choices equally. Our social and physical environments - our families, our schools, our neighborhoods, our workplaces - all contribute in big ways to whether we are healthy or unhealthy, yet the health risks and benefits that we gain from these environments are not distributed equally either. For example, research tells us that...

- An accumulation of adverse experiences in childhood is associated with unhealthy behavior and ultimately poor health in adulthood. In Washington State health surveys completed 2009-2011, Latino adults report that as children they experienced physical abuse, living with an alcoholic, living with someone who was incarcerated and domestic violence in the home at higher rates than non-Hispanic White adults.<sup>3</sup>
- Educational achievement is strongly associated with health status.<sup>4</sup> Yet the achievement gap for Latino children still exists in Washington State by almost any measure. At just 70%, the 5-year graduation rate for Hispanic students in Washington is over 11 points behind that for non-Hispanic White students.<sup>5</sup>
- People of color in Washington disproportionately live and work in environments that are hazardous to their

health, including disproportionate exposure to pesticide illness for Hispanic farmworkers in the state.<sup>6</sup>

Clearly more progress is needed on equity in the social determinants of health in order to protect the future health of Latinos in Washington.

### Representation

Without representation of Latino interests at policymaking tables, it is unlikely that gaps in Latino health can ever be fully addressed. Ultimately, the big policies governing public healthcare coverage for low-income groups and immigrants, and those that can address social determinants of health are made through political processes. The policymakers making the important decisions about programs to provide public subsidy for healthcare coverage and those who make decisions about schools and the environment and other social determinants, these people are elected officials. They are political actors who by the nature of their positions respond to the policy preferences of the people who vote them into office. So even the best of policies cannot address the needs of Latinos in Washington if Latinos in Washington are absent from the political process. And any way you count it, Latinos are under-represented in the political process in the state - from lack of representation in the state legislature and in local elected bodies, to low voting rates. Only 47% of Washington's Latino citizen adults voted in the 2012 presidential election, compared with 67% of all non-Hispanic citizen adults.<sup>7</sup>

To improve the health status of Latinos in Washington State, Latinos need to be a part of the political process - naturalized, registered, informed, and voting. Individual Latinos need to join their diverse opinions about healthcare coverage and social determinants with others who are like-minded, to make their voice heard to elected representatives, and to be a part of the process.

1. *The Personal Responsibility and Work Opportunity Reconciliation Act (PWRORA) 1996*, often known as *Welfare Reform*, prohibited states from using federal matching funds to extend Medicaid to legal immigrants who had not yet fulfilled a five year waiting period.
2. The federal Basic Health option is based largely on Washington State's Basic Health Plan and was championed in Congress by Washington's Senator Maria Cantwell.
3. Author's calculations using BRFSS ACE module data, 2009-2011, marginal weighted rates controlled for age: Living with physical abuse 22.4% Hispanic v. 20.1% NHWhite; alcoholic 30.2% Hispanic v. 28.9% NHWhite; incarcerated adult 9.2% Hispanic v. 6.8% NHWhite; domestic violence 23.4% Hispanic v. 18.1% NHWhite.
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7. U.S. Census Bureau, *Voting and Registration in the Election of November 2012, Table 4b. Reported Voting and Registration by Sex, Race and Hispanic Origin, for States: November 2012*. <http://www.census.gov/hhes/www/socdemo/voting/publications/p20/2012/tables.html>



## Why We Need the “Washington Voting Rights Act”

David Pérez, Constitutional Law Attorney in Seattle,  
co-author of the Washington Voting Rights Act

There has been a lot of talk about the Washington State Supreme Court race between Steven González and Bruce Danielson, which occurred back in 2012. At first, it did not seem like González had much to worry about. González was a decorated prosecutor, having successfully tried Ahmed Ressam, the Millennium Bomber, as the Assistant U.S. Attorney. He was also a well-known judge, having spent ten years on the King County Superior Court, earning a reputation as the hardest working and most intellectual judge on the bench. Based on this stellar resume, Governor Gregoire appointed González to fill a vacancy on the State Supreme Court.

As González was gearing up to run for re-election, it did not seem like anyone would challenge him. But then, at the very last minute—literally, the final hour before the filing deadline—Bruce Danielson threw his hat into the ring. Now we had a race. Danielson, a relatively unknown and unaccomplished lawyer would square off against a sitting State Supreme Court Justice. González raised a record amount of money for a primary race, secured endorsements from both parties (including Rob McKenna, Jay Inslee, Reagan Dunn and Bob Ferguson) and zipped across the state campaigning. González had every possible advantage over Danielson, who did not campaign or even raise a dime.

**Well, he had every advantage except one, his last name.**

### *Racially Polarized Voting in Central Washington*

Government by consent of the governed is the essential promise of democracy. It is a promise that through democracy we can produce a government of the people, by the people, and for the people. These are not just clever words or empty phrases on ancient parchment. These are our ideals. And for centuries Americans have died to protect and to defend these ideals.

But here in Washington State, outdated electoral systems have eroded our democratic principles by failing to keep pace with our state’s rapidly changing demographics. As a result, large segments of our state’s population—particularly African Americans, Asian American and Pacific Islanders, Native Americans and Latinos—have been virtually shut out of the political process.

This is one of those times where the numbers do not lie. For example, in 9 counties across Central Washington (Adams, Benton, Chelan, Douglas, Franklin, Grant, Okanogan, Walla Walla and Yakima) Latinos constitute over 33% of the total population, yet hold less than 4% of the local elected offices. Combined, these ten counties elect 69 port commissioners, 66 county officers, 51 judges and 30 county commissioners.

**Not a single one is Latino.**

Rarely has our state been faced with this challenge, not to its fiscal health or its economic growth, but to the values that form the basis for our democracy. Election data shows that the main culprit is the combination of at-large elections and what sociologists call racially polarized voting.

In an at-large election, there is no neighborhood or local districts where only voters in that district may vote for a candidate to represent that particular district. All the candidates must run citywide or countywide. At-large elections that exhibit racially polarized voting allow voting blocs with slim majorities to dominate local elections. In fact, in the 9 counties listed above, 99% of all local elections are at-large.

For example, each Yakima City councilmember is elected at-large - that is, each candidate must run citywide. But because white voters in Yakima tend to vote for white candidates and the Latino voters tend to vote for Latino candidates, the white candidates always win. As a result, 3 out of 7 Yakima council members live the same neighborhood, and all 7 are white. Although Latinos constitute 41% of the city's population, a Latino has never been elected to the city council. Not even once. Many have run—but they keep losing.

The importance of these local races cannot be overstated. It is in these local races—for city council, for school board, or for fire district—that new candidates first enter the leadership pipeline. Once they have gained local experience, they might later try to run for higher office.

But the pipeline is closed off to racial minorities because nearly all of these local elections are conducted at-large.

For those of us who have been aware of this phenomenon—that is, racially polarized voting in Central Washington—the González race was not a surprise. If anything, it was a surprise that González did as well as he did in Central Washington. González losing each of these counties by a large margin is entirely consistent with the pattern of racially polarized voting that has been occurring throughout Central Washington for over thirty years.

While the final result in the statewide race was different because large Western Washington counties voted heavily for González, in Eastern and Central Washington Latino candidates running for local elected office ran into the exact same problem without the benefit of having King, Snohomish and Pierce County to bail them out. The good news here is that this election also proves that racially polarized voting is not occurring in King County, where voters have a long history of voting for minority candidates such as Ron Sims, Larry Gossett and most recently Steve González who received 75% of the vote.

The cynics who benefit from this system - a system that effectively silences 49% of Central Washington—wink at this reality, knowing what it means for minority populations. Knowingly breaking the American promise that no matter who you are or what your last name may be, you have a right to political representation.

TABLE 1

County	Total Office-Holders	Latino Office-Holders	% Latino	% Latino Population (2008)	González Votes	Danielson Votes
Adams	137	5	3.6%	55.1%	29.5%	70.5%
Franklin	110	3	2.7%	49.2%	35.7%	64.3%
Yakima	250	40	16.0%	41.4%	32.0%	68.0%
Grant	297	13	4.4%	35.7%	32.2%	67.8%
Douglas	129	3	2.3%	25.1%	29.9%	70.1%
Chelan	182	4	2.2%	23.1%	37.7%	62.3%
Walla Walla	139	2	1.4%	18.5%	39.7%	60.3%
Benton	137	1	0.7%	16.4%	42.7%	57.2%
Okanogan	213	3	1.4%	16.3%	33.8%	66.2%

Fortunately, there is a way out; it is called the Washington Voting Rights Act. Lawmakers in Olympia considered the bill last year, but it never went to a vote. This landmark bill would allow voters to challenge those at-large voting systems that, combined with racially polarized voting, function as an obstacle to minority representation in local government. If successful, the challenges would result in new district-based election systems.

In full disclosure, I wrote the Washington Voting Rights Act back in 2011, and for the past three years have been advocating for the passing of the bill. After encountering similar problems in California, legislators adopted the California Voting Rights Act of 2002. The Washington Voting Rights Act is modeled after the California version.

Some say that the legislature ought to leave it to the local governments to decide for themselves how to conduct their elections. But these advocates of local control are missing the point. A system that gives 49.2% of one county's population less than 3% of its elected offices is not local control (see: Franklin County in Table 1). A system that silences 41% of Yakima City is not local control. Using at-large elections to circumvent our democratic principles is not local control.

True local control would empower the people by making sure local government represents local constituencies. Under the Washington Voting Rights Act, local control would flourish once again.

The González race is a sobering reminder that our country's principle value: All persons are created equal may be self-evident but it certainly is not self-enforcing. We have yet to reconcile the values of the American Republic with the hopes of the American people.

And that is why the steady erosion of our state's democracy is not a Latino problem. Nor is it a Black problem, an Asian American problem or a Native American problem. It is a Washington State problem. With this Act we can finally overcome this new barrier to representative democracy.

**And make no mistake, we shall overcome.**

David Pérez helped coordinate González's appointment campaign and worked on his election campaign.

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## Health and SafetyNet Programs TANF

Eliseo Juarez (EJ), MA

### *Basic needs section: Focus TANF policy recommendations and racial disproportionality*

Washington State has long been a leader in innovative programs that serve our state's disabled and vulnerable populations as well as those experiencing economic hardship. In the 1990's groundbreaking programs like State Food Assistance, Basic Health and more helped build the foundation for our state's social services that ensured Washingtonians could meet their basic human needs. Leaders from both parties lay the groundwork for our state's welfare programs with the creation of our state's social Safety Net programs of General Assistance: Disability Lifeline (DL); Aged, Blind, Disabled (ABD); Housing and Essential Needs (HEN); Temporary Assistance for Needy Families (TANF) which provides a modest cash benefit for families with children; and many more.

However, during the recession that began in 2008, our state has made devastating cuts to these programs that keep families from hunger, seniors housed and hundreds of thousands of our friends and neighbors from struggling. Massive increases in caseloads for each program, reductions in benefits, eligibility restrictions, and complicated application requirements have made these programs less available to meet the needs of our state. Of particular concern is how Latino families are interfacing with our state's Safety Net.

Programs designed to help struggling families have been cut during a time when they are needed most. Those cuts have also come with concerning impacts on Latino families' ability to access their services and navigate their practically yearly amendments to eligibility requirements and benefit structures. For instance, in every month since Oct. 2011, we have seen over 150 families each month pushed out of the state's TANF program after reaching the 60 mo. time limit. This arbitrary cap is the single most aggressive tactic pushing families into crisis and taking their last lifeline to accessing food and shelter.

While the number of Latino children and families accessing the state's welfare programs grows, it is not disproportionate in comparison to the overall population growth in Washington. In fact, participation in programs like TANF and DL had less participation rates by Latino families than that of their White neighbors. Yet, changes and cuts to these programs disproportionately impact the Latino community.

Innovative programs like the Children's Administration's Racial Disproportionality Advisory Committee continue to illustrate the program improvements and efficiencies achievable when looking specifically at these populations in state programs like the Department of Social and Health Services (DSHS). The great strides achieved with this Committee, created by the legislature in 2007, should serve as a model for every state agency and especially those

working with marginalized and migrant populations. This program is not only looking at child welfare participation and disproportionality, but in 2011 went further to examine tactics to reduce disproportionality across DSHS programs and initiatives.

There's a need to look at the TANF programs with the Racial Disproportionality Advisory model to see where the state is succeeding and failing to meet the basic needs of Latinos in Washington on this program. It is the largest and most successful welfare program in our nation's history that helps families gain stability. We must understand the racial element of its operation to ensure the changing demographics of our state are met over the next decade.

The state's regressive tax structure is the primary culprit in deep cuts to TANF. The need for additional sources of revenue is highlighted no better place than in our state's Safety Net as tens of thousands of families could have avoided food insecurity, hunger, traumatic health events, and treatment, if TANF had maintained benefits at pre-2008 levels or kept up with inflation. Therefore, we choose to look at the State's Safety Net through TANF as the best indicator of the overall health of our welfare system.

**The following remedies<sup>1</sup> are recommended to our state's TANF program to ensure our communities can gain economic stability and meet their basic human needs:**

#### **Restore the TANF grant by 15%**

TANF provides struggling families with children a modest cash grant to help meet their most basic needs, such as housing, clothing, and health and hygiene items. In 2011, the TANF grant was cut by 15%, decreasing the benefit level to \$478 per month for a family of three.<sup>2</sup> The reduced grant is equivalent to 30% of the Federal Poverty Level and only covers 26% of the resources needed for a family to maintain a basic standard of living. Restoring the 15% TANF grant cut will help families stabilize and will accelerate their pathway to economic security. This policy requires budget action.

#### **Modify TANF Time Limit Policy**

In 2011, the Secretary of DSHS implemented a strict 60-month time limit of TANF receipt. This policy has ended cash assistance to 17,981 children and 8,978 families since its inception. Prior to 2011, TANF parents who were compliant with WorkFirst's participation requirements, but unable to find a job, were eligible for a

hardship extension. Parents received extensions because they faced employment barriers such as a temporary disability or the high unemployment rate due to the Great Recession. Revising the TANF time limit policy is necessary and reinstating some of the previously eligible groups, who either cannot work or cannot find work due to factors beyond their control, is crucial. This policy requires an RCW change.

#### **Reform TANF to Improve Employment Outcomes**

Washington's TANF program is hampered by restrictive federal definitions of what counts as work participation. This policy results in parents being required to participate in programs that meet federal rules rather than programs designed to move them to employment. DSHS employees are required to spend their time counting hours and verifying participation rather than focusing on helping parents develop a plan that will lead to steady employment. The application for a federal TANF waiver of these requirements is necessary in order to free the program to focus on training, including the provision of basic and post-secondary education. If the waiver is not available, the state should move forward with strategies that would allow it to provide services to families that maximize the likelihood of them moving off of TANF and out of poverty. This policy requires possible RCW change and budget action.

#### **Implement Racial Disproportionality Advisory Committees Across State Government**

Building on the work started in 2007 by the Washington state legislature, we recommend the formation of the Washington State Racial Disproportionality Advisory Committee to explore the root causes of and make recommendations for remediation of the racial disproportionality and disparity in Washington State. Expanding the scope and authority of these bodies to examine the TANF program and all programs within our state's social Safety Net to ensure equitable access, service, and information on poverty in Washington State.

1. *The Welfare Advocates Group (WAG) TANF Legislative Priorities (May 2013)*. WAG is a coalition comprised of leading health and human service advocates in Washington. The WAG forwards policies that improve the health, economic security, and well-being of all people in our state.
2. *Washington State Budget & Policy Center (January 2011)*. "Value of work supports for low-income families at historical low." Retrieved from: <http://budgetandpolicy.org/schmudget/value-of-workfirst-grant-at-historical-low>



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## Latino Maternal and Child Health

Jennie A. McLaurin, MD, MPH  
Ileana-Ponce González, MD, MPH

There are approximately 790,000 people of Latino/Hispanic ethnicity in Washington state, half of whom are immigrants and a third of whom are undocumented.<sup>1</sup> A disproportionately young population with a median age of 23, this represents about 12% of the state's overall adult population and 20% of the child population. Over 16,000 newborns, or 18% of all births in Washington, are designated as Latino/Hispanic (Pew, 2014). Thus, Maternal and Child Health (MCH) is an important area of concern.

This brief report examines a subgroup of MCH topics as they comprise areas of health disparity or of urgent need in the Latino/Hispanic MCH population of Washington State. Five issues selected for priority attention are:

1. Access to Prenatal Care
2. Birth Defects and Special Needs
3. Adverse Childhood Experiences (ACEs)
4. Food insecurity
5. Immunizations

These topics span the MCH spectrum of concern and have both programmatic and policy implications.

### *Access to Prenatal Care*

Initiation of prenatal care in the first trimester of pregnancy is a Healthy People (HP) 2020 goal with a target of

78%. Washington Latinas lag behind their White and Asian counterparts, with rates at 73% as compared to 80-81% (MCH Data Report, 2013). Latinas are also at higher risk for no access to prenatal care during pregnancy, with national rates at about 8% (Child Trends). Washington's rural Hispanics are at increased risk for disparities in access to prenatal care (Baldwin et al, 2013). Although Washington does allow prenatal care coverage for low-income women regardless of their citizenship status by utilizing the Unborn Child provision of the Child Health Insurance Program legislation, studies in several areas of the country have found that Hispanic migrant women begin prenatal care later and have fewer prenatal visits compared with the general population, particularly undocumented women.<sup>2,3</sup> This is reflected in less preventive health care, including prenatal care, and poorer health outcomes, including those associated with childbirth.<sup>4</sup>

### *Birth Defects and Special Needs*

Although overall infant and child mortality for the Latino/Hispanic is at or below the state average, special concerns are Washington's high rate of Neural Tube Defects (NTD) and access to special needs services. A cluster of 27 NTD in Central Washington from 2010-2013 resulted in a rate of anencephaly that is four times

the expected national rate (8/10,000 v 2/10,000). The CDC is studying this issue and has determined that the rate does not vary by ethnicity, but the overwhelming number of women in the area (Benton, Franklin and Yakima counties) studied are Latino/Hispanic, so comparisons on ethnicity are difficult. Nationally, Latinas are at highest risk for NTDs, a fact that is attributed to low amounts of dietary folate. Current data from the CDC has not attributed this cluster to a specific cause, but well water nitrate toxicity is a stated concern. CDC investigations relied on medical chart information and not on interviews of the women. As Central Washington is heavily agricultural, pesticide exposure is a possibility that merits urgent investigation but has yet to receive any attention to date.

Washington's Spanish-speaking Hispanics are less likely to report a child with special needs than English-speaking Hispanics (4% vs. 12%, respectively). Limited English proficiency restricts access and understanding of services delivered. Hispanic children are more likely than other Washington children to have "communication" reported as a special need. Child development screening that is culturally appropriate is not yet available on a large scale, making assessment of special needs in areas of emotional and social well-being particularly difficult.

### *Adverse Childhood Experiences (ACEs)*

Adverse Childhood Experiences were studied in 2009 by the CDC in five states, one of which was WA (CDC 2009). Adverse experiences include physical, sexual and emotional abuse and neglect, parental separation or divorce, mental illness and incarceration of a household member, substance abuse exposure and exposure to domestic violence. These events are significant risk factors for leading causes of illness and death in the United States.

Hispanics comprised about 11% of the study and information was based upon adult recall of childhood experiences. In these initial large studies, Blacks were more likely than Whites and Hispanics to have had three or more adverse experiences (15%, compared with 11 % Whites and Hispanics) and the Hispanic distribution of adverse experiences was more evenly distributed across the range of 0-5+ than for other ethnic groups. This preliminary data did not consider events such as deportation of a parent, separation due to migration or exposure to homelessness. Culturally distinct interpretations of adverse experiences have not been well studied.

### *Food Insecurity*

HP 2020 aims to reduce food insecurity to a rate of 6% (HP 2020). Washington mirrors most of the country with an overall rate of 14.6%. However, disparities are dramatically evident, with Asians and Whites experiencing the smallest rates of food insecurity (11% and 15%, respectively) while Latino/Hispanics have a rate of 29%. Factors influencing food insecurity include living in a household with children, rural locale and limited use of supplemental food programs. These factors are commonly seen in the demographic profile of Washington Latino/Hispanic population.

### *Immunizations*

Three-fourths of Washington state two-year olds are immunized on schedule, similar to the national average. While vaccine refusal is a problem in Washington overall, it is least evident in Hispanic families. More worrisome is the vulnerability of Latino babies to pertussis, which was epidemic in 2012 with rates still high in 2013. Hispanic infants are more at risk for pertussis than other infants, for reasons that are not clear. All women are at risk of pertussis unless vaccinated with a booster as disease immunity wanes over time. Immigrant women are least likely to be fully immunized, with Mexican immigrant adults having the biggest disparities in immunization coverage (CDC, personal communication, Dr. Alfonso Rodriguez).

### *Program and Policy Recommendations*

The five MCH priorities discussed here have implications for policy and program development at the local, state and national level. Recommendations include:

- Assuring access to comprehensive prenatal care for all women residing in Washington state, regardless of length of residency or documentation of citizenship. As the Affordable Care Act continues to be implemented, opportunities for strengthening prenatal care to immigrant, migrant and rural women should be examined.
- Monitoring NTDs in Washington newborns with detailed investigations of all occurrences, including an evaluation of toxic exposures such as pesticide residues.
- Implementing NTD prevention programs with special emphasis on Latina women particularly those in

Central Washington. Programs should include folate supplementation for women of childbearing age through culturally appropriate means, such as folate enriched corn masa. Well water testing and methods to reduce nitrate and agricultural chemical exposures are also needed.

- Developing outreach programs to educate LEP Hispanic parents on the identification of and resources for children with special needs.
- Promoting the incorporation of ACEs evaluations for all Washington families as part of child development screening programs and supporting the development of culturally tailored ACEs surveys that examine the impact of adverse experiences such as parental deportation and family migration.
- Expanding supplemental food programs to include school holidays and increased resources in rural locales. Making vaccine available to adults who lack basic coverage with a special emphasis on pertussis coverage in women of reproductive age.

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# Colorectal Cancer Screening among Washington State Latinos

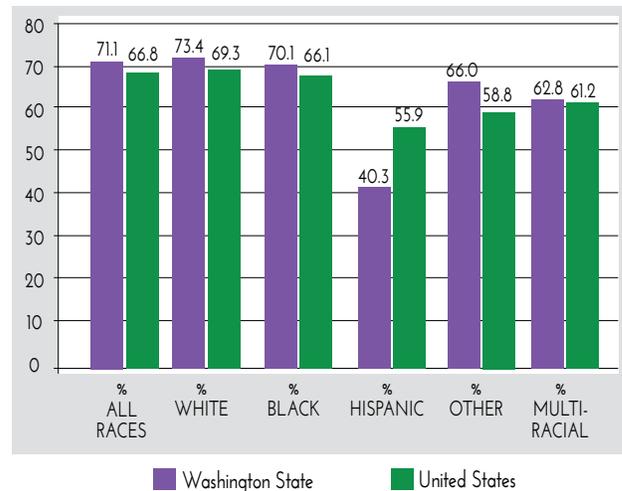
Gloria D. Coronado, PhD

Colorectal cancer is the leading cause of death in non-smokers in the US; the Surveillance, Epidemiology and End Results program (SEER) predicts that, in 2014, there will be 133,830 new cases and 51,310 deaths from colorectal cancer.<sup>1,2</sup> The disproportionate burden of colorectal cancer among Latinos is reflected in a lower proportion of incident cases detected in localized stages; SEER data from 2007 show that 37% of incident colorectal cancer cases in Latinos were detected in localized stages, compared to 41% in non-Latino whites.<sup>3</sup> The advanced stage of disease detection is thought to be attributable, in part, to lower rates of screening. Data from the Behavioral Risk Factor Surveillance System from 2012 show that 53.1% of Latinos ages 50-74 were current with colorectal cancer screening compared to 66.4% of non-Latino whites.<sup>4,5</sup> Colorectal-cancer screening rates are also low among those who lack health insurance (36.7% vs. 68.9% among those with insurance) or who lack a regular source of care (30.7% vs. 69.3% without a regular source of care).<sup>4</sup>

In Washington State, the disparity in colorectal cancer screening rates, comparing the general population and Latinos, is significantly wider than in national data. The percentage of Washingtonians aged 50 and older who have ever had a sigmoidoscopy or colonoscopy is slightly

higher than the national average, but rates among Latinos are noticeably lower (40.3% vs. 71.1%; See Figure 1).<sup>6</sup> The reasons for this disparity are not fully understood. The purpose of this report is to (1) present current guidelines for screening; (2) summarize the scientific literature on barriers to colorectal cancer screening faces by Latino and; (3) highlight effective strategies to raise the rates of colorectal cancer screening among Latinos.

FIGURE 1  
Percent of persons age 50+ who have ever had a sigmoidoscopy or colonoscopy comparing Washington State and the United States - 2012



### 1. Screening recommendations

Colorectal cancer screening carries the US Preventive Services Task Force (USPSTF) highest grade for a screening services and screening for average-risk adults should begin at age 50 and continue until age 75. The USPSTF recommends against routine screening for adults age 76 and older, though some considerations may support screening for individual patients. The USPSTF recommends screening by annual high-sensitivity fecal occult blood test (FOBT), including fecal immunochemical test (FIT), sigmoidoscopy every 5 years, combined with interval FOBT screening, or colonoscopy every 10 years. A FOBT/FIT is a take-home test that checks for blood in the stool that is not visibly apparent. A sigmoidoscopy is an invasive medical examination of the large intestine from the rectum through the last part of the colon. A colonoscopy is an invasive medical examination of the large bowel and the distal part of the small bowel that uses a camera on a flexible tube that is passed through the anus.

### 2. Latino barriers to colorectal cancer screening

Several previous qualitative reports have identified reasons why individuals fail to obtain colorectal cancer screening, and several reports have identified reasons specific to Latinos. Some reasons are related to the individual, other are related to the health system. Below is a list of the prominent barriers to colorectal cancer screening:

- Lack of awareness about the need for screening in the absence of symptoms and details about screening procedures and options;
- Fear of the procedures, possible results, or the need of additional testing;
- Lack of provider recommendation;
- Cost (perceived or actual) is a major barrier; and
- Embarrassment about receiving a colorectal exam, discomfort with the invasive nature of a colonoscopy or with preparation for a colonoscopy.

Coronado et al. conducted a clinic-based program to raise the rates of colorectal cancer screening using a direct-mail approach.<sup>7</sup> The program, called STOP CRC, involved a partnership with Virginia Garcia Memorial Health Center, a community health center near Portland, Oregon. Nearly 40 of patients who were mailed a FIT test completed and mailed back the test to the lab.<sup>7</sup>

Among a subset of those that did not complete screening, one-on-one telephone interviews were conducted. Interview findings showed marked differences in reported barriers among English- and Spanish-speaking patients.

FIGURE 2  
Barriers to Colorectal Cancer Screening, by Preferred Language

ENGLISH LANGUAGE SPEAKERS		SPANISH LANGUAGE SPEAKERS	
2	Fear or result, cost or follow up	7	
1	Did not receive FIT kit	6	
6	Concern about mailing fecal matter	0	
4	Busy / forgetful	0	
2	Other health conditions	2	
3	Provider encouraged colonoscopy	0	
2	Prefer conversation with provider	1	
0	Living out of the country / traveling	2	
2	Not as good as colonoscopy	0	
2	Unemployed / financial	0	
1	Unnecessary / waste of resources	0	
0	Confusion about why receiving FIT kit	1	
0	Unsure if FIT kit is free	1	

Individuals who screen positive on FOBT/FIT need to undergo a colonoscopy. Few investigations have reported on the rate of receipt of follow-up colonoscopy. A limited number of studies have reported proportions ranging from 22 - 81%.<sup>8,9</sup> More research is needed to identify the rate of follow-up to abnormal fecal testing results in health systems where Latinos generally receive care and the success of interventions to prompt follow-up care.

### 3. Successful programs to raise the rates of colorectal cancer screening

Both community - and clinic-level strategies can be effective at raising rates of colorectal cancer screening. Enhancements to health systems and clinical practice are described below:

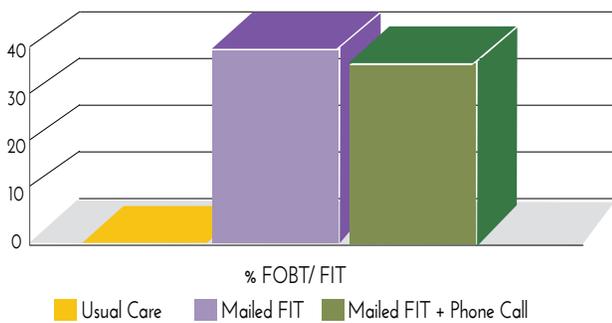
- Choose a Fecal Immunochemical Test (FIT):** The medical literature has demonstrated that when offered a single-sample FIT, patients were over 15 percent more likely to complete testing, compared to a 3-sample FOBT.<sup>10</sup>
- Implement systematic approaches:** Health plans can develop systems that make it easier for patients to be screened, such as creating standing orders for colorectal cancer screening with annual FOBT/FIT

kits. Evidence-based system approaches to increase screening include:<sup>11</sup>

- Explore non-visit-based outreach strategies to increase screening rates, such as mailing FOBT kits directly to patients, especially in settings with an electronic health record system to facilitate the ready identification of patients who are eligible and overdue for screening. Studies have shown this strategy can improve screening rates in white, middle-class insured populations as well as populations with higher levels of poverty, limited English proficiency, and racial and ethnic diversity.<sup>7,9,12</sup>

In Coronado et al.'s STOP CRC study, fecal testing rates rose nearly 40% in a clinic that directly mailed FIT kits to patients homes (Figure 3).<sup>7</sup> The pilot STOP CRC intervention was similarly effective in English- and Spanish-speaking patients and relied on wordless instructions, developed by the project, to inform patients how to complete the test.<sup>13</sup>

FIGURE 3  
Fecal Test Completion in 3 FQHC Clinics,  
by Intervention Arm



- Consider implementing a Flu-FIT program. It has been demonstrated in the medical literature that offering and providing take home FOBTs or FITs at the time of annual flu shot increases colorectal cancer screening rates.<sup>14</sup>
- Increase screening through supportive clinic environments, such as including information about colorectal cancer screening status in patient records and using electronic health records or registries to identify patients who are not up-to-date with screening.

(c) **Implement effective communication systems to ensure care for high-risk patients and follow-up to abnormal fecal test results:**

- Identify and facilitate services for patients who are at increased risk for colorectal cancer; that is, patients who have a family history of colorectal cancer among first- and second-degree relatives at a young age or who have colorectal-disease (e.g. Crohn's Disease or Ulcerative Colitis) that raise their risk of colorectal cancer.
- Ensure follow-up for any abnormal results; assist patients to get insurance coverage if they are eligible (most Medicaid programs cover screening and follow-up care in full) or identify and access community resources to cover the cost of follow-up such as Project Access Now or the Cervical, Breast, and Colon Health Programs. Most Medicaid programs cover screening in full.

(d) **Support patient choice:** The medical literature has demonstrated that when offered more than one screening option, the rate of screening completion is increased. Health care providers should explain and offer all recommended test options and match the patient with the test they are most likely to complete.<sup>15</sup> The best test is the one that gets done.

Community-level strategies may include distributing FOBT/FIT kits at health fairs, or during the delivery of other preventive screening exams, such as mobile mammography. The in-person delivery of FIT kits has shown to have high return rates, especially in the Latino population (Coronado, unpublished findings). Media campaigns that use Spanish-language television, radio, or new technology (social networking or text messaging) focusing on the importance of screening can support community- and clinic-based efforts.

(e) **Effective Messaging:** While little is known about effective messages to prompt completion of colorectal cancer screening in the Latino community, messages that allay fears and embarrassment may be useful. Messages for the general population note that people are most likely to get screened if they are encouraged by someone they know and trust, particularly by doctors and people who have already been

screened. The most powerful messages emphasize that colorectal cancer can be prevented; is highly treatable; is the number two cancer killer; is easy to do (particularly fecal testing); that it affects both men and women; and that screening is recommended when there are no symptoms. Personal testimony from someone who has been screened and/or has experienced colorectal cancer can serve as an important motivator to get screened.

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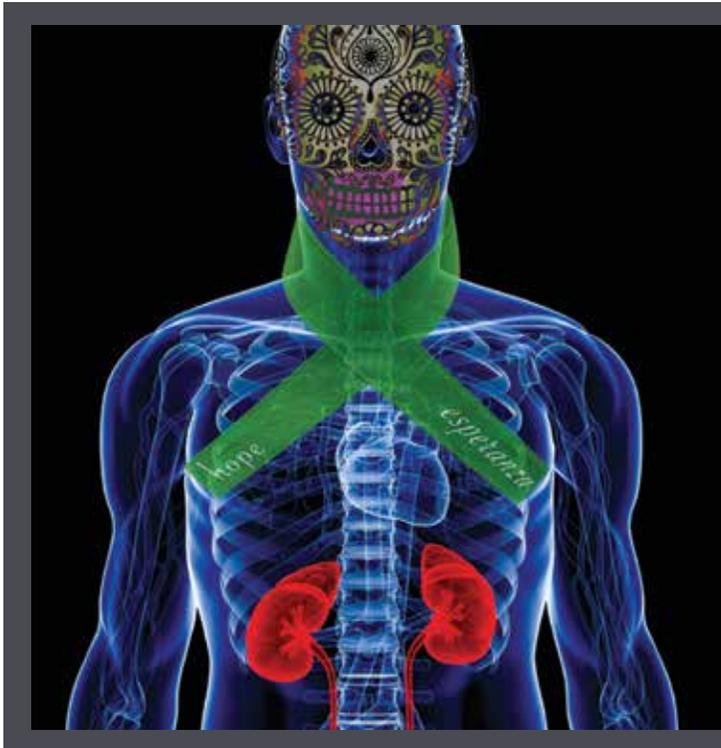
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## Latinos and Kidney Disease

Rudy Rodriguez, MD

In the United States, Mexican Americans are known to have a higher prevalence of diagnosed diabetes than whites, and a higher prevalence of undiagnosed diabetes than both whites and blacks.<sup>1</sup> Kidney disease is one of the most feared complications of diabetes due to the associated increased morbidity and mortality related to chronic kidney disease and end-stage renal disease (ESRD). ESRD is the last stage of chronic kidney disease when the kidneys are no longer able to remove waste and excess water from the body to maintain life. The treatment for ESRD is dialysis (hemodialysis, home hemodialysis, peritoneal dialysis) or kidney transplantation. Despite treatment with dialysis, the five-year survival for hemodialysis patients is only 36%, 42% for peritoneal dialysis, and 85% for kidney transplant patients.

In 2011, the United States Renal Data System (USRDS) reported that the overall ESRD prevalence rate for patients in the U.S. was 1,901 per million population.<sup>2</sup> Of note, there are large differences in incidence and prevalence rates among racial and ethnic groups in the U.S. The prevalence rate for ESRD is greatest in African Americans (5,584 per million) as compared to Native Americans (2,701), Asians (2,265), and whites (1,396). In 2011, the prevalence rate was 2,818 per million among Latinos.

The ESRD Network Program consists of a national network of 18 ESRD Networks, and each Network serves a geographic area. ESRD Network programs are focused on quality improvement work. Among the Renal

Networks, the prevalence of ESRD ranged from a low of 841 per million population in Network 16 (Alaska, Idaho, Montana, Oregon, Washington) to 1,686 in Network 8 (Alabama, Mississippi, Tennessee).

Percent Change in General Population  
in the Network Area

STATE	2012	2013	% CHANGE
ALASKA	731,449	735,132	0.5%
IDAHO	1,595,728	1,612,136	1.0%
MONTANA	1,005,141	1,015,165	1.0%
OREGON	3,899,353	3,930,065	0.8%
WASHINGTON	6,897,012	6,971,405	1.1%
NETWORK 16	14,128,683	14,263,904	1.0%
US	313,914,040	316,128,839	0.7%

Source: July 1, 2012 and 2013 Annual Population Estimates from the US Census Bureau at <http://www.census.gov>

The ESRD rates in the Pacific Northwest are the lowest in the U.S. because of the low percentage of African Americans in the state (3.9 compared to 13.1 nationally). The Washington State Latino population was 11.7% of the state population compared to the 16.9% of the national population in 2012. In 2011, there were 12,080 patients on dialysis in Network 16 (Alaska, Idaho, Montana, Oregon,

and Washington). In Network 16, the cause of ESRD was diabetes in 43.7% of the dialysis patients and the racial/ethnic breakdown of these ESRD patients was 76.4% white, 9.1% African American, 4.3% Native American, 10% Asian, and 10.9% Latino. There were 6,773 kidney transplant patients in Network 16 in 2011, and the racial/ethnic breakdown was 82.5% white, 6.0% African American, 2.3% Native American, 8.9% Asian, and 7.6% Latino. Network 16 ranks #10 for percentage of Latino patients on dialysis and #9 for percentage of Latino patients with a kidney transplant among the 18 Renal Networks in the U.S.

In the U.S. in 2011, approximately 388,000 (65%) patients were treated with hemodialysis, 31,200 (5.2%) were being treated with peritoneal dialysis, and 180,317 (30%) had a functioning kidney transplant. In Washington State, 85.7% of patients chose center hemodialysis while 11% chose peritoneal dialysis which is much higher than the national average. In 2013, Washington reported 6,467 prevalent dialysis patients and 1,660 new or incident patients. Of the 6,467 patients, 10.8% were of Latino ethnicity. In 2013, 1,113 patients were awaiting kidney transplants while only 399 kidney transplants were performed during this period in Washington State.<sup>3</sup>

The USRDS collects data on pre-ESRD nephrology care (cared by a nephrologist/kidney specialist prior to beginning dialysis). An alarming statistic is that 94.7% of Latinos reported no nephrology care prior to starting dialysis compared to 40.3% of whites, 45.8% of African Americans, 38.9% of Native Americans, and 38.7% of Asians. The lack of access to nephrology preparation for dialysis and transplantation in the Latino community could be related to high rates of uninsured status prior to starting dialysis. In 1972, Congress passed the Social Security Amendments of 1972, and under this Act, Medicare extended coverage to individuals who were under 65 years of age, had ESRD, and had worked long enough to qualify for Social Security. Therefore, recent immigrants who have not worked long enough to qualify for Social Security will not qualify for

Medicare ESRD coverage. Today, Medicare pays for approximately 90% of all dialysis and transplant costs in the US. The total Medicare expenditures per person per year in 2011 were \$87,945 for hemodialysis, \$71,630 for peritoneal dialysis, and \$32,922 for kidney transplant.

Given the human and financial costs of kidney disease, preventive and pre-ESRD care are vital services to provide to patients at high risk for kidney disease like Latinos. Early treatment of diabetes and aggressive control of hypertension is essential in preventing kidney disease and slowing the progression of kidney disease. Immigrant populations from Central America may also be especially at risk for serious kidney disease. El Salvador and other Central American countries are being overwhelmed by the number of patients with a new kidney disease, Mesoamerican Nephropathy.<sup>4</sup> This kidney disease affects farm workers in these countries yet the cause remains unknown. The prevalence of this new disease is unknown among Central American immigrants to the U.S.

In Washington State, patients who do not qualify for Medicare are able to receive dialysis paid by Medicaid or by special state funds. Unfortunately, preventive treatments and pre-ESRD care for early stages of kidney disease are difficult to obtain in uninsured populations. Specialty care like nephrology care is not usually provided by Federally Qualified Health Centers. Uninsured Latino populations are therefore at higher risk for kidney disease but are not able to easily access the specialty care needed for prevention and early treatment of kidney disease.

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Dialysis Prevalence ESRD Incident Data

STATE	2013 GENERAL POPULATION	NUMBER OF DIALYSIS PER PATIENT	DIALYSIS PREVALENCE per million	NUMBER OF NEW ESRD PATIENTS	ESRD INCIDENCE per million
ALASKA	735,132	507	690	135	184
IDAHO	1,612,136	1,224	759	322	200
MONTANA	1,015,165	768	757	215	212
OREGON	3,930,065	3,743	952	936	238
WASHINGTON	6,971,406	6,467	928	1,680	238
NETWORK	14,263,904	12,842	900	3,337	234

Sources: Figure 1 and Section IV: Data Tables in this report. Network totals include 133 prevalent dialysis patients and 69 new ESRD patients with residence reported to be in non-Network states. New ESRD patients includes 100 patients whose first modality was transplant.



## Breast Cancer among Latinas

Yamile Molina, PhD  
Rachel M. Ceballos, PhD

Breast cancer is the most common cancer and leading cause of cancer death among Latinas.<sup>1</sup> Compared to non-Latina Whites (NLW), breast cancer incidence and mortality are lower among Latinas. Regardless, the probability of cause-specific survival at 5 years is lower for Latinas compared to NLW (86% vs 89%). As rates of breast cancer survival increase along with the projected population growth of Latinos in the U.S. and Washington State, considerations about the psychosocial impact of breast cancer and quality of life during long-term cancer survivorship should be more thoroughly investigated. Breast cancer patterns in Washington State are similar to national patterns.<sup>2</sup> From 2009-2011, breast cancer remained the most common cancer among Washington State Latina residents (18%) and was one of the top ten causes of Latino cancer deaths (6%). Latinas had lower incidence (96.1 vs. 139.5 per 100,000) and mortality rates of invasive breast cancer between the years of 2007-2011 (8.6 versus 22.3 per 100,000). Yet, a greater percentage of Latinas had a late stage breast cancer diagnosis during 2009-2011 relative to NLW (32% vs. 25%). Although additional data are required, current evidence suggests Latina breast cancer survivors are at risk for lower quality of life compared to NLW.

### *Breast health care among Latinas*

These patterns highlight barriers to breast health care among Latinas, including lack of access, late stage diagnosis, and inappropriate treatment.<sup>3</sup> Nationally, Latinas are less likely to get regular breast cancer screening (e.g., 47% vs. 52% in 2010);<sup>4</sup> have longer times to get diagnostic follow-up care after receiving abnormal screening results; experience longer times to begin treatment; are less likely to be adherent to recommended therapy as cancer patients; and are less likely to obtain regular screening to detect new or recurrent cancers after a diagnosis. Little is known about disparities across the breast health care continuum in Washington State. National patterns suggest there is a need to gather such state-level data. For example, Mexican women have routinely had the lower rates of breast cancer screening in studies relative to women from other countries of origin (44% vs. 48-55%)<sup>4</sup> and represent the majority of Latina residents in Washington State.

Many factors contribute to these inequalities.<sup>5</sup> Latinas experience systemic barriers, including a lack of insurance, socioeconomic disadvantage, and a lack of bilingual and culturally appropriate resources. Other factors are knowledge and awareness of breast health care options, medical mistrust, competing priorities (e.g., family health), cultural beliefs (e.g., *vergüenza*, *mal de ojo*) and psychosocial factors (e.g.,

cancer worry). These factors likely intersect to impact access and quality of care. Inadequate patient-provider communication is common and experienced by Latinas throughout the breast cancer continuum, including during initial screening appointments, follow-up diagnostic care, treatment, and survivorship. Latinas who attend culturally competent facilities also experience delays in receipt of care, as these facilities have fewer resources and require complicated coordination of care (e.g., community health centers, community hospitals). There are limited data in Washington State concerning breast health care among Latinas, but available data suggest similar patterns. Specifically, Latinas experience a number of access (insurance, cost, and provider recommendation), cultural, and intrapersonal barriers (fear, knowledge) throughout the breast cancer care continuum.

### *Future opportunities to improve Latina breast health under the Affordable Care Act*

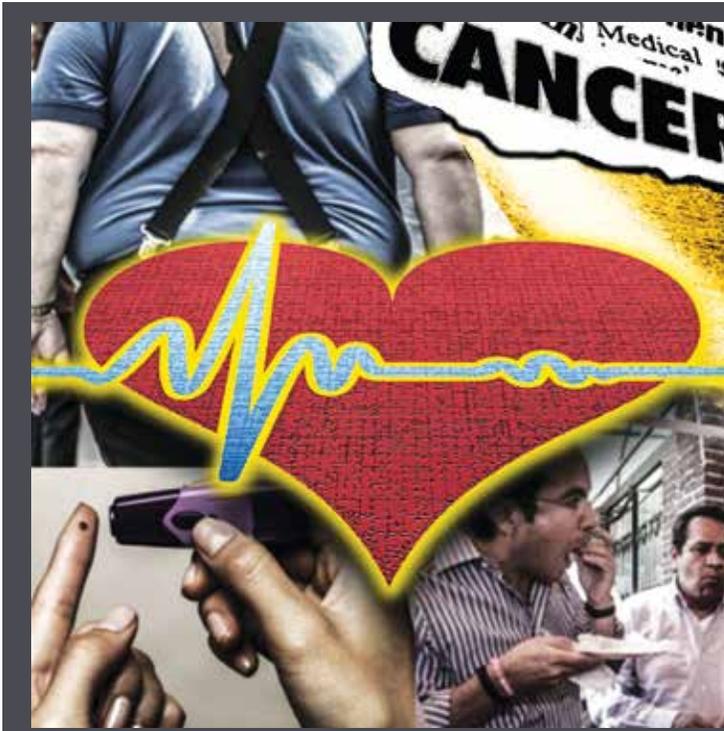
The Affordable Care Act (ACA) represents a fundamental change in health care access and quality, including breast health care for Latinas.<sup>6</sup> Systemic barriers to care have been addressed through increased insurance options and the elimination of co-payments for mammography. The health reform further has facilitated certain strategies for clinical practice to improve culturally appropriate quality of care, including authorized support for community-based practice and patient navigation as well as diversification of the healthcare workforce. The ACA has further enabled greater research be dedicated to characterizing and addressing cancer disparities, including the institute designated for the National Center on Minority Health and Health Disparities, and the creation of the Patient-Centered Outcomes Research Institute. Nonetheless, there may be persistent challenges to improving the breast health of Latinas as well as new ones, including ineligibility for new insurance options and navigation challenges in a changing healthcare environment. The future of alternate options to obtain breast cancer-related care for individuals who are not eligible for ACA-based resources, such as the Washington State Breast, Cervical, and Colon Health program (BCCHP), is uncertain. Increased patient demand and new laws regarding coordination of care may impact the ability to deliver high quality breast cancer-related care. Regarding research, there is a to evaluate the implementation and impact of the ACA for health disparities, including breast health disparities among Latinas, in order to refine existing clinical processes and provide evidence-based care. There

is no guaranteed or mandated funding for new centers, which may impact the amount of research that is able to be conducted concerning breast cancer among Latinas. Collaboration across stakeholders in research, practice, and policy is thus vital to capitalize on the opportunities of this new health environment and improve Latina breast health in the near and long-term future.

### *Improving breast health for Latinas in Washington: research, practice, & policy*

Washington State is well-positioned for such collaborations and has a diverse array of stakeholders, including research institutions (e.g., Fred Hutchinson Cancer Research Center, University of Washington), advocate groups (e.g., local Susan G. Komen and American Cancer Society chapters), healthcare providers and networks (e.g., Molina Healthcare of Washington, Sea Mar Community Health Centers, Migrant Clinicians Network), community-based organizations (e.g., Familias Unidas, El Centro de la Raza), and government agencies (e.g., Washington Commission on Hispanic Affairs, Mexican Consulate). Stakeholder collaborations have sought to increase breast cancer screening through culturally and linguistically appropriate breast cancer education programs, yearly community and health events (e.g., Latinos Promoting Good Health events) and patient-centered programs (e.g., promotoras, patient navigators). The BCCHP and other groups further assist Latinas with cost and insurance barriers. Continued funding and support for these programs is requisite toward improving the odds of early detection of breast cancer among WA-based Latinas. Simultaneously, in order to claim the promise of early detection, more work is needed to characterize and address the health care needs of Latina residents during diagnostic follow-up care, treatment, and survivorship. Available literature suggests there are many unmet healthcare needs for our local populations during these stages of continuum, including those influenced by socioeconomic disadvantage, limited English proficiency, cancer knowledge, and psychological consequences (e.g., cancer fatalism, worry). Greater research, practice, and policy efforts are warranted to examine these needs and take action.

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## Overview of Chronic Diseases in Washington State

Beti Thompson, PhD  
Fred Hutchinson Cancer Research

Chronic diseases are those that endure for a considerable period of time. If ignored, chronic disease can lead to further problems such as life-long disability, poor quality of life, more serious diseases, or death. Chronic disease is ubiquitous in the world.<sup>1</sup> In the United States (US), it is the leading cause of death and disability.<sup>1</sup> Washington State is no different; chronic diseases take up many health care resources and result in a variety of disabilities.<sup>2</sup> Examples of chronic disease that are pervasive in Washington State are cardiovascular disease, cancer of all types, diabetes, and obesity.<sup>3</sup> Many of the deaths and much of the disabilities could be avoided with lifestyle behavior changes, including changes in risky behaviors such as tobacco use, poor nutrition, and sedentary behaviors. In addition, chronic diseases are very costly; the Centers for Disease Control (CDC) estimates that 75% of health care dollars go to the treatment of chronic diseases.<sup>1</sup>

Chronic diseases are not equally distributed throughout the population. Certain ethnic, racial, and underserved groups are more likely to suffer from chronic diseases than non-Hispanic Whites (NHW). These disparities remain a vexing problem in Washington as in the rest of the US. Similarly, some groups have lower incidence (rates of disease) and mortality (deaths from a disease) than NHWs. In this section, we review the trends in some of the primary causes of chronic diseases and focus on differential factors in those trends.

### Cancer

Cancer has overtaken cardiovascular disease as the primary killer of Washington residents.<sup>4</sup> In Washington State, about 28,604 invasive cancers were diagnosed annually between 2007-2011. In terms of mortality, 25% of all deaths in Washington can be attributed to cancer. The major cancer killers are lung cancer (26.2% of all cancer deaths), colorectal cancer (8.6% of all cancer deaths), and breast cancer (6.9% of all cancer deaths).<sup>3</sup> Cancer incidence is lowest among Asians and Hispanics and highest among African Americans and Native Americans. Cancer mortality is lowest among Asians and Hispanics and highest among African Americans and Pacific Islanders/Hawaiians.

### Cardiovascular Disease

Between 2009-2011, an estimated 5% of Washington adults had heart disease. Heart disease and stroke are the most common cardiovascular-related diseases, and together resulted in 27% of all deaths annually in Washington State between 2009 and 2011.<sup>3</sup> Cardiovascular disease mortality has been decreasing in the past three decades. This is thought to be due to improved treatment of cholesterol and hypertension, reductions in smoking, and improved treatment. Mortality rates from stroke in Washington accounted for 6% of all deaths, and the mortality rates are among the highest in the US.

Statistically, significantly higher percentages of adults of American Indian or Alaska Native ethnicity (11%) or Hispanic ethnicity (7%) had heart disease, compared to all Washington State adults. Asian adults had a statistically significantly lower prevalence of heart disease (3%).

Hypertension is a major cause of heart disease. The adult prevalence of hypertension in Washington State was 29%. Higher percentages of adults of American Indian or Alaska Native ethnicity (37%) or identifying as African American (43%) were hypertensive, compared to all Washington State adults. Percentages of adults of Hispanic ethnicity (24%), or Asian ethnicity (24%) had lower prevalence of hypertension, compared to all Washington State adults.<sup>5</sup>

## Diabetes

Diabetes in Washington State doubled since 1994 when the rate of diabetes was 4% of the population; it is now estimated at over 8%.<sup>6</sup> Diabetes can lead to heart disease and stroke, high blood pressure, kidney disease, and nervous system disease. Diabetes is a chronic disease that requires regular and ongoing treatment to manage the amount of sugar in the blood. Unfortunately, many individuals ignore their diabetes and this can lead to grim sequelae such as blindness, amputation of lower extremities, and other adverse outcomes. Up to a third of individuals with Type II diabetes do not know they have the disease. Many minority groups have higher rates of diabetes including those of American Indian or Alaskan Native ethnicity (17%), African Americans (13%), and those of Hispanic ethnicity (12%). Of Hispanics, diabetes rates are highest for Mexican Americans (13.3%) and Puerto Ricans (13.8%).<sup>6</sup>

## Obesity

Obesity is a serious chronic disease that is very costly in terms of morbidity. In the US, more than one-third of adults are obese.<sup>7</sup> Obesity is responsible for many conditions including heart disease, stroke, diabetes, and a variety of cancers. Obesity varies by state, with Washington State having 26.8% adults who are obese.<sup>7</sup> Because obesity is linked to many other diseases, the medical cost of obesity is enormous. According to the CDC, the annual medical costs for people with obesity is over \$1400 higher than those of normal weight.<sup>7</sup>

Obesity is more likely to be found in African-Americans (47.8%) and Hispanics (42.5%) compared to non-Hispanic Whites (32.6%) and Asian Americans (10.8%). For the most part, for African Americans and Hispanics, those with higher socioeconomic status are more likely to be obese than those of lower socioeconomic status.

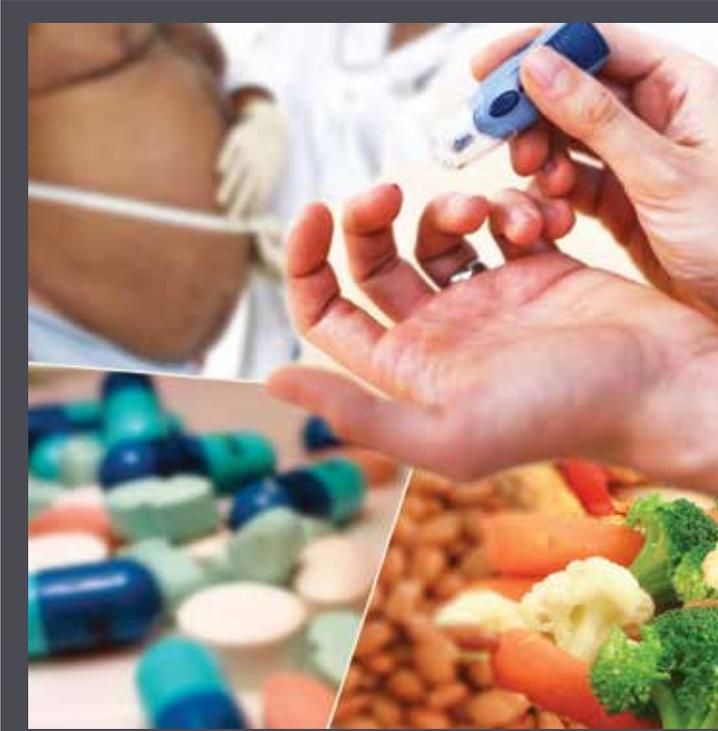
## Common Chronic Disease Risk Factors

Although data on diets and nutrition in Washington State is somewhat scarce, it appears that Washingtonians follow the rest of the nation in consumption of fruits and vegetables. Only a third of adults ate two or more servings of fruits in a day and 28.3% reported eating three or more servings of vegetables a day.<sup>5</sup> Healthier choices in diet have been linked to reduced risks of many cancers, diabetes, and obesity.

Between 2009 and 2011, an estimated 20% of Washington adults reported no physical activity in the past month. Almost half of adults responded that they had achieved the recommended amount of moderate intensity physical activity (300 minutes per week) or vigorous physical intensity (150 minutes per week).<sup>8</sup>

A significant risk factor for chronic disease is tobacco use. Between 2009 and 2011, an estimated 16% of Washington adults smoked cigarettes. Smokers were more likely to be found among young adults aged 18 through 24 (22.1%), among those with less than a high school education (29.1%), and among Native Americans (36.4%) and African Americans (19.6%).<sup>9</sup> Annually, an estimated 7600 adults died of tobacco use between 2000 and 2004.

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## The State of Diabetes in the Latino Community

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In 2010, it was estimated that 325,400 people had diagnosed diabetes in Washington state, while 192,400 remained undiagnosed. An additional 1,674,600 were estimated to have pre-diabetes. Projections for 2025 estimate that the prevalence of pre-diabetes will increase by 22% from 2010. The number of patients with diagnosed diabetes will increase by 218% and the number of people with undiagnosed diabetes by 137%.<sup>1,2</sup>

In parallel with national statistics, diabetes disproportionately affects Latinos in WA.<sup>2</sup> Where Latinos live is a key factor in how diabetes impacts their lives. In 2011, diagnosed age-adjusted diabetes prevalence in the two Latino-majority counties (Adams and Franklin) had increased by 2.8% in only 6 years.<sup>3</sup> These counties, where the majority of Latinos reside, have a medium-to-high prevalence of diabetes. In Adams County, where Latinos represent 58% of the population, there is up to 10.3% of age-adjusted occurrence of diabetes; in Franklin County, where Latinos represent 64% of the population, there is a 9.6% occurrence of age-adjusted diabetes.<sup>3</sup> More alarming is the estimation of 37% of Latinos in our state, with undiagnosed diabetes, possibly already beginning to suffer from complications of this chronic illness, i.e. eye, kidney, lower extremity, brain, and heart damage.<sup>2</sup> National statistics reveal that Latinos are more likely to experience serious complications secondary to diabetes:

Washington Hispanic American Diabetes Data and Forecast	2010	2025
Population	621,500	879,600
Pre-diabetes	158,300	224,000
Diagnosed diabetes	35,600	95,300
Undiagnosed diabetes	21,000	35,400
Total with diabetes (diagnosed and undiagnosed)	56,600	130,700
Complications		
Visual impairment	6,400	16,300
Renal failure	110	240
Leg amputations	175	340
Annual deaths attributable to diabetes	580	1,180
Total annual cost (2010)	\$534 M	\$1.3 B
Annual medical costs	\$383 M	\$0.9 B
Annual non-medical costs	\$151 M	\$0.4 B

Source: Washington State Today and Future Trends. *In Diabetes 2025 Forecasts, the Institute for Alternative Futures (IAF), 2011*

Mexican-Americans suffer about 70% more kidney failures as a consequence of poor control of their diabetes as non-Hispanic Whites, and have a 50% higher risk of dying from it.

Diabetes is the fifth leading cause of death among Latinos in the U.S. and is a leading cause of heart and kidney disease, stroke, blindness, and amputations.<sup>4</sup> In 2010, Latinos  $\leq 65$  years old contributed 24% of the total deaths secondary to diabetes in Washington state, compared to 19% in the White non-Latino population.<sup>1,3</sup> As frightening as these statistics are, it is also believed that mortality in diabetes may be underrepresented, as death records may not accurately portray the extent to which diabetes contributes to mortality.

According to the Institute for Alternative Futures (IAF), the total annual cost of diabetes in the Washington Latino community was \$534 million; \$383 million from medical costs and \$151 million from non-medical costs.<sup>1,3</sup>

## Diabetes in the Latino Community: Unique Challenges

### A. Latino Diversity

The composition of the Latino population is continuously changing, posing a challenge for the need for up-to-date information on its growing diversity. This is important when analyzing the diabetes risk different groups carry. For example, diabetes is more prevalent in Puerto Ricans and Mexican-Americans than in Central/South Americans and Cubans; Latinos born in the U.S. are generally less healthy than immigrants, further predisposing the population to diabetes.<sup>5,6</sup> Such epidemiological observations underline the need for continuous local up-to-date epidemiological data to tailor strategies.

### B. Diabetes Knowledge

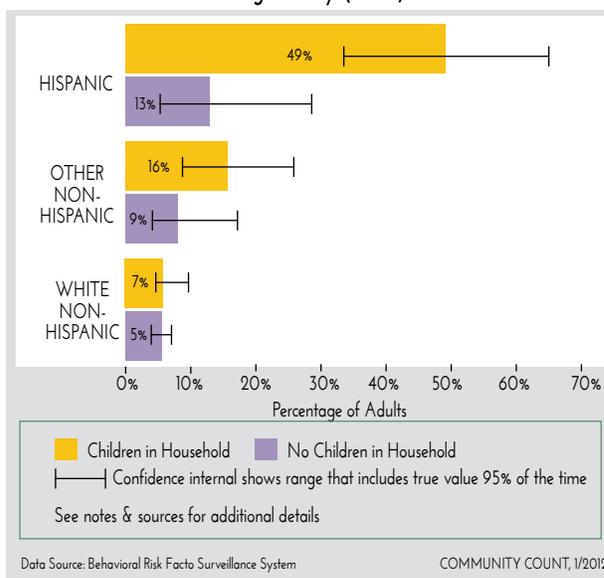
In Lower Yakima Valley, where the majority of the population is Latino-American with a 30% greater age- and gender-adjusted prevalence for diabetes than for non-Latino Whites, research in general “diabetes knowledge” pointed to family history and gender as factors that should be investigated for community-level education about diabetes prevention and control. Having a diagnosis of diabetes, age, and birthplace had limited or no significant relationship with disease knowledge.<sup>7</sup> In surveys by the Pew Hispanic Center, the majority of Latinos who had low diabetes knowledge scores

had health insurance and available medical care and about 6 in 10 reported obtaining their health information from medical professionals.<sup>8</sup> Further studies and outreach efforts are needed in this neglected population to overcome issues of health illiteracy and chronic disease management.

### C. Social Determinants of Health: Barriers to Diagnosis and Treatment

Persistent disparities in health care exist related to socioeconomic status.<sup>9,10</sup> “Food insecurity”, referring to limited or uncertain access to food resulting from inadequate financial sources, is associated with an up to two-fold risk for diabetes, the result of reliance upon inexpensive, calorie-dense foods.<sup>11,12</sup> This highlights the importance of affordable access to nutritious food. Data from King County in 2010 demonstrated that Latino households compared to other non-Latino households had the highest percentage of food insecurity, up to 49% in households with children compared to 7% in non-Latino White households.

Adults who ran out of food, children in household by race/ethnicity, King County (2010)



Other factors associated with disparities in diabetes include cultural and language barriers.<sup>9,13</sup> Hispanics are more likely than other groups to lack regular healthcare insurance, resulting in overuse of hospital emergency departments. Surveys in the Latino community have identified that the primary reason Latinos give for not having a regular health care provider, aside from lacking

health insurance, is their belief that they do not need one; reporting they are seldom sick and they prefer to treat themselves.<sup>8</sup> Washington state Latinos must be educated about healthcare maintenance, including the asymptomatic nature of early diabetes and its “silent,” yet serious, complications. It is imperative to promote screening measures that will become standards-of-care and “second nature” in the Latino population.

#### *D. Health Care/Coverage Access and Conceptions*

According to a report by The Healthy Americas Survey in California, 82% uninsured Latinos had not yet looked for information about health insurance online at [healthcare.gov](http://healthcare.gov) or their marketplace website close to the deadline. About 46% of them reported they had only heard “a little” or “nothing” about it. The majority reported price as the determining factor in whether or not to sign up. Latinos preferred in-person assistance as the most helpful way to learn about their options and they preferred more information on the Affordable Care Act (ACA) in Spanish.<sup>14</sup>

Distrust of the health care establishment, lack of minority and bilingual physicians who may have better understanding and communication with fellow ethnic patients, conscious or unconscious biases, clinical uncertainty, and negative racial stereotypes or perceptions influence diabetes disparities. Surveys about quality of healthcare services have reported that 23% of Latino patients felt they received poor treatment, a third of them cited their “inability to pay” as the reason for poor treatment, followed by their race or ethnicity, their accent or English proficiency and their medical history.

Such perceptions result in avoidance of health care entities and screening measures, missing follow-up appointments, lack of health insurance, access to care, ability to navigate the system, and lack of a regular healthcare provider; conditions that negatively affect outcomes.

#### *Promising Programs and Opportunities for Intervention*

Given the projected increase in the number of Latinos living in our state; in order to construct appropriate behavioral, educational and clinical intervention programs, community-level

assessment of general diabetes knowledge as means of diabetes prevention, treatment and follow-up are urgently needed. Targeting primarily underserved regions, where diabetes has been proven to have the biggest detrimental impact, must take priority.

As the Latino population continues to expand, promising programs have emerged. The need for high-quality, community-engaged research that results in community interventions, has resulted in the University of Washington Latino Center for Health. In 2014, community leaders, researchers, health care providers and policymakers participated in the inaugural 2014 Latino Health Conference.

Discussion about diabetes in the Latino community was an important topic and led to professional networking opportunities and developing collaborations focused on diabetes outreach opportunities, care and health policies.

The University of Washington’s mission on health equity, diversity and inclusion seeks to address the health issues facing the growing Latino community, has resulted in the launch of a specialized Latino Diabetes and Endocrinology Clinic in the summer of 2014. The goal is to provide care that is culturally and linguistically sensitive to the Latino community affected by diabetes, obesity and metabolic problems. In addition to specialized clinical care in diabetes, the clinic seeks to spread awareness of factors associated with knowledge and to serve as a guide toward the development of culturally-appropriate, community-level interventions focused on improving diabetes prevention and outcomes.

Sea Mar Community Health Centers (SMCHC), a community-based organization, specializes in services to Latinos and served 81,334 Latinos in 2012. In addition to medical services, they carry out many outreach bilingual programs that serve as models to continue educational activities on issues of diabetes and lifestyle. Through their community health workers, or *Promotores*, they help connect and reach the Latino community by going into locations visited by this population (churches, community centers, etc.). *Promotores* assist, counsel, and guide on finding resources, preventative care, helping navigate “the system,” reducing language barriers and fears of an unfamiliar complicated healthcare system.

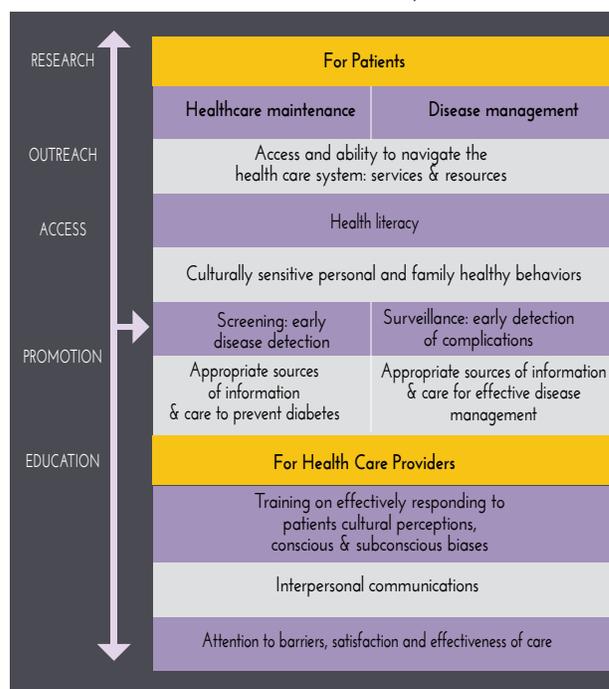
Latinos receive most information about health care from the media, family, friends, churches and community groups, emphasizing the importance and effectiveness of Promotores' role in diabetes and healthcare education. This is an opportunity not to be missed as up to 70% of Latinos report obtaining information by such means, leading to changes in lifestyle and/or to visit a health care professional and influencing their decisions about treatments.<sup>9</sup>

The effect of home-based educational interventions by Promotores for low-income Latinos with pre-diabetes and diabetes in Yakima Valley has demonstrated that healthy eating and physical activity resulted in better outcomes.<sup>15</sup> Key to the success of this intervention was the recognition of select culturally sensitive information (symbols, themes, patterns, concepts, values, norms, and relationships) to promote healthy lifestyles, in their native language. Not surprisingly, culturally appropriate health education is more effective than routine health education in improving diabetes control and increasing diabetes knowledge. *The Promotores* model should help tailor future interventions in this field.

With the implementation of the ACA and the expansion of Medicaid in our state, goals to achieve health equality for all, a promise to help close many of the gaps in the Latino community, is in the air. Some of the tools to reduce diabetes include stopping diabetes discrimination by insurance companies. Latino patients can no longer be denied insurance or forced to pay higher fees secondary to their diagnosis. They will continue to have coverage when needed the most, as there will be no annual limits. Much work still lies ahead as the ACA is fully implemented, nonetheless, it is a step in the right direction. Emphasis should be applied to help Latinos obtain access and familiarize themselves with the system to fully take advantage of what is available.

As we strive to eliminate diabetes disparities, access to bilingual and culturally appropriate care must be improved, and new methods of evaluating clinical, behavioral, and psychosocial aspects of health and access must be developed. Success will depend upon the implementation of multi-level programs; from promotion of preventive measures and fundamental changes in our society, such as access to opportunities for physical activity and healthy meals in schools and the workplace, to screening for asymptomatic adults and identification of those at higher risk (pre-diabetes, obesity), to improvements and access to quality medical care, to optimizing provider and patient knowledge alike, and compliance with therapy to improve outcomes and minimize suffering.

Multi-level Strategies to Overcome Diabetes Disparities in the Latino Community



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## Hispanics and Obesity in Washington State

Jason A. Mendoza, MD, MPH, FAAP

Obesity is a major global health problem and the United States remains at its historically highest rates.<sup>1</sup> According to the latest national estimates from the US Centers for Disease Control, 68.5% of adults and 31.8% of 2-19 year olds are overweight or obese.<sup>2</sup> Nationally, rates of overweight and obesity among Hispanic adults (77.9%) are higher than their non-Hispanic white peers (67.2%);<sup>2</sup> similar disparities in overweight and obesity rates exist for Hispanic children and teenagers (38.9%) compared to their non-Hispanic white peers (28.5%).<sup>2</sup> According to the Washington State Department of Health, in 2007-2009, 32% of Hispanic adults were obese compared to only 26% of non-Hispanic white adults.<sup>3</sup> Also, from 1990-2009, the rates of obesity among Hispanic adults increased steadily and at a higher rate than for non-Hispanic white adults.<sup>3</sup>

In children and adolescents, obesity is associated with greater risk of sleep apnea, nonalcoholic fatty liver disease, hypertension, insulin resistance and diabetes.<sup>4</sup> For example, more and more children and adolescents are being diagnosed with type 2 diabetes, a disease which was previously rare in youth and was formerly called adult-onset diabetes.<sup>5</sup> Hispanic youth in the US have rates of type 2 diabetes that are increasing (e.g., from 0.45 per 1000 in 2001 to 0.79 per 1000 in 2009 in contrast to the lower increases of 0.14 per 1000 in 2001 to 0.17 per 1000 in 2009 for non-Hispanic white youth).<sup>5</sup> Among adults, obesity is

a serious health problem because it substantially increases the risk of serious chronic diseases such as type 2 diabetes, cardiovascular disease, cancer, osteoarthritis, and chronic kidney disease.<sup>6</sup> Obesity is also a cause of premature death in adults, with a 30% higher overall mortality for each 5 kg/m<sup>2</sup> increase in BMI above the 22.5-25 kg/m<sup>2</sup> reference range.<sup>7</sup>

Obesity is costly. For adults, the estimated direct (medical) and indirect (household and labor-market) cost among full-time employees in the US is \$73.1 billion annually.<sup>8</sup> For US children, the estimated direct cost for additional prescription drug, emergency room, and outpatient visit costs was \$14.1 billion annually<sup>9</sup> and the estimated cost for inpatient care was \$237.6 million annually.<sup>6</sup>

**What can be done to prevent and treat obesity among Hispanics in Washington State?** Certainly, we have moved beyond simply telling individuals to eat less and be more active. It is now widely recognized that obesity is a complex problem with multiple biological, familial, cultural, economic, environmental, and societal determinants. When viewing obesity through the lens of Hispanic individuals and families, several themes emerge. Regarding children, studies among Hispanic mothers reported that they may view heavier children as healthier children, especially immigrant mothers who experienced or witnessed malnutrition.<sup>10-12</sup> Hispanic

mothers may also encourage their children to eat more, since a good appetite is considered a sign of health.<sup>10-12</sup> As a result, focusing on Hispanic parents' efforts towards providing their children with culturally relevant healthy foods/ portions sizes and physical activities may be more important than helping them recognize obesity in their children.<sup>12</sup> Outside of the home, children spend the majority of their time at school and this setting provides an excellent opportunity to address risk of obesity. Successful school-based interventions focusing on Hispanic children included strategies that addressed both nutrition and physical activity.<sup>13</sup> Involving parents in school-based interventions may bolster success, likely due to the primary importance of the family unit to many Hispanic cultures. Emerging evidence indicates that walking or cycling to school is a promising strategy for obesity prevention and physical activity promotion among Hispanics and other minority groups.<sup>14-18</sup> Among Hispanic adults, successful obesity interventions targeted both healthy nutrition and physical activity, were led by bicultural and bilingual staff, and occurred in community clinics, community centers, and churches.<sup>19,20</sup>

Policy options to prevent obesity are necessary since individuals and families live in communities shaped by local and state policies. Perhaps the most crucial time to address obesity is during pregnancy and early childhood periods, when behaviors and biological processes are set for the long term.<sup>21</sup> Therefore, policies to ensure health care coverage and culturally competent health services during pregnancy and early childhood are necessary to reduce risk of obesity across the entire lifespan. Pricing instruments such as sales taxes ( $\geq 10\%$ ) on sugar sweetened beverages and fast food or subsidies for fruit and vegetables are the most promising effective policy options for reducing risk of obesity at the population level,<sup>22</sup> although their acceptance may be challenging. Finally, individuals and families often have difficulty making lifestyle changes when the environment in which they live is not conducive to healthy eating and physical activity. This difficulty has been related to a lack of available community resources and concerns for safety. Therefore, policies to support (1) supermarkets in areas of limited access to healthy foods (e.g. in neighborhoods served only by convenience/corner stores or that lack food stores altogether), (2) places to be physically active such as parks and sidewalks, and (3) ensuring neighborhood safety so individuals and especially children can exercise and play outside, are all important strategies that require urgent action by policy-makers.<sup>23</sup>

In summary, Hispanics in Washington State and nationally have among the highest rates of obesity in the nation. Multiple approaches among individuals, families, communities, and by the State of Washington are necessary to successfully address this important health problem. The Health Disparities Research Center at the Fred Hutchinson Cancer Research Center and the Latino Center for Health at the University of Washington both have extensive experience among Hispanic populations and can help guide communities and policy-makers who wish to address obesity among their Hispanic constituents.

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## Providing Oral Health Care Keeps People Healthy

Mark Koday  
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Kelly Richburg

Oral health is an essential component of overall health across the lifespan. Untreated dental disease can cause intense pain that affects a child's ability to eat, learn, and sleep. Children with dental problems are more likely to miss school and have problems getting good nutrition. For adults, poor oral health can negatively impact employability.<sup>1</sup> Employers are reluctant to hire people with obvious and visible dental problems, particularly for positions that require interacting with the public.<sup>2</sup> Moreover, productivity suffers if an employee is in pain or missing work because of an agonizing dental problem. In addition, there is mounting evidence of the relationship between gum disease and other health conditions, including diabetes, heart disease, stroke, and pregnancy complications.<sup>3</sup> For example, untreated oral disease can make it more difficult for people with diabetes to control their blood sugar, which leads to devastating complications, including blindness, amputation and heart disease.<sup>4,5</sup>

When people lack access to dental care, they often go to hospital emergency rooms because they have nowhere else to turn. In 2010, the Washington State Hospital Association reported that dental issues were the most common reason that uninsured patients visited the emergency room and the sixth most common

reason among Medicaid-insured individuals.<sup>6</sup> Over an 18-month period, 54,000 dental-related visits to emergency rooms in Washington resulted in more than \$36 million in charges. Moreover, emergency rooms are only equipped to deal with pain and infection, not the underlying dental problem.

Given that oral diseases are highly prevalent and preventable, the opportunity exists to invest in strategies that improve health and reduce the costs associated with unnecessary disease.

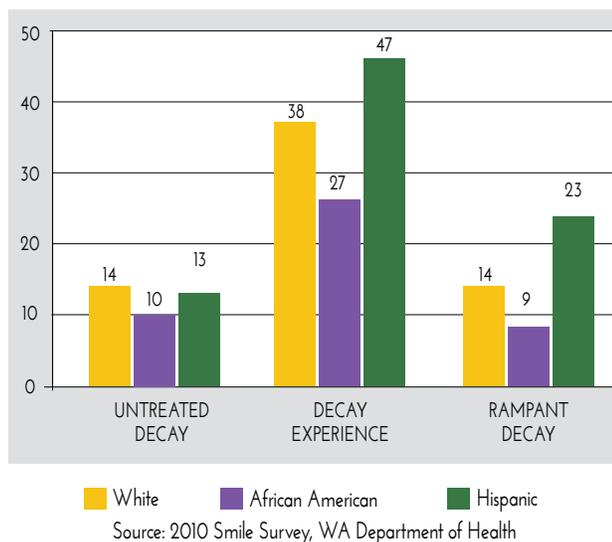
### *Oral Health Disparities Among Latinos Progress made, more work remains*

**The good news:** Untreated tooth decay among Latino children declined dramatically between 2005 and 2010 (from 28% to 13% of low-income preschoolers and from 30% to 13% of 2nd/3rd graders).<sup>1</sup> This reduction in untreated disease was experienced by most racial and ethnic groups, except Native Americans, however was experienced most dramatically by Latino children. These improvements occurred with the expansions of programs and policies, such as the Access to Baby and Child Dentistry program, which increase in capacity of Community Health Centers (CHCs) to serve more

young children, and engagement of primary care medical providers and early learning educators to address oral health with children and families. Latino children also experienced a decline in tooth decay experience (from 52% to 47% of low-income preschoolers), a sign that investments in prevention are working.

**Work remains:** Despite these improvements, Latino children still experience higher rates of tooth decay and rampant decay (7 or more decayed teeth) than non-Latino white children. In fact, rampant decay increased among low-income Latino preschoolers from 17% in 2005 to 23% in 2010. Additionally, access to oral health care for adults, including Latino adults, is limited. The restoration of Apple Health (Medicaid) Dental coverage for adults in January of 2014 was an initial step, however, reimbursement rates remain low which limits provider participation in the program.

Dental Disease Rates Among  
Low-Income Preschoolers by Race/Ethnicity



There are many obstacles to care for Latinos in Washington including availability of dental services and/or availability of bilingual/bicultural services, transportation, cost, and language barriers, to name a few. Building the capacity of community based organizations and investing in models that work, such as community health workers, provide opportunities to address some barriers to care. Specific policy recommendations to improve oral health outcomes for Latinos are described next.

### Policy Recommendations:

1. **Protect existing programs.** Given the wide-ranging health impacts of oral disease, it is imperative to protect Apple Health dental coverage. Protecting funding for existing programs, including the Access to Baby and Child Dentistry program, Apple Health adult dental coverage and reimbursements for primary care medical providers who deliver oral health preventive services to Apple Health children is critical.
2. **Enhance reimbursements for at-risk patients.** Now that adult coverage is available, the next step is ensuring that people have access to the care they need. Access is particularly important for populations most at-risk from complications, including people with diabetes and pregnant women. Enhanced Medicaid reimbursement rates for diabetics and pregnant women, along with increasing the number of allowable periodontal maintenance visits for these patients based on practice recommendations for treating active gum disease could improve access for these populations.
3. **Community Health Centers (CHCs)** infrastructure expansion. CHCs provide critical access to dental services for many patients, reducing dental-related emergency room visits. Expanded health coverage through the Affordable Care Act necessitates that Washington State make critical investments in CHC infrastructure to meet the growing demand.
4. **Include adult and family dental on the Exchange.** Beyond the Apple Health population, dental coverage should also be made available as an option for people purchasing health coverage on Washington Healthplanfinder, the state's Health Benefit Exchange. Again, coverage is available for children, but adults interested in dental coverage currently have no way to purchase it through the Exchange. As people's income rises and they no longer qualify for Apple Health coverage, they have few options for securing affordable dental plans. Adult dental plans on the Exchange can bridge this gap. More than 26 other states already provide adult dental plans on their Exchanges.

5. **Ensure access to safe, fluoridated drinking water.** Access to drinking water sources that are adequately fluoridated is an important part of ensuring good oral health. More than 64% of Washingtonians receive the benefits of living in communities with fluoridated drinking water. A commitment to safe, fluoridated drinking water in our communities means less tooth decay, better oral health and improved overall health.
6. **Include oral health preventive care within contracts with Managed Care Organizations.** As they seek to improve the overall health of their clients and reduce medical costs, Managed Care Organizations can engage medical providers in their networks to assess patients for oral disease risk deliver preventive services and refer patients in need of treatment to dental providers. Contracts with the managed care organizations can include the collection of measures

that track the number of patients that receive oral health screenings, non-emergent emergency room visits related to non-traumatic dental issues, and referrals to dental providers for diabetic and pregnant enrollees and children 0 to 2 years of age.

1. Centers for Disease Control and Prevention, Fact Sheet: "Oral Health for Adults," 2013. Available at: [http://www.cdc.gov/OralHealth/publications/factsheets/adult\\_oral\\_health/adults.htm](http://www.cdc.gov/OralHealth/publications/factsheets/adult_oral_health/adults.htm)
2. White, M. "No Teeth Means No Job." Deseret News, June 27, 2012. Available at: <http://www.deseretnews.com/article/865569512/No-teeth-means-no-job-How-poor-oral-health-impacts-job-prospects.html?pg=all>
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6. Washington State Hospital Association (2010). Emergency Room Use. Available at: [http://www.cdc.gov/OralHealth/publications/factsheets/adult\\_oral\\_health/adults.htm](http://www.cdc.gov/OralHealth/publications/factsheets/adult_oral_health/adults.htm).

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## Latinos and Mental Health in Washington State: The State of Disparities

Gino Aisenberg, PhD. MSW

### *Mental health disparities*

Latinos continue to experience disparities in the availability, access, and provision of quality mental health care and service that is culturally and linguistically competent (USDHHS, 2010). Latinos have less access to mental health care and, after entering care, they face a higher risk of practitioners misconstruing or misdiagnosing their symptoms. Thus, **Latinos are less likely to receive care consistent with evidence-based treatment** (USDHHS, 2001; Vega et al., 2010). Nationwide, less than 1 in 5 Latinos with a diagnosable mental health condition; contact a general health provider (<1 in 10 among recent immigrants) and less than 1 in 11 contact a mental health specialist (<1 in 20 among recent immigrants) (NCLR, 2005).

In general, **Latino high school youth with mental health problems are more likely to fail, drop out of school, or attempt suicide.** Nationwide, significantly more Latina female high school students (13.5%) reported attempting suicide in the last year than non-Hispanic Black (8.8%) and White female students (7.9%) (CDC, 2012). Recent research suggests using marijuana during adolescence increases the likelihood of onset of schizophrenia later in life (Smith et al., 2014).

**Statewide, Latinos face significant economic, health and mental health disparities.** Overall, 26% of Latino adults and 36% of Latino children live in poverty, 52% of Latinos aged 18-64 years are uninsured and 27% report poor health compared to 14% of non-Hispanic Whites (WA DOH 2013). Latinos remain underrepresented in the public health system (after controlling for Medicaid status) and receive fewer service hours than other ethnic groups (WA DSHS, 2005).

Among children in the state's child welfare system, the percentage of Latino children increased from 12.2% (2003) to 16.4% (2009) (Kids Count Data Center, 2009). In the US child welfare system, 50% of children have mental health problems (Burns et al., 2004) while approximately 70% of youth in the juvenile justice system have a diagnosable mental health disorder (Skowrya & Cocozza, 2006). Yet, most of these children in out-of-home placements do not receive necessary mental health services, particularly impacting Latino and African-American children who are overrepresented in these systems (Garland et al., 2003; Hurlburt et al., 2004).

Latinos residing in low-income, high crime communities are at elevated risk for mental health disorders. Research shows that traumatic exposure to community violence is a major risk factor for three reasons: 1) development of emotional

and behavioral problems, including post-traumatic stress disorder and depression (Aisenberg & Ell, 2005), 2) impaired school and job functioning and performance (Holt et al, 2007) and 3) engagement in aggressive, delinquent behaviors or substance abuse (Kilpatrick et al, 2003).

Figure 1 highlights that Latino youth reported higher depression rates compared to non-Hispanics on the Health Youth Survey 2012.

**FIGURE 1**  
Washington State Latino Adolescent Health  
Depression Disparities Rate

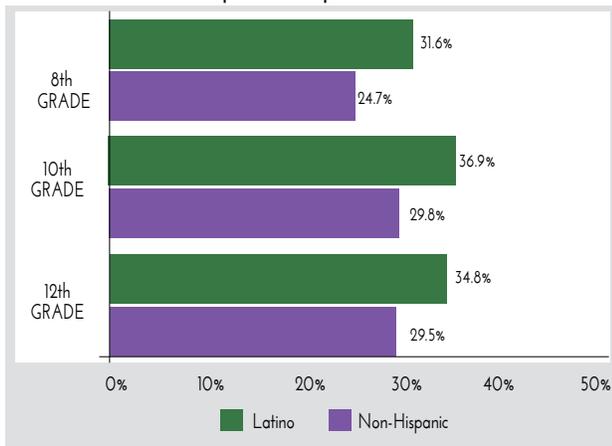
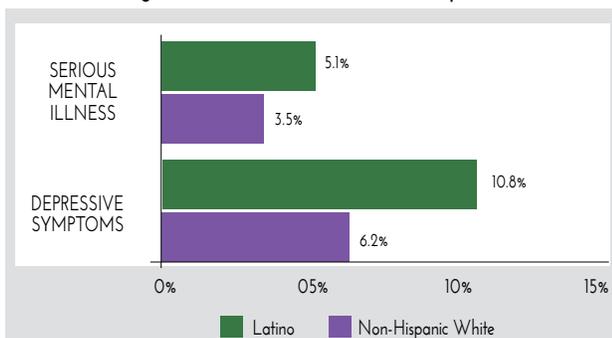


Figure 2 reveals that from 2009-2011 adult Latinos have higher age-adjusted rates of self-reported severe mental illness and depressive symptoms than non-Hispanic Whites (WA DOH 2013).

**FIGURE 2**  
Washington State Latino Adult Health Disparities Rate



These findings warrant substantial and sustained action, especially in light of the growth in numbers of the Latino population in the state and country.

### Barriers

Barriers to accessing and utilizing mental health services exist at the individual, provider and organizational level.

- **Individual level** Mental health care remains a stigma within the Latino community, including Latinos who are gay, lesbian, bisexual and transgendered. Treatment of mental health symptoms is less understood and, with regards to medication, is less trusted. **Language barriers, discrimination, lack of insurance and transportation, lack of availability of services for co-occurring disorders, as well as economic, acculturative and migration-related stress, and a fear of deportation are potent barriers to help-seeking** (Magaña & Hovey, 2003; Piette, 2000).
- **Provider level** A serious workforce issue exists in Washington State that negatively impacts the ability to be responsive to cultural factors among Latinos that affect mental health outcomes. Studies have found that Latinos are more likely to seek mental health care in primary care settings and prefer psychotherapy over anti-depressants (Dwight-Johnson et al., 2004). Yet, psychotherapy is rarely available in such settings, especially in Spanish. The scarcity of skilled bilingual and bicultural practitioners seriously hampers the provision of linguistically competent and culturally responsive mental health services. This scarcity is more pronounced in our rural communities.

**FIGURE 3**  
MH Specialists per 1,000 Medicaid Enrollees



- **Organizational level** The availability and use of mental health specialists to serve as cultural brokers for practitioners working with Latinos and other diverse populations has been underutilized in Washington and not sufficiently funded to be impactful. Compared to other racial/ethnic Medicaid enrollees, Hispanics have the lowest ratio of mental health specialists (See Figure 1). The use of mental health specialists for Latino children in out-of-home placements is nearly non-existent. Another systemic barrier is the lack of reimbursement for tele-behavioral health services that have demonstrated effectiveness in treatment outcomes and increasing access.

## Innovative treatment

An innovative response to many of the existing barriers to providing culturally competent, evidence-based depression care for Latinos was a recent study stemming from a community-academic partnership of the Yakima Valley Farm Workers Clinic (YVFWC) and researchers from the University of Washington and Group Health Research Institute. They implemented a randomized clinical trial to provide a telephone-based cognitive behavioral treatment to low income, rural Latinos who were primary care patients in Eastern Washington. Results showed that those who received the eight session intervention had significantly lower depression scores and improved outcomes at 6 months than those receiving usual care (Dwight-Johnson et al., 2011).

## Policy Recommendations

Legislation is crucially needed to address persistent disparities experienced by Latinos in the access and utilization of mental health services. It is recommended that elected officials initiate policies:

1. **To promote the development of a skilled bilingual and bicultural Latino workforce to address the mental health needs of diverse Latinos populations.** In order to improve Latino access and utilization of mental health services, collaborative efforts to increase the numbers of linguistically and culturally competent practitioners must be robustly supported and funded. Initiatives to bring together government officials and leadership of schools of social work, psychology, and nursing across colleges and universities to develop and implement a strategic plan of action in partnership with community based agencies to address this issue is fundamental.
2. **To fund sustainable and systematic coordination of care between primary care, mental health care, schools, child welfare and juvenile justice, including assessment.** It is imperative that service delivery be transformed to be less fragmented, less costly, and more effective with regards to the mental health needs of Latinos. Enhanced coordination and evaluation of services will improve outcomes by:
  - a) Reducing duplication of services and
  - b) Promoting greater efficiency in the use of public resources, resulting in significant cost savings.
3. **To expand use of mental health specialists for Latino children and youth in out-of-home placements.** It is important to note that many youth with mental health needs end up in the juvenile justice system not because of the seriousness of their offenses but because of their need for mental health treatment that is otherwise unavailable to them in the community (Skowryra & Coccozza, 2007).

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## The Legalization of Recreational Marijuana in Washington State: Now What?

Marcos Zuniga, MPH

### Introduction

We have lived, and will continue to live, in a society of changing perspectives. An example of this phenomenon is our perspectives on legalization of marijuana. Gallup polling has tracked this trend, and most recently, poll results showed for the first time that a “clear majority of Americans (58%) say the drug should be legalized.”<sup>1</sup> This is in comparison to results from 1968 in which a mere 12% favored legalization.

Washington’s citizens have not been immune to this shift in views on marijuana legalization. The first significant shift occurred in 1998 when the Washington State Medical Care Use Act (69.51A RCW) was adopted through voter approval of Initiative 692.<sup>2</sup> This law legalized the use and possession of specified amounts of marijuana for medical purposes. An even more significant shift occurred in November 2012 when voters in Washington approved Initiative 502 (I-502) by a vote of 56 to 44 percent. I-502 legalized the recreational use of marijuana by adults 21 and over.

Whether or not you voted in favor of I-502, Washington Latinos should be aware of their rights and obligations under the law, as well as the opportunities that I-502 offers.

### Conflicting Laws

Washington’s move to legalize recreational use of marijuana for adults coincided with Colorado’s efforts to do the same.<sup>3</sup> And while our system of government allows states to be the incubators of innovation, which is what Washington and Colorado did regarding legalization, the federal government still considers marijuana to be illegal. Under the U.S. Controlled Substance Act, the products of the cannabis plant are deemed illegal.<sup>4</sup> In fact, the Controlled Substances Act lists marijuana as a Schedule I drug, on par with heroin and LSD. Schedule I drugs are defined as drugs having a high potential for abuse with no currently accepted medical use.<sup>5</sup>

The federal government dealt with this conflict last summer when the Department of Justice issued guidance stating that it would not interfere with the states’ effort to implement a legal recreational marijuana system so long as the licensed operations were well regulated.<sup>6</sup> This was welcomed guidance by the states, but the cautionary wisdom here is that the federal government could change its views and decide to prosecute under a different presidential administration. So only time will tell.

### Individual Rights and Obligations

Now that the law is in effect, it is important that Washington residents know what the law does and does not permit. The following is a list of key elements under the new law.<sup>7</sup>

- Adults age 21 and over can no longer be arrested for possessing limited amounts of marijuana.
- Adults can possess up to an ounce of usable (dried) marijuana, 16 ounces of marijuana-infused product, and 72 ounces of marijuana-infused product in liquid form.
- Home grows are illegal unless you are an authorized medical marijuana patient.
- Public consumption will remain unlawful under Washington law. Initiative 502 specifies that it is illegal to use marijuana in view of the general public and the state’s Smoking in Public Places Law (RCW 70.160) makes it illegal to smoke anything in a place of employment or public place. Violations, however, will result in a civil infraction resulting in a fine, but not arrest.
- This law does not change Washington State employment law, which allows for employment drug testing in certain circumstances, which in turn may lead to job termination.
- The new law created a standard for marijuana impairment while driving, similar to the Driving Under the Influence (DUI) for alcohol. A DUI in the case of marijuana will measure the active Tetrahydrocannabinol (THC) in a driver’s system. THC is the component that causes the “high.” An officer, however, will still need probable cause for an arrest, and reasonable grounds to require a blood or breath test.

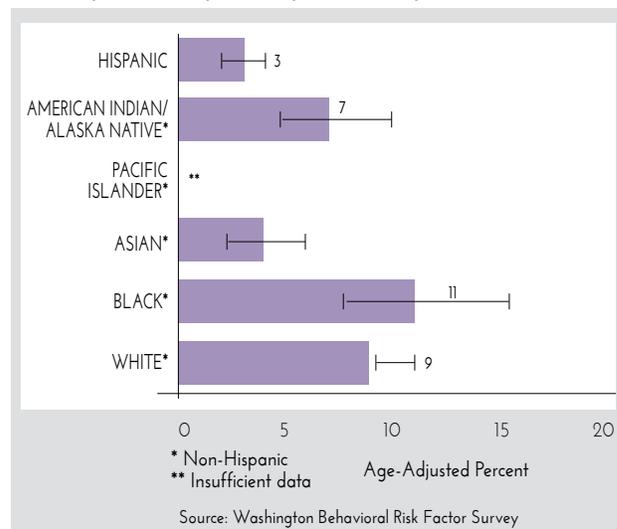
### Opportunities

I-502 created a tax scheme in which an excise tax of 25% would be levied by the state on each wholesale sale of marijuana.<sup>8</sup> The initiative further specified how the excise tax revenues must be spent. These monies are earmarked for efforts such as marijuana education and public health programming; youth drug prevention, health care, research and evaluation.<sup>9</sup> The Latino

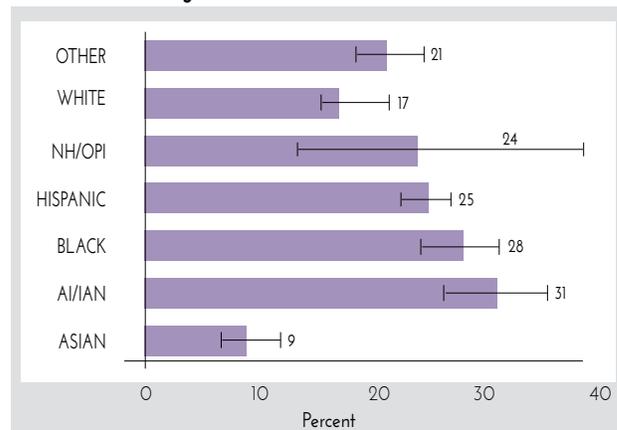
community’s ability to access these funds will be critical to addressing our community’s basic health care needs, and for treating and caring for Latinos who have been disproportionately impacted by marijuana use and abuse. By most estimates, the revenues that will be generated from the sale of recreational marijuana will be in the hundreds of millions.<sup>10</sup> Thus implementation of the new law has the potential of benefiting the Latino community by funneling needed financial resources to community based treatment and health care programs.

Another opportunity that will derive from I 502’s implementation is economic growth through job creation. Jobs can include becoming a licensed operator, an employee of a licensed operator,<sup>11</sup> or an employee of one of the ancillary industries that will service the new marijuana industry.

**Marijuana Smoking Among Adults by Race & Hispanic Origin in Washington, 2010-2012**



**Marijuana Use in Past 30 Days by Race/Ethnicity Among 10th Grade Youth, WA HYS, 2012**



## Concluding Remarks

I-502 presents some interesting issues for Washington's Latinos. First, we should not shy away from finding employment in this new industry. Second, the health care provider community should try every means possible to access the millions of dollars in tax revenues that will be generated through the sale of recreational marijuana. In addition, the Latino community should receive appropriate prevention messages and have access to marijuana treatment for those who need it. Last, but not least, every effort should be made to conduct outreach in the Latino community so that everyone knows what their legal rights are under the new law.

1. Art Swift, *For the First Time, Americans Favor Legalizing Marijuana*, Gallup Inc. (Oct. 22, 2013), <http://www.gallup.com/poll/165539/For-the-First-Time-Americans-Favor-Legalizing-Marijuana>.
2. The full text of Initiative 692 is available online at <http://www.sos.wa.gov/elections/initiatives/text/i692.pdf>.
3. Colorado's initiative was called Colorado Amendment 64, and passed on November 6, 2012, with 55% to 45% voter approval.
4. 'Marijuana' is the American term for the dried leaves and flowers of the cannabis plant, both *Cannabis sativa* and *indica*.
5. Some social scientist and authors point to our country's history of racial and ethnic discriminatory laws and practices as the true explanation for why marijuana was outlawed in this country. See for example, Martin A. Lee's book *Smoke Signals: A Social History of Marijuana - Medical, Recreational, and Scientific*. Martin A. Lee, *Smoke Signals: A Social History of Marijuana - Medical, Recreational, and Scientific* (Scribner, 2012).
6. A copy of the Department of Justice's guidance can be found at <http://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf>
7. These are just some of the rights and obligations that one should be aware of. The ACLU of Washington has created a Frequently Asked Question piece on I 502 that is in both English and Spanish, which can be found at <https://aclu-wa.org/subissues/marijuana>.
8. Those requirements were codified in RCW 69.50.535.
9. See RCW 69.50.540 for the specifics associated with disbursement of the tax revenues.
10. See for example, BOTEC Analysis Corporation's report on projected revenues. BOTEC is the consulting firm the Liquor Control Board hired to analyze various issues related to I 502's implementation. This report is found at [http://www.liq.wa.gov/publications/Marijuana/BOTEC%20reports/8b\\_Tax\\_revenue\\_under\\_different\\_scenarios-%20Final.pdf](http://www.liq.wa.gov/publications/Marijuana/BOTEC%20reports/8b_Tax_revenue_under_different_scenarios-%20Final.pdf)
11. The window for applications to be a licensed operator closed in December 2013, but there is nothing preventing the Liquor Control Board from opening the application window again should the need occur.

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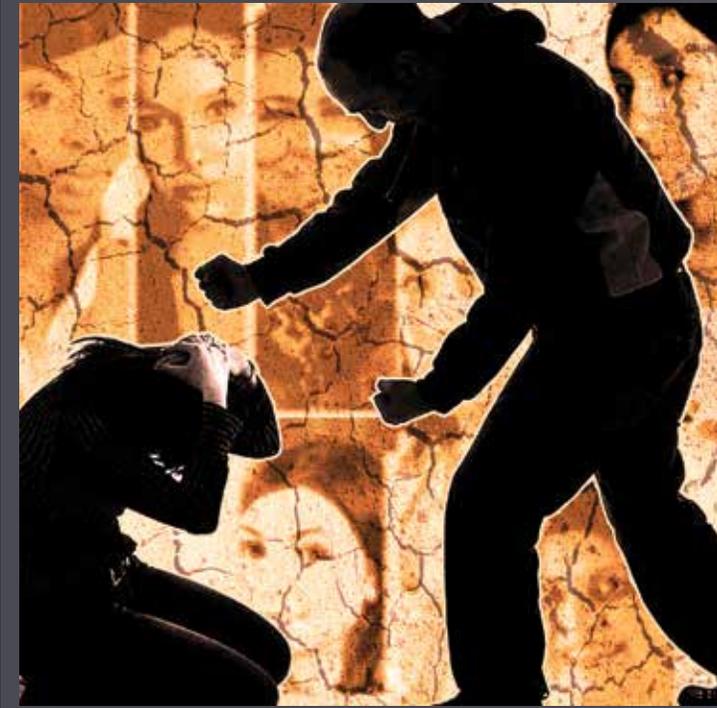
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## Domestic Violence in Latino Communities: Dispelling Myths and Acknowledging Realities

Miriam G. Valdovinos

Intimate partner violence (IPV) also referred to as domestic violence, spousal abuse and/or dating abuse is a social and public health problem in the United States with negative impacts and mental health consequences. IPV is defined as an ongoing pattern of beliefs, attitudes, and behaviors where one partner in the intimate relationship (marital, cohabitation and dating) attempts to maintain power and control over the other through the use of psychological, physical and/or sexual coercion.<sup>1</sup> Its health consequences include physical injuries, depression, anxiety disorders, post-traumatic stress disorder, substance abuse, sexually transmitted infections, suicidal behaviors and death.<sup>2</sup> IPV occurs across all racial, ethnic and economic groups; it impacts heterosexual and same-sex partnerships as well as all genders. U.S. estimates indicate that one in four women will experience domestic violence in their lifetime vs. one in ten men.<sup>3</sup> In 2012, a total of 45,944 domestic violence-related crimes were reported in Washington State with 50% (26,519 of 52,819) of simple assaults and 29% (58 of 203) of murders categorized as domestic violence-related.<sup>4</sup> IPV is often under-reported, particularly in immigrant communities that may distrust coming forward due to fear of retaliation, so caution is warranted with these findings. Addressing IPV in Latino communities requires that we understand their lived complexities to efficiently tackle the deleterious effects.

### *Latinos & IPV*

Some research suggests that Latinas may experience IPV at rates higher than White women<sup>5</sup> but other studies have found no significant differences between these two groups. The National Crime Victimization Survey, a leading source of IPV data, reports no significant differences in the prevalence of IPV for Latinos as compared to other groups.<sup>6</sup> Nevertheless, Latinos confront numerous obstacles and challenges to address IPV and to obtain culturally responsive services. The IPV situations of immigrant women permanently residing in industrialized countries (like the U.S.) are magnified by their immigrant position, limited host-language skills, lack of access to dignified jobs, isolation from family and concerns stemming from their uncertain legal status.<sup>7</sup> The main barriers faced by Latinas when seeking IPV help include: lack of information about legal rights and availability of domestic violence services; fear reporting IPV will result in residency/citizenship denial or deportation; distrust and fear the police will inadequately respond to IPV disputes; and negative experiences with domestic violence programs including long delays or failure to obtain a shelter bed, difficulty communicating with staff because of the lack of bilingual staff, geographic inaccessibility and transportation difficulties.<sup>8</sup> In a study of Latina immigrants in the U.S.<sup>9</sup> up to 48% of them reported the IPV increased since they immigrated to the U.S. In

another study, non-immigrant women were twice as likely (55%) as documented immigrant women (30%) and four times as likely as undocumented women (14%) to file IPV reports, indicating a greater fear of reporting to authorities by undocumented immigrants.<sup>10</sup>

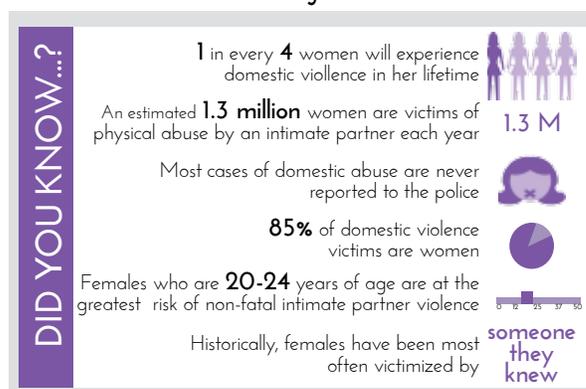
## Policy Recommendations

Undoubtedly, IPV's reach is greater than we often assume. As legislators, there are unique obligations to uphold and enhance protections for all IPV survivors in WA State, including Latina/o immigrants. The recommendations below closely align with the need to meaningfully reform the nation's immigration laws and system<sup>11</sup> to reduce the ongoing obstacles for Latina/o IPV survivors to access safety and justice.

1. **Establish policies that encourage immigrant IPV survivors to come forward without fear.** The entanglement of local law enforcement and federal immigration enforcement (i.e. Secure Communities program, 287(g) programs) weakens community policing efforts by discouraging cooperation of immigrant communities. It detracts local police from their mission to create safe communities, and it often pushes victims further into the shadows. Similarly, expanding grounds of inadmissibility, ineligibility or deportability for domestic violence, without adequate humanitarian waivers, actually has a negative impact on victims since abusers often use the criminal legal system against their victims to further exploit or harm. A critical look at these policies is urgently warranted.
2. **Strengthen existing protections for immigrant survivors of violence.** The U Visa is an important protection for immigrant victims and a tool for law enforcement to promote public safety by encouraging immigrant victims to report crimes and cooperate with law enforcement in investigations and prosecutions. However, the current cap of 10,000 U Visas a year is inadequate and was reached very early in the fiscal year. We need to increase the number of U Visas annually available. Advocacy groups recommend increasing the U Visa cap to at least 18,000.
3. **Support survivor self-sufficiency and remove vulnerabilities to further victimization.** If employment authorization documents (EADs) are granted to VAWA self-petitioners and U Visa applicants, their struggle to survive during the long waiting period of their applications (16 months or longer) is minimized. Providing a pathway to legal status and work authorization will reduce vulnerabilities and enhance self-sufficiency.

We need to Congress should also improve and protect survivors' access to critical safety-net benefits. This will help them avoid living with an abusive partner or becoming homeless, and enable them to pursue a better path to safety and stability. This also affects the likelihood of someone returning to a violent partner because she is unable to establish financial stability which is an elevated concern for undocumented survivors. Ongoing financial support for service provision such as emergency shelter, transitional housing, transportation, legal representation, immigration advocacy, child care, bilingual advocacy, rural outreach, financial skills and advocacy related to children's needs is crucial.

### Here are some facts about Domestic Violence as provided by the National Coalition Against Domestic Violence



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## Aging and Caregiving

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The number of Latinos age 65 and older is expected to quintuple by 2050, making them the largest and second fastest aging sub-population in the United States.<sup>1</sup> The majority of Latinos in the U.S. are of Mexican origin (64% in 2012).<sup>2</sup> The increasing diversity of older adults in the U.S. will become even more pronounced in the state of Washington. Currently 11.7% of the state population is Latino and this percentage is projected to more than double in the coming decades.<sup>3, 4</sup> Consistent with national trends, the majority (83%) of Washington's Latino population is of Mexican origin.<sup>5</sup>

One clear health disadvantage with older Latinos appears to be their high prevalence of diabetes and its associated negative consequences. The diabetes prevalence rate for Latinos is two to five times higher than the rate for the general population.<sup>6</sup> The average age of onset of diabetes is 49 years for Latinos, compared to 55 years for the U.S. Caucasian population.<sup>7</sup> One study suggests that Latinos with diabetes suffer both greater consequences (e.g., higher mortality rates) and more severe complications than individuals with diabetes in the general population.<sup>6</sup> Older Latinos with diabetes are more likely than non-Latino white counterparts to suffer complications such as end-stage renal disease and eye disease, among other problems.<sup>6, 8-10</sup>

The negative consequences and severe complications of diabetes may eventually lead to functional limitation, a restriction or lack of ability to perform an action or activity in the manner or within the range considered normal.<sup>13</sup> Functional limitation may lead to permanent limitation of activity, also known as disability, defined as a long-term reduction in a person's capacity to perform the average kind or amount of activities associated with his or her age group.<sup>13</sup> Disability is most commonly measured in terms of Activities of Daily Living (ADLs)<sup>R1</sup> and Instrumental Activities of Daily Living (IADLs).<sup>R2</sup>

Research has found that older Latinos report more restricted activity days and have higher rates of limitations in ADLs and IADLs due to chronic conditions, compared to their non-Latino white counterparts.<sup>11, 12</sup> Moreover, higher prevalence of limitations is present in all age groups, with the highest risk being in older Mexican-American women. Several other studies indicate that older Latinos have disability rates equal to or higher than those of elderly non-Latino whites, suggesting that their need for long-term care services is at least equal to that of non-Latino whites.<sup>11, 14</sup> However, older Latinos remain in the community with greater levels of disability while their non-Latino white counterparts have already entered nursing homes.<sup>15</sup> There

is accumulating evidence that older minorities, including Latinos, under-utilize health care services when controlling for need.

Thus, the impact of chronic disease on disability has important consequences for the rapidly growing population of older Latinos in Washington and nationally. Social epidemiologists have established that disability, not death, is the principal consequence of chronic conditions in our aging society. Given that Latinos have higher functional impairment levels and that this impairment is likely to increase with age, their overall health outlook is not positive: a frail, older Mexican American population with tremendous caregiving needs.

Over three-quarters of all non-institutionalized elderly persons who receive care rely solely on unpaid helpers.<sup>16</sup> In fact, 43.5 million U.S. adults care for someone 50+ years of age and more than 15 million adults care for someone who has Alzheimer's disease or other dementia.<sup>17</sup> Twelve percent of informal elder caregivers in the US are Latino.<sup>18</sup> This estimate suggests a substantial future need for elder care within Latino families because the population is still relatively young.<sup>19</sup> Similar to the general population, the majority of informal care among Latinos is performed by a family member, most likely an elderly spouse, daughter, or daughter-in-law.<sup>20</sup> Although informal care arrangements are not unique to Latinos, it is their level of apparent commitment to the family and to its members that is so pronounced in the literature. The Latino family has been described as having a very strong extended-family orientation that traditionally includes close friends and children's godparents who share social support privileges and family responsibilities.<sup>21</sup> Research findings seem to reflect a strong extended social network. For example, studies indicate that older Latinos, compared to non-Latino whites, receive more informal care and use fewer formal services, including nursing home placement.<sup>22-24</sup> In a nationally representative sample of over 7,000 community-dwelling adults age 70 and older,<sup>24</sup> more Latinos (44.3%) received informal care than African Americans (33.9%) or non-Latino whites (24.6%). Regarding hours of weekly informal care, on average older Latinos (11 hours) received more hours than older African Americans (6.3 hours) or Non-Latino whites (7.5 hours). Additionally, older Latinos (77%) compared to the general population (60%) rely on family more than

formal sources after a hospitalization for a health-related crisis; only 14% of Latino elderly compared to 30% of the general population cared for themselves after such an episode.<sup>14</sup>

Caregiving is challenging, stressful and can erode caregivers' physical, psychological and financial resources.<sup>25</sup> The negative health consequences of caregiving have been well-documented, including increased risk of mortality from all causes.<sup>26</sup> Given the ongoing heavy reliance of Latino older adults on their families, the demand for informal caregiving is likely to increase in the future as Latino adults arrive at old age in greater numbers and in poorer health than their non-Latino peers. In order to prevent poor health outcomes for Latino caregivers, additional supports will be necessary in the future. Latinos' usage of formal services and healthcare supports is influenced by cultural values. Supports that are provided to Latino caregivers need to take into consideration the strong family ties and social support networks that Latino families may rely on as well as the traditional respect that is given to elders within families. Supports should build upon the strengths of existing family structures so that they are culturally relevant and allow for Latino caregivers to access services in a culturally acceptable way.

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- R2. *Instrumental activities of daily living commonly include household maintenance activities such as meal preparation and light housework, managing finances, using the telephone, and shopping.*

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NOTES - CONTINUE

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## The State of Language Access in Washington 2014

Joana Ramos, MSW

It's quite fitting to be taking a look this year at the status of language access in Washington State, and how it relates to the health of the Latino population. 2014 marks the 50th anniversary of the enactment of the Civil Rights Act of 1964. Title VI<sup>1</sup> of the Act includes a ban on discrimination based on national origin. This year also coincides with the 40th anniversary of the Supreme Court ruling that denial of language assistance was a form of national origin discrimination.<sup>2</sup> In the area of healthcare, 2014 is a very important year as it marked the start of new opportunities for health insurance under the Affordable Care Act, offering coverage for the very first time to many Latinos. As a group, Latinos have had the highest rates of uninsured, and rank higher on all the negative effects of lack of access to care and socioeconomic factors affecting health.

At the state level, since the early '90s Washington has had rules and policies on civil rights and requirements for language assistance services in the context of medical and social services programs provided through the Department of Social and Health Services (DSHS) and later also the Health Care Authority (HCA). These measures were a result of lawsuits on behalf of Spanish-speaking clients and prospective-clients in Yakima County who were not being served by DSHS.<sup>3</sup> As part of the settlement, Washington State agreed to

provide and pay for the services of interpreters and to ensure competency of interpreters and translators serving these programs. The Americans with Disabilities Act and state law also mandate language access for people with disabilities affecting communication. This article will focus exclusively on spoken and written languages and on health in the broader sense of individual and family well-being. The term immigrant will be used here to mean a person who was not a US citizen at birth, including refugees, asylees, and foreign-born persons of any immigration status or who are non-immigrant residents, including students and temporary workers.

By law, all agencies and programs that receive federal funds are mandated to provide meaningful language access services to the limited English proficient (LEP)<sup>4</sup> individuals through the assistance of qualified interpreters, translators, or bilingual personnel. While the federal rules<sup>5</sup> do not specify the way in which language services must be provided—such as in person or over the phone, or by staff or contract interpreters—the rules do require that language service providers have verified fluency in English and their target language(s); specialty subject knowledge in both languages; and training in communication skills and ethics. All programs of an organization must offer language access to clients or potential clients who need it, regardless of whether only one part or

one program of the organization receives federal funds. Likewise an LEP person does not personally need to be a beneficiary of a federally-funded program to qualify for language assistance.

### What's going on in Washington State?

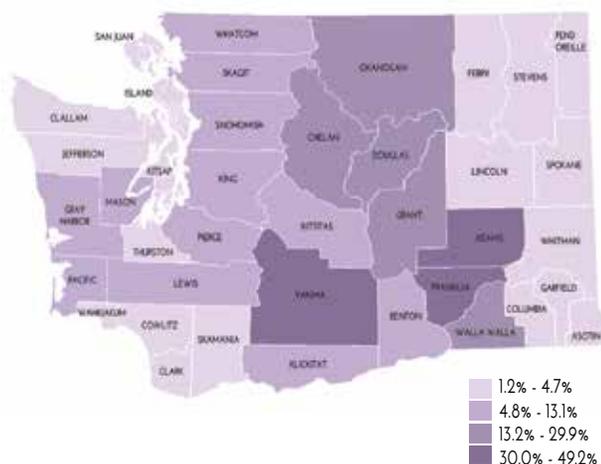
A look at Washington's rapidly changing demographics highlights the importance of language access services. By conservative estimates, LEP persons are now 8% of the total state population or some 512,000 people over the age of 5. This figure represents a 210% increase in the number of LEP persons from 1990- 2010,<sup>6</sup> contrasting an 80% increase in the LEP population nationally during the same period. Most of the LEP persons are foreign-born<sup>7</sup> with immigrants now 13% of the state population.<sup>8</sup>

Of the 18% of Washingtonians who reported speaking a language other than English at home, about half speak Spanish. While 8% overall reported being LEP, on average<sup>9</sup> Spanish-speakers have a 48% LEP rate, with figures much higher in several Eastern WA counties, where an average of 12% of LEP persons live in linguistically-isolated households where no one speaks English, 3 times the state average. Among the 56,000 Washington parents of children less than 8 years old (11% of parents of children in this age group) who reporting having LEP, 91% are foreign-born.<sup>10</sup> Children of immigrants are now 28% of Washington's 221,000 children ages 0-8 years old.<sup>11</sup>

Percent over age 5 in Households with LEP, 2012

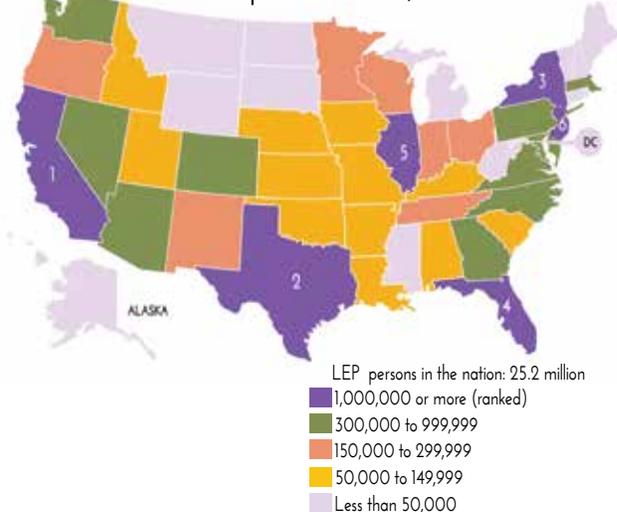


Percent over age 5 in Households where Spanish is Spoken, 2012



Source: OFM (2014) Washington Trends: Socio-Economic Conditions <http://www.ofm.wa.gov/trends/social/maps207.asp>

US Population with LEP, 2010



Source: Migration Policy Institute, LEP Data Brief, 2011, <http://tinyurl.com/8v2vcwp>

While these figures offer an essential baseline, they do not tell the whole story. Not only are immigrants traditionally undercounted in the Census, the data does not accurately reflect the languages spoken by individuals—overlooking the increasing number of Latino immigrants who speak indigenous languages or Portuguese. Developing fluency in English or any new idiom is a process which occurs across a continuum, from comprehension to speaking to reading to writing, over a number of years. Individual ability to learn another language links to many personal factors like age, formal education, native language literacy, opportunity for instruction in the new language, socioeconomic factors, and history of trauma. While many people can converse adequately in their new language about routine

daily matters, they may lack the level of fluency needed to handle complex topics like legal issues, medical care, school placements and discipline, and much more. Stressors like emergencies, catastrophic illness, and natural disasters also affect one's ability to communicate in a non-native language. In other words, the need for language assistance is much greater than what Census data portrays, and Census data alone should not be relied upon for planning purposes.

Language access requirements apply across all sectors, yet despite real progress that has been made, language barriers to services continue to be a problem. In the area of healthcare, while some facilities now do an excellent job in providing language assistance, there is huge variation across the state. It is still common to hear about people being turned away because of a lack of interpreter services, or being told to bring a relative or friend or even their child to interpret for them at medical appointments. Or there may be a notion that it is okay for providers to "get by" with inadequate "medical Spanish" or rely on ad hoc approaches like using untrained bilingual employees or even translation software applications on a computer or smartphone. These practices persist despite an extensive body of evidence documenting the many negative impacts of absent and/or inadequate language services in healthcare settings, in terms of medical errors, unnecessary tests and treatments, and mortality, not to mention financial burdens to patients, their families, institutions, and government at all levels.<sup>12</sup> Written communications are also a problem area in language access. Not only may assumptions be made that merely providing Spanish translations of information is sufficient, but also, and far too often, poor quality translations containing serious errors are offered, such as occurred with the WA Health Benefit Exchange.<sup>13</sup>

In the legal setting too, language services outside the courtroom continue to be a barrier to access to justice. Courts at every level are required to provide language services and many do. However, the availability of language assistance services in settings outside of the courtroom is often limited. Many courts around the state fail to provide language services in their offices or in related programs and services.<sup>14</sup> This means that many LEP individuals involved with the legal system do not get the same kind of the information and help that English-speakers do. Washington's K-12 education system has long had ELL

programs for students, and there are additional federal and state rules about communication services. However, services for families and parents interacting with schools vary. There is a lack of qualified interpreters available to facilitate communication on critical matters between schools and parents, including IEP meetings, and sometimes students are asked to interpret for parents. The mandate to provide language assistance services exists, and efforts are ongoing to assist schools with the creation of a Model Language Assistance Plan to help implement the necessary services. Although the critical links between early childhood experiences and success in school and life are well known, Washington lacks comprehensive statewide early childhood development and education services which are readily accessible to immigrant families and offers very limited language assistance for existing programs.<sup>15</sup> Higher rates of poverty, lower education levels, and LEP status, among Latino immigrant parents put their children at greater risk for poor outcomes as early as kindergarten. Preventive measures need to begin early to address the multiple factors, intertwined with all the social determinants of general health, behind the current low high school graduation rates<sup>16</sup> and concerning incidence of high-risk behaviors and their consequences,<sup>17</sup> among Latino youth.

For adults seeking to learn English, offerings of instructional programs do not come even close to filling the need.<sup>18</sup> And at a time when the need for professional language assistance providers has never been higher, Washington continues to have very few interpreter training programs, with those few under constant threat of budget cuts or even elimination.<sup>19</sup> Legislation passed this year, enacting a Seal of Biliteracy<sup>20</sup> to recognize bilingual skills of high school graduates, is a positive first step, but needs to be quickly linked to a post-secondary pipeline to viable language careers to be part of the solution for meeting Washington's language service's needs.

### *Working for Solutions*

The good news is that despite the many challenges, language access advocates are hard at work to change the status quo. The Washington State Coalition for Language Access (WASCLA) was formed to bring together policy makers, advocates, interpreters, translators, service providers, and community members for

collaborative efforts to eliminate language barriers to all essential services. WASCLA offers services statewide, including monthly open calls, a directory of interpreters and translators, conferences, and recently launched the Tools for Health project; the first-ever resource published in Washington's 30 top languages to inform the public about their language access rights. I Speak cards and consumer flyers are available for free download, with a supply of print materials also available.<sup>21</sup>

An example in the education field was the passage of SHB 1709 this year, which directed the Office of the Education Ombudsman to research implementing a training program specifically for interpreters to serve public schools. And in May of 2014, The Governor's Interagency Council on Health Disparities approved language access policy provisions for the State Action Plan to Eliminate Health Disparities, which includes a directive for development of language access plans across all state agencies, not only in health services.

Achieving equal access is still very much a work in progress with new approaches urgently needed. Listed below are policy recommendations in key areas of language assistance services. The list is not meant to be exhaustive and topics are not listed in order of importance.

### *Policy Recommendations:*

#### **Language Access Rights and Enforcement**

- Educate consumers about patient rights, how to request language services, and the complaint process
- Train providers, health professional students in all disciplines, and policy makers about patient rights, legal responsibilities of providers, and how to implement language assistance services across practice settings
- Enforce federal and state laws and local ordinances; create regulations for the Washington Law Against Discrimination

#### **Data Collection and Reporting**

- Survey and report current language assistance services of all Washington healthcare facilities as a starting point for implementation reforms

- Collect and publish data on race, ethnicity, and language (R/E/L) of healthcare consumers as part of comprehensive demographic data collected by public and private insurers and medical facilities

#### **Best Practices**

- Ensure that all Washington healthcare facilities and organizations implement
  - HHS Culturally and Linguistically Appropriate Services (CLAS) Standards in their institutions
    - Utilize free CLAS training available through September 2015 via the Governor's Interagency Council on Health Disparities
  - Language Access Plans (LAP)
  - Joint Commission Standards for Communication for accreditation; verify Title VI compliance for facilities with other accreditations
- Implement voluntary audits of collection of patient preferred language for healthcare and associated provision of interpreter services at healthcare facilities in order for facilities to set their own baseline and targets for improvement. Monitor progress to target on an ongoing basis, sharing with key healthcare facility stakeholders to encourage use of medically qualified interpretation.
- Learn about industry best practices and apply them locally, such as:
  - The Robert Wood Johnson Foundation's Speaking Together Toolkit<sup>22</sup>
  - Team STEPPS Improving Patient Safety Systems for Patients with Limited English Proficiency<sup>23</sup>
  - *Hablamos Juntos: Improving Patient-Provider Communication for Latinos*<sup>24</sup>
  - Health Care Interpreter Network in California, offers shared interpreter for hospitals<sup>25</sup>
  - Seattle Area Interpreter Leadership (SAIL) group, of hospital interpreter services program managers

#### **Quality Assurance and Risk Management**

- Ensure that language services are provided only by competent staff and/or contract interpreters, not by untrained employees, volunteers, or family and friends of patients. Minors should never interpret except if there is no other option for emergencies.
- Utilize the services of the assigned qualified interpreter, even if a patient requests that their relative or

friend interpret for them. Reminders may be needed that interpreters serve both provider and patient; a relative or friend may remain during the encounter as a supportive person.

- Require language proficiency testing of self-identified bilingual employees and providers, including physicians, before they can provide language-specific patient care
- Ensure translations are of high quality, culturally relevant, and meet community literacy needs by use of robust translation protocols in LAPs.
- Provide information in multiple formats for access by those with low literacy

#### Workforce development

- Support and enhance interpreter training, certification programs, and continuing education
- Provide resources for bilingual staff and community health workers to become certified as medical interpreters

#### Service delivery models and funding

- Develop new systems for provision of language assistance, such as multi-county or regional interpreter networks that utilize communication technologies to offer services remotely.
  - Example: Health Care Interpreter Network, for public and private sectors, with hospital staff interpreters & contract interpreters
  - Could make 24/7 coverage available, critical to underserved and rural locations, and for languages less common statewide
  - Could offer shared language services for clients of multiple sectors from central hub
- Ensure that HCA's Interpreter Services program for Medicaid fully utilizes remote technologies (telephone, VRI) to offer equal access to LEP patients
- Ensure that all eligible providers/facilities register to utilize Medicaid-supported interpreter services, and receive necessary technical assistance, and at the same time develop funding support for language

assistance as a routine healthcare service for all LEP persons regardless of coverage status.

- Require adequate program evaluation procedures for existing and future language service delivery programs

#### Engage communities

- Recognize expertise of community members and community-based organizations (CBOs) as vital partners in provision of culturally appropriate language access services in their own specific locales
- Ensure funding and logistical support to establish truly equitable partnerships
  - do not expect CBOs to always volunteer their services
  - schedule meetings and programs at times viable for community members; at minimum, offer transportation, childcare, and meals
- Openly address issues of community trust based on past negative experiences such as with medical researchers, or fear of participation based on possible reprisals due to immigration status
- Issue public apologies when official miscommunications occur

#### Policy Initiative and Legislation

A few jurisdictions in Washington are addressing language assistance needs through official actions. Examples can be replicated given the necessary political will, often a far greater challenge than logistical considerations. These include Seattle's Office of Immigrant and Refugee Affairs, and policies such as King County Equity & Social Justice Initiative, including an Executive Order on Translations for county government services. At the state level, the Governor's Interagency Council on Health Disparities facilitates an Interagency LEP Workgroup, for all agencies, not restricted to health sector.

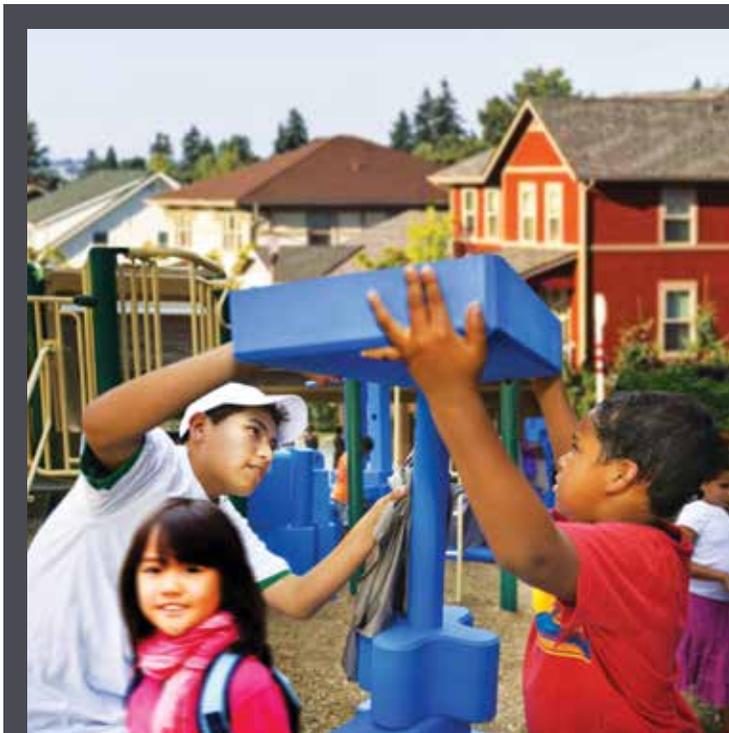
Promotion and passage of new legislation is a lengthy and uncertain endeavor, but should be considered along other mechanisms to bolster language access services.

Some examples of laws pertaining to language access in health care from other states include:

- California: all private health plans must provide language assistance services (interpretation and/or translations) to LEP customers and collect R/E/L data.
- Massachusetts: all hospital emergency departments and acute psychiatric facilities must provide access to trained interpreters for patients at all times.
- New York City and New York State: requires language assistance services at pharmacies, sets conditions for provision of accurate interpretation and translated information under terms of the laws, for LEP customers
- New York State requires all hospitals to have an LAP, appoint a Language Access Coordinator, provide interpreters within 10 minutes in emergency departments, and within 20 minutes elsewhere in hospital; notify patients of language access rights, prohibits minors, relatives and strangers from interpreting except in emergencies.
- Oregon: established uniform standards and practices for the collection of data on race, ethnicity, language, and disability status by OR Health Authority and Department of Human Services.

*DISCLAIMER ABOUT THIS ARTICLE: Opinions expressed are the author's own and may not necessarily represent those of the Washington State Coalition for Language Access*

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## Health and Housing

Marty Miller

The quality of your home has a direct impact on your health. For those with low-incomes and fewer affordable housing options, that reality is directly experienced. Historically, farmworkers have suffered a disproportionate share of housing challenges; unaffordable rents, high rates of over-crowding and substandard living conditions. These conditions not only affect adults working to support Washington State's multi-billion dollar agriculture economy, but it can also have a detrimental impact on children. A recent publication by the MacArthur Foundation titled *How Housing Matters* states, "poor housing quality was the most consistent and strongest predictor of emotional and behavioral problems in low-income children and youth."<sup>1</sup>

Poor housing conditions can lead to a variety of personal and societal problems. High rates of over-crowding increases the risks of communicable diseases. Poor water quality and sanitation service have obvious health consequences. For farmworkers who work in Washington's orchards and fields, pesticide exposure can present a health risk if proper application principles are not strictly adhered to, including thoroughly washing clothes, boots, etc. before entering the home at the end of the day.

While the past year has seen significant gains in access to health insurance, it is valuable to consider our recent history to see what a significant gulf exists for those with the least access to adequate health care. In July, 2008, the Washington State Farmworker Housing Trust conducted major survey of farmworkers in Washington State.<sup>2</sup> Among their findings:

- 80% of the workers surveyed did not have health insurance for themselves;
- 67% did not have health insurance for any member of their family; and
- 37% needed medical or dental attention in the past year.

At that time, the percentage of farmworkers without health insurance (80%) was similar to that found by the Kaiser Commission on Medicaid and Uninsured (85%) in 2000, and was significantly higher than the number of low-income adults nationally who were without health insurance (37%).

Fortunately, housing providers in Washington State have made tangible progress in creating quality affordable housing for farmworkers and their families. The housing community has effectively leveraged significant public and private investments from sources including the Washington State Housing Finance Commission (WSHFC), the Washington Department of Commerce (Commerce), USDA Rural Development (RD) and other resources. Since 1999, when the WSHFC prioritized farmworker housing developments in the allocation process, there have been 1,652 units created using the Low Income Housing Tax Credit (LIHTC) program.<sup>3</sup> In that same timeframe, the Department of Commerce reported having committed \$103.9 million in state and federal resources to farmworker housing. These funds leveraged the creation of 1,344 units of year-round housing, many of which also use the LIHTC program. Commerce's investment achieved additional<sup>4</sup> results including:

- 9,244 seasonal beds
- 12,059 bed nights of emergency shelter for homeless migrant workers

While affordable housing provides a valuable resource in and of itself, providing resident services also has a significant positive impact, particularly related to health. As an example, one leading housing provider in Washington State is Catholic Charities Housing Services (CCHS) of Yakima. Through dedication and creative, persistent fundraising they are setting a new standard in providing access to resources for residents of their housing developments. On-site services include:

- Nutrition classes
- Health fairs
- Health care enrollment
- Pesticide training
- Dentistry
- Domestic violence counseling

Partnerships with local providers such as Yakima Neighborhood Health Services, Yakima Valley Farmworkers Clinic and many others have also proven invaluable.<sup>5</sup>

Another tool to address the quality of farmworker housing and, by extension, the health of farmworkers and their families, is the establishment of a Temporary Worker Housing<sup>6</sup> Standard administered by the Washington State Department of Health. Authorized in 1999 by the Washington Legislature, this standard was the result of a significant effort among agricultural employers, farmworker advocates, housing providers, public agencies and other interested parties to create minimum health and safety requirements for temporary (farm) worker housing. The result has been consistent expectations of employers, housing providers and regulators for building and operating seasonally-occupied farmworker housing.

While many challenges remain, creating affordable housing and providing resources to link residents to services has proven to be a winning combination in addressing the housing and health needs of our valuable farmworker population.

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5. Anna Green (CCHS of Yakima), interview on May 29, 2014
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## Curanderos and Ethnomedicine in WA State

Brian McNeill, PhD  
Jorge Chacón, PsyD

Contrary to popular notion espoused in almost every Introductory Psychology textbook, the applied practice of psychology did not begin with the work of Freud. In all civilizations, traditional or indigenous healers have existed and worked within the realm of physical/psychological/spiritual medicine. Similarly, in every Mexican barrio or neighborhood, someone knows of a healer traditionally referred to as a *curandero* or *curandera*. *Curanderismo* is a Mexican folk healing practice and tradition that represents a mestizo fusion or syncretism of Judeo-Christian religious beliefs, symbols, and rituals along with Native American/Indigenous herbal knowledge and health practices. The *curandero* is believed to have supernatural power or access to such power as his or her abilities are perceived as *el don* or a gift from God. *Curanderos* treat a variety of physical ailments and social problems.

As Latina/os of Mexican origin, our knowledge or exposure to the practice of *curanderismo* may vary with our upbringing, degree of acculturation and/or ethnic identity, social class, and geographic location. As Harris, Velásquez, White, and Renteria (2004) note, a fourth or fifth generation Chicana/o may not possess a complete knowledge of *curanderismo*, but may have knowledge of beliefs most salient to their family of origin and acquired through the socialization process. Indeed, it may be rare that most Mexican-Americans do not practice some aspect of *curanderismo*, whether it is the use of teas, herbs, or foods for the

treatment of physical, mental, or spiritual illness (Harris, et al, 2004). Epidemiological studies of the use of *curanderos* indicate a wide range of usage, varying from 1% to 54% depending on the sample and study (e.g., Mayers, 1989). However, in my travels and investigations of *curanderismo*, I have found that admitting to consulting with a *curandero* is not always a socially desirable response. For example, while traveling in Mexico, my hosts, two professors from the Universidad Nacional Autónoma de México looked at me strangely when I inquired about *curanderos* in the area. I received similar responses and denials of *curanderismo* from other university personnel. However, when I inquired of la señora who took care of the household as to where I could find a *curandero*, she responded that she could find me one in 15 minutes! Later, after getting to know me, my hosts admitted that when it seemed like nothing was working for a sick son, la abuelita was called and a *curandero* was brought in for a consultation, and was successful. Consequently, as healthcare professionals working with Latino/a populations, we need to not only understand the role and functions of traditional healers and their methods, but also understand why their methods work, and how they may not be all that different from the procedures and rituals we employ as mental health professionals.

The *curandero* is typically a known individual in the community who shares their clients' experiences, geographic location, socioeconomic status, class, language, religion,

and beliefs regarding the causes of pathology (Trotter & Chavira, 1997). It is this shared worldview between the patient and the healer that explains why Mexican-Americans seek help from curanderos and why they are effective (McNeill & Cervantes, 2008). Thus, curanderos are respected for their role as healers, spiritual advisors, and counselors, and for their lengthy training and education in both indigenous and religious beliefs, practices, and rituals. As a result, the curandero is often the first person an individual will turn to in times of need, prior to seeking treatment with a physician or psychologist, or when a family's attempts at conventional treatment fails (Harris et al. 2004). People who are undocumented or lack health insurance may also turn first to the curandero.

Curanderos take a holistic orientation, valuing good relations between the physical and social environments, and the supernatural. According to Ramirez (1998), curative activities typically fall into four categories including:

1. Confession, atonement, and absolution to rid the body of sin and guilt that can cause illness and maladjustment. Healing occurs through prayer, or *limpias* (spiritual/ritual cleansings) in which the body may be sprinkled with holy water or smudged with the incense *copal*.
2. Restoration of balance, wholeness, and harmony through self-control. Illness and maladjustment are viewed as a lack of self-control as a person allows feeling, emotions, or desires to run unchecked, and is viewed as being out of balance, or their spirit to be fragmented. Curative rituals may consist of ridding the person's body of negative elements or confronting the evil spirit that has possessed the person or taken their soul.
3. Involvement of family and community in treatment occurs as family members and close friends may accompany the patient to the home of the curandero and make a commitment to support the reintegration of him or her into the family, community, and culture. In these ways, wholeness and harmony of the family and community are restored.
4. Communication with the supernatural sets the curandero apart from others, as they are believed to be able to communicate with the spirit world directly or to facilitate communication between the person who needs help and the supernatural world.

Similarly, Trotter and Chavira (1997) describe healing activities of curanderos in South Texas in terms of the three treatment levels that include the *nivel material* (material

level), the *nivel espiritual* (spiritual level), and the *nivel mental* (mental level).

Curanderos are known for their expertise on ethnobiology and ethnomedicine. Ethnomedicine, also known as alternative medicine or traditional healing, is a viable practice in numerous countries and currently gaining worldwide respect. In the United States ethnomedicine is slowly being recognized as an alternative to modern medicine. Curanderos diagnose, then treat within the realm of their expertise, referring to others (e.g., a physician) when necessary. There are various types and specialty areas of curanderos including *parteras* (midwives), *sobadores* (who treat muscle sprains), and *yerberos* (herbalists). Harris et al. (2004) note that spiritual healing, massages, tea, and prayer are prescribed by curanderos for emotional conditions or cultural syndromes such as *susto* (extreme fright or fear), *mal puesto* (hexes), *mal de ojo* (the evil eye), and *envidia* (envy or extreme jealousy). Professional curanderos also address physical ailments (e.g., diabetes), social problems (e.g., marital conflicts, family disruptions), psychological disturbances (e.g., depression), changing people's fortunes in love, business, or home life, and removing or guarding against misfortune or illness (Trotter and Chavira, 1997; Ortiz, Davis, & McNeill, 2008).

**Why is the curandero often effective?** In 1972, E. Fuller Torrey first published *The Mind Game* (1983), in which he studied *curanderismo* in California, as well as healing traditions in other cultures including Ethiopia and Borneo. He concluded that the differences between psychiatrists and so called "witchdoctors" may not be so great, citing common components in all healing traditions. These components include a shared worldview, the personal qualities of the therapist, patient expectations, and use of techniques. Over a number of years, Frank and Frank (1991) have argued that all healing practices share (1) an emotionally charged, confiding relationship with a healer, (2) a healing context in which the therapist has the power and expertise to help, and socially sanctioned role to provide services, (3) a rationale or conceptual schema to explain problems, and (4) a ritual or procedure consistent with the treatment rationale. Fischer, Jome, and Atkinson (1998) review the evidence supporting what they term "universal healing conditions" in a culturally specific context which includes the therapeutic relationship, a shared worldview, client expectations, and a ritual or intervention. Recent research in common factors associated with psychotherapy effectiveness by Wampold (2001a, 2001b) supports the view that all healing traditions share common healing factors responsible for effectiveness. In his impressive review and analysis of

the research on the efficacy of psychotherapy, Wampold (2001b) presents a strong empirical case for the lack of evidence supporting the medical model of psychotherapy where specific therapeutic treatments or “ingredients” (e.g., empirically supported treatments) are assumed to be primarily responsible for the effectiveness of psychotherapy. In this sense, Curanderismo may be considered what the American Psychological Association defines as “Evidence-Based Psychology Practice.” Perhaps for these reasons, curanderismo continues to survive and serve a vital function in Mexican-American communities.

Consequently, as practitioners, it is vital that we not engage in what Torrey (1983) terms “Psychiatric Imperialism” in which we assume that our contemporary western therapeutic approaches are good, and what we do not know or understand, or what is different to us is, therefore, deficient. We need to open up our own worldviews to appreciate and understand why our gente may turn first to a curandero or priest in times of need, and that referral to, or consultation with a traditional healer may be the best therapeutic decision.

In Washington State there are several traditional healers (including Native Americans) who possess the knowledge and experience in dealing with a variety of illnesses. Many have been invited to speak as lecturers on curanderismo at the University of Washington, School of Medicine as well at UC Davis in California. These are considered prestigious higher learning institutes and acknowledge the value of curanderismo and Native American healers.

Research in the areas of ethnobiology and ethnomedicine has increased in the last ten years. Medicinal plants are being inventoried, protected and used. The number of research publications has increased tremendously and the three international scientific societies involved in this area - the Society for Economic Botany, the International Society of Ethnobiology and the International Society of Ethnopharmacology have experienced an interest and growth in their memberships. These are in numerous ways connected with ethnomedicine. These three societies held their first joint scientific congress in June 2004 in the UK in an attempt to promote integration of these fields.

There has been an increase interest in indigenous, folk and local knowledge with the World Health Organization, the Food and Agricultural Organization and other international organizations. The interest is based on the newly found respect and appreciation of indigenous knowledge and practices that have a profound impact in the fields

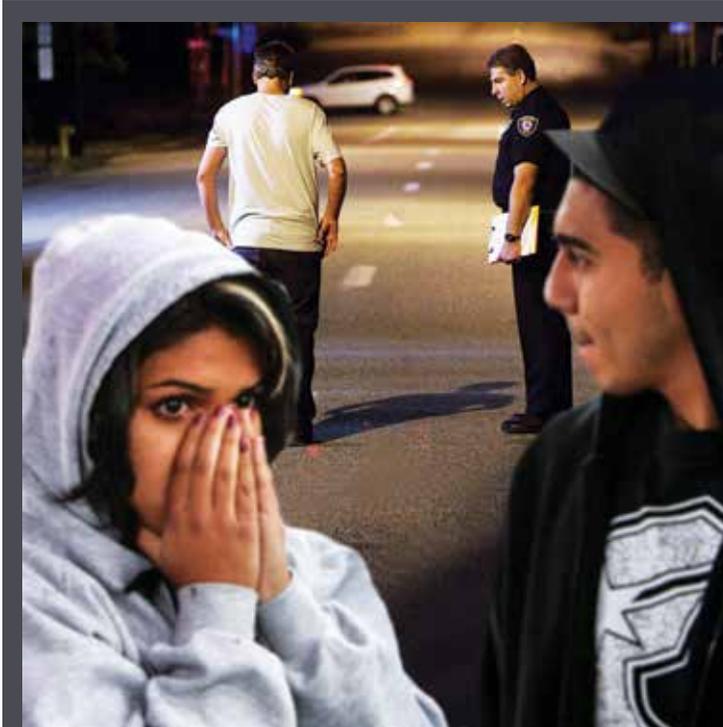
of ethnobiology, ethnomedicine, biodiversity conservation, and health care. Finally there is an acknowledgment and awareness that indigenous and local knowledge should be researched, understood and used for enhanced human living.

However, even though there is an increased awareness, the general thinking of healthcare providers consider ethnomedicine based on superstition and on cultural belief systems. A competent curandero/a values the gift of healing and life, is taught under rigorous conditions, some have access to the spirit world, is familiar with the human anatomy, life psychology, has understanding of illnesses, uses local herbs and resources and often sees/feels what others do not.

Chicanas and Chicanos are increasingly returning to and reclaiming their cultural roots that include the indigenous influences, practices, and consciousness which have often been hidden, internally and externally oppressed, or viewed as primitive. For many, these traditions have never been lost and provide strength, resilience, and comfort during difficult times and life transitions. Similar trends are also apparent in the resurgence of other Latino spiritual healing traditions such as *Santería* and *Espiritismo* in Cuban American and Puerto Rican communities respectively. As practitioners of *Santería* say, *Hay muchos caminos* (there are many ways).

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# Latinos, Criminal Justice and Health

David Morales, JD

Latinos are overrepresented at all levels of the criminal justice system.<sup>1</sup> As a result of disparities, such as economic opportunities, nature of policing, the adequacy of legal representation, representation on juries, and skewed conviction and sentencing for Latino defendants, Latinos are more than twice as likely to be incarcerated as non-Hispanic White individuals. Throughout the process, Latinos are not provided adequate bilingual language services or contact with culturally competent staff to work with. Studies show that the Latinos have low confidence in the fairness of the criminal justice system and high exposure to its consequences. The perception of bias is not misplaced; it is a logical reaction to a system that plainly does not work for Latinos.

A high percentage of Latinos who are put through the criminal justice system are in need of mental and/or drug abuse programs. Guaranteeing access to mental and drug-abuse programs that these individuals require is a persistent challenge. On the front end, there is a clear need for effective diversion programs that confront the complex realities of most drug crimes. At the institutional level, it is important that incarcerated persons are given the opportunity to leave their past behind and obtain the help that they might not otherwise have

gotten in their previous lives. Finally, research has shown that the recidivism rate is greatly affected by whether treatment is available when an inmate is released or paroled.<sup>2</sup>

There are programs in this state that are helping to meet this need. In King County a program called Law Enforcement Assisted Diversion (LEAD), was created to fill some of these needs by a coalition of legal defense, law enforcement and other community groups. The program diverts low level drug and prostitution offenders into community-based treatment and support centers as an alternative to prosecution and jail time. Individuals put into this program will work with a case manager to develop a plan that addresses this person's drug involvement and may receive long term treatment and even job training. Although studies on LEAD's effectiveness have not been released, diversion programs in general have been shown to dramatically reduce a person's chances of committing a similar crime.<sup>3</sup> This program is one of the first of its kind in the nation and a model for what can be done in the rest of Washington State. Access to such programs should be a priority for the state legislature.

It is important to assure that persons who are addicted to drugs or suffer from poor mental health receive the proper level of support while they are under the supervision of the state. Mentally ill prisoners disproportionately are cited, commit suicide, and cost more in Washington prisons.<sup>4</sup> They make up between 20 and 30 percent of the state's inmate population.<sup>5</sup> Access to treatment for these individuals can greatly vary. Although the Department of Corrections has uniform policies around health care, there are wide variances among the different jail systems in the state.<sup>6</sup> Furthermore, treatment at institutions designed for mental health patients is limited to only the seriously mentally ill.<sup>7</sup> Similarly, persons in need of drug treatment make up a disproportionate share, nearly half, of the prison population.<sup>8</sup> Studies have shown that drug treatment while in prison saves the state money over time by lowering recidivism.<sup>9</sup> In prison, treatment has proven beneficial over waiting until a person is released into the community, although both have net benefits to the state.<sup>10</sup> The state should continue to support drug programs within the prison context. One improvement might be assuring that drug assessments are done at an earlier stage in the criminal justice pipeline than when an individual is turned over to the Department of Corrections.<sup>11</sup> To provide effective mental health treatment it is important that all persons who need treatment are given access, not just the most gravely ill. Further, the state should work with sheriff's departments to standardize the treatment of mentally ill persons within local jails.

Many individuals in need of mental health services and drug treatment often fall through the cracks and do not receive continuous care after they are released. There is an ongoing challenge in delivering health care to persons once they are released from incarceration. Between 70 to 90 percent of persons released from prisons and jails are without health insurance.<sup>12</sup> The state's choice to expand Medicaid coverage has the potential to save significant long-term cost by enrolling persons in the program once they become eligible.<sup>13</sup> At this point, the Washington Department of Corrections identifies persons who are soon to be released and informs them about their right to purchase health care in the Exchange or a government funded health insurance. While the Department of Corrections is taking steps to

enroll individuals in Medicaid, only a few of the county jails in Washington State take these steps. The bigger problem lies in getting private insurance for individuals who they do not qualify for Medicaid, the marketplace does not let individuals enroll while they are incarcerated so they often do not have medical treatment when they get out of prison. This is a problem that may be fixed through legislative action that allows incarcerated individuals within a short period of time from release to enroll in the marketplace.

Latinos stand to gain improvements to the delivery of health care within the criminal justice system. Diversion programs are one way in which many of the disproportionalities in the justice system may be minimized and state resources saved. Effective treatment while in prison can make a large difference to persons in need of mental health services and those battling drug addictions. To assure that efforts made in prison are not lost, care must be provided past the time of relief. The Affordable Care Act has given the state of Washington a new set of tools with which to tackle an old problem. If the state were to take advantage of all the ACA offers, large amounts of resources spent incarcerating individuals may be saved through actions aimed at continuing care once inmates are out.

1. See *Preliminary Report on Race and Washington's Criminal Justice System* p. 9 (Task Force on Race and the Criminal Justice System 2011).
2. Research has shown that 65 percent of incarcerated persons meet the criteria for alcohol or drug abuse. [http://sentencingproject.org/doc/publications/inc\\_Affordable\\_Care\\_Act.pdf](http://sentencingproject.org/doc/publications/inc_Affordable_Care_Act.pdf)
3. [http://www.justicepolicy.org/uploads/justicepolicy/documents/04-01\\_rep\\_md\\_treatmentorincarceration\\_ac-dp.pdf](http://www.justicepolicy.org/uploads/justicepolicy/documents/04-01_rep_md_treatmentorincarceration_ac-dp.pdf)
4. <http://tacreports.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf>
5. *Id.*
6. *Id.*
7. [http://csgjusticecenter.org/documents/0000/1498/Implementing\\_EBPs\\_-\\_Seidlitz.pdf](http://csgjusticecenter.org/documents/0000/1498/Implementing_EBPs_-_Seidlitz.pdf)
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10. [http://www.wsipp.wa.gov/ReportFile/1112/Wsipp\\_Chemical-Dependency-Treatment-for-Offenders-A-Review-of-the-Evidence-and-Benefit-Cost-Findings-Full-Report.pdf](http://www.wsipp.wa.gov/ReportFile/1112/Wsipp_Chemical-Dependency-Treatment-for-Offenders-A-Review-of-the-Evidence-and-Benefit-Cost-Findings-Full-Report.pdf)
11. <http://www.doc.wa.gov/family/offenderlife/substanceabuse.asp>
12. <http://csgjusticecenter.org/wp-content/uploads/2013/12/ACA-Medicaid-Expansion-Policy-Brief.pdf>
13. <http://www.dshs.wa.gov/pdf/ms/rda/research/4/84.pdf>



## Health Coverage for Immigrants after the Affordable Care Act: Unfinished Business

Janet Varon; Founder and Executive Director  
of Northwest Health Law Advocates

Jorge Baron; Executive Director  
Northwest Immigrant Rights Project (NWIRP)

While the Patient Protection and Affordable Care Act (ACA) of 2010, offers new opportunities for health coverage to Washington residents, it does not address the needs of all immigrants. Insurance at affordable rates is unavailable for some immigrants, and others are required to pay for coverage and care, even at low income levels.

### *What public health programs are immigrants now eligible for?*

For purposes of health insurance coverage, there are three categories of immigrants:

- U.S. citizens and Nationals
- “Lawfully present” immigrants
- Undocumented immigrants (not lawfully present)

Citizens and Nationals include U.S. citizens by birth or naturalization, and citizen children of parents who are not citizens. Depending on their income, they may be eligible for full-scope Medicaid or subsidized coverage in Qualified Health Plans (QHPs), which are private health plans sold on the Washington Health Benefit Exchange. In Washington, households with income below 138% of the Federal Poverty Level (FPL) may now qualify for Medicaid (recently renamed “Apple Health”). Households with income above that level, but

below 400% FPL, may receive premium tax credits if their income, and cost-sharing reductions if their income is below 250% FPL. Children and pregnant women are eligible for Apple Health at higher income levels.

Lawfully present immigrants are of two types for purposes of determining Apple Health eligibility: “qualified” and “non-qualified.” The qualified categories include Lawful Permanent Residents (LPRs, sometimes referred to as “green card holders”), refugees, persons granted asylum, and certain others. Qualified immigrants with income below 138% FPL are eligible for full-scope Apple Health coverage, with some restrictions including a five-year waiting period for LPRs (except pregnant women and children under age 19). Table 1 gives details of which immigrants may qualify for Washington Apple Health and other programs.

“Non-qualified” immigrants include certain people with pending immigration applications, persons in temporary status, and citizens of the Marshall Islands, among others (see Table 1 for details). These immigrants are not eligible for full-scope Apple Health unless they are pregnant, under age 19, or have a disability. Non-qualified immigrants with household income below 138% FPL can get limited Apple Health when they need treatment for emergency conditions, cancer, and kidney dialysis.

Non-qualified immigrants as defined above, LPRs in their five-year waiting period, and immigrants with income over 138% FPL may enroll in QHPs and receive premium tax credits and cost-sharing reductions depending on their income, as described above.

U.S. citizens and lawfully present immigrants are required to carry insurance under the ACA's "individual mandate" and may be required to pay a financial penalty (some exceptions apply). In 2014, the penalty is \$95 or one percent of your yearly household income, whichever is higher; the amount increases each year.

**Undocumented immigrants, including "Dreamers" whom the U.S. has temporarily authorized to remain in the U.S. through the Deferred Action for Childhood Arrivals (DACA) program,** are eligible only for limited Apple Health for emergency conditions, cancer or kidney dialysis. They are not allowed to buy QHP insurance in the Exchange, so they cannot get premium tax credits or cost-sharing reductions. They are exempt from the individual mandate. Undocumented children and pregnant women are eligible for Apple Health if their income falls below certain limits.

The only way for uninsured undocumented immigrants to get coverage is to buy an insurance plan at full price outside the Exchange. Subsidies are not available, even for those with limited income. As a result, the cost of coverage is prohibitively expensive for lower-income households.

### *What issues continue to prevent immigrants from accessing health coverage?*

For many immigrants, the ACA's promise of affordable care is still unrealized. There are three major reasons:

- Undocumented individuals (including Dreamers who have been approved for DACA) are excluded by federal law from Medicaid and subsidies that make coverage more affordable.
- Persons excluded from Medicaid due to their immigration status but eligible for QHP subsidies still have difficulty affording the premiums, deductibles, cost-sharing and copayments.

- Immigrants in "mixed status" households experience barriers in applying for coverage. These are households including individuals with different citizenship or immigration statuses or without documented status.

### *How can these issues be addressed?*

It is imperative to provide access to health care for all residents of Washington State. The following agenda is suggested for addressing the health care needs of immigrants:

- **Legislation to fill coverage gaps for documented and undocumented immigrants.** Our state's own Apple Health for Kids program is an excellent model, providing a unified program for children regardless of their immigration status. This model should be extended to adults. A bill recently introduced in California does just this, creating state-funded "look-a-like" programs for immigrants who, but for the federal restrictions, would otherwise qualify for Medicaid or QHP enrollment with subsidies.
- **Legislation to adopt the "Federal Basic Health Option (FBHO)."** To ensure that immigrants have affordable coverage and don't fall through the cracks, the state should adopt this new option under the ACA. By offering more affordable coverage, the Federal Basic Health Option helps low-income immigrants and other low-wage workers avoid high out-of-pocket costs of plans on the Exchange – such as high deductibles that may cause them to skip needed care or rack up bills they cannot pay, leaving providers to foot the bill. FBHO offers a higher value product. Under this option, which is similar to the former Washington Basic Health program, the state can negotiate lower costs for enrollees, better benefits, and increased access to health care, compared to the Exchange. The state would receive federal tax credit funds to cover the costs of lawfully present immigrants, and should provide state funding for others.
- **Eliminating Barriers to Getting Coverage.** Immigrants report a number of reasons that they have not enrolled eligible family members in Apple Health and QHPs. These include fear of immigration enforcement (on the part of immigrants in mixed-status households), concern that their status might be jeopardized if they apply, and difficulty with the application process (including computer glitches with the Washington Healthplanfinder website), limited literacy, and language barriers<sup>1</sup>. In addition, some immigrant community members may be confused about eligibility of someone in the family

simply because a parent or other family member is undocumented. The Healthplanfinder web-based application is still not translated into any language other than Spanish. The Health Benefit Exchange and the Health Care Authority should prioritize solving systems problems, addressing systems glitches and simplifying the process for immigrant applicants. In addition, the Exchange should provide sufficient resources for in-person assistance to immigrants applying for coverage. This assistance should be provided by sources trusted in the immigrant community who can convey that applicant information is not shared with immigration agencies.

In addition, the Exchange must improve access to the application, enrollment and renewal processes for limited English proficient individuals. A robust Language Access Plan (LAP) to address glaring deficiencies is needed. The Exchange recently released a long-awaited draft plan, to be reviewed by its Health Equity Technical Advisory Committee. The purpose of a

LAP is to promote effective communication between the Exchange and limited-English proficient individuals with the purpose of eliminating or reducing limited English proficiency as a barrier to accessing health care coverage.

The Affordable Care Act is an important step forward in helping large numbers of Washington residents gain access to health care. However, the law unfortunately restricts many community members from getting some or all of the benefits of the ACA based on their immigration status. Efforts to bridge these gaps and ensure that every Washington resident has access to quality, affordable health coverage are necessary. Everyone in the state will benefit from efforts to ensure that all Washington residents are covered.

1. Jessica Stephens and Samantha Artiga, Kaiser Commission on Medicaid and the Uninsured, Key Facts on Health Coverage for Low-Income Immigrants Today and Under the Affordable Care Act (March 2013), accessed 6/21/14 at <http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8279-02.pdf>, citing Gomez, D., Day, L., and S. Artiga, "Connecting Eligible Immigrant Families to Health Coverage and Care: Key Lessons from Outreach and Enrollment Workers," KCMU, October 2011.

TABLE 1.  
CITIZENSHIP AND IMMIGRATION ELIGIBILITY CHART

Program	Citizen or National	Lawful Permanent Residents (age 19 and over)	Lawful Permanent Residents (under age 19)	Refugees, Asylees, Victims other humanitarian entrants <sup>1</sup>	Lawfully Present Immigrants <sup>2</sup>	Undocumented Immigrants
Health Insurance Premium Tax Credits & Cost Sharing Reductions	✓	✓	✓	✓	✓	—
Washington Apple Health for Adults (ages 19-64)	✓	✓ <sup>2</sup>	NA	✓	—	—
Washington Apple Health for Pregnant Women (ages 19-64)	✓	✓	NA	✓	✓	✓ <sup>4</sup>
Washington Apple Health for Kids (ages 1-18)	✓	NA	✓	✓	✓	✓ <sup>4</sup>
Alien Emergency Medical	—	✓ <sup>5</sup>	—	—	✓	✓ <sup>4</sup>

✓ Eligible      — Not Eligible      NA Non-Applicable

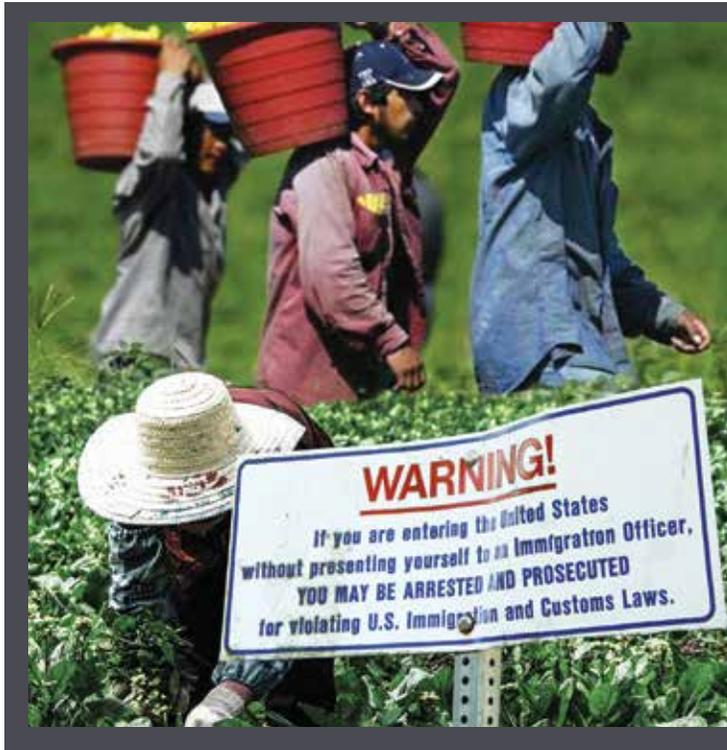
1. Refugees and Asylees are exempt from the federal 5-year waiting period for Medicaid eligibility. Other humanitarian entrants are also exempt, including: Victims of Trafficking and their family members, Cuban/Haitian Entrants, Persons Granted Withholding of Deportation/Removal, Special Immigrants from Iraq and Afghanistan, certain battered immigrants, and Hmong and Highland Laotians. Exemption for these groups is subject to verification of eligible immigration status, which is validated by the Federal Data Services Hub during the Washington Healthplanfinder application interfacing. Note that active duty military/veterans and their family members are also exempt from the 5 year federal waiting period (even if not in an exempt humanitarian category).

2. Includes a broad range of immigration categories, including persons with immigration applications pending for Asylum, Adjustment, and other forms of relief, persons in temporary status such as nonimmigrants and persons granted Temporary Protected Status, citizens of the Marshall Islands, Micronesia or Palau, and others.

3. Certain adult Lawful Permanent Residents who entered the U.S. after 8/22/1996 must be in LPR status for five years before they become eligible (this primarily applies to persons who obtained status through a visa petition filed by a family member or employer; see footnote 1 for a list of groups exempt from this requirement.) This five year federal waiting period does not apply to Washington Apple Health for Pregnant Women.

4. The Washington Apple Health program is an "umbrella program" that encompasses various programs for very specific populations. It is important to note that some Washington Apple Health Programs are funded in part by the Federal Government, and some programs are funded only by Washington State.

5. Adult Lawful Permanent Residents that are not pregnant and who have not satisfied the 5-year federal waiting period will be eligible for Alien Emergency Medical. After satisfying the wait period, the individual will no longer be eligible for the program as they will then be eligible for Washington Apple Health for Adults.



## Migrant Health Overview

Seth Doyle, Manager  
of the Community Health Improvement Program at  
Northwest Regional Primary Care Association (NWRPCA)

Washington is one of the most productive and diverse agricultural regions in the world. Hundreds of different crops are grown in the state, and it is a leading producer of apples, pears, cherries, potatoes, onions, wheat and hops among many other fruits, vegetables, grains and commodities. There are 39,500 farms and ranches scattered across the state, with the greatest concentration—and those with the greatest impact on the state’s economy—found in the rural counties of central and eastern Washington. In 2012, the value of the state’s agricultural production reached a record high of \$9.89 billion.<sup>1</sup>

Farmworkers are essential to the economic output of the state’s prominent agricultural industry, yet they are among the most vulnerable and medically underserved populations in the state. In 2012 Washington’s Community Health Centers or CHCs (Federally Qualified Health Centers) served 93,799 farmworkers.<sup>2</sup> While this constitutes the highest number of farmworkers served in a single state outside of California, it is still just a fraction of the estimated population. Providing health care services to farmworkers and their family members is a significant challenge as they experience a myriad of barriers to health care access, including extreme poverty, unfamiliarity with the culture and language, frequent mobility, and work and living arrangements that impede access

to health care. Furthermore, due to the nature of their work, farmworkers are disproportionately affected by environmental and occupational hazards, including pesticide exposure, unintentional injury, and heat-related illness or death. Farmworkers are also more likely to suffer from chronic conditions such as diabetes, infectious diseases such as tuberculosis, substance abuse issues and mental health conditions.

The plight of farmworkers has become increasingly well documented over the last half century. The airing of Edward R. Murrow’s documentary *Harvest of Shame* on Thanksgiving Day in 1960 was an important event in helping to create greater public awareness of the lives of farmworkers. The documentary uncovered the exploitation of migrant farmworkers and the abject living and working conditions they had to endure.

Efforts to address these harsh conditions led to the passage of the Migrant Health Act in 1962, which helped to establish an infrastructure for the delivery of health care services for farmworkers. Throughout the 1960s and ensuing decades, labor organizing led by Cesar Chavez and Dolores Huerta of the United Farm Workers (UFW) helped to bring about new laws and protections for farmworkers, especially in the state of California.

Washington, too, has played a key role in this history. The state was one of the first to establish a UFW presence outside of California. Tomás Villanueva, the State's most revered farmworker rights advocate, was the founder and first president of the Washington UFW and co-founder of the farmworker health clinic that would later become Yakima Valley Farm Workers Clinic. In fact, several of the state's oldest CHCs were founded to serve the migrant farmworker population. Today there are 25 CHCs in the state, 9 of which are Migrant Health Centers. Table 1 lists Washington's Migrant Health Centers.

TABLE 1  
Migrant Health Centers in Washington

Migrant Health Center	Year Founded	Total Patients Served in 2012*
Columbia Basin Health Association	1973	29,605
Columbia Valley Community Health	1972**	24,230
Community Health of Central Washington	1993	27,394
Family Health Centers	1985**	12,547
Moses Lake Community Health Center	1991**	23,880
Sea Mar Community Health Centers	1078	146,246
Tri-Cities Community Health	1981	21,029
Yakima Neighborhood Health	1975	18,299
Yakima Valley Farm Workers Clinic	1970***	119,614

\* Source: HRSA Uniform Data System. Note: Numbers reflect all patients served by the Health Center, not just farmworkers.

\*\* The North Central Washington Migrant Health Project was founded in 1972 to serve migrant farmworkers in Grant, Okanogan, Chelan and Douglas Counties. Okanogan and Grant counties would establish their own clinics in later years—Family Health Centers and Moses Lake CHC, respectively—and the Migrant Health Project became Columbia Valley Community Health.

\*\*\*The Farm Workers Family Health Center began as a project of the UFW Co-op of Washington in 1970. It later incorporated as Yakima Valley Farm Workers Clinic in 1978.

## Farmworker Demographics

The most widely cited source for farmworker demographic data comes from the National Agricultural Workers Survey (NAWS), which collects data on crop farmworkers on an ongoing basis. Results from the NAWS data indicate that 84% of farmworkers are Hispanic/Latino and most (68%) were born in Mexico. Farmworkers are predominantly young men (78% male and average age of 36). 33% of farmworkers are U.S. citizens, while 48% of farmworkers do not have legal authorization to work in the country.<sup>3</sup>

Washington has one of the highest farmworker populations in the country. According to a population estimate provided by the National Center for Farmworker Health, Inc. (NCFH) there are 619,699 farmworkers (including workers in horticulture and livestock) and their dependents (spouses and children) in the State<sup>4</sup>. In the past, most of the state's farmworkers were considered "follow the crop" migrants, working in the fields during peak harvest seasons and then returning to their homes in California, Texas or Mexico. However, beginning in the 1960s-70s the trend of farmworkers "settling out," or establishing permanent residences in Washington communities began to increase significantly. Today, approximately 70% of farmworkers in Washington are seasonal. Most of the migrant farmworkers in the state are indigenous Mexicans, especially Triqui and Mixtec people, and recent immigrants from the non-traditional sending states of southern Mexico such as Oaxaca, Chiapas, and Guerrero.

## Health Problems

Agriculture consistently ranks among the most dangerous industries in the United States. According to the Occupational Safety and Health Administration (OSHA), "farmworkers are at high risk for fatal and non-fatal injuries, work-related lung diseases, noise-induced hearing loss, skin diseases, and certain cancers associated with chemical use and prolonged sun exposure."<sup>5</sup> In 2011, agricultural workers had a fatality rate of 24.9 deaths per 100,000, 7 times higher than the rate for all workers in private industry.<sup>6</sup> The following are a sample of occupational hazards that farmworkers endure:

- **Unintentional injury:** According to the Binational Farmworker Health Survey, 27% of workers reported experiencing at least one injury during their working lifetime. Injuries occur most often due to misuse of ladders while working with deciduous fruit trees.<sup>7</sup>
- **Pesticide exposure:** The Bureau of Labor Statistics reports that crop production workers have the highest incidence of skin diseases of any industrial classification. Pesticide exposure can also result in extreme nausea, disorientation, dizziness, and has been linked to death. Also, there is some evidence that pregnant women exposed to pesticides are at increased risk for giving birth to children with deformities.<sup>8</sup>
- **Heat Stress:** Farmworkers are four times more likely than nonagricultural workers to suffer from heat-related illness.<sup>9</sup>

In addition, farmworkers suffer from increased rates of chronic health conditions, including hypertension and diabetes. Moreover, poor living conditions can cause or exacerbate many health problems. Farmworkers, for instance, have a tuberculosis prevalence that is six times higher than in the U.S. general population. Here, it is important to note the socioeconomic and political context of farmworker health. As anthropologist Seth Holmes observes in his ethnography *Fresh Fruit, Broken Bodies*, “consistent with the concept of structural vulnerability, these health disparities falls along citizenship, ethnicity, and class lines.”<sup>10</sup>

### Health Care Access

In 2012, Community Health Centers in Washington served 93,799 migrant/seasonal farmworker (MSFW) patients; approximately 15% of the NCFH estimated population. Nearly all of these MSFW patients were served by the state’s 9 Migrant Health Centers (listed in Table 1). MSFW patients represent 11% of all patients served by CHCs in the state and 22% of the patients served by Migrant Health Centers. Out of the 302,129 Hispanic/Latinos served by CHCs in 2012, 76% were served at a Migrant Health Center. Given the demographics of the farmworker population and historical trend of farmworkers “settling out,” it is not surprising that so much of the state’s Hispanic/Latino population resides within the service area of a Migrant Health Center. Table 2 illustrates the numbers of MSFW and Hispanic/Latino patients served by Washington’s Community Health Centers.

**TABLE 2**  
MSFW and Hispanic/Latino Patients Served at  
Community Health Centers in WA

WASHINGTON STATE	Total patients served	818,777
	Total migrant/ seasonal	93,799
	Migrant (330g grantees)	31,653
	Seasonal (330g grantees)	60,207
	Migrant/ Seasonal (non 330g)	1,939
	Hispanic/Latino (330g grantees)	230,067
	Total Hispanic/Latino	302,129

Source: 2012 HRSA Uniform Data System. Note: 330 refers to the section of the Public Health Service Act that authorizes funding for the Community Health Center Program. 330\*g refers to the special designation given to Migrant Health Centers.

### Barriers to Care

Farmworkers experience multiple barriers to health care access, including extreme poverty, unfamiliarity with the culture and language (on the part of both farmworkers and service providers), lack of knowledge of available services, lack of transportation, and work and living arrangements that impede access to health care. Furthermore, very few farmworkers have health insurance and it is very rare for them to receive any type of employer-sponsored benefits. While the Affordable Care Act has increased access to coverage for millions of Americans and hundreds of thousands of Washingtonians, many farmworkers, due to immigration status, are unable to access coverage. Also, the political climate around immigration has led to significant fear in farmworker communities, further exacerbating access to care challenges.

### Summary and Recommendations

Agriculture is a prominent industry and economic engine in Washington. Farmworkers are an essential part of the state’s multi-billion dollar agricultural industry, yet they remain a highly vulnerable and medically underserved population. Despite progress made in certain areas, many of the same issues impacting the health and lives of farmworkers 50 years ago are still true today. Farmworkers earn below poverty wages, lack health insurance, and are highly vulnerable to workplace injuries, exploitation and abuse. While there is a structure in place to care for farmworkers through the state’s Migrant Health Centers, utilization data indicates that the majority of farmworkers in the state are not accessing care. Improving access to care and health outcomes for farmworkers will require a multi-faceted, multi-sectorial approach. Given the vital role of farmworkers in our economy and society, it is essential that we work collaboratively and proactively to help improve the lives of the men and women whose daily labor is what nourishes us and helps keep us healthy.

The following is a list of recommendations to help improve the health and health care services for farmworkers:

- Expanded resources for improved data collection, including farmworker enumeration studies and surveillance of farmworker health issues and access to health care.

- Funding opportunities for expansion of outreach programs, along with training opportunities - and budget allocation - for outreach program staff, including community health workers and promotoras/es de salud.
- Training opportunities - and budget allocation - for providers unfamiliar with farmworker health issues, and strategies for recruitment of culturally and linguistically competent providers.
- Ongoing customer service and cultural competency training that reflect changing community demographics, including continued growth in the Hispanic/Latino population and increasing indigenous Mexican populations.
- National and state-level advocacy and awareness campaigns to address health care access for undocumented individuals.

1. Washington State Department of Agriculture. Available online: <http://agr.wa.gov/AgInWa/>.
2. Health Resources and Services Administration (HRSA), Uniform Data System. Available online: <http://www.hrsa.gov/data-statistics/index.html>. Every year Community Health Centers are required to report certain information to HRSA's Bureau of Primary Health Care, including data on patient demographics.
3. National Center for Farmworker Health (NCFH). "Facts About Farmworkers." 2012.
4. NCFH Disclaimer: This is a threshold estimate only. In order to derive a validated and complete estimate, the data referenced here must undergo an established research and review process, which is designed to be conducted on a county-by-county basis. The numbers contained herein have not been adjusted to reflect the following factors which could increase the total estimate of potential migratory and seasonal farmworker users in the state: 1) Local data that confirms the identified factor for estimating the number of non-working dependents of agricultural workers or offers a different factor; 2) Aged and disabled former farmworkers; 3) Under-reporting by agricultural employers; 4) Unemployed and underemployed agricultural workers in the county; 5) Unique weather conditions in 2007 that may have skewed the COA data; 6) Changes in agricultural practices that have occurred since 2007 that would drive the numbers up or down accordingly; and 7) Data that has been suppressed by USDA for a variety of reasons.
5. Occupational Safety and Health Administration. Available Online: <https://www.osha.gov/dsg/topics/agriculturaloperations/>
6. Ibid.
7. Arcury, T.A., Quandt, S.A. 2007. "Delivery of Health Services to Migrant and Seasonal Farmworkers." Annual Review of Public Health.
8. Ibid.
9. Hansen, E., Donohoe, M. 2003. "Health Issues of Migrant and Seasonal Farmworkers." Journal of Health Care for the Poor and Underserved.
10. Holmes, S. 2013. Fresh Fruit, Broken Bodies.

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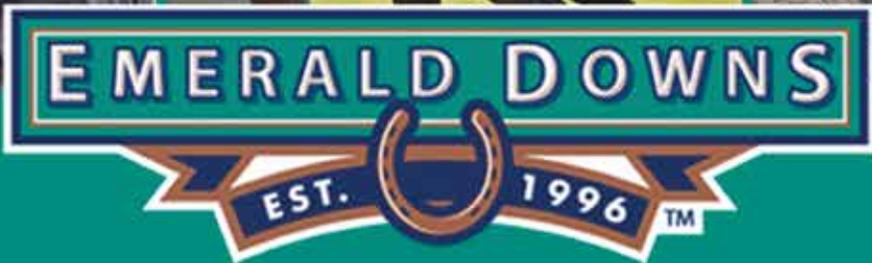
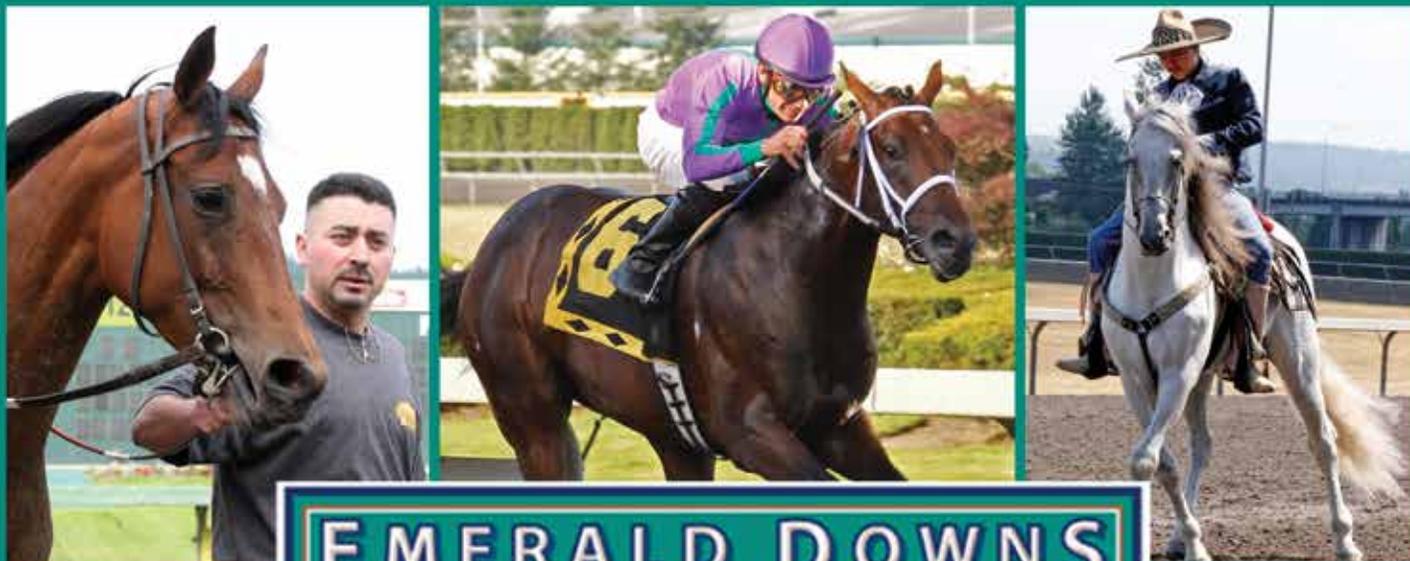
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## Health and Economic Development

Andres Mantilla

The face of Washington's economy is changing. Census after census, the influence of Latinos can be seen and felt. Over the last twenty years, the Latino population has outpaced growth of all minorities at the state level. 1 in 6 Americans is now a Hispanic and Hispanics under the age of 17 (who are disproportionately impacted by poverty-related issues) make up 23% of the US population and the largest growing minority in Washington.<sup>1</sup> This has allowed Latinos to achieve a steady increase in buying and spending power.<sup>2</sup> Washington's workforce is increasingly more Latino immigrant with new workers filling jobs in construction, healthcare and agricultural as well as in faster growing technology and engineering sectors.<sup>3</sup>

Yet, great disparities in health, income, education, social mobility and long-term economic prosperity still remain. In 2008, a disparity study from the Governor's Inter-agency Council on Health Disparities found, "Washington's communities of color continue to face a disproportionate burden of disease and death and disparities between men and women also remain for some health outcomes. While the reasons for such inequities are numerous and interrelated, what is clear is that health disparities in our State are persisting, sometimes even growing, and always unjust."

In order to ensure that the future for Latinos in Washington State is bright it is more important than ever to adopt a

holistic approach to economic development and wealth generation. At the center of this is a renewed focus on health economics. The connection between health and economic development cannot be overstated and is ripe for economic analysis. It is essential that policymakers evaluate the important correlation between healthy behavior, illness and widening the circle of prosperity. These correlations begin at an early age and predict early death or terminal illness. Moreover, they are further exasperated when considering race and ethnicity.<sup>4</sup> Choosing healthy alternatives including healthy food options, sanitary living conditions and regular healthcare drastically improve access to the socioeconomic capital needed to succeed in life. These paired with quality education, access to living wage jobs, and ongoing educational and wealth creation opportunities are how the Latino population will continue to grow.

### *Socioeconomic Mobility, Transit Oriented Development (TOD) and Healthy Behaviors*

Smart development and livable communities is often an ignored indicator for healthy behaviors. However, as our state booms, Latinos are on the move. The Pew Research Center estimates that Latinos are more likely than ever to move to metropolitan areas. These patterns offer up

an important challenge to Washington State policymakers when considering development, career access and economic revitalization programs. Increasingly, our urban areas are becoming denser and require smart development solutions that can meet the market's need for meaningful job access, affordable housing and scalable innovation. Recently, U.S. Census population estimates slated Seattle as the fastest growing American big city adding nearly 18,000 new residents in the span of one year. Growth generates opportunities to design livable healthy communities. In 2013, researchers at Harvard University found that a leading indicator of income inequality was the opportunity for intergenerational mobility. The closer populations lived to centers of employment the quicker they could climb the socioeconomic ladder. As important and tightly correlated as mobility to Transit-Oriented Development (TOD) are the positive health impacts of smart TOD including increased connectivity and walkability.<sup>5</sup> Smart TOD can also reactivate underdeveloped or eroding communities help combat food scarcity in

lower income communities and create a more stable economic base and opportunity for Latino workers. Active models of this exist in Los Angeles, CA and Austin, TX; Los Angeles anticipates it will generate 400,000 new jobs over the next 20 years.<sup>6</sup> In Washington State too often these correlations are not made or leveraged when considering growth management and economic development initiatives.

Policymakers have an opportunity to utilize these efforts and leverage these correlations. As the face of our state changes, becomes more diverse and increasingly Latino it is in our states best economic interest to actively invest in the future.

1. United States Census 2010
2. United States Census 2010
3. One America, BUILDING WASHINGTON'S FUTURE Immigrant Workers' Contributions to Our State's Economy
4. Center for Chronic Disease
5. University of Houston
6. LA County MTA, 2013

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# Latino Children and Environmental Health Hazards

Catherine Karr, MD, PhD

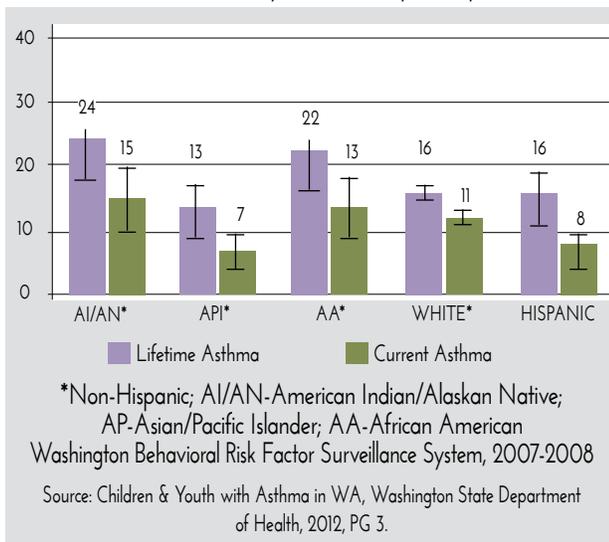
Increasingly, many of the key health problems of children today are linked in part to environmental contaminants and conditions (e.g. asthma, ADHD, low birth weight, obesity). This is because when it comes to environmental hazards, children are not just small adults. Where there are pollutants in the air they breathe, the water they drink, where they play, or in the food they eat, children typically will take in more on a per pound basis compared to their adult counterparts.

Once exposed, children are uniquely vulnerable to toxic effects that interfere with normal growth and developmental processes.

Latino children often experience disproportionate exposures to air pollutants, pesticides, toxic industrial chemicals, as well as lead and mercury from candy, traditional folk remedies, religious practices, and other sources associated with living in lower resourced urban areas or agricultural settings. These early life insults may leave long term consequences. In this report, we highlight asthma. This is an important environmental disease for all children but for which the impacts may be greater for Washington's Latino children.

FIGURE 1

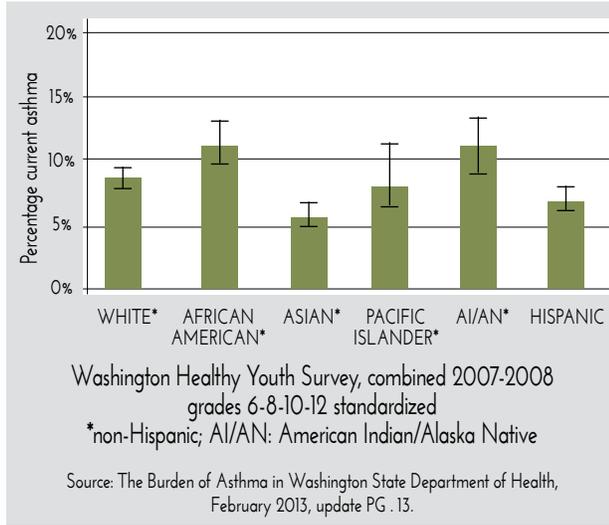
One or more children w/Asthma Among Household of Children Prevalence by Race/Ethnicity of Respondent



## *Asthma is an important environmental disease for Latino Children in Washington State*

Pediatric asthma is major public health problem and the numbers of affected children are rising. The Washington State Department of Health estimates that nearly one in ten (7.1 %) of Washington Latino students in middle or high school currently have asthma. As the figure below shows, 16% percent of Hispanic households with children have at least one child with asthma.

FIGURE 2  
Youth with current asthma by race and Hispanic ethnicity  
2008 and 2010



National and Washington State data consistently report lower asthma prevalence for Latino children compared to other ethnic or racial subgroups such as non-Hispanic white children. These data are derived from survey response to having an asthma diagnosis from a doctor, nurse or other health care provider. On the contrary, data on hospitalizations or ED visits for asthma find higher rates for Latino children, as do self-reported data on asthma symptoms such as wheeze. These discrepancies may reflect poorer access to primary care among Latino youth, limiting opportunities for asthma diagnoses and adequate management of disease. A 2011 American Lung Association report, *Luchando por el Aire: The Burden of Asthma on Hispanics* states that “compared to non-Hispanic whites, Hispanics with asthma are less likely to be in the care of a regular doctor or clinic, less likely to be prescribed appropriate medicines, less likely to have access to specialized care, and more likely to end up being treated in the emergency department or hospitalized in a crisis.”

In Washington State, the large majority of Latinos are of Mexican ancestry. Interestingly, asthma is more prevalent in US born Mexican Americans than those born in Mexico. Again, this may reflect differences in access to care and diagnosis as well as environmental differences associated with acculturation. While few studies on asthma have focused on U.S. children in rural, agricultural settings, exploratory studies suggest that asthma prevalence and poor asthma health may be particularly high (doubled) among the rural poor including Mexican American farm worker children.

## *Environmental conditions play two roles in childhood asthma: a cause and a trigger for exacerbation of disease*

Asthma is a chronic disease for which there is no cure. If not controlled, it can be severe and even life threatening. With asthma, the airways of the lungs become swollen and the muscles around the airways can tighten in response to “triggers”. This makes it difficult for air to move in and out of the lungs, causing symptoms such as coughing, wheezing, shortness of breath and/or chest tightness.

Research shows childhood asthma begins early in life. Multiple modifiable risk factors have been identified along with heredity (having family members with allergies or asthma is a well-known risk factor). Environmental exposures are linked to asthma in two important ways - as risk factors for development of the disease and as environmental “triggers” for exacerbation of existing disease. Overall, research is most convincing linking asthma development with early life exposure to tobacco smoke, house dust mites, dampness/mold, and traffic related air pollutants.

## *The evidence for environmental triggers that exacerbate asthma is very clear*

In addition to respiratory infections such as the common cold, allergens, irritating gases, and particles in the air are all well-established triggers that can make asthma worse. Each child is unique and may respond to one or several triggers.

### Common Environmental Triggers

- Cigarette smoke
- Allergens - pollen, mold, animal dander (cats/dogs), dust mites, cockroaches, rodents
- Indoor air pollution - gases and particles from poorly ventilated gas stoves, wood burning appliances, strong scent from perfumes, cleaning products
- Outdoor air pollution - traffic related air pollutants, particles and gases from industrial sources

Additional asthma triggers of concern are under investigation but have yet to be firmly established. These include

pesticides, phthalates and emissions from concentrated animal feeding operations such as industrial scale dairies. Children living in poverty or poor quality housing, nearby major roadways, or close to industrial sites or industrial agriculture are more likely to be exposed to asthma triggers. Latino children are disproportionately represented in these higher risk scenarios.

*Putting knowledge about asthma and the environment into practice improves child health.*

National guidelines recommend that health care providers work with patients and develop a written asthma management plan. These individualized plans identify actions to take to reduce asthma exacerbations including control of triggers for the child. However, only 30% of youth with asthma in Washington State report they have a written asthma action plan from their health care provider.

One effective approach to complement and reinforce care delivered in the clinic has been the use community health workers or promotoras. With home visits they are well equipped to help families identify triggers and offer practical advice on how to control them.

In Washington State, the Yakima Valley Farmworkers Clinic has been at the forefront of optimizing asthma care

through their longstanding Asthma Education Program. With a largely Latino farmworker family patient base, the program serves roughly 300 children with asthma and their families each year.

In addition to service delivery, the program works with the University of Washington in a community-university research partnership El Proyecto Bienestar to better understand and improve environmental health in the community. A recent study demonstrated that children living in closer proximity to dairies have higher exposure to dairy related air pollutants. These pollutants were further linked to decrements in asthma health among children with asthma in the Yakima Valley. The partnership is now moving ahead to an intervention study which hopes to improve child health by enhancing the asthma program and reducing these exposures.

*Summary*

Childhood asthma is a clear example of how environmental factors can be an important influence on child health. Having a robust understanding of the links between health problems with environment can be translated to improved health. After all, environmental causes of illness and disease are by nature, preventable. Latino children who face a disproportionate burden of high risk exposures have the most to gain from attention to improved environmental health conditions.

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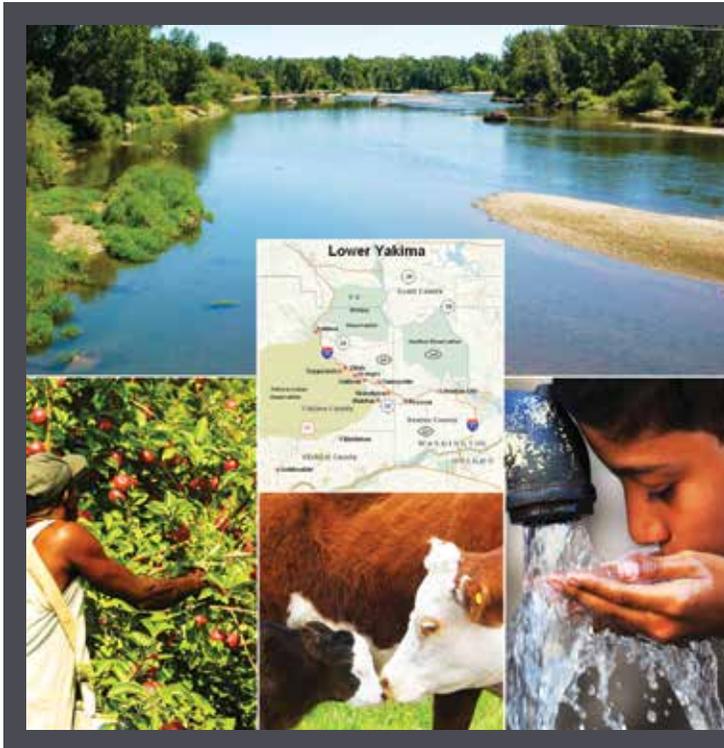
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## Environmental Health Risks of Latinos in Washington State

Victoria Breckwich Vasquez, DrPH, MPH, MA  
Nicole Davis, BA  
Anais Munios, Student, University of Washington

### *Environment Influences Health in Washington*

There is increasing evidence that the environments people live in determine their health. Researchers have documented area variations in health for a wide range of health-related outcomes. These include differentials in mortality,<sup>1</sup> chronic disease,<sup>2</sup> high blood pressure,<sup>3</sup> poor health behaviors,<sup>4</sup> violent crime,<sup>5</sup> and drug and alcohol abuse.<sup>6</sup> These studies highlight the importance of the social environment, in addition to individual characteristics, in shaping individual behaviors and health outcomes.

Washington is a geographically-diverse state, with different risks based upon where one lives. The Cascades divide our state but there is more that impacts our health than just living on one side or another. King County and its health department have found vast differences in health based upon where one lives even within the City of Seattle and its surroundings.<sup>7</sup> Other health departments across the nation have found similar disparities between neighborhoods.<sup>8</sup> Hispanics/Latinos live in urban and rural settings throughout Washington, yet there is no research documenting how their health is impacted by their environment, except in general terms.

### *Water Quality*

The Environmental Protection Agency (EPA) has standards to protect public health by limiting the levels of contaminants in our drinking water. Nitrate is a chemical found in most fertilizers, manure, and liquid waste discharged from septic tanks.<sup>9</sup> Dairies and livestock feedlots, land irrigated for agricultural means, as well as urban/rural residential areas where private wells are located are some of the main sources of nitrate and bacterial contamination. Rain or irrigation water can carry nitrates down through the soil into groundwater, polluting drinking water from these wells.<sup>10</sup> Nitrate is an acute contaminant, meaning that just one exposure may negatively affect a person's health<sup>11</sup>. Exposure to nitrate via drinking water reduces the ability of red blood cells to carry oxygen. The EPA's Maximum Contaminant Level (MCL) for nitrate is 10 mg/L.<sup>12</sup> Over 2,000 people in Yakima Valley are exposed to nitrate levels exceeding this MCL through their drinking water.<sup>13</sup> This is a concern for infants because exposure can lead to methemoglobinemia, referred to as "blue baby syndrome," a serious health condition that is fatal if left untreated.<sup>14</sup>

Groundwater contamination has become a major concern for agricultural communities, mostly located in Eastern Washington. The Lower Yakima Valley is one such community at high risk of nitrate contamination. According to the Washington State Department of Agriculture and other agencies, people in the Lower Yakima Valley are dependent on groundwater as a drinking water source.<sup>15</sup> Most families do not have access to public water systems and are served by private water wells. Twelve percent of the valley's wells that have been tested do not meet drinking water quality standards.<sup>16</sup> This particular area houses approximately 41.1% Hispanic/Latino residents, which is four times the state average.<sup>17</sup> These residents, whose primary language is Spanish, do not have access to the most current outreach programs designed to prevent the deterioration of groundwater quality.

### *Pesticides*

A pesticide is any substance or mixture of substances intended for preventing, destroying, repelling, or mitigating any pest.<sup>18</sup> The term pesticide also applies to herbicides, fungicides, and various other substances used to control pests. Pesticides can cause harm to humans, animals, or the environment because they are designed to kill or otherwise adversely affect living organisms. In the United States, the EPA estimates around 10,000 and 20,000 agricultural-related poisoning and injury incidents occur through skin exposure and absorption. Evidence shows long-term health effects of pesticides, including dermatologic problems, neurological issues, birth defects and some cancers.<sup>19</sup> Special concerns are directed toward children whose pesticide exposure and absorption rates are greater due to their size and developing systems.

Pesticides are commonly used in agricultural environments where Latino worker populations work, live and study. As agricultural workers, Latinos are commonly exposed to pesticides and need to take special precautions. Personal protective equipment such respirators, goggles and boots are commonly recommended by the label on the pesticide container itself. Pesticide "drift" is the movement of pesticides to off-target sites during and after application. Distance from source, wind

direction, and wind speed have been identified as primary determinants of drift. Pesticides have the potential to travel great distances<sup>20</sup> and also disperse as they spread.<sup>21</sup> Acute pesticide illnesses have been found to be associated with drift.<sup>22</sup> Pesticide applications therefore represent a potential health concern for those living in nearby communities, particularly for children and other vulnerable members of the community. Pesticide handler training and fieldworker training are ongoing efforts to ensure the proper use and handling of pesticides. Community member notification systems are currently being explored.

### *Promising Programs and Practices*

Research programs and interventions in farmworker communities address these health hazards in a variety of ways. One of these programs is El Proyecto Bienestar (EPB), which utilizes a community-based participatory research framework in order to better address the environmental and occupational health risks in Yakima Valley farmworker communities. EPB is administered by a core group of four partner organizations: Pacific Northwest Agricultural Safety and Health Center (PNASH), Northwest Communities Education Center/Radio KDNA, Yakima Valley Farm Workers Clinic and Heritage University. With direction from their Community Advisory Board, this program performs research and organizes activities that benefit farmworkers, their families, and their communities.

The Practical Solutions for Pesticide Safety Guide (available in English and Spanish) is a collection of 24 solutions and ideas identified on farms and developed in conjunction with farmers, educators and researchers in Washington State. A training for pesticide safety educators that features several solutions in the guide is currently in development at PNASH.

The Lower Yakima Valley Groundwater Management Area Education and Outreach Workgroup has plans to develop materials and outreach activities to educate the population on water quality and nitrates. With proper education, outreach and well-testing, nitrate contamination can be reduced.

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## Occupational Health Risks of Latinos in Washington State

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### *Washington-Specific Injury and Fatality Rates for Hispanics/Latinos*

Hispanics/Latinos have a higher rate of occupational injuries than other groups; likely due to both a higher presence in more risky occupations and industries, and higher rates of injuries within specific occupations.<sup>1,2</sup> In a recent Washington State study, the authors found that disparity also increases over time (an average of 5% per year).<sup>3</sup> From 1997-2004, occupational injuries serious enough to require 2 days away from work among Hispanics/Latinos doubled (from 7%-15%) in that time period.<sup>4</sup> Work-related traumatic injuries were 2.6 times more likely to be reported to the Washington State Trauma Registry by Hispanic/Latino workers than by non-Hispanic/Latino workers.<sup>5</sup> A current report of worker's compensation claimants who prefer to communicate in Spanish, finds that accepted claims were most likely to involve injury to the back, involve workers in the agricultural industry, and be concentrated in workers 22-40 years old.<sup>6</sup> Deaths among Hispanic/Latino workers from 2008-2012 in Washington numbered 38 (11%) of total deaths recorded in this period: 14% were in agriculture, 5 in construction, and others were widely dispersed among other industries.<sup>7</sup>

### *Agricultural workforce and health risks*

Occupational safety and health is one of the primary workplace concerns amongst migrant and seasonal workers in

Washington State. Because this population is largely underserved and understudied, many of the health hazards related to strenuous agricultural tasks and other occupational risks go undetected. The most common risks to farmworker occupational health and safety are heat stress, musculoskeletal injuries, and hearing loss.<sup>8</sup> Additionally, migrant farmworkers frequently experience sexual harassment in the workplace.

Exposure to extreme heat during agricultural work can cause injury and illness including heat-related illness.<sup>4,5</sup> If left untreated, this may result in heat cramps, heat syncope (fainting), heat exhaustion, or heat stroke, a potentially fatal condition. According to the EPA, more than 20% of cases of heat stroke are fatal and nearly 500 people in the U.S. are killed each year by the effects of heat.<sup>9</sup>

Other occupational health risks for agricultural workers are musculoskeletal injuries and hearing loss. Farmworkers are at high risk of musculoskeletal injury due to the nature of farm labor. Bending, carrying heavy items, and other repetitive motions over long periods of time are all direct causes of these types of injuries. Hearing loss is also significant among migrant farmworkers. Studies show that more than half of these workers have some degree of major hearing loss, mostly due to occupational exposure to tractor and machinery noise, with little to no hearing protection used.<sup>10</sup>

Sexual harassment in agriculture has also become a prevalent and dangerous occupational health and safety risk. The Equal Employment Opportunity Commission (EEOC) defines sexual harassment as a hostile environment and employment that is contingent on the exchange of sexual favors.<sup>11</sup> Sexual harassment can result in negative health and work-related consequences. Women and men agricultural workers often experience physical, psychological, and relational distress due to sexual harassment.<sup>12</sup>

One particular group with high occupational health and safety risks are indigenous farmworkers from Mexico and Central America. This population endures great challenges including discrimination and extreme social hierarchies.<sup>13</sup> This deteriorates existing occupational risks, leading to the most labor-intensive jobs and poorest of housing and social conditions<sup>14</sup>. Furthermore, language barriers increase the difficulty to develop occupational training material, due to the complexity of their languages and available people to translate.

### *Hispanic/Latino-Impacted Occupations*

Day laborers work on short-term informal agreements with employers in a wide range of work settings including manufacturing, construction, yard work, landscaping, and maintenance at private residences. Latino day laborers experience high rates of work-related injuries and are underserved in terms of safety and health programs and interventions.<sup>15</sup> In a Washington-based survey of 180 day laborers, the authors found that about 25% of them reported being injured at some time, consistent with self-reported injuries in a national sample of day laborers.<sup>16</sup>

Latino immigrant workers in Washington are also low-wage janitors. Several workplace exposures include non-standard shifts, isolated work, high work loads, and working with a range of cleaning agents, increase their risk of injury on the job.<sup>17</sup> In a study of the health of union and non-union janitors in Washington State, the authors found that increasing work intensity and job demands among them are likely taking a toll on psychosocial conditions, safety and health.<sup>18</sup>

### *Promising programs and practices*

The Pacific Northwest Agricultural Safety and Health Center (PNASH) at University of Washington is one of ten national centers conducting research, education, and prevention/intervention programs in agricultural industries. Activities aim to prevent occupational injury and illness, and promote best health and safety practices in agriculture throughout the Northwest. Recent projects include sexual harassment prevention (research and prevention campaign), production of educational videos (heat-related

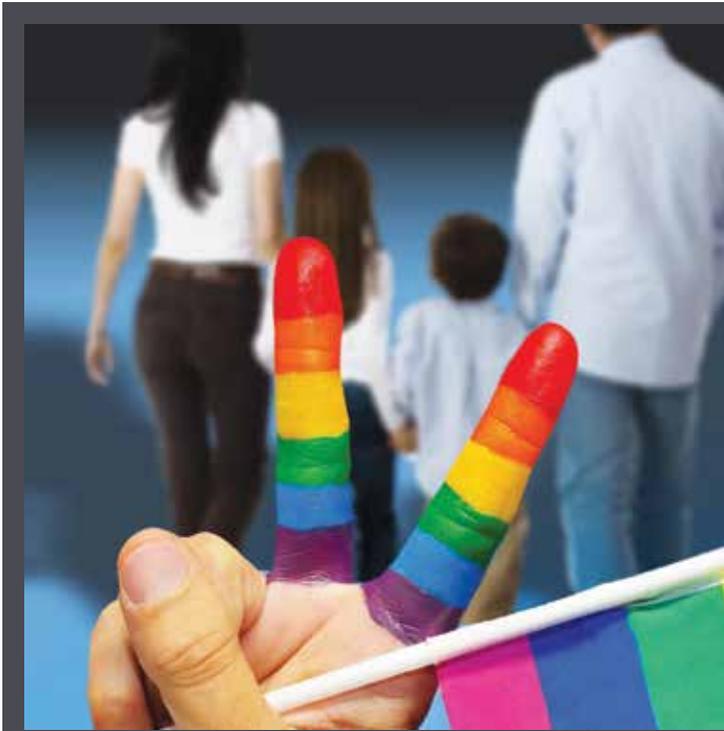
illness, ladder safety), and pesticide education (*radionovelas*) In conjunction with Radio KDNA in Yakima Valley.

Another program/intervention is the Hispanic Outreach Unit at the Washington State Department of Labor & Industries' Department of Occupational Safety and Health, which has developed comprehensive outreach and education in Hispanic/Latino communities with the goal of ensuring equal access to benefits, rights and regulations.

### *Gaps and challenges*

The Washington State Department of Agriculture farmworker training courses are well-known and respected for their hands-on, demonstration-focused exercises. However, these are under-staffed and under-resourced, with courses often booked the previous year. Also, pesticide handler certification courses are held several times a year and the industry provides financial support. Yet, there is a dearth of centralized fieldworker training and supervisor training courses.

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# Latino LGBTQ Communities in Washington State

Marcos Martinez

Recognition of the health and wellbeing of LGBTQ Latinos in Washington State is overdue, for this is a portion of our community that has long remained invisible, underserved and understudied.

It is important that all public health agencies and academic researchers recognize that LGBTQ Latinos are a valued part of our communities and their health and wellbeing must be taken into account when we design research and studies focused on community health.

The Latino LGBTQ community is diverse. While L, G, B, T & Q are usually tied together as an acronym that suggests homogeneity, each letter represents a wide range of people of different ethnicities, countries of origin, ages, identities, immigration and socioeconomic status. What binds us together as social and gender minorities are our common experiences of stigma and discrimination.

Lack of awareness of health needs by health professionals and a long history of racial discrimination results in barriers and challenges to access culturally competent services and prevents members of our community from achieving the highest level of health care possible.

It is difficult to define the size and distribution of the Latino LGBTQ population. Among the many factors is the reluctance of members of the community to answer survey questions about their identity based on fear of being ostracized and stigmatized. However, the 2010 United States Census identified that Washington State has the highest number of same-sex households (one in six).

### *Marriage and Family:*

While the life of individuals within LGBTQ community at large has improved since the passage of marriage equality, the picture for Latinos/as is different due to many factors including their immigration status. Information on the number of Latino same-sex couples and households is needed.

As same-sex couples are gaining more social acceptance, health care and other federal benefits that create family stability, the conversations about creating families, giving birth, or adopting children is very common. Yet again, more information is needed in regards to Latino families that addresses these issues.

### *Aging LGBTs:*

According to a recent national study, "Hispanic LGBT Older Adult Needs Assessment" published by the National Hispanic Council on Aging (NHCOA) and other partners, LGBT Latinos of the baby boomer generation face the prospect of having to go back "in the closet."

For aging LGBT Latinos this prospect can be especially concerning due to hostile environments within elder care facilities. This study echoes concerns about a general lack of data specific to aging LGBT Latinos. However, it does point to problems including prejudice and discrimination that many suffer for being members of both a sexual minority and an ethnically marginalized group.

### *HIV/AIDS:*

Latinos are disproportionately affected by HIV in our state and more so in King County, where the prevalence of HIV is higher for all ethnic groups. HIV continues to be a serious health issue for Latino gay and bisexual men. HIV also affects Hispanic women in areas of eastern Washington, where women may be infected by their male sex partners. Little attention has been paid to the risk of HIV infection for Hispanic women.

King County has over 6,000 residents diagnosed with HIV infection, including people who moved here after diagnosis in another county or state, and excluding those we believe have moved away. Over 4,750 HIV infected persons in King County have died since 1982.

The total number of people living with AIDS or with HIV infection in King County is increasing each year as new diagnoses exceed deaths among infected persons. The proportion of cases is increasing among men who have sex with men, Hispanic males, and people under age 30 or over 50 years of age (HIV/AIDS Epidemiology Report-1st Half 2013, Page 25).

### *Health Disparities within LGBTQ Latinos:*

Although there are no LGBTQ specific diseases, our community experiences numerous health disparities which affect the ability of the Latino/a individual to access a healthy lifestyle and achieve their economic potential.

According to national data from LGBTQ Health Disparities, **members of the LGBTQ community are more likely than their heterosexual counterpart to experience difficulty accessing health care. Individuals in same-sex relationships are significantly less likely than others to have health insurance, are less likely to report unmet health needs, and, for women, are less likely to have had a recent mammogram or Papanicolaou test (Buchmueller, 2010). These differences result, at least in part, from decreased access to employer-sponsored health insurance benefits for same-sex partners and spouses (Mayer, 2008).** Data from Health Disparities in the LGB community in King County also revealed that: **One in five (21%) LGB residents could not access healthcare due to financial barriers. This was twice the rate of other King County residents. This was especially true for lesbian and bisexual women, when compared to both gay and bisexual men and other female residents of King County.** Note that this study did not include Transgender data.

What data we do have for transgender health is very limited. Transgender health data from the national report "Injustice at Every Turn" provides the following data:

- Discrimination was pervasive for all respondents who took the National Transgender Discrimination Survey, yet the combination of anti-transgender bias and persistent structural and interpersonal acts of racism was especially devastating for Latino/a transgender people and other people of color.
- Non-citizen Latino/respondents were often among those most vulnerable to harassment, abuse and violence in the study; often live in extreme poverty, with 28% reporting a household income of less than \$10,000/year and are infected and affected by HIV in devastating numbers.

Similarly to the lack of data including Transgender individuals, data for the health of Latino LGBTQ community overall in the State of Washington is very limited. Small numbers of studies addressing the LGBTQ community in general have been conducted in King County and two are Latino specific. In 2011 the City of Seattle published a needs assessment survey of the LGBT community titled "Snapshot Seattle." Unfortunately only 3% of the respondents were Latinos.

*Results from different studies conducted in King County of the LGBT community in general suggest the following:*

**Higher rates of heavy drinkers.** The rate of heavy drinkers among LGB residents, almost one in ten (9%), was significantly higher than the rate for other residents of King County, approximately one in twenty (6%). This difference was especially significant among lesbian and bisexual women (15%), both when compared to gay and bisexual men (5%) and other women in King County. Among both LGB residents in general and lesbian and bisexual women in particular, this difference was most pronounced in the younger age groups.

**Higher levels of smoking.** One in four (25%) members of the LGB community are current smokers, which is significantly higher than the 14% of other King County residents who currently smoke.

**Higher rates of mental distress.** LGB residents reported twice as many days of mental distress in the past month than other residents of King County.

**Lower levels of mammogram testing.** One in five lesbian and bisexual women (20%) in the over 40yrs of age had not received a mammogram. This rate was significantly higher than the less than one in ten (7%) of other female respondents in this age group in King County. This difference remains significant regardless of health care coverage.

**Lower levels of Pap smear testing.** Thirteen percent of lesbian and bisexual women had not had a Pap smear exam as compared to sixteen percent of other female residents of King County.

In conclusion, while we must acknowledge and applaud the great strides that have been made in assuring equality for the LGBTQ residents of Washington state, serious health concerns continue to exist and must be addressed if our state is to fully realize its vision of a just and equitable future. Latino advocates and researchers can play a pivotal role by bringing to the forefront new studies, data and information that help policy makers in addressing these most pressing concerns.

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# WA Hispanic Health Priorities: Concluding Thoughts on WA State Latinos and Health

Health care issues have long been identified as significant determinants of disparity among the Hispanics/Latinos living in Washington State. These health related problems, and potential solutions, are part of the daily conversation among leaders of the community.

In response to our request for comments, a selected group of them agreed to provide their personal views, which are collected and summarized here (see acknowledgments). These valuable opinions should enrich the corresponding analysis and debate.

### *Health is a critical issue that needs immediate attention.*

The United States Hispanic/Latino population is rapidly growing and represents a sizeable work force that can be a determining factor in the economy of the country. The Hispanic/Latino population in Washington State has a high level of manual laborers, documented immigrants, and undocumented residents. With this mix of individuals comes a wide variety of barriers that make it difficult the access to health care. Consequently, many members of our community still lack the basic health services and education. Most Washingtonians get their health insurance through their employers, but Latinos disproportionately work for employers in industries that

don't provide health insurance to their employers. In addition, many Latinos work for themselves as independent contractors or small entrepreneurs without access to employer-provided health insurance.

### *Practical solutions need to be identified and implemented.*

Practical solutions should start by addressing the social determinants of health, including language, culture and affordability. A focused effort should be put forth to de-stigmatize the "illegal" label, which alienates and discourages the Latino population from blending into the main stream. Communication is key to implementing solutions that will connect the Latino to health care, and promoters can play a key role in reaching the community. Integrated care will help organizations to focus on the whole patient, this requiring effective cultural competence. Ultimately, appropriate health insurance may change the pattern of Latino immigrants going to the doctor only when they are very sick.

### *Some health conditions significantly affect the health of the Hispanic/Latino population.*

Although we should aim at preventing and treating any condition that affect the health of our community,

a few of these conditions raise our level of concern. These include diabetes, alcoholism (especially among men) and depression (especially among women). Those may be related to the cultural shock that immigrants experience when moving to new environments. Domestic violence is also a critical problem that needs to be addressed vigorously. In general, our community needs effective approaches to the management of chronic diseases, not only diabetes, but also obesity, hypertension, hypercholesterolemia. The Hispanic/Latino community tends to be very reluctant to partake in mental health services, contributing to high need for depression treatment. Appropriate resources are needed for education and HIV prevention programs among Latinos. Finally, special attention is also needed in relation to health issues derived from agricultural and other work-related activities, such as conditions resulting from pesticide exposure.

### *Access to health care has been a major factor affecting the Hispanic/Latino community.*

As mentioned before, lack of health insurance is a major barrier among Latinos. The Affordable Care Act (ACA) will help some individuals, but not all. In this regard, there is a need for additional promotional and educational material in the Spanish language. Recently, a large amount of the communication budget for the WHBE was spent on TV advertisement in the English media, while the investment on ethnic media was minimal; this disparity of effort is what makes larger the gap on information. Expanding coverage to all uninsured individuals through effective state programs would address this important barrier. One possibility is to create a state-run single payer health insurance. Even with universal insurance, a competitive market for health care plans in the State is an environment that must be sought in order to ensure high quality of care, cost efficiency, good clinical outcomes, and overall patient/customer satisfaction. Specifically, we must think about the potential re-implementation of the “Basic Health Plan”. Other barriers created by lack of culturally appropriate patient information, language, and patient behavior should be addressed by specific programs and incentives at educational institutions such as the University of Washington. In the long run, documentation of immigrant who are living and working in Washington State, would provide them with the

opportunity to obtain jobs that provide health insurance or participate in the ACA health care exchange. Also promoters are effective at connecting with at risk communities and provide proper language interpretation. Communicating with the Hispanic/Latino population in the language that best services them not only increases access to information and existing services, but also provides a more welcoming environment that increases their comfort level. Wellness campaigns to reduce the incidence of preventable diseases would eventually lower the cost of health care overall. Ultimately, issues with Hispanic/Latino accessing services has a lot to do with the availability of funds. Supporting organizations whose mission already includes bicultural and bilingual services, or those who work with low wage immigrants, will be most effective in reaching these communities.

### *Final comments*

The health care system is moving away from individualized and compassionate to an emphasis on outcomes and financial goals. Promoting, encouraging—perhaps even demanding—participation of health care providers, physicians, nurses, in the design of medical programs at health care plan levels is desirable to fully engage this crucial element of the health care workforce. This tactic could also bring back the heart and soul of patient care throughout history—the patient-doctor relationship. There is a large indigenous population in Washington State and there is a high need to reach out to the population. While the Spanish-speaking community tends to have a strong network, it could be more inclusive of an indigenous community that doesn’t speak the language and feels excluded from many Latino-focused organizations and initiatives. It is important to advocate for additional funding at the state and local level to support the Latino population for awareness of behavioral or life styles that affect health and how to seek access to services.

### *Acknowledgments*

The views summarized here are those from Rogelio Riojas (President and CEO of Sea Mar Community Health Centers), Hilary Stern (Executive Director of Casa Latina), and other contributors who requested confidentiality. Their responses were consolidated and summarized by José Esparza, MD, PhD from Esparza+.

## VI. 6.1 OVERVIEW



**Jerry Garcia**; PhD was born and raised in the state of Washington. He is a first generation college student and graduated from Quincy High School. Professor Garcia received his doctorate from Washington State University and had academic appointments with Iowa State University, Michigan State University, and is the former Director

of Chicano Studies and the College Assistance Migrant Program at Eastern Washington University. Dr. Garcia is the co-founder of the Sea Mar-Chicano Education Program Executive Internship with Mr. Rogelio Riojas, CEO of Sea Mar Community Health Centers in Seattle, Washington. Dr. Garcia's latest book *Looking Like the Enemy: Japanese Mexicans, the Mexican State, and U.S. Hegemony, 1897-1945*, was released by the University of Arizona Press, February 25, 2014.

## VI. 6.2 POLICY



**Vickie Ybarra**; PhC, MPH, RN is a RWJF Doctoral Fellow in Political Science at the University of New Mexico where she studies health policy, the social determinants of health, immigration policy, and Latino politics. She holds previous degrees in Nursing and Public Health from the University of Washington. Prior to returning to school,

Vickie worked for 21 years as a nurse then an administrator at the Yakima Valley Farm Workers Clinic. She served as Governor Gregoire's first Chair of the Governor's Council on Health Disparities from 2006 to 2010. Vickie looks forward to returning home to Washington after finishing her studies in 2015.

## VI. 6.3 VOTING RIGHTS AND HEALTH



**David Perez**; is an attorney at Perkins Coie, handling complex civil litigation matters. Representative clients include companies in advertising, aviation, manufacturing, and technology industries, as well as the financial sector. David also maintains a robust pro bono practice that focuses on issues related to civil rights, voting rights, and

constitutional law. Before joining Perkins Coie, David co-authored the Washington Voting Rights Act, and has testified in favor of the bill as its lead drafter in the State legislature. David received his B.A. from Gonzaga University where he was selected as the student commencement speaker, and his J.D. from Yale Law School.

## VI. 6.4 SAFETYNET PROGRAMS-TANF



**Eliseo (EJ) Juárez**; is the Political Director for Progressive Majority Washington. Prior to this he worked with Washington's largest anti-poverty organization, the Statewide Poverty Action Network, running campaigns related to Washington's Safety Net programs like Temporary Assistance for Needy Families (TANF), Disability Lifeline,

and State Food Assistance. He serves on the Board of Directors for Seattle Education Access and has served on the Commission on Hispanic Affairs since 2013. EJ holds a B.A. from Saint Martin's University and a M.A. in Cultural Studies from the University of Washington, Bothell. EJ is originally from Yakima, Wash. and now resides in Seattle.

## VII. 7.1 MATERNAL AND CHILD CARE



**Jennie A. McLaurin**; MD, MPH is a Specialist in Child and Migrant Health, Bioethics for MCN with 30 years of experience in migrant and community health. She is a board certified pediatrician with a master in public health and in bioethics and has worked at the local, state, and national level. Her career includes work as an outreach worker,

physician, clinic medical director, state medical director of migrant health, and federal consultant and program planner on a variety of topics related to health disparities, social determinants of health, child health, cultural competency and Patient Centered Medical Homes. She has authored, edited, and reviewed a number of journal publications, books, monographs, and abstracts on migrant health care. Teaching experience includes graduate level course development and frequent lectures in university and public settings. Dr. McLaurin worked in North Carolina for most of her clinical career but has lived in Ferndale, WA for the past twelve years and works across the nation with Migrant Clinicians Network and as a HRSA consultant.

## VII. 7.1 MATERNAL AND CHILD CARE



**Ileana Ponce-González**; MD, MPH is a Senior Advisor for Scientific and Strategic Planning at MCN. She obtained a degree in Medicine and Surgery from the Faculty of Medicine at the University of Nicaragua, a Clinical Genetics degree at the University of Chile and a Master in Public Health degree at the Bloomberg School of Public Health,

Johns Hopkins University. Before joining MCN, Dr. Ponce-Gonzalez worked as a Scientific Review Officer for AHRQ and the NIAID/NIH for twelve years. She has made dynamic and positive contributions to the prevention and treatment of infectious diseases and a wide-range of tropical illnesses.

## VII. 7.2 COLORECTAL CANCER



**Gloria D. Coronado**; PhD is an epidemiologist who conducts research on health disparities related to cancer prevention among underserved populations. She designs and evaluates clinic-based interventions to improve participation in cancer prevention screening and diagnostic follow-up among patients at Latino-serving community health clinics. In

her diverse portfolio of research, Dr. Coronado has examined Latino parents' acceptance of the HPV vaccine for girls, evaluated strategies for reducing pesticide exposure for children of farm workers, and developed innovative, culturally tailored programs for reducing diabetes and cancer risks among Latinos in a rural setting. She has collaborated broadly with Latino-serving community-based organizations both locally and nationally. Previously work at the Center for Health Research from the Cancer Prevention Program at the Fred Hutchinson Cancer Research Center, where she led a training program that prepared diverse undergraduate and post baccalaureate students to conduct cancer research. She received her PhD in epidemiology from the University of Washington and became a research associate professor in the university's Department of Epidemiology. She also received training at Stanford University. In 2009, she participated in the National Hispana Leadership Institute, an executive leadership training program. Acknowledgments to the Merwyn "Mitch" R. Greenlick Endowed Senior Investigator in Health Disparities Research. The Kaiser Permanente Center for Health Research. gloria.d.coronado@kpchr.org

VII. 7.3 KIDNEY DISEASE



**Rudy Rodriguez;** MD is the Director of Hospital and Specialty Medicine at the VA Puget Sound Health Care Systems and Vice Chair of the Department of Medicine at the University of Washington. He is a nephrologist and serves as the chair of the VA-wide Renal Field Advisory Committee and on the American Board of Internal Medicine Nephrology Board. His academic interests include kidney disease, health disparities and increasing diversity in academic medicine. He was previously a faculty member at the University of California San Francisco and worked as a nephrologist at San Francisco General Hospital.

VII. 7.4 BREAST CANCER



**Yamile Molina;** PhD is a Senior Fellow trainee in the University of Washington (UW)'s Bio behavioral Cancer Prevention and Control Training Program and an affiliate of the Fred Hutchinson Cancer Research Center (FHCRC). She focuses on Latinas' breast healthcare experiences and works with mammographers, health departments, and community-based organizations.

VII. 7.4 BREAST CANCER



**Rachel M. Ceballos;** PhD is an Assistant Member in the FHCRC Division of Public Health Sciences and an Assistant Professor in the UW School of Public Health. Dr. Ceballos' research examines the role of psychosocial factors on biobehavioral outcomes, with a focus on cancer survivorship among Latinos and African Americans

VII. 7.5 CHRONIC DISEASES



**Beti Thompson;** PhD is a full member at the Fred Hutchinson Cancer Research Center (FHCRC) and a professor in the Department of Health Services, at the University of Washington (UW). She has been PI, co-PI, or co-investigator on more than 25 NIH funded grants. Dr. Thompson has a national and international reputation in community

research and health disparities research. Her current major research focus is on disease prevention through lifestyle change, as well as encouraging populations to participate in disease screening activities. Much of her work takes place at the community level. She has written over 200 published manuscripts. Contact: Fred Hutchinson Cancer Research Center, 1100 Fairview Avenue N, M3-B232, P.O. Box 19024, Seattle, WA 98109, Telephone: 206-667-4673, E-Mail: bthomps@fhcrc.org

VII. 7.6 DIABETES



**Lorena Alarcon-Casas Wright;** is a Clinical Assistant Professor at the University of Washington Medical Center in Seattle, Washington, USA. Dr. Wright clinical and research interests are in all areas of diabetes care: type 1 and type 2 diabetes, diabetes in The Latino community, cystic fibrosis related diabetes, post-transplant diabetes, diabetes in pregnancy, and glycemic biomarkers. Dr. Wright is actively involved in teaching and mentoring. She is part of the Teaching Faculty of the Course "Hispanic Health and Health Disparities" at the UW School of Medicine. Dr. Wright enjoys mentoring minority premedical and medical students and is part of the mentoring committee for Women in Endocrinology, also a member of The American Association of Clinical Endocrinologists Pacific Northwest Steering Committee.

VII. 7.7 OBESITY



**Jason A. Mendoza;** MD, MPH, FAAP is a pediatrician, University of Washington School of Medicine associate professor of pediatrics and a UW adjunct associate professor of health services. He teaches and practices general pediatrics at Harborview Medical Center in both the pediatric clinic and on the inpatient pediatric service. Dr.

Mendoza earned his undergraduate degree from the University of Chicago and subsequently attended Rush Medical College where he earned his MD. He received his pediatric residency training at the University of Washington/Seattle Children's Hospital and advanced research training through the UW Robert Wood Johnson Clinical Scholars Program, where he also earned a MPH through the UW School of Public Health. Dr. Mendoza is a Principal Investigator in the Center for Child Health, Behavior and Development at the Seattle Children's Research Institute. His research seeks to address disparities in childhood physical activity and nutrition outcomes among racial/ethnic minorities and socioeconomically disadvantaged populations through innovative behavioral interventions and policies in school and community settings. His studies have been funded by the US National Institutes of Health (NCI and NHLBI) and the Robert Wood Johnson Foundation (Active Living Research Program). Dr. Mendoza leads research on (1) reducing Latino preschoolers' sedentary activities, such as television viewing, (2) increasing elementary school children's physical activity such as through the Walking School Bus, Bicycle Train, and other Safe Routes to School programs, and (3) promoting adolescents' physical activity through wearable mobile health (mHealth) devices. He leads global health research on the influence of household food insecurity on HIV+ children in the US and Sub-Saharan Africa. Dr. Mendoza also co-leads research examining household food insecurity among US adolescents and young adults with diabetes.

VII. 7.8 ORAL HEALTH



**Mark Koday;** is the Chief Dental Officer and Dental Residency Director for Yakima Valley Farm Workers Clinic (YVFWC). YVFWC serves over 131,000 patients annually and has 19 medical sites and 10 dental sites thorough Washington and Oregon. Dr. Koday received his DDS at Indiana University School of Dentistry in Indianapolis, Indiana. His professional associations include: WA State Oral Health Coalition (founding member and chair), Yakima County Oral Health Coalition (founding member and chair), ADA (member), and Washington State Dental Association (member).

VII. 7.8 ORAL HEALTH



**Laura Flores Cantrell;** is a Senior Program Officer at the Washington Dental Service Foundation. She was previously the Executive Director of the Latino Community Fund of Washington. Prior to entering the nonprofit sector, she served as Assistant General Counsel for an energy development firm in Bellevue, Washington. Ms. Cantrell

has worked in advocacy and public policy for nearly 20 years. Her professional experience has focused on improving the well-being of migrant and seasonal farmworkers, communities of color and at-risk children. She currently serves on the board of Progreso: Latino Progress, Washington's first Latino-led, Latino-accountable 501(c)(4) advocacy organization. Ms. Cantrell also serves on the national board of directors for the Mexican American Legal Defense and Educational Fund.

## VII. 7.8 ORAL HEALTH

**Kelly Richburg**; is the Policy Advocate/Analyst at Washington Dental Service Foundation, a nonprofit organization dedicated to preventing oral disease and improving overall health for all Washingtonians. She previously worked at the U.S. Government Accountability Office and RTI International. Kelly has a graduate degree in Child and Family Policy from Tufts University and a bachelor's degree from Vassar College.

## VII. 7.9 MENTAL HEALTH



**Gino Aisenberg**; PhD, MSW, an Associate Professor at the University of Washington School of Social Work, is a bilingual/bicultural Latino mental health researcher. His interests focus on three interrelated areas impacting underserved ethnic minority populations: 1) traumatic exposure of children and families to community violence and associated post-traumatic stress disorder, 2) depression care for adults, and 3) evidence-based practice. In 2013, Dr. Aisenberg was named Associate Dean, the Graduate School, to provide leadership in promoting diversity and community partnerships. He is the founding co-director of the, Latino Center for Health, a multidisciplinary community-based research center, established in 2014 to promote the health and well-being of Latinos in Washington state and the region.

## VII. 7.10 SUBSTANCE USE AND ADDICTION



**Marcos Zuniga**; MPH is the former Drug Policy Outreach Coordinator for the ACLU of Washington where he was responsible for organizing Communities of Color across the state to voice their concerns on issues related to implementation of Washington State's historic and groundbreaking passage of Initiative 502, legalizing recreational use of marijuana. Mr. Zuniga has worked in both private and public sector law firms that include MFR Law Group, the U. S. Department of Health & Human Services, and Legal Services. His law degree is from SUNY Buffalo Law School. Prior to becoming an attorney, Mr. Zuniga worked in substance abuse prevention in Detroit, Michigan. He also holds a Master of Public Health and Bachelor of Science from the University of Michigan in Ann Arbor. Mr. Zuniga has resided in Washington State since 1991.

## VII. 7.11 DOMESTIC VIOLENCE



**Miriam Georgina Valdovinos**; born in Anaheim, California is the eldest daughter of Juana & Jorge Valdovinos, immigrants from Michoacán, Mexico. She completed her Bachelor's and Master's degrees in Psychology at CSU, Fullerton being the first in her family (but not the last) to pursue college. She is currently a PhD candidate at the University of Washington, School of Social Work. She returned to school after 10 years of domestic violence fieldwork in California and Texas' community centers, emergency shelters, transitional housing programs, and school settings. She investigates intimate partner violence and its deleterious effects that plague our communities. Ultimately, she wants her research to be a catalyst in the ways we engage with undocumented survivors

## VII. 7.12 AGING AND CAREGIVING



**Carolyn Mendez-Luck**; is Assistant Professor at the College of Public Health and Human Sciences at Oregon State University. She completed her Ph.D. and M.P.H. degrees from the University of California, Los Angeles, and a post-doc at the Veteran's Administration HSR&D Center for the Study of Healthcare Provider Behavior in Sepulveda, CA. Prior to joining OSU, she was an adjunct assistant professor of Community Health Sciences at the UCLA School of Public Health where she currently holds a research scientist position. She is also a faculty associate with the UCLA Center for Health Policy Research. Dr. Mendez-Luck's research addresses aging-related health disparities in Latino and other vulnerable populations. Her research focuses on the social and cultural factors associated with caregiving, health, and aging in Mexican-origin populations. She is currently the principal investigator of three studies that focus on health living in local Oregon communities, and on diabetes management among Latino families in Los Angeles and the Willamette Valley. One long-term goal of Dr. Mendez-Luck's research program is to link individual health to family health by designing culturally-relevant programs aimed at improving diabetes management in the home.

## VII. 7.12 AGING AND CAREGIVING



**Katherine Anthony**; is a third-year doctoral student in public health at Oregon State University. Her research interests include resilience and aging in ethnic minority populations, cultural influences of caregiving, health, and aging, intergenerational gardening, and health-promoting interventions. Her current research examines Latina caregivers' views of caregiving burden and the influence of cultural values on their coping strategies. Ms. Anthony's aim is to better understand resilience and aging among ethnic minorities with the ultimate goal of creating health behavior interventions that are culturally relevant and build upon existing supports within elders' communities.

## VII. 7.13 LANGUAGE ACCESS



**Joana Ramos**; MSW of Seattle is an independent health policy consultant and founding member of the Washington State Coalition for Language Access. She is Co-Chair of WASCLA's Board of Directors and Chair of the Healthcare Committee. Her background in policy and direct practice in health and human services, and as a Brazilian Portuguese medical interpreter, guides her work to eliminate health inequalities. Joana led WASCLA's multi-year campaign to preserve Washington's Medicaid Interpreter Services program; created the first collaboration to address language barriers in pharmacies; directed the Tools for Health project; and continues advocacy efforts to ensure language access to Washington Healthplanfinder for ACA

## VII. 7.14 HEALTH AND HOUSING



**Marty Miller**; is the Executive Director of the Office of Rural and Farmworker Housing (ORFH). ORFH is a private nonprofit organization that provides comprehensive development services to construct or rehabilitate rural and farmworker housing throughout Washington State. Marty has been a valuable member of ORFH since 1993. With the partnership of their local sponsors, ORFH has developed nearly 1,500 units in rural Washington State serving over 7,500 farmworkers and other low-income rural residents. During his tenure, ORFH became a certified Community Development Financial Institution (CDFI) through which they offer a number of innovative lending products.

VIII. TRADITIONAL MEDICINE



**Brian McNeill;** received his Ph.D. in 1984 from Texas Tech University in Counseling Psychology, and is currently a Professor and Co-Director of the Pacific Northwest Center for Mestizo and Indigenous Research and Outreach at Washington State University. He is the co-editor of *The Handbook of Chicana and Chicano Psychology and Mental Health* (2004), *Latina/o Healing Practices: Mestizo and Indigenous Perspectives* (2008), *Intersections of Multiple Identities* (2010), and the co-author of *IDM Supervision: An Integrative Developmental Model for Supervising Counselors and Therapists* (2010). His research interests and areas of expertise include *Chicana/o Latina/o Psychology*, *Clinical Supervision*, *Recruitment and Retention of Culturally Diverse Students in Professional Psychology*, and *Investigations of Latina/o Spiritual Healing Traditions*. Dr. McNeill is a licensed Psychologist in the states of Washington and Idaho where he practices and consults.

VIII. TRADITIONAL MEDICINE



**Jorge Chacón;** holds a master's in psychology from Western Washington University and works as a family counselor in Wenatchee. He's a Vietnam War veteran and a veteran of the Chicano activism in the '60's. For the past 40 years, he's been following the teachings of his grandmother and practices traditional healing primarily in

Wenatchee and surrounding communities. Don Chacón is of the third generation in his family to practice the art of Curanderismo, but one of few traditional Mexican healers in the state.

IX. CRIMINAL JUSTICE



**David Morales;** is a legal aid attorney in Yakima Washington with the Northwest Justice Project. His practice focuses on the representation of farmworkers in employment and civil rights matters and systemic reform to jury selection. He has previously worked on matters of incarceration while serving as an editor on the *Jailhouse*

*Lawyer's Manual* for the Columbia Human rights Law Review and as a member of the Challenging the Consequences of Mass Incarceration Clinic. David is a 2012 graduate of Columbia Law School and a 2008 graduate of U.C. Berkeley.

X. 10.1 IMMIGRATION



**Janet Varon;** is the founder and Executive Director of Northwest Health Law Advocates. She coordinates the state-wide legal advocates' Medical Assistance Work Group and serves on the Healthy Washington Coalition Steering Committee. Janet is a member of the boards of the National Health Law Program and the

Medical-Legal Partnership for Children. She previously chaired the state's Medical Assistance Advisory Committee and served on the Governor's Certificate of Need Task Force and on the Low-Income Populations Advisory Group to the Joint Select Committee on Health Care Reform Implementation. Before starting NoHLA, Janet worked for 13 years as a staff attorney at Evergreen Legal Services. Janet is a graduate of Harvard Law School.

X. 10.1 IMMIGRATION



**Jorge Baron;** has been the Executive Director of the Northwest Immigrant Rights Project (NWIRP) since April 2008, after serving as a staff attorney with the organization since 2006. NWIRP is the only nonprofit organization providing comprehensive immigration legal services to low-income individuals and families in Washington

State. He is originally from Bogota, Colombia and immigrated to the United States in 1986. He graduated from Duke University in 1995 and spent five years working the film and television industry in Los Angeles California before pursuing a legal career. Mr. Barón received his law degree from Yale Law School in 2004. After graduation, he served as a law clerk for Judge Betty B. Fletcher of the U.S Court of Appeals for the Ninth Circuit in Seattle. He then served as an Arthur Liman Public Interest Fellow at New Haven Legal Assistance Association in New Haven, Connecticut before moving back to the Pacific.

X. 10.2 MIGRATION



**Seth Doyle;** is Manager of the Community Health Improvement Program at Northwest Regional Primary Care Association (NWRPCA). In this role, Seth oversees NWRPCA's examination of, and response to, changing population demographics and dynamics, models of community collaboration that address health disparities

and promote equity, models of clinical care delivery, and workforce and staffing innovations for community health centers. Seth joined NWRPCA in 2007 as Migrant Health Coordinator, providing training and technical assistance to migrant health centers in Idaho, Oregon, and Washington. Prior to joining NWRPCA, Seth worked as a Health Educator and Case Manager for the Urban League of Rhode Island. Seth holds a masters degree in Latin American Studies with a Public Health Minor from the University of New Mexico.

XI. ECONOMY AND HEALTH



**Andrés Mantilla;** is Senior Vice President at Ceis Bayne East Strategic where he brings extensive experience in areas of community outreach and engagement, economic development and public policy. Prior to joining CBE Strategic, Andrés served as Business Services Manager and Strategic Advisor to the City of Seattle's Office of Economic

Development where he guided the city's relationships with neighborhood business districts to form multi-year commercial revitalization strategies. He also served on Seattle Mayor Greg Nickels' Community Outreach Team working on policy and engagement with Seattle's immigrant businesses and in communities of color. Andrés is the Vice-Chair for the Washington State Commission on Hispanic Affairs advising the Governor and other policymakers on the impact of legislation and policies on Washington Latino communities. He also serves on the Boards of Directors for King County Conservation Voters, Seattle Foundation's Neighbor 2 Neighbor and NARAL Pro-Choice Washington. He holds a degree from the University of California, Santa Barbara in Latin American Studies.

XII. 12.1 ENVIRONMENTAL HAZARDS



**Catherine Karr**; MD, PHD is a pediatrician, environmental health researcher, and director of the Northwest Pediatric Environmental Health Specialty Unit (PEHSU) at the University of Washington. Her educational background includes a MS in environmental health/toxicology, PhD in epidemiology, and MD from the University of Washington. She is currently Associate Professor in the Department of Pediatrics and Department of Environmental and Occupational Health Sciences. Her special research interests include community engaged research, health of agricultural communities, and global children's environmental health. She is involved in primary care pediatrics and resident teaching at the University of Washington Pediatric Care Center.

XII. 12.2 ENVIRONMENTAL HEALTH RISKS

XII. 12.3 OCCUPATIONAL HEALTH RISKS



**Victoria Breckwich Vasquez**; is Director of Community Engagement & Education at the Pacific Northwest Agricultural Safety and Health Center at University of Washington Seattle. In addition, she is an Affiliate Clinical Instructor at University of Washington Bothell. Her research to practice trajectory has focused on community-based participatory research and its contributions to healthy public policy. She was formerly at the City of Berkeley Public Health Division in charge of assessment, planning and evaluation. She has a DrPH from UC Berkeley and a MPH and MA (Latin American Studies) from UC Los Angeles.

XII. 12.2 ENVIRONMENTAL HEALTH RISKS

XII. 12.3 OCCUPATIONAL HEALTH RISKS



**Nicole Davis**; BA, she was born and raised in the Pacific Northwest; she grew up in Arlington Washington and graduated from the University of Washington Bothell campus as a health studies major. She is passionate about public health, health care access, and health equity among fragile populations. Additionally, her academic interests lie within the field of epidemiology, as she is mainly concerned with how diseases disproportionately affect underserved communities. In her free time Nicole enjoys music, hiking, and travelling.

XII. 12.2 ENVIRONMENTAL HEALTH RISKS

XII. 12.3 OCCUPATIONAL HEALTH RISKS



**Anais M. Muñoz**; student at the University of Washington Bothell, is a native of Puerto Rico, studied nutrition in Spain and lives in Washington since 2012. As an aspiring Occupational Therapist, she strives to work alongside community engagement leaders in projects that promote public health action in an effort to better understand the occupational and environmental risks that concern the Hispanic/Latino community in Washington State.

XIII. LGBTQ AND HEALTH



**Marcos Martinez**; is the Executive Director of Entre Hermanos, a community based non-profit that serves the Latino gay/lesbian/bisexual/transgender community of Seattle and King County. Entre Hermanos' mission is to support the health and well-being, and develop leadership in the Latino LGBT community. The organization was created to address the HIV/AIDS epidemic in the Latino community, and to provide advocacy and support. Marcos has served on the state of Washington's HIV Prevention Planning Group; on the steering committee for the National Latino AIDS Action Network, and as co-chair of the University of Washington Center for AIDS Research Community Action Board (CFAR CAB). He also served on the board of the Minority Executive Directors Coalition, and the Citizens' Telecommunications Technology Advisory Board. Previously Marcos worked in community radio for 20 years in Albuquerque New Mexico.

*Thank you!*



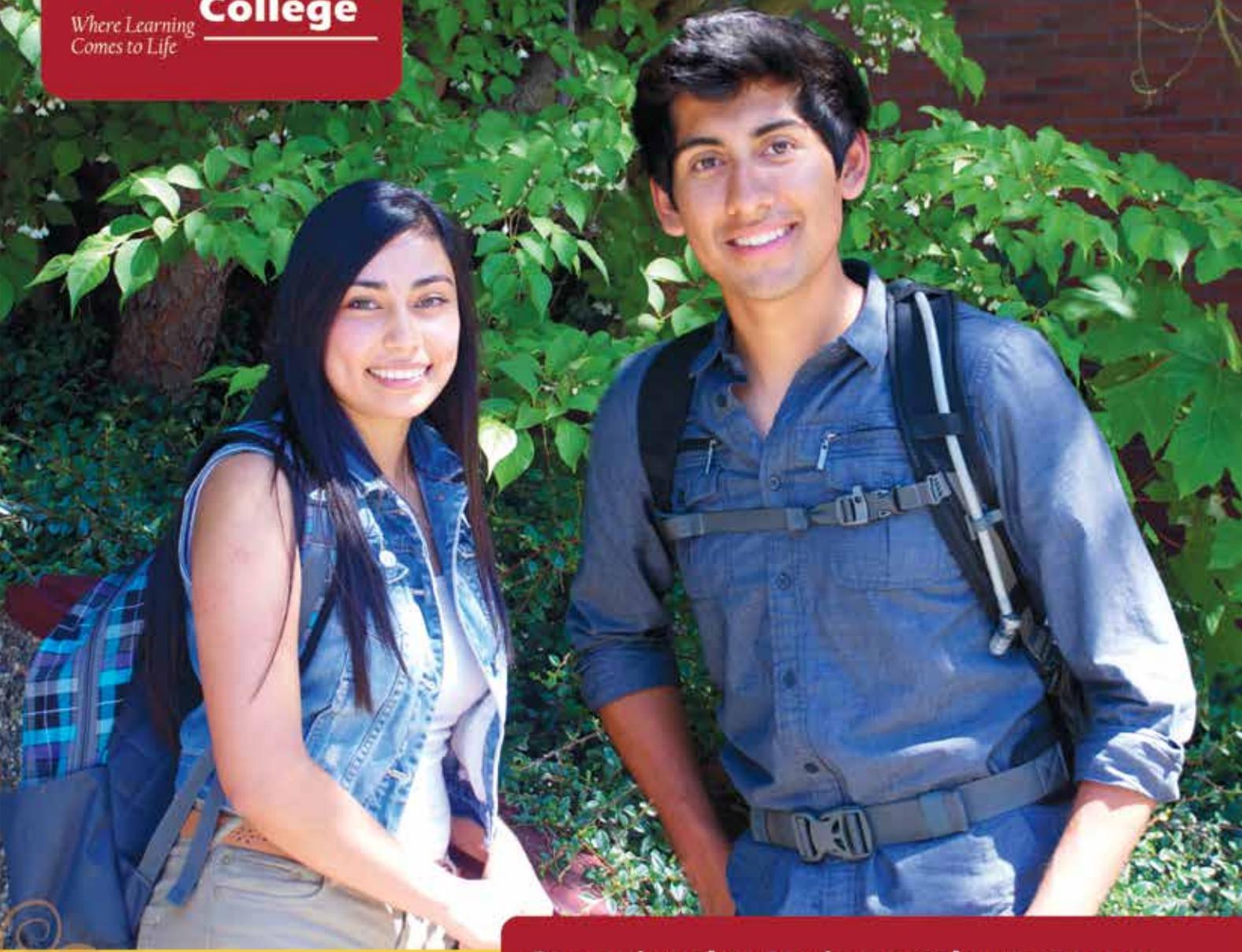
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