

**DEVELOPING MINORITY HEALTH COMMUNICATIONS CAPACITY IN
WASHINGTON STATE**

PROJECT NARRATIVE

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2. PROJECT SUMMARY

Background

Disparities in health by race/ethnicity are well documented in Washington State. In 2006, the State Legislature passed, and the Governor signed, a bill creating the Governor's Interagency Council on Health Disparities (i.e., the Council). Resulting statutory language charges the Council with, among other things, developing a state action plan to eliminate health disparities related to race, ethnicity, and gender. The Council is committed to engaging racial and ethnic communities in its work, and plans to solicit input from affected groups as it develops the action plan. Communicating with diverse communities—including those who may not speak English, may have limited English proficiency, and may not be acculturated—is a complex and difficult task. Existing funding and staffing are not sufficient to provide a robust outreach and communication strategy adequate to effectively reach large numbers of diverse subpopulations. Nonetheless, effective outreach is a responsibility the Council takes very seriously.

The Council believes that eliminating disparities will require increased awareness of health disparities among affected populations, and it recognizes that one way to combat disparities is to reach affected communities with targeted, effective, and culturally appropriate health messages that might, for example, encourage utilization of appropriate screenings or promote healthier lifestyle choices. Washington's December 2006 windstorms—which resulted in widespread power outages and subsequently an epidemic of carbon monoxide poisonings and deaths, primarily among immigrant populations—highlighted the need to improve our ability to communicate with hard-to-reach populations in emergencies. It drove home for Washington, just as Hurricane Katrina had for the nation, the link between health disparities and emergency preparedness and response.

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

State statute charges the Council with promoting communication and collaboration between public and private organizations and communities of color to address health disparities, so it would be appropriate for the Council to play a key role in facilitating an integrated approach by providing staffing and leadership to support planning and coordination.

Project Purpose

This project will provide dedicated state staffing to develop the Council's capacity to engage communities of color in its work, particularly in the development of an action plan to eliminate health disparities in Washington State and in increasing awareness of health disparities. It will do so in a manner that—through leadership, collaboration, coordination, planning, and the creation of linkages between public and private entities—simultaneously increases the overall capacity of organizations throughout Washington to communicate with hard-to-reach individuals and groups, particularly minorities, in ways that help eliminate disparities.

Project Objectives

1. By August 31, 2008, the Council will convene and staff a Minority Health Communications Interagency Workgroup to coordinate statewide efforts aimed at improving the capacity to communicate effectively with racial/ethnic communities.
2. By August 31, 2009, the Council will create a minority health communications directory with information regarding where racial/ethnic minority communities reside, community organizations and other trusted sources that can serve as information conduits, and specific cultural and linguistic needs of the communities.
3. By August 31, 2009, the Council will create a minority health communications improvement plan to document communications gaps, recommend strategies for filling those gaps, identifying best practices, and suggest ways that existing resources for reaching minorities might be maintained and the information they contain kept current.
4. By August 31, 2009, the Council will begin using and evaluating the newly identified communications channels to reach communities of color to increase awareness of health disparities and to seek input into the Council's work.
5. By August 31, 2010, the Council will develop and disseminate a final report that highlights project successes and barriers, lessons learned, and practical recommendations for other states to use in their efforts to reach and communicate with racial/ethnic minority communities.

Project Plan

The Council's first objective is to convene and staff a minority health communications interagency workgroup. The Council recognizes that there are already a number of existing activities in Washington State aimed at improving communication with racial/ethnic minorities, as well as other hard-to-reach populations. The motivation behind many of these efforts stems from a need to improve the capacity to reach these populations with emergency preparedness and response information. Other efforts are geared toward trying to communicate health education and promotion messages to minority communities. To date, these efforts have been working toward a shared goal, but in parallel and with limited overlap. Thus, there is a need for leadership

and improved communication and collaboration between these various entities. As a result of its legislative charge to serve a convening role and to reach out to communities of color, as well as its representation from key state agencies, boards, and commissions, the Council is uniquely positioned to provide a leadership role in coordinating these efforts. The workgroup will provide a forum for groups to learn about each others' activities, identify opportunities for collaboration, and provide input into a shared vision and plan for improving communications capacity in Washington State.

Second, the Council will develop a directory of community contacts and other information related to the cultural and linguistic needs of communities. To compile the information for this directory, the Council will work with its partners in the minority health communications interagency workgroup to identify additional activities aimed at reaching communities of color and will meet with those groups to learn about where communities reside and appropriate communication channels.

These meetings will also identify where significant communication gaps exist. These gaps may be where communication channels have yet to be identified or where methods need to be strengthened. Therefore, in addition to developing and populating the minority health communications directory, a third objective of this project is to create a minority health communications improvement plan. The plan will document the communication gaps that were identified, describe any known barriers related to those gaps, explore successful strategies in creating effective communication pathways for similar communities, and provide specific recommendations for filling the gaps.

The fourth objective is to use the communication channels as they are developed in order to: (1) let communities know that the Council exists, (2) share information about the Council's work, including its main responsibility to develop an action plan to eliminate health disparities, (3) inform communities about the Council's public meetings and other opportunities that are available for them to participate in, (4) request active involvement and input from communities to help shape the Council's work products and recommendations, and (5) provide information about health disparities in order to increase awareness about the differences in health status among different racial/ethnic groups.

The last objective is for the Council to develop a final report that provides detailed documentation of the approach taken to develop communication capacity in Washington State. The final report will highlight project successes and barriers, lessons learned, and practical recommendations for other Washington State organizations and other states to use as they proceed with their efforts to reach minority communities with vital health information.

Evaluation Plan

As this project is a partnership development and capacity building project, the evaluation will be solely a process evaluation and is, therefore, qualitative in nature. The evaluation plan detailed in this application includes a logic model depicting the relationships between proposed project activities and expected impacts and outcomes. The evaluation plan also includes a list of key activities, evaluation questions, indicators, and the data sources to be used for each objective.

3. BACKGROUND

3.1. STATEMENT OF NEED

3.1.1. Washington Demographics

Washington State's population is growing, aging, and becoming more racially and ethnically diverse – three factors which have a substantial impact on health. In 2006, the population of Washington State was estimated to be 6,395,798.¹ Between 1990 and 2006, the population increased by 31%, compared to the growth rate for the nation of 13%. Like the nation as a whole, the population in Washington is getting older, with a median age increase from 33 years in 1990 to 37 years in 2005.²

Washington is also becoming more diverse. Between 1990 and 2005, Washington's minority population growth has been significant, increasing from 16% to 23%. During this period, the Hispanic population increased from 4% to 8%, the proportion of Asians and Pacific Islanders increased from 4% to 6%, the proportions that were African American and multiracial each remained steady at 3%, and the proportion that was American Indian and Alaska Native remained unchanged at 2%.²

Projections of the state's racial/ethnic composition are available through 2030. These forecasts predict that while the state's non-Hispanic white population will increase 34.5% from 2000 through 2030, all minority groups will increase at a notably faster rate. The fastest growing minority groups are expected to be the multiracial group with an increase of 161%, Hispanics with an increase of 149%, and Asians and Pacific Islanders with a relative increase of 132%. The proportions of African Americans and American Indian and Alaska Natives are also expected to grow at rates faster than that projected for non-Hispanic whites at 60% and 51%, respectively. Therefore, by 2030, Washington's non-Hispanic white population is expected to decline as a share of the total population to 68%, while the state's minority population will grow to 31% - nearly one in every three residents.²

3.1.2. Health Disparities in Washington State

In Washington State, as in the United States as a whole, white non-Hispanic and Asian populations *generally* have better health outcomes than African Americans, American Indians and Alaska Natives, and Hispanic populations. In 2004, the Washington State Department of Health published *The Health of Washington State 2004 Supplement*, which provided a statewide assessment of health disparities by race/ethnicity, as well as by poverty and education.³ Some selected examples of disparities in health outcomes experienced by racial/ethnic minority

¹ US Census Bureau. Washington State & County Quick Facts. <http://quickfacts.census.gov/qfd/states/53000.html>. Accessed June 25, 2007.

² Washington State Office of Financial Management Forecasting Division. Population Estimates. <http://www.ofm.wa.gov/pop/default.asp>. Accessed June 26, 2007.

³ Washington State Department of Health. 2004. *The Health of Washington State 2004 Supplement*. Olympia, Washington.

populations documented in the Department of Health report using combined data from 2000-2002 follow:

- Age-adjusted mortality rates were significantly higher for African Americans (968 per 100,000) and American Indian and Alaska Natives (940 per 100,000) than for whites (797 per 100,000) or Asians and Pacific Islanders (524 per 100,000). Similarly, American Indians and Alaska Natives and African Americans had the lowest life expectancies at 74 and 75 years of age, respectively, compared to life expectancies of 78 years and 83 years, respectively, for whites and Asians and Pacific Islanders.
- Crude incidence rates for HIV/AIDS were six times higher among African Americans than the rate for whites. Crude rates were also higher among Hispanics than among non-Hispanics.
- Crude incidence rates for tuberculosis were highest among Asians and Pacific Islanders, African Americans, and American Indian and Alaska Natives, which all had rates between 7 and 13 times higher than the rate for whites. Hispanics had higher rates than non-Hispanics.
- Age-adjusted coronary heart disease mortality rates for American Indians and Alaska Natives (167 per 100,000) and whites (153 per 100,000) were both significantly higher than the rate for Asians and Pacific Islanders (90 per 100,000). African Americans had the highest rate (188 per 100,000).
- The age-adjusted mortality rate for stroke was higher among African Americans and American Indian and Alaska Natives compared to whites and Asians and Pacific Islanders.
- African Americans had higher age-adjusted death rates from female breast cancer and lung cancer than whites. Asian and Pacific Islanders had higher rates of invasive cervical cancer than whites.
- Age-adjusted mortality rates from diabetes were higher among all racial/ethnic groups than among whites, with the rate among African Americans (57 deaths per 100,000) more than double the rate among whites (24 deaths per 100,000). The rate among Hispanics was higher (36 per 100,000) than the rate among non-Hispanics (25 per 100,000).
- The age-adjusted mortality rate for motor vehicle injuries among American Indians and Alaska Natives was more than double the rate of any other racial group. The rate among Hispanics was higher than the rate among non-Hispanics.
- The age-adjusted mortality rates due to homicide were higher among African Americans and American Indians and Alaska Natives than among other racial groups, and were higher among Hispanics than non-Hispanics.

Currently, the Department of Health is updating its *Health of Washington State* publication with data from 2003-2005. While at the time of writing this application the report is not available for citation, preliminary data reveal that the disparities documented above persist.

The reasons why disparities in health outcomes are experienced by racial/ethnic populations are numerous, interrelated, and complex. One reason is that different populations have different opportunities and environments, which can contribute to different health choices. In Washington State, African Americans, American Indian and Alaska Natives, and Hispanics *generally* have more risk factors and fewer protective factors than non-Hispanic whites or Asians, therefore, increasing their likelihood to suffer from poorer health. Just some examples of differences in risk and protective factors follow:

- For the years, 2003-2005, smoking rates were higher among American Indians and Alaska Natives (37%), Hawaiians and Pacific Islanders (27%) and African Americans (25%), relative to Hispanics (17%), whites (19%) and Asians (12%). While the smoking rates for whites have decreased from 1999 to 2005, they have remained relatively stable among all other racial and ethnic groups, therefore, disparities are widening.⁴
- Data from King County, Washington's largest county, revealed that certain Asian subgroups, such as Korean and Vietnamese men, have particularly high rates of smoking, at 29% and 38%, respectively.⁵
- In 2004, obesity rates were higher among American Indian and Alaska Natives (31%) and African Americans (33%) than among whites (22%).⁶
- According to data from the Behavioral Risk Factor Surveillance Survey from 1995, 1997, and 1999, American Indians and Alaska Natives had higher rates of heavy drinking than other racial/ethnic groups.⁷
- Data from 1997 through 1999 indicated that African American and American Indian and Alaska Native women were less likely to initiate breast feeding than white or Asian and Pacific Islanders.⁷

Disparities in health outcomes also exist as a result of differences in access to and quality of health care services. In Washington State, Hispanics were three times more likely to be without health insurance; African Americans and American Indians and Alaska Natives were also less likely to have health insurance than whites. Similarly, African Americans and American Indians and Alaska Natives were less likely to report that they have a personal doctor or health care provider.⁷

⁴ Washington State Department of Health (2007). Adult Smoking Rates in Washington: A Report on Current Disparities.

⁵ Smyser M, Krieger J, and Solet D. 1998. The King County Ethnicity and Health Survey. Public Health-Seattle and King County. Seattle, WA.

⁶ Washington State Department of Health. Washington Obesity Rates by Sex, Age, Race/Ethnicity, and Income. http://www.doh.wa.gov/cfh/NutritionPA/facts_and_figures/data_charts/disparites_obesity_in_adults.doc. Accessed June 26, 2007.

⁷ Washington State Department of Health. 2002. Health of Washington State. Olympia Washington.

Even when access-related factors like those mentioned above are controlled for, racial and ethnic minorities still tend to receive lower quality of care.⁸ Stereotyping and biases due to lack of understanding and discrimination on the part of health care providers contribute, in part, to the inequities in care received by minority patients.⁸ In 2000, 5% of King County residents in Washington participating in a “Communities Count” survey indicated that they felt as though they had been discriminated against in a health care setting during the past year; the proportion was even higher for all minority participants (10%) and African American participants (16%).⁹

The relationship between lower socioeconomic status (often defined by having a lower level of income, education, or job status) and having higher rates of ill health and mortality has been well-documented.¹⁰ Health disparities by race/ethnicity, therefore, can be partially explained by the marked differences in socioeconomic status experienced by different racial/ethnic groups. However, studies that have controlled for socioeconomic status have demonstrated that race/ethnicity is still an independent predictor of health for many health indicators and outcomes.¹⁰

In addition, communication barriers can also result in the health disparities experienced by racial and ethnic minorities. Minority communities, particularly those with limited English proficiency, are less likely to be reached with health information and messages about health disparities. In the past, as well as in the current day, the public health and medical fields have tended to rely on getting health messages out to the public in written materials and through mainstream public channels that may not reach certain populations. Further, traditional materials may not be culturally or linguistically appropriate for all audiences, and as a result, some minority populations might not think those messages are meant for them. In addition, communication barriers can hinder the participation of communities of color in the policy making process. For example, minority communities may be less likely to participate in public hearings, to write or speak to their legislators, or even to vote. Such a reduced level of participation by racial/ethnic populations may contribute to the creation of policies, which, either directly or indirectly, can perpetuate health inequities.

Such communication barriers contributed to the disproportionate impact on minority communities in Washington following a series of severe windstorms and subsequent widespread power outages in December 2006. The first windstorm struck on December 11 and 12, resulting in the loss of power to nearly 70,000 people, followed by a second storm that resulted in further power outages to more than 120,000 people. On December 14 and 15, a third windstorm struck, leaving more than 4 million people in the Pacific Northwest without power. All 39 counties in Washington State were impacted by the storms. By December 16, hospitals started seeing patients with carbon monoxide poisoning because of improper use of barbecue cookers and generators as residents attempted to cook or to stay warm while temperatures dropped into the low 30s. By December 21, there were more than 260 patients with carbon monoxide poisoning,

⁸ Institute of Medicine. 2003. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. National Academies Press.

⁹ Public Health Seattle & King County. 2001. *Racial and Ethnic Discrimination in Health Care Settings*. Seattle, Washington

¹⁰ LaVeist, TA. 2005. *Minority Populations and Health: An Introduction to Health Disparities in the United States*. Jossey-Bass. San Francisco, California.

many of whom required treatment in a hyperbaric oxygen chamber. Fifteen people lost their lives in these windstorms; eight of the deaths were due to carbon monoxide poisoning.¹¹

During the time of the windstorms and carbon monoxide poisonings, the media reported that the poisonings and deaths were primarily among residents who did not speak English and/or did not use mainstream media for information. According to a Seattle Times article, 90% of patients treated for carbon monoxide poisoning at Harborview Medical Center did not speak English.¹² Many of the poisonings occurred among African and Southeast Asian immigrants.¹³ Preliminary, unpublished data from the Washington State Department of Health appear to substantiate findings reported in the media that the majority of the victims were racial/ethnic minorities who predominantly spoke languages other than English.

Upon report of the first poisonings, the Washington State Department of Health responded by sending press releases out to more than 50 media outlets, coordinating prevention and response messages at the state and local level, and requesting translation assistance from the CDC.¹⁴ Public Health—Seattle & King County’s response included working closely with community-based organizations and other community partners to get prevention messages out. Public Health Seattle and King County staff, as well as other state and local health department staff, initiated efforts to post flyers in various languages at businesses frequented by minority communities and went door to door to deliver prevention messages and distribute carbon monoxide detectors.

As the Washington 2006 windstorms and other tragedies such as Hurricane Katrina have shown, public health emergencies and natural disasters will generally result in a disproportionate impact on minority communities. According to former Surgeon General, Dr. David Satcher, “The same things that lead to disparities in health in this country on a day-to-day basis led to disparities in the impact of Hurricane Katrina.”¹⁵

¹¹ Washington State Military Department. 2007. Windstorm Response: After Action Report: A Statewide Report to the Governor. Olympia, Washington.

¹² King, W. Staffers Scramble on Heating Alerts. Seattle Times. Wednesday, December 20, 2006. <http://archives.seattletimes.nwsource.com/cgi-bin/texis.cgi/web/vortex/display?slug=stormwarning20m&date=20061220&query=carbon+monoxide%2C+language>. Accessed July 5, 2007.

¹³ Seattle Times Staff. Four More Dead from Apparent Carbon Monoxide Poisoning. Seattle Times. Monday, December 18, 2007. <http://archives.seattletimes.nwsource.com/cgi-bin/texis.cgi/web/vortex/display?slug=webmonoxide18&date=20061218>. Accessed July 5, 2007.

¹⁴ Macdonald SC. "Emergency Response in Outbreaks of Non-Infectious Conditions: A story of three outbreaks." Presented at Western Regional Epidemiology Network, Ashland, Oregon, May 2007.

¹⁵ Payne, JW. At Risk Before the Storm Struck: Prior Health Disparities Due to Race, Poverty Multiply Death, Disease. Washington Post. Tuesday, September 13, 2005. Page HE01. <http://www.washingtonpost.com/wp-dyn/content/article/2005/09/12/AR2005091201412.html>. Accessed July 1, 2007.

3.1.3. Need to Develop Minority Health Communications Capacity

The Governor’s Interagency Council on Health Disparities is the state entity that has been given the responsibility, by legislative mandate, to develop a plan to eliminate health disparities in Washington State.¹⁶ Additionally, the Council has the responsibility under Section 43.20.275 of the Revised Code of Washington to “promote and facilitate communication, coordination, and collaboration among relevant state agencies and communities of color, and the private sector and public sector, to address health disparities.” To fulfill this charge, the Council must develop the capacity to reach racial/ethnic minority communities, particularly those with limited-English proficiency, in Washington State. More specifically, this includes the ability to identify where racial/ethnic minority populations reside, as well as the appropriate channels for reaching them.

As detailed later in this proposal (see program plan), a number of groups in Washington State also have a need for improving communication with racial/ethnic minorities, as well as other hard-to-reach populations, and have taken steps toward this end. To date, these efforts have been working toward the same goal, but often in parallel and with limited overlap. Thus, there is a need for leadership and improved communication and collaboration between these various entities. The Governor’s Interagency Council can provide such leadership. As a result of its legislative charge to serve a convening role and to reach out to communities of color, as well as its representation from key state agencies, boards, and commissions, the Council is uniquely positioned to provide a leadership role in coordinating efforts to develop the capacity to reach racial/ethnic minority communities in Washington State. Section 3.2.1 of this application details the state agencies, boards, and commissions that are represented on the Council.

The development of appropriate and effective communication channels can serve multiple needs, including the following:

- The Council will utilize these networks and channels to obtain input from racial/ethnic minorities into the work of the Council, most notably, the development of the state action plan to eliminate health disparities in Washington by race/ethnicity. These channels will help to serve the communities by providing a needed mechanism for racial/ethnic minority populations to provide their voice into Washington State policy making related to minority health and health disparities.
- The Council can also use communication pathways to reach communities of color with information—this information may be about the Council and its activities or it may be intended to raise awareness of health disparities.
- Such communication mechanisms can also be used by other agencies such as the Department of Health to reach communities with general public health information and specifically, information on minority health and health disparities in order to increase health knowledge and encourage positive health behaviors.

¹⁶ Section 43.20.270 of the Revised Code of Washington.

- Further, the channels can be used to effectively reach minority communities, including those with limited English proficiency, in the event of an emergency with potentially life-saving information and resources. This will help to ensure that these communities are not further impacted disproportionately. Of note, the focus of this proposal is on reaching racial/ethnic minorities. The Council will not necessarily be focused on reaching other populations that may be disproportionately impacted during emergency situations, such as the disabled, elderly, transportation challenged, socially isolated, etc. Therefore, the Council’s efforts can supplement the efforts of emergency preparedness and management groups, but can not be relied upon solely to reach these audiences. That said, the Council’s leadership to improve coordination and communication among various state and local entities should result in increased capacity for outreach to hard-to-reach populations overall.

3.2. EXPERIENCE

3.2.1. Governor’s Interagency Council on Health Disparities

The Governor’s Interagency Council on Health Disparities (the Council) was established by the Washington State Legislature in 2006 when it passed, and the Governor signed, Second Substitute Senate Bill 6197. As an entity formally established in Washington State statute to improve the health of racial and ethnic populations, the Council meets the definition of a state and territorial office of minority health.

The 17-member Council has a chair appointed by the Governor, two public members, and representatives of the following 14 state agencies, boards and commissions:

- Commission on Asian Pacific American Affairs
- Commission on African American Affairs
- Commission on Hispanic Affairs
- Governor’s Office of Indian Affairs
- Workforce Training and Education Coordinating Board
- State Board of Health
- Office of Superintendent of Public Instruction
- Health Care Authority
- Department of Health
- Department of Community, Trade, and Economic Development
- Department of Agriculture
- Department of Social and Health Services
- Department of Ecology
- Department of Early Learning

3.2.2. Council Responsibilities

According to sections 43.20.270 and 43.20.275 of the Revised Code of Washington (RCW), the Council is charged with the following responsibilities (see Appendix A for the RCW):

- **Develop an action plan:** By 2012, the Council must create a state action plan for eliminating health disparities in Washington State. The plan will look at health disparities broadly and also must address a number of diseases and conditions specified in the legislation.
- **Convene advisory committees:** To help with its work, the Council is required to establish advisory committees to address specific issues.
- **Address language barriers:** The Council must hold hearings and conduct research in order to make recommendations for improving the availability of culturally appropriate health literature and interpretive services within public and private health-related agencies.
- **Promote communication:** The Council is charged with promoting communication among state agencies and between state agencies and communities of color, the public sector and the private sector to address health disparities.
- **Gather information:** Through public hearings, inquiries, studies, and other efforts at information gathering, the Council will work to understand how the actions of state government ameliorate or contribute to health disparities.
- **Conduct health impact reviews:** Collaborate with the State Board of Health in the development of health impact reviews requested by the Governor or the Legislature. A health impact review is a review of a proposal for a legislative or budgetary change to determine the extent to which the proposal would exacerbate or ameliorate health disparities.
- **Provide regular updates:** The Council must update the Legislature on its progress in 2008, 2010, and 2012.

3.2.3. Council Organization and Staff

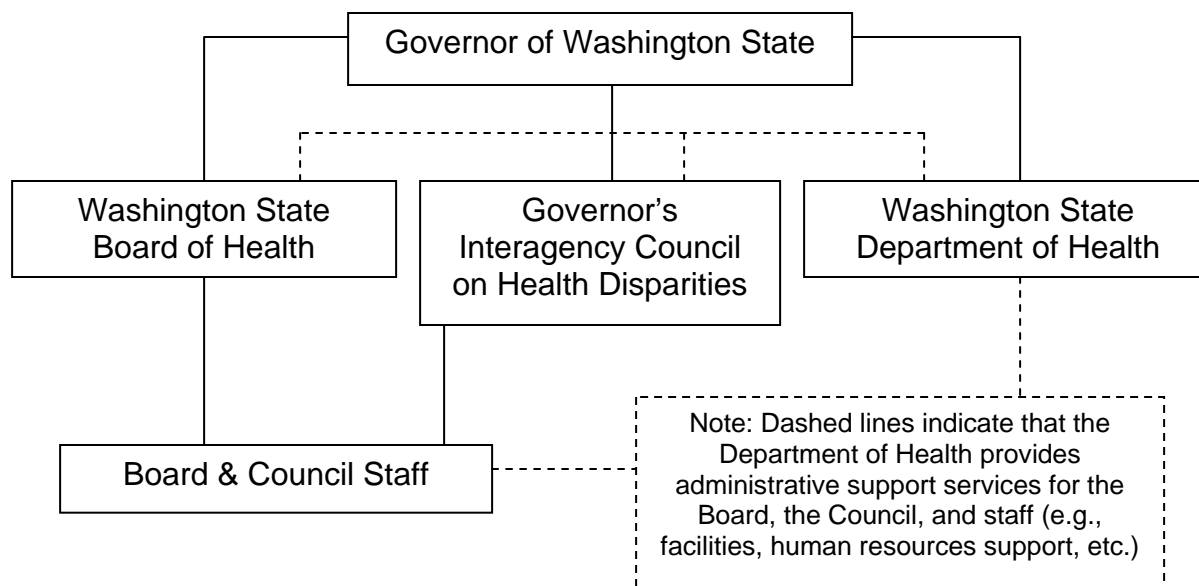
The Council is considered a Class 1 group under RCW 43.03.220, which is defined as “any part-time board, commission, council, committee, or other similar group which is established by the executive, legislative, or judicial branch to participate in state government and which functions primarily in an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

As the name makes clear, this Council is accountable to and receives broad policy direction from the Governor. The Governor appoints the Council Chair, the two consumer representatives, and the agency directors who in turn appoint representatives to the Council. Four of the agencies represented on the Council—three minority commissions and the Governor’s Office of Indian Affairs—are units of the Governor’s Office. Council staff consults with the staff of the Governor’s Executive Policy Office.

In accordance with RCW 43.30.375, the Council is staffed by the Washington State Board of Health, which is a distinct constitutional agency of the State of Washington. The Board staff employs an executive director and a confidential secretary. The Washington State Department of Health provides technical staff in accordance with RCW 43.20.0303 and other administrative

support services under the terms of a memorandum of understanding between the Board and the Department. Most Council staff members, then, are Department of Health employees on loan to the Board of Health. The Board's executive director oversees their day-to-day activities in a manner consistent with the direction of the Council and the Board. The Secretary of Health, who directs the Department of Health, is an ex-officio voting member of the Board and appoints a representative to the Council. As depicted in Figure 1, the Chairs of the Board of Health and the Council and the Secretary of Health all report directly to the Governor; all three entities work together collaboratively though no one agency is directly accountable to another.

**Figure 1:
Organization of the Governor's Interagency Council on Health Disparities and Related Agencies in Washington Government**



The 2006 supplemental operating budget (Engrossed Substitute Senate Bill 6386) contained a proviso stating that “\$173,000 of the general fund-state appropriation for fiscal year 2007 is provided solely for the state board of health to provide staff support to the governor's interagency committee on health disparities, as provided in Senate Bill No. 6197.” This is ongoing funding. In effect, the Board is the fiscal agent for the Council and the Department is the fiscal agent for the Board. For purposes of this award, then, the eligible entity would be the Council; it meets the definition of a State and Territorial Office of Minority Health because is an entity formally established by statute to improve the health of racial and ethnic populations. The formal recipient, however, would be the Department of Health since it administers the budget and all grants and contracts for the Board, which staffs the Council.

With the creation of the Council, Board staff underwent reorganization and hired additional staff to support the Council, see Figure 2. Currently, the Council is supported by 1.75 FTE, see Table 1.

**Figure 2:
Governor’s Interagency Council on Health Disparities’ Staff**

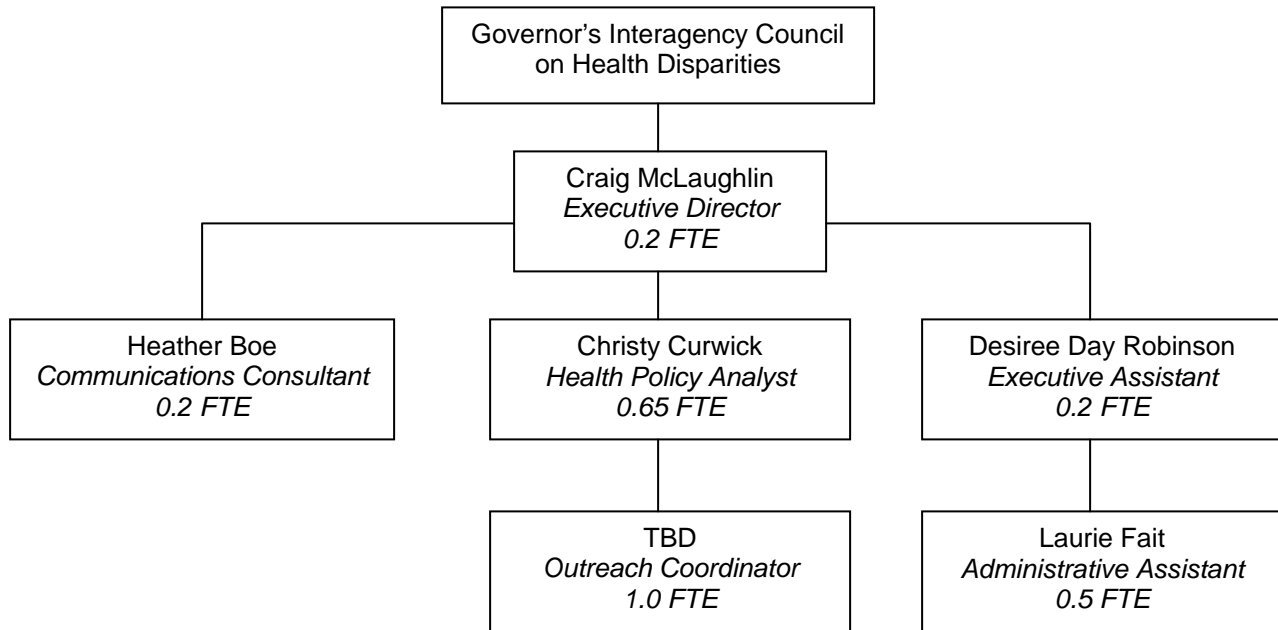


Table 1: Governor’s Interagency Council on Health Disparities Staff and Roles

Council Staff	FTE	Roles and Responsibilities
Health Policy Analyst	0.65	Lead policy staff to the Council.
Administrative Assistant	0.50	Provides administrative support and assists with meeting planning.
Executive Director	0.20	Provides general supervision and oversight.
Executive Assistant	0.20	Oversees budget, payroll, and human resource functions.
Communications Consultant	0.20	Supports media relations, publications, and Web site.
Total FTE:	1.75	

3.2.4. Past Activities and Accomplishments of the Council and the Board

Funding for the Council became available in July 2006. By October 2006, the Governor’s office had appointed the chair and two public members, all agency representatives were appointed, and the State Board of Health had hired additional staff to support the Council. The first meeting of the Council, held in conjunction with a public forum, was on October 20, 2006. By the end of 2006, the Council had adopted a work plan, which outlined the broad steps that the Council will

undertake in order to develop an action plan by 2012. Since then, the Council has begun implementation of its work plan by developing a complete list of health conditions, social determinants of health, and other health indicators that will be considered in the plan. In addition, it has adopted a set of criteria that will be used in the first of two prioritization phases. The first prioritization phase will be based on epidemiologic evidence regarding the prevalence and severity of the indicator. The Council is scheduled to conduct this first phase of prioritization by the end of summer.

As directed by statute, the Council also provided input into the development of forms and procedures for conducting health impact reviews. At its December 2006 meeting, the Council discussed and approved a health impact review request form and a document outlining the procedures for requesting and completing health impact reviews. These forms and procedures were presented to and adopted by the Board, the entity responsible for completing health impact reviews. During the 2007 Washington legislative session, the Council provided input and review of two health impact reviews that were requested by legislators. One request was for a review of a drop-out prevention program and the other was for a review of a program to provide financial incentives to teachers who teach at hard-to-staff schools or who teach hard-to-staff subjects. The aim of both reviews was to determine whether the programs would result in positive or negative impacts on health disparities.

To date, the Council has also taken significant steps toward achieving its mandate to develop recommendations for improving the availability of culturally and linguistically appropriate health educational materials and interpretive services. In February 2007, it contracted with the Cross Cultural Health Care Program, a non-profit research and training organization, to assess possible mechanisms for improving the availability, organization, and access to written health education materials targeted for diverse audiences.

Toward the same goal, the Council has initiated efforts to obtain input from the public, particularly the end-users of translation and interpretive services. Through its contract with the Cross Cultural Health Care Program, the Council will receive results from focus groups held with cultural navigators. The aim of these focus groups was to obtain the perspectives of cultural navigators regarding the barriers and successes that their clients have faced while utilizing the health care system. A cultural navigator's role is to facilitate an individual's access to and understanding of available health and social services in a manner that fosters a deep respect for and an understanding of the individual's culture. The assessment and the focus group reports were both completed June 30, 2007, and the results will be used by the Council as it develops its recommendations.

The Council has also approved a work plan to hold additional focus groups with diverse communities to obtain direct input from the public. One focus group has already been held by a graduate student at the Evergreen State College, who interned with the Council while completing her capstone project for her Masters in Public Administration degree. Her focus group was held at the La Aldea de Batania, a church in Tacoma Washington. There were 25 participants in attendance. Twenty were women; 5 were male and all were Latino. Twenty were from Oaxaca or Michoacán México and 5 were from El Salvador. All participants spoke Spanish as their primary language, with only limited English proficiency. Additional focus groups will be held with

different community participants throughout the summer. Again the results of the focus groups will be presented to the Council members for consideration as it develops its recommendations for improving translation and interpretive services.

Because the Board provides staff to the Council, it is also important to consider the abilities and past accomplishments of the Board and its staff. The Board has an established history of providing leadership in the development of innovative public health policy. In particular, it is able to convene policy development workgroups of stakeholders from state and local government and the private sector to tackle difficult issues.

In 2001, for example, the Board issued a groundbreaking report on the lack of diversity in the health care workforce.¹⁷ One of the authors of that report, Vickie Ybarra, went on to serve on the Institute of Medicine panel that produced the 2004 report *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*.¹⁸ Ms. Ybarra is currently chair of the Council. More recently, Board staff co-sponsored a very successful policy summit, Each Child Successful, that explored potential policies for simultaneously addressing health disparities and the academic achievement gap.

¹⁷ Finkbonner, J, V. Ybarra and M. Pageler. *Final Report—State Board of Health Priority: Final Report*. Olympia, WA: Washington State Board of Health. May 2001. Accessed on July 8, 2007 from http://www.sboh.wa.gov/Pubs/documents/HDReport_2001.pdf

¹⁸ Institute of Medicine. *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*, February 5, 2004. Accessed on July 8, 2007 from <http://www.iom.edu/CMS/3740/4888/18287.aspx>.

4. OBJECTIVES

Project Purpose

This project will provide dedicated state staffing to develop the Council's capacity to engage communities of color in its work, particularly in the development of an action plan to eliminate health disparities in Washington State and in increasing awareness of health disparities. It will do so in a manner that—through leadership, collaboration, coordination, planning, and the creation of linkages between public and private entities—simultaneously increases the overall capacity of organizations throughout Washington to communicate with hard-to-reach individuals and groups, particularly minorities, in ways that help eliminate disparities.

Project Objectives

1. By August 31, 2008, the Council will convene and staff a Minority Health Communications Interagency Workgroup to coordinate statewide efforts aimed at improving the capacity to communicate effectively with racial/ethnic communities.
2. By August 31, 2009, the Council will create a minority health communications directory with information regarding where racial/ethnic minority communities reside, community organizations and other trusted sources that can serve as information conduits, and specific cultural and linguistic needs of the communities.
3. By August 31, 2009, the Council will create a minority health communications improvement plan to document communications gaps, recommend strategies for filling those gaps, identifying best practices, and suggest ways that that existing resources for reaching minorities might be maintained and the information they contain kept current.
4. By August 31, 2009, the Council will begin using and evaluating the newly identified communications channels to reach communities of color to increase awareness of health disparities and to seek input into the Council's work.
5. By August 31, 2010, the Council will develop and disseminate a final report that highlights project successes and barriers, lessons learned, and practical recommendations for other states to use in their efforts to reach and communicate with racial/ethnic minority communities.

5. PROGRAM PLAN

The purpose of this project is to develop partnerships to improve the capacity to reach racial/ethnic minority communities and to engage communities of color in the work of the Council to develop an action plan to eliminate health disparities in Washington State.

The Governor's Interagency Council on Health Disparities will take a leadership role in identifying and coordinating the work of partners to develop and strengthen communication networks and channels to reach communities of color. The Council will use these networks and channels to inform minority communities about the Council and to obtain their input into the Council's policy-making activities. These communication pathways can also be used to reach communities with general public health information, as well as targeted messages related to health disparities and minority health. Finally, they can be used to effectively reach minority communities, including those with limited English proficiency, in the event of an emergency with potentially life-saving information and resources.

This project meets the following Office of Minority Health expectations: (1) improving state and territory-wide planning, coordination, collaboration, and linkages among public and private entities that specifically address minority health and health disparities; and (2) improving coordination and collaboration among state and territorial public health offices that benefit minority health and contribute to eliminating health disparities.

5.1. Convene and Staff a Minority Health Communications Interagency Workgroup (Objective 1)

Currently in Washington State, a number of agencies and organizations are working toward developing improved communication channels for reaching a variety of high-risk or hard-to-reach populations. The motivation behind many of these efforts stems from the need to better reach these populations with emergency preparedness and management information. Some activities include:

- The Emergency Management Division of the Washington Military Department is the state's lead emergency preparedness agency. This group is responsible for coordinating and leading the preparedness and response activities for all the state agencies. This group coordinated interagency efforts to review emergency preparedness and response activities related to the 2006 windstorms and develop recommendations for improvement, including recommendations to improve communication with hard-to-reach populations.
- The Public Health Emergency Preparedness and Response (PHEPR) program of the Washington State Department of Health coordinates efforts to prepare the state for public health emergencies such as natural disasters, bioterrorism, and infectious disease outbreaks. One specific objective of the PHEPR program is to create plans and develop outreach channels to ensure emergency preparedness messages reach special populations.
- One accomplishment to date has been the creation of a network of regional emergency communications liaisons within local health jurisdictions to assist with emergency

communication planning, outreach and resource development. There is a liaison for each of the nine Public Health Emergency Preparedness and Response regions in Washington State. These regions have also been adopted by the Washington Military Department as their Emergency Management Division Regions.

- In addition to PHEPR activities, the Washington State Department of Health has a number of activities aimed at improving communication and services to diverse communities, as well as improving the diversity and cultural competency of the public health workforce. The Community and Family Health Division included a number of objectives and strategies to address health disparities in its strategic plan, including a strategy to build connections with communities experiencing health disparities. In addition, the division of Community and Family Health has a Multicultural Workgroup, which is focused on the cultural competency and diversity of staff, and a Translations and Language Services Workgroup, which ensures the use of best practices in providing translations of the agency's materials. A Health Disparities Workgroup within the Office of Maternal and Child Health coordinates activities related to health disparities and works to improve the cultural competence and diversity of staff. In addition, the Office of the Secretary has a Tribal Liaison and Agency Multicultural Health Coordinator.
- Staff at the Department of Social and Health Services were actively involved in the post-windstorm efforts to review emergency communications activities and develop recommendations for improving the states' ability to communicate with and protect vulnerable populations. The agency has been developing its own internal emergency preparedness and response plan, and will soon be initiating planning activities related to community outreach.
- The commissions that represent communities of color in Washington State each maintain their own individual directories of community contacts that are used for a variety of purposes. The Washington State Commission on African American Affairs receives daily requests from state agencies and other groups for assistance with reaching the African American population with health and other messages. The commission has plans to improve and expand its directory and develop systems for improving directory access and sustainable funding.
- The Seattle and King County Public Health Department has formed a Vulnerable Populations Action Team (VPAT) to coordinate countywide emergency preparedness efforts with vulnerable communities and the organizations that serve them. One of the vulnerable population groups that VPAT serves are limited- or non-English proficient populations. The VPAT strategy is to work in collaboration with community partners, including capacity building within community-based organizations, to identify communities' needs and to get messages out prior to and during an emergency event.
- The Washington State Minority and Justice Commission, which is charged with ensuring that racial/ethnic bias does not exist in the courts, has developed a workforce diversity resource directory. The directory's purpose is to increase recruitment of racial/ethnic minorities into positions in the Washington courts. The directory contains the names and contacts of

numerous associations, agencies, and media outlets that can be accessed for sending out recruitment announcements.

In an effort to facilitate communication and collaboration around all the various activities listed above, the Council will convene an interagency minority health communications workgroup (i.e., the workgroup). The workgroup will provide a forum for groups to learn about each others' activities, identify opportunities for collaboration and provide input into a shared vision and plan for improving communications capacity in Washington State.

The workgroup will be staffed by the Council and will meet regularly. Meeting frequency will be decided by the group and will be an agenda item at the first meeting. As other activities to reach racial/ethnic minority communities are identified, those groups will be invited to attend the workgroup.

The Council has considerable support for this project. Commitments to participate in the workgroup have been obtained from several of the key agencies listed above—see letters of support from the Commission on African American Affairs, the Department of Health, and the State Board of Health. Moreover, the proposal has been endorsed by the Governor's Executive Policy Office.

5.2. Create a Minority Health Communications Directory (Objective 2)

In an effort to fill the Council's need to provide information to and seek input from racial/ethnic minority communities, the Council will develop a directory of community contacts and other information related to the cultural and linguistic needs of communities. To compile the information for this directory, the Council will work with its partners in the minority health communications interagency workgroup to identify additional activities aimed at reaching communities of color and will meet with those groups to learn about where communities reside and appropriate communication channels.

In addition to the known activities listed above in Section 5.1., there are most likely a number of other local and statewide efforts being initiated by organizations throughout Washington to identify and reach minority communities. The Governor's Interagency Council on Health Disparities is well-equipped to identify these other activities through its own diverse membership. As detailed in the background section of this application, the 17 Council members represent key state agencies and boards, such as the Department of Health, the Department of Social and Health Services, the Workforce Training and Education Coordinating Board, and the Department of Community, Trade and Economic Development, to name a few. Moreover, the Council has representation from the commissions that serve the Hispanic/Latino, Asian and Pacific Islander, African American, and American Indian and Alaska Native populations in Washington State. Council members will each develop a list of relevant activities and key contacts within their own agencies and organizations, as well as brief descriptions of each activity. In addition, members will be questioned about relevant activities that they may be aware of in other organizations, including work being initiated by organizations that are not represented on the Council. With input from the Council members, a standardized survey tool will be developed. Each Council member will take the lead to ensure that the survey is filled out

for its agency. The participants in the minority health communications interagency workgroup will also be a source for this information.

Once we have compiled a list of activities that are focused on identifying and improving communication with racial/ethnic minority communities, as well as a primary contact for each activity, we will meet with key contacts to learn about each activity, with a particular focus on what has already been accomplished to establish and strengthen communication networks and other channels for reaching racial/ethnic minority populations. More specifically, our aim is to identify and collect information on where racial/ethnic minority communities reside (with a special emphasis on those that do not speak English, have limited English proficiency, or have not been fully acculturated into mainstream society), as well as the most appropriate methods and channels to communicate with each community. A secondary purpose of the meetings will be to identify successes and obstacles related to each activity, including ongoing needs. Much of this information will come from the meetings themselves; however, we recognize that these meetings may lead to follow-up conversations with additional stakeholders. The Council will use the information collected to develop a minority health communications directory.

The exact form, content, and organization of the minority health communications directory will be determined following these meetings, as we'd like the directory to be shaped by the input we receive. We recognize that the directory may be a useful tool for many of the agencies and organizations that we meet with and that participate in the interagency workgroup, and therefore, we will try to incorporate stakeholder needs into the design of the directory. At a minimum, however, we envision that the directory will contain information regarding the following variables:

- **Community Contacts.** Community contacts have direct ties to the communities that they serve. These would be the groups and individuals that have both the capacity to reach individual community members with information as well as the trust and respect of the community. Examples of community contacts could be community-based organizations, local-level public agencies, associations, business owners, faith-based organizations, and individual community leaders, among others.
- **Geographic Region.** Document where racial/ethnic minority populations reside and the regions served by the community contacts. Examples include PHEPR regions, local health jurisdictions, counties, cities, and/or neighborhoods.
- **Communication Channels.** Identify and include pathways by which community contacts provide information to the communities that they serve, as well as community preferences for how they receive information. Examples may include, holding forums or other in-person gatherings, disseminating flyers, posting information in venues frequented by the community, sending emails or other forms of electronic communication, sending information in the mail, making phone calls, etc.
- **Language and Literacy.** Include information on primary languages spoken by racial/ethnic minority communities in the different regions of the state. Identify languages used by the

community contacts, both for written and oral communications. Include any information on literacy levels.

- **Other Considerations.** Document any other cultural considerations that may serve as barriers to communication, or may help to facilitate communication with different racial/ethnic communities.

Because the Council has its own needs for this directory (i.e., ongoing communication with racial/ethnic minority populations throughout the process of developing the state action plan), it will maintain this directory, to the extent possible within existing resources, beyond the life of this grant. One of the charges of the minority health communications interagency workgroup, however, will be to explore possible collaborative strategies for ensuring the directory's ongoing maintenance and sustainability and to make recommendations as part of the minority health communication improvement plan (see Objective 3).

5.3. Develop a Minority Health Communication Improvement Plan (Objective 3)

The meetings held during the information gathering portion of this project will also identify where significant communication gaps exist. These gaps may be where communication channels have yet to be identified or where methods need to be strengthened. Therefore, in addition to developing and populating the minority health communications directory, a second work product of this project will be a minority health communications improvement plan.

The successes and obstacles to reaching racial/ethnic minority communities that are identified during the informational meetings, as well as other input obtained from stakeholders will be used to shape the plan. At a minimum, however, the plan will list the communication gaps that were identified, describe any known barriers related to those gaps, explore successful strategies in creating effective communication pathways for similar communities, and provide specific recommendations for filling the gaps. The plan will also describe best practices, identify opportunities, and recommend strategies for maintaining the directory and sustaining related efforts.

5.4. Engage Racial/Ethnic Minority Communities in the Council's Work (Objective 4)

The Council has ongoing needs to communicate with racial/ethnic minority communities to: (1) let communities know that the Council exists, (2) share information about the Council's work, including its main responsibility to develop an action plan to eliminate health disparities, (3) inform communities about the Council's public meetings and other opportunities that are available for them to participate in, (4) request active involvement and input from communities to help shape the Council's work products and recommendations, and (5) provide information about health disparities in order to increase awareness about the differences in health status among different racial/ethnic groups.

In order to fulfill these communication needs, the Council will begin to use communication channels as they are developed throughout this project. Similarly, the communication channels

may be utilized in order to send other health or emergency preparedness messages, as partners see appropriate.

As a part of the Council's work plan, it will be developing a revised list of priority health conditions, social determinants of health, and other health indicators, the top five of which will be the focus of the action plan to eliminate health disparities. The Council will actively request input from racial/ethnic communities into this prioritization process. In order to evaluate the Council's ability to reach minority populations and engage them in the Council's work, efforts will be taken to document the following: (1) the content of the materials that are developed and disseminated, (2) the number of individuals and groups that these materials were distributed to, (3) the various channels that were used to reach the communities, and (4) the number of individuals who provide input into this process and/or the number of organizations that provide input on behalf of the communities that they serve. In addition, we will carefully document any anecdotal or other informal feedback that we receive from community members, community contacts, or others that can help improve future communication.

5.5. Develop and Disseminate a Final Report (Objective 5)

As a mandate from the Washington State Legislature, the Governor's Interagency Council on Health Disparities has been charged with improving communication and collaboration between the state, the private sector, and Washington citizens in an effort to address and ultimately eliminate health disparities. The Council recognizes the importance of this responsibility and it also recognizes that it is not an easy task.

The challenge of reaching racial/ethnic minority populations, particularly those with limited English proficiency, is not unique to Washington State, but rather one that is shared by local communities and states across the country.

Therefore, the Council will develop a final report, providing detailed documentation of the approach taken to develop such communication capacity in Washington State. The final report will highlight project successes and barriers, lessons learned, and practical recommendations for other states to use as they proceed with their efforts to reach minority communities with vital health information. The Council will post the report to its website and disseminate to all state offices of minority health and other minority health contacts.

5.6. Project Staff

This section provides descriptions of project staff members, including their experience and qualifications, project roles and responsibilities, and percent time devoted to this project.

Outreach Coordinator (100%):

An Outreach Coordinator will be hired to perform many of the project activities outlined in this proposal. The Outreach Coordinator will be the staff member responsible for recruiting, convening and staffing the minority health communications interagency workgroup. This individual will prepare meeting schedules and agendas for the workgroup, facilitate workgroup

meetings, develop and disseminate workgroup minutes, and provide general staff support for projects and activities of the workgroup.

The Outreach Coordinator will lead efforts to develop the minority health communications directory. This will include identifying existing outreach activities and contacts for those activities, meeting with contacts, and compiling information for the directory. The Outreach Coordinator will seek input from Council members and workgroup participants on the design of the directory and will use this input when pulling the information together for the final directory product. This position will also be responsible for documenting communications gaps and recommendations in the minority health communications improvement plan.

This position will serve as the Outreach Coordinator for the Council, ensuring that as communication networks and channels are identified and developed, that they will be used to engage racial/ethnic minority communities into the Council's policy work. This will include developing and maintaining effective working relationships with community-based organizations, advocacy groups, commissions, and other organizations representing communities of color. This work will also involve creating and disseminating Council meeting notices and other information about the Council's activities, requests for input, and educational materials related to health disparities.

In addition, the Outreach Coordinator will be responsible for the preparation of all project progress reports and for preparing the final report. This position will maintain detailed documentation for the process evaluation (see Section 6 – Evaluation Plan), and will write up the evaluation for inclusion in all progress reports. In preparing the progress reports and the final report, the Outreach Coordinator will develop and disseminate drafts, seek input from stakeholders, follow-up on revisions, and coordinate printing and dissemination activities.

A position description for the Outreach Coordinator is included in the appendices.

Christy Curwick, Health Policy Analyst, Governor's Interagency Council on Health Disparities (20% total, 10% in kind):

Ms. Curwick currently serves as lead staff to the Council. For this project she will serve a project management role, ensuring that all project activities are completed and objectives are met on schedule. Ms. Curwick will be responsible for hiring and supervising the Outreach Coordinator position and will provide direction and oversight for all project activities. Ms. Curwick will work closely with the Outreach Coordinator in efforts to reach out to racial/ethnic minority communities and engage them in the work of the Council.

Ms. Curwick has the necessary knowledge, experience, and skills to ensure that this project is completed successfully and on schedule. In brief, following her completion of the Masters in Public Health program at Loma Linda University, she went on to complete a three-year fellowship program with the Centers for Disease Control and Prevention's Public Health Prevention Service (PHPS). Through the PHPS program, Ms. Curwick received both formal and on-the-job training in public health program planning, implementation, and evaluation. She then used the knowledge and experience she gained in the PHPS program to successfully plan, create,

and manage public health surveillance systems for occupational injuries and illnesses while working for an occupational health research program at the Washington State Department of Labor and Industries. She served as lead project staff to ensure the completion and success of occupational injury and illness surveillance and prevention projects under two cooperative agreements funded by the National Institute for Occupational Safety and Health. Since October 2006, Ms. Curwick has served as lead policy staff to the Governor's Interagency Council on Health Disparities. In this role, she supervises one additional staff member who is primarily responsible for conducting health impact reviews to determine whether proposals for legislative or budgetary changes would result in positive or negative impacts on health disparities. A copy of Ms. Curwick's resume is included in the appendices.

Craig McLaughlin, Executive Director, State Board of Health (5% in kind):

Craig McLaughlin will contribute management, policy development, and communications expertise to the project. Mr. McLaughlin has been with the State Board of Health since 2001, when he was hired as Senior Policy Manager, and has served as Executive Director since 2004. During his time with the Board he has spearheaded several projects that depended on working with multiple agencies and stakeholders to develop policy solutions. He is currently working with numerous agencies, advocacy organizations, and mental health providers to articulate a vision for a prevention-oriented, public health model for promoting mental health. Prior to joining the Board, he served as Director of College Relations for The Evergreen State College. As a newspaper editor and freelance journalist for more than a decade, Mr. McLaughlin wrote and edited articles on a broad range of health issues. He has served as a communications consultant to foundations and as a management consultant to media organizations. He is co-author of a forthcoming graduate-level textbook, *Health Policy Analysis: An Interdisciplinary Approach*.¹⁹ Mr. McLaughlin earned his Masters in Journalism from the University of California at Berkeley and completed all coursework toward a Masters in Public Administration with a concentration in Health Administration at the University of New Mexico. He will provide general oversight and guidance for all project activities, with special emphasis on recruiting for the minority health communications interagency workgroup and other partnership-building activities. In addition, he will oversee the management of the project's budget. Mr. McLaughlin's resume is included in the appendices.

¹⁹ McLaughlin, C.P. and C.D. McLaughlin. *Health Policy Analysis: An Interdisciplinary Approach*. Boston: Jones and Bartlett Publishers. 2008 (scheduled for publication September 15, 2007).


5.7. Project Timeline

Project Activity	Year 1				Year 2				Year 3			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Convene/staff interagency communications workgroup												
Identify and recruit partners	■	■	■	■								
convene and meet regularly				■	■	■	■	■	■	■	■	■
Develop a minority health communications directory												
Identify existing efforts to reach minority communities	■	■	■									
Identify contacts for each activity	■	■	■									
Hold meetings with contacts / compile information		■	■	■	■	■						
Develop the directory					■	■	■					
Develop a communications improvement plan												
Identify gaps in current communications capacity		■	■	■	■	■						
Develop recommendations to fill gaps		■	■	■	■	■	■					
Develop the plan					■	■	■	■				
Engage racial/ethnic communities in Council's work												
Develop and disseminate informational materials			■	■	■	■	■	■	■	■	■	■
Send out requests for input into the Council's work			■	■	■	■	■	■	■	■	■	■
Evaluate efforts to obtain input into Council's priorities								■	■	■	■	■
Develop progress reports/financial status reports		■		■		■		■		■		■
Create and disseminate the final report									■	■	■	■

6. EVALUATION PLAN

As this project is a partnership development and capacity building project, the evaluation plan will be solely a process evaluation and is, therefore, qualitative in nature. The relationship between project activities and expected results is depicted in the logic model (below). The logic model provides a broad overview of potential activities and short-term and long-term results that can be expected. However, a few of the activities and results shown are beyond the scope of this project and, therefore, also beyond the scope of this evaluation. Specifically, this evaluation plan will only include the activities and results that are indicated by the symbol (*) in the logic model.

Project Logic Model: Developing Minority Health Communications Capacity in Washington State

ACTIVITIES			RESULTS	
If we take these initial steps...	...to build the capacity to reach racial/ethnic communities...	...and we use the channels and networks effectively...	...then we may contribute to these impacts...	...and ultimately help produce these outcomes:
Convene a minority health communications interagency workgroup* Identify and learn about existing efforts to reach racial/ethnic minority communities in Washington State*	Identify where racial/ethnic minority communities reside* Identify community contacts that can serve as channels to reach communities* Identify appropriate modes of communication* Identify language, literacy, and cultural needs*	Provide outreach about the Council* Seek input into the Council's work* Disseminate culturally and linguistically appropriate health messages Provide emergency preparedness and response information	Improved participation among racial/ethnic communities into the Council's policy-making work* Increased health knowledge, attitudes, and behaviors among racial/ethnic minority communities Program and policy changes in organizations, systems, and environments	Reduction in health and health care disparities by race/ethnicity
EVALUATION				
				

Note: The symbol (*) indicates activities and impacts that will be included in the evaluation plan. Those activities, impacts, and outcomes that are not denoted by (*) are beyond the scope of this project.

Objective 1: By August 31, 2008, the Council will convene and staff a minority health communications interagency workgroup to coordinate statewide efforts aimed at improving the capacity to communicate effectively with racial/ethnic communities.

Key Activities for Objective 1:

- Identify and recruit partners
- Convene the group and hold regular meetings

Evaluation Plan for Objective 1		
Evaluation Questions	Indicators	Data Source
How many individuals and/or organizations participate in the workgroup?	Number of participants and organizations they represent.	Administrative Records.
How often does the workgroup meet?	Date of first meeting and number of meetings held per year.	Meeting minutes.
Do workgroup members regularly participate?	Number of participants at each meeting.	Meeting minutes.

Objective 2: By August 31, 2009, a minority health communications directory will be created to document racial/ethnic minority communities, community organizations and other trusted sources that can serve as information conduits, and specific cultural and linguistic needs of the communities.

Key Activities for Objective 2:

- Identify existing efforts to reach minority communities
- Identify contacts for each activity
- Hold meetings with contacts and collect information
- Develop the directory

Evaluation Plan for Objective 2		
Evaluation Questions	Indicators	Data Source
How many state/local efforts to reach minority communities were identified?	Number of efforts identified.	Administrative records.
How many meetings were conducted?	Number of meetings held.	Administrative records.
How many variables were included in the directory?	Number of directory variables.	Directory data dictionary.
How many entries were created in the directory?	Number of entries in the directory.	Directory properties.

Objective 3: By August 31, 2009, a minority health communications improvement plan will be created to document communications gaps and recommendations for filling these gaps.

Key Activities for Objective 3:

- Identify gaps in current communications capacity
- Develop recommendations to fill gaps
- Develop the plan
- Disseminate the plan

Evaluation Plan for Objective 3		
Evaluation Questions	Indicators	Data Source
How many communication gaps were identified?	Number of gaps identified.	Administrative records.
How many of the communication gaps were recommendations developed for?	Number of gaps with recommendations.	Administrative records.
How many groups/individuals received a copy of the plan?	Number of recipients of the plan.	Distribution list.

Objective 4: By August 31, 2009, the Council will have begun using the newly identified communications channels to reach communities of color with information on health disparities and to seek input into the Council’s work.

Key Activities for Objective 4:

- As communication channels and networks are developed, the Council will develop and disseminate informational materials, including requests for input into Council activities.
- The Council will make a special effort to evaluate the ability to reach racial/ethnic minority communities with information on the Council’s work to develop a final list of top-five priorities and to seek community input into this process.

Evaluation Plan for Objective 4		
Evaluation Questions	Indicators	Data Source
How many materials were developed?	Number of materials developed.	Administrative records.
How many individuals/groups received the materials?	Number of individuals, organizations, and groups that were sent materials.	Distribution lists.
What channels were used to reach racial/ethnic minority communities?	Number of various channels and contact that were used – descriptions of these channels.	Administrative records and distribution lists.
How much input into the prioritized list was received?	Number of individuals providing or submitting input.	Administrative records and records of public testimony.

Objective 5: By August 31, 2010, a final report will be developed and disseminated, which highlights project successes and barriers, lessons learned, and practical recommendations for other states to use.

Key Activities for Objective 5:

- Develop the report
- Disseminate the report

Evaluation Plan for Objective 5		
Evaluation Questions	Indicators	Data Source
How many groups/individuals received a copy of the report?	Number of recipients of the report.	Distribution list.