SPECIAL POPULATIONS

an excerpt of

Washington State Primary Care Needs Assessment

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OBJECTIVE

The Washington State Primary Care Needs Assessment

has been created in partnership with the Area Health Education Center for Western Washington and Washington Healthcare Access Alliance with support and leadership from the Washington State Department of Health Primary Care Office. The full report provides an overview of primary care capacity in Washington, and identifies priorities for programming and legislation. An advisory committee of diverse area experts was consulted in regard to structure, content and sources. Data included was collected from a wide range of public, private, for- and nonprofit partners in the fields of healthcare, economics, education, and social services.

Data Sources and Limitations

Information included in this report is publicly accessible. Some data referenced was sourced directly from authoring organizations. In some instances, data referenced was voluntarily contributed through surveys, and may not be statistically representative of the population. Additionally, data for minority groups, including racial minorities, LGBTQ individuals, immigrants, and refugees, may be impacted by underreporting. Comparative data is provided where available.

This excerpt comes from the full report, ***Washington State Primary Care Needs Assessment***, which is intended to provide a broad overview of primary healthcare access and capacity to inform policy and programming that addresses the needs of Washington's underserved communities. Included here is state-specific information related to special populations. The full document includes robust and accessible health equity data to inform meaningful policy and programming, workforce development solutions, resources, and recommendations.

SPECIAL POPULATIONS

Socioeconomic inequality and geography are barriers that affect primary care access in Washington State and thus impact health outcomes. Because of such barriers, across the state and between population groups, health disparities persist.

The writers of this report wish to acknowledge the complexity of individual identities and experiences. The descriptions below do not cover all the barriers to accessing care nor all populations.

COMMUNITIES OF COLOR

Residential segregation by race persists in Washington, particularly in populous areas where red-lining was legal and common before implementation of the Fair Housing Act. Historically, predominantly non-White neighborhoods have not received the resources needed to support healthy living, such as investments necessary for safety, walkability, and access to fresh food. As a result, health disparities are apparent between neighborhoods. Washington State's prioritization of health equity has generated significant data that demonstrate the interdependence of "race and place" as determinants of health. Indeed, health status and zip code are closely related in Washington *(Washington State Department of Health, 2019).*

Data from the Behavioral Risk Factor Surveillance System (BRFSS) show a smaller percentage of Washington State adults report fair or poor health status than those in the rest of the United States. In 2014, 16% of Washington adults reported fair or poor health compared to 18% nationally *(Washington State Department of Health, 2016).*

Data from 2012 to 2014 revealed that reporting fair or poor health was significantly more likely among Hispanic (36%) and American Indian/Alaska Native (30%) adults than for the state as a whole (16%). Fewer Asian adults reported fair or poor health (12%) compared to adults in all other racial and ethnic groups. People of color constitute 29.2% of Washington residents: 12.9% identify as Latino, 9.3% as ethnically Asian, 4.3% as Black, 1.9% as American Indian/Alaska Native and 0.8% as Native Hawaiian or other Pacific Islander. However, communities of color are disproportionately underserved by Washington's healthcare system.

The racial distribution of patients seeking care in safety net settings does not reflect the racial distribution of the population of the state, suggesting inequities in access to care. Although 79.1% of Washington State residents identify as White, only 56.81% of patients seeking care in federally qualified community health centers self-identify as White (Washington Association for Community Health, 2019), and only 20.7% of patients attending a 2018 free clinic event in Seattle identified as White *(Seattle Center Foundation, 2019).* This disproportionate representation suggests not only significant barriers to care for patients of color, but, additionally, barriers to care between levels of safety net entities, with federally qualified community health centers providing a wider scope of consistently available healthcare services than a four-day free clinic event.

Immigrants & Refugees

Imigrants and refugees make up a significant share of Washington's population. According to the Office of Financial Management, approximately one million of the state's population, or 14%, were first generation immigrants in 2017. Many have since obtained citizenship through naturalization, though approximately half remain non-citizens.

While healthcare coverage for the state as a whole has made gains, federal programs like the Affordable Care Act (ACA) have greatly reduced the number of uninsured, but also have strict eligibility criteria for citizenship and legal immigrant status. As a result, glaring disparities in access to health coverage exist between U.S.-born citizens and various immigrant populations including naturalized citizens, legal immigrants, and undocumented immigrants within Washington State.

Prior to the ACA, uninsured rates for U.S.-born citizens, naturalized citizens, legal immigrants, and undocumented immigrants were all high, though with significant variations between the groups. U.S.-born citizens had the lowest rates at 17%, followed by naturalized citizens (20%), legal immigrants (close to 30%), and undocumented immigrants (above 55%). Since the implementation of the ACA, the uninsured rates for both U.S.-born and naturalized citizens fell to 5.7% in 2017, the legal immigrant group dropped to 12.9%, and the undocumented immigrant group, to 40.7% *(Office of Financial Management, 2019a).*

Despite the decrease in uninsured rates across all groups, gains in health coverage were not similar among the various immigrant groups when compared to U.S.-born citizens. Prior to implementation of the ACA, uninsured rates for naturalized citizens were 1.2 to 1.3 times higher than those of U.S.-born citizens. The ratios remained similar between 2014 and 2017. Legal immigrants are still two times as likely to be uninsured than U.S.-born citizens.

The gap widened considerably, however, for the undocumented immigrant group whose uninsured rate was 3.3 times higher than those of U.S.-born citizens in 2013, grew to 5.1 in 2014, and continued climbing to 7.2 in 2017. This means the gap between the uninsured rate for the undocumented immigrant group and the U.S.-born citizen group more than doubled between 2013 and 2017 *(Office of Financial Management, 2019a).*

Migrant Workers

In 2018, there were an estimated 3 million agricultural workers in the United States, 16% of whom identified as migrating and 84% as seasonal workers. The majority of workers were foreign born and many reported limited English-speaking ability. Economically, agricultural workers represent some of the most disadvantaged people in the nation with more than 30% subsisting at income levels below the national poverty guidelines. A mere 8% of farm workers report being covered by employer-provided health insurance *(National Center for Farmworker Health, Inc., 2018).* At the same time, according to the U.S. Bureau of Labor Statistics, agriculture is frequently ranked as one of the most high-risk industries in the nation where injuries and illnesses result from exposure to the elements, farm equipment, and interaction with pesticides.

In addition to aerospace, technology, and entrepreneurship, Washington has a multi-billion-dollar agriculture industry and is the second-highest food-producing state in the nation *(American Immigration Council, 2017).* While the exact population total for migrant and seasonal workers in Washington State is difficult to estimate, the number of H-2A workers, a program that enables agricultural employees to legally hire foreign workers, has steadily climbed, since 2010, from 2,981 workers to more than 12,000 in 2015. In central Washington's Chelan County alone, where the state's fruit production is concentrated, farm owners employed 7,900 seasonal workers in 2012. During the spring 2020 COVID-19 outbreak, at least 240 people working in food and agriculture in Yakima Valley tested positive by the end of April including more than half the workers on one farm. At that time Yakima county had more than 1,600 confirmed cases and nearly 60 deaths – the highest infection rate of all west coast counties.

Glaring disparities in access to health coverage exist between U.S.-born citizens and various immigrant populations including naturalized citizens, legal immigrants, and undocumented immigrants within Washington State.

Tribal Communities

Native Americans make up approximately 2% of the total population in the United States. Unlike other racial and ethnic minorities, Native Americans have rights to federal healthcare services through a series of acts that resulted in the formation of the federal agency known today as the Indian Health Services. Healthcare services are provided to federally recognized tribes, of which there are 573 throughout the United States; there are also an estimated 245 tribes that are not federally recognized.

Despite legal rights, Native Americans contend with numerous barriers to receiving quality healthcare including cultural barriers, discrimination, geographic isolation, and disparate poverty. As a result, Native Americans are disproportionately impacted by health disparities. Thirty percent of Native Americans in Washington report being in fair or poor health compared to just 14% of their White counterparts *(Washington State Department of Health, 2016).* In Washington, American Indians and Alaska Natives report experiencing worse health than other racial and ethnic groups, across 27 key health issues identified in the Washington State Health Assessment *(Washington State Department of Health, 2018).*

Native Americans also have higher overall mortality rates, a greater share of disease burden, and live with mental health disorders and related conditions at higher rates when compared with the general U.S. population. Compared to their White counterparts, Native Americans suffer mortality at a 50% higher rate and an infant

mortality rate that is 1.6 times the rate of White populations *(U.S. Department of Health and Human Services Office of Minority Health, 2019).*

Native Americans endure higher rates of chronic disease when compared to all other racial and ethnic groups. At 16%, more Native American adults have diabetes per capita than any other ethnicity *(Centers for Disease Control and Prevention),* and the tuberculosis rate in 2017 for Native Americans was nearly 4 times higher than for the White population *(U.S. Department of Health and Human Services Office of Minority Health, 2019).*

Within Washington State, where there are 29 federally-recognized Native American tribes, the all-cause mortality rate for American Indians and Alaskan Natives is about 71% higher than the rate for non-Hispanic Whites. Leading causes of death include cardiovascular disease (23.5%), cancer (19.4%), unintentional injury or accident (11.4%), and chronic liver and chronic lower respiratory disease (6.1% and 5.9%, respectively). High rates of poor mental health and depression coupled with limited access to treatment have led to higher rates of suicide for Native Americans *(American Indian Health Commission for Washington State, 2017).*

Even though America's problematic treatment of Native Americans has created barriers, tribal communities have made advances in health and well-being. In Washington, there are 31 ambulatory primary care clinics operated by tribes, two operated by Urban Indian Health Programs, and four by the Indian Health Service which have added specialty care options to address community specific needs including traditional healing practices, naturopathy, and nephrology.

Tribal advocacy led to the passing of the Dental Health Aide Therapy Law in 2017, which helped Indian healthcare providers expand dental services as part of their integrated system of care. This was an important victory in addressing oral health disparities in tribal communities. American Indian and Alaskan Native children in Washington are three times more likely to experience tooth decay than their White counterparts, and adults experience twice the prevalence of untreated cavities than the general population (*American Indian Health Commission for Washington State, 2017).*

In 2019, the Washington Indian Health Improvement Act was passed funding tribal healthcare systems. Each tribal government is an independent sovereign nation and has its own governmental public health system. Additionally, other agencies also serve these tribes and tribal peoples in various ways.

The Northwest Portland Area Indian Health Board is a non-profit tribal advisory organization that serves the 43 federally recognized tribes of Oregon, Washington, and Idaho though its engagement in many areas of Indian health, including legislation, health promotion, and disease prevention as well as data surveillance and research via the Northwest Tribal Epidemiology Center (The EpiCenter). The EpiCenter collaborates with northwest American Indian tribes to provide health-related research, surveillance, training, and technical assistance to improve the quality of American Indians' and Alaskan Natives' healthcare. Current projects funded by the EpiCenter are aimed at addressing various morbidities such as Hepatitis C and diabetes, in addition to preventive and public health initiatives. The EpiCenter also posts guidance regarding respectful ways to engage in research in Indian Country in order to be sensitive to local culture, traditions, research priorities, and lifestyles of American Indian and Alaskan Native communities *(Northwest Portland Area Indian Health Board, 2019).*

The Seattle Indian Health Board's Urban Indian Health Institute (UIHI) works to decolonize data, for indigenous people, by indigenous people. UIHI is a Tribal Epidemiology Center, managing public health information research and data for urban American Indian and Alaska Native communities *(The Urban Indian Health Institute, 2019).* This and the EpiCenter are two of the 12 Tribal Epidemiology Centers in the country and are Tribal Public Health Authorities, providing key research and assessment for and with the tribes and urban Indian health programs.

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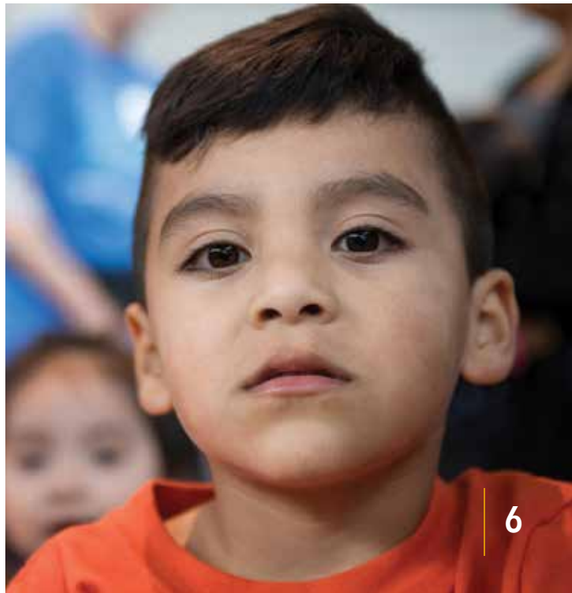


Under & Uninsured

The percentage of the population of Washington without insurance is lower than the national average, 7.5% compared to 8.5% nationally. Of those uninsured nationally, 45% cite the high cost of insurance as the main reason they lack coverage *(Kaiser Family Foundation, 2018),* and the lowest income residents are the least likely of any income group to have health insurance. The same study cites uninsured non-elderly adults as being twice as likely to have problems paying medical bills as their insured counterparts. Since most of the uninsured population have low or moderate incomes, medical bills quickly turn into medical debt.

Although lack of health insurance coverage exists among all population demographics, the disparities are greater for people of color, low income, and immigrant and refugee populations. Hispanic residents are most likely to be uninsured at 17.7%, followed by American Indian or Alaska Native residents at 14.8%. White residents have the lowest uninsured rate at 5.1% *(Office of Financial Management, 2019).*

For foreign-born Washington residents who have not gained citizenship, the share of the total uninsured population increased from 22.1% in 2013 to 34.7% in 2017. In contrast, foreign-born residents of Washington who have become American citizens show a significantly lower rate at 12.9%.

Families below 100% of the Federal Poverty Level have an uninsured rate of 10.3%, over three times the rate of more affluent families: only 2.8% of those above 400% of the Federal Poverty Level are uninsured *(WA State Office of Financial Management, 2018).*

Washington's uninsured population data compared to national percentages

HEALTH PROFILE	% NATIONAL	% WASHINGTON
UNINSURED BY RACE:		
White	5.4%	5.1%
Hispanic	17.8%	17.7%
Black	9.7%	9.5%
American Indian/ Alaska Native	n/a	14.8%
Asian/Native Hawaiian & Pacific Islander	6.8%	5.1%
Two or more Races	n/a	5.0%
UNINSURED BY FEDERAL POVERTY LEVEL:		
Under 100%	16.3%	10.3%
100-199%	13.6%	9.4%
200-399%	9.6%	8.6%
400%+	3.4%	2.8%

Note: U.S. Census Bureau, 2019 and Office of Financial Management, 2019.

Elderly

In 2016, more than 1,073,000 people -- 15% of Washington's population -- were aged 65 or older. By 2040, the elderly population is forecast to reach nearly 2 million, or 22% of the state's total population, and by 2030, the population over the age of 85 is expected to double. Washington is aging faster than the nation as a whole.

Washington's physician shortage disproportionately burdens the elderly. Among the states, Washington is ranked 26th with just 270 physicians per 100,000 residents. This means longer wait times and scattered services, especially in Washington's rural and island communities where the majority of the state's aging population resides. It is projected that by 2030, over 30% of the population in 12 rural counties will be older than 65 years *(Washington State Department of Health, 2018).*

Low income seniors often seek healthcare in Washington's safety net system. In 2018, 8.25% of the patient population at the Washington Association for Community Health was age 65 or older *(Washington Association for Community Health, 2018).* Compared to other populations, the elderly population is increasing much more rapidly than other demographics served by the Washington Association for Community Health. Of the 2018 Seattle/King County Clinic event patients, 14% reported their age as 65 or older, up from 11.4% in 2014 *(Seattle Center Foundation, 2019).*

For seniors, income level correlates with oral health. Acora Foundation survey respondents with higher incomes reported higher rates of dental visits, higher rates of having all their original teeth and healthy gums and teeth, and having dental insurance that covered the cost of appointments. These patients also reported being in better health overall. Low income seniors are significantly more likely to be affected by dental disease and are the least likely to have dental insurance *(2017).*

LGBTQ+

While sexual and gender minorities have many of the same health concerns as the general population, they experience certain health challenges at higher rates and often face additional barriers in accessing care. Major health concerns include increased development of chronic conditions and higher prevalence and earlier onset of disabilities, HIV/AIDS, and sexual and physical violence *(Kates, Ranji, Beamesderfer, Salganicoff, & Dawson, 2015).* Across income ranges, 15% of LGBT people in the U.S. were uninsured in 2017 compared to 7% of the non-LGBT population *(Center for American Progress, 2017).*High school students who identify as lesbian, gay, or bisexual are nearly 5 times more likely to attempt suicide than their heterosexual peers. And 48% of all transgender adults report that they have considered attempting suicide, compared to 4% of the overall population. Lesbian, gay, and bisexual adults are more than twice as likely as heterosexual adults to live with mental illness. LGBTQ+ individuals also face increased risk for substance abuse and homelessness *(National LGBT Health Education Center, 2018).*

Safety concerns with when and how to disclose identity status to doctors create additional barriers for LGBTQ+ individuals when accessing healthcare. This means it is likely that health centers are serving many more LGBTQ+ people than data accounts for (*National LGBT Health Education Center).* In 2017 8% of LGBQ people and 29% of transgender people reported a healthcare provider refused to see them due to their sexual orientation or gender identity in the past year *(Center for American Progress, 2018).* Medical training often does not include LGBTQ health and cultural competency.

State protections specifically for LGBTQ+ residents include legislation addressing housing, legal marriage, employment, hate crimes, public accommodations, anti-bullying, education, gender marker change, and transgender healthcare coverage. In 2019, Washington became one of 19 states that passed laws forbidding discrimination in healthcare based on gender identity or sex stereotypes.

Veterans

Washington has the 12th largest veteran population in the country, with a total of 552,291 veterans *(U.S. Department of Veterans Affairs, 2018).*

More veterans residing in Washington are female than the national average, and Washington has a higher rate of unemployment for veterans: 6.4% in Washington compared to 5.3% in the US.

Even though a higher percentage of the veterans in the state have a service-connected disability, a lower percentage of them use Veterans Administration healthcare than they do nationally. This utilization is also lower than in states with comparable veteran populations. With only 26 VA facilities in the state, Washington lags behind states that have comparable veteran populations but host between 30 and 37 facilities.

The total Veterans Administration medical expenditures in Washington State were over $1.5 billion for fiscal year 2018 *(U.S. Department of Veterans Affairs, 2018).* This is 35% of the Washington State's Veterans Administration expenditure. In states with comparable veteran populations, medical expenditures made up a larger percentage. In Tennessee, which has a small population of veterans, 40% of expenditures went to medical care. In Illinois, with a larger population of veterans, 52% went to medical care. This is a lower level of spending per Washington State veteran than is reported in states with comparable veteran populations.

Individuals experiencing homelessness

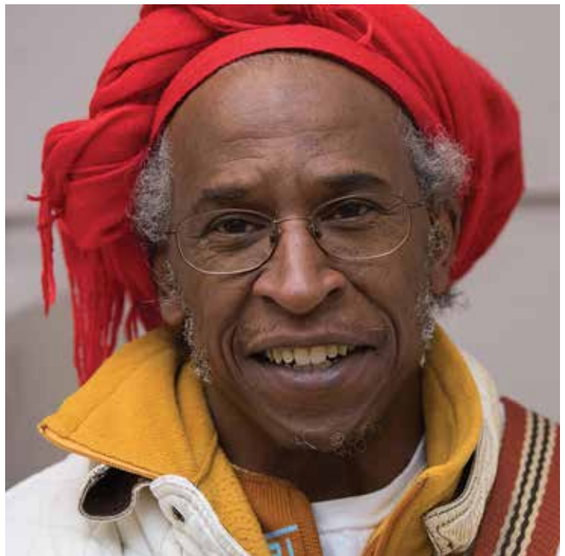
Washington has the fifth highest prevalence of homelessness in the nation, with more than 22,000 homeless individuals identified during the state's one-night count *(U.S. Department of Housing and Urban Development, 2018).* Within this population, an estimated 2,451 individuals were in families with children, 1,089 individuals were unaccompanied youth and young adults, and 830 identified as veterans.

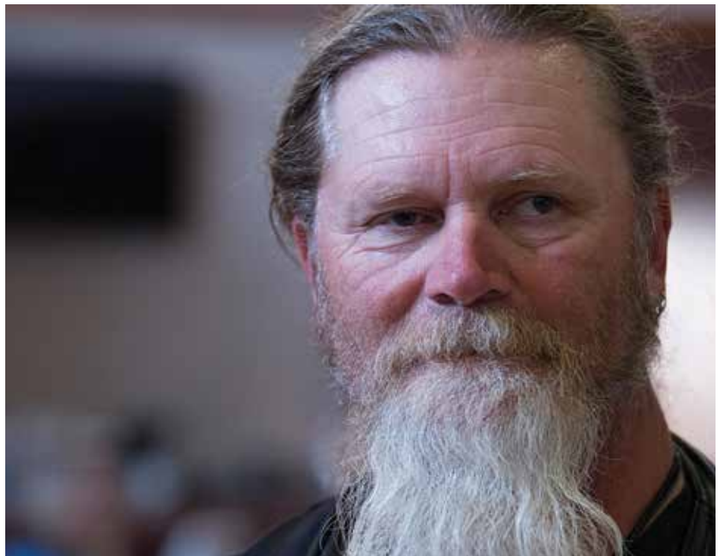
In 2015, a state of emergency was declared by the mayor of Seattle. Since then, the homeless population in King County grew year after year, from 10,047 in 2016 up to 12,112 in 2018. In 2019, for the first time since the state of emergency was declared, the number of individuals experiencing homelessness decreased by 8%, to 11,199 individuals. The number of unsheltered persons living on the street or in parks, tents, vehicles, or other places not meant for human habitation decreased from 52% of the population in 2018 to 47% in 2019 *(Seattle/King County Continuum of Care, 2019).*

Among homeless individuals, LGBTQ youth are disproportionately overrepresented. A report in partnership with the Department of Commerce, found that between 22% and 24% of homeless youth in Washington identified as LGBTQ *(A Way Home Washington, 2016).* YouthCare, an organization serving homeless youth in Washington, estimates that 23% of their client population is LGTBQ; this is down from 40% in 2014 (*Youthcare, 2017).*

According to the Count Us In survey of unhoused individuals, 64% of respondents reported living with at least one health condition. Psychiatric or emotional (36%) disorders were the most frequently reported conditions, followed by post-traumatic stress disorder (35%) and drug or alcohol abuse (32%). Chronic health problems (27%) and physical disability (23%) were also reported.

Although these data demonstrate that a significant number of individuals experiencing homelessness need care, individuals from this group face some of the steepest barriers to accessing care. Nearly 9% of patients attending the Seattle/King County Clinic in 2018 reported living in a shelter, on the street, in a vehicle, or in transitional or supportive housing *(Seattle Center Foundation, 2019).* With limited access to healthcare, the number of deaths among King County's homeless population has risen for the fourth year in a row, from 124 in 2015 to 194 in 2018 *(King County Medical Examiner's Office, 2018).*





Youth Exiting Foster Care

Washington is one of 25 states and the District of Columbia to sign into law the Fostering Connections to Success and Increasing Adoptions Act of 2008, effectively extending foster care support beyond 18 years of age.

Within Washington's foster care system, 19% of the population are age 14 and up. Of that 19%, 28% are transition age, 18 years of age and older. Compared to national percentages, Washington has more female youth in foster care: 54% compared to 49% nationally *(Annie E. Casey Foundation, 2018).*

Foster youth often lack the safety nets and support systems needed to help them navigate the transition period of becoming independent at higher rates than their peers. Called "emerging adulthood" in a report by the National Conference of State Legislatures, the transition from adolescence to adulthood is complex and lengthy, not a direct jump. For many, achieving full adulthood may not take place until their late 20s *(National Conference of State Legislatures, 2015).*

It has become commonplace for young adults to weather this period with their parents. According to the U.S. Census Bureau Report, more than one third of young adults, ages 18 to 34, are living in their parents' home *(US. Census Bureau, 2017).* By virtue of being discharged from foster care at age 18, foster youth are required to find housing, secure a job, attend higher education, and enroll in health insurance often without adequate support. Foster youth in Washington are able to remain on Medicaid until age 21. The state also offers federally funded transition services such as employment programs and vocational training, educational financial assistance, and room and board assistance.

Despite services, outcomes for young adults in Washington who experienced foster care are worse than their peers in the general population and in the U.S. foster care population. Only 39% of Washington's foster care population attain employment by the time they turn 21, compared to 49% of the U.S. foster care population and 63% of the state's general population. In addition, 30% of the state's foster care population become young parents by age 21 (*Annie E. Casey Foundation, 2018).*

Formerly Incarcerated Individuals

Many formerly incarcerated individuals leave prison with at least one chronic problem with physical health, mental health, or substance abuse *(Urban Institute, 2018).* In conjunction with either lack of health insurance or access to health services, such ailments can make it harder for these individuals to reintegrate into the community, reducing their ability to maintain employment, housing, relationships, sobriety, and, thus, to avoid recidivism.

According to the U.S. Department of Health and Human Services, 64% of jail inmates, 56% of state prisoners, and 45% of federal prisoners were found to have mental health problems *(Commonwealth Fund, 2019).*

Under the Affordable Care Act and Medicaid Expansion, many states are connecting formerly incarcerated individuals with health coverage. In July of 2017, the Washington State Health Care Authority revised its scope of coverage regarding justice-involved individuals. Previously, Medicaid coverage was terminated when a person became incarcerated. Now, healthcare coverage is suspended at the time of incarceration, limiting coverage to inpatient hospitalizations lasting longer than 24 hours while incarcerated and reinstated once the individual is released *(Washington State Healthcare Authority, 2017).*

Even with reinstated healthcare coverage, providers who have worked with formerly incarcerated individuals note a tendency of these individuals to be wary of engagement with healthcare providers, reflecting their mistrust of institutions *(Commonwealth Fund, 2019).* Community Health Workers in Transitions Clinic Networks are helping to break down this barrier.

Transitions Clinic Network is a national network operating in 11 states and Puerto Rico. Located in communities most impacted by incarceration, Transitions Clinic Network is geared toward individuals with chronic diseases recently released from incarceration. Their model employs a community health worker and an individual with a history of incarceration as part of the clinical team, reflecting a philosophy that people closest to the problem are also closest to the solution. Country Doctor Community Health Center in Seattle is a participating member of Transitions Clinic Network.

Findings from a randomized control trial found that Transitions Clinic Network programs significantly reduced emergency room visits and patients had fewer and shorter preventable hospitalizations and fewer parole and probation violations *(Northwest Regional Primary Care Association, 2018).*

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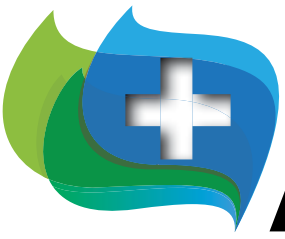

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