

A Comparative Analysis of the Health Status of Hispanic Children:
The Cases of Washington State and Arizona

by

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ABSTRACT

For the last quarter century, Washington State has been ranked in the top third of the United States in health status while Arizona has been consistently around the bottom third. This gap can be partly explained by data related to traditional determinants of health like education, income, insurance rates and income. Moreover, Washington State invests three times more resources in the public health sector than Arizona. Surprisingly, however, Hispanic children in Washington State have poorer health status than Hispanic children in Arizona. This dissertation explores possible explanations for this unexpected situation, using as a conceptual framework the cultural competency continuum developed by Cross.

The study consisted of analysis of health-related data from Washington State and Arizona, and interviews with state health administrators, local health departments, community-based organizations and university administrators in both states. This research makes a modest contribution to the role that cultural competence plays in the development and implementation of health policy and programs, and the potential impact of this approach on health status. The dissertation ends with recommendations for health policy-makers and program planners, particularly in states with a significant proportion of minority groups.

DEDICATION

In Honor of my Father, Doeg Nelson

and my mother, Rose Marie Nelson

without whom I would not exist.

And to my son Geoffrey Doeg Nelson Hill who

provides meaning to my existence.

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INTRODUCTION

Historically, some states consistently have high health status ranking and others have consistently low rankings. Two such states that have been consistent in their health rankings are Arizona and Washington. Washington has been regularly among the top third of the United States while Arizona is consistently in or near the bottom third. These large differences in health status could be explained by the fact that Washington State ranks higher in traditional determinants of health such as education, income, insurance rates, income, and invests three times more resources in the public health sector. Washington also has a more progressive approach by developing health policies with the intent of making health care accessible to all of its citizens. However, Arizona has a better health status rate for Hispanic children. This is surprising because, according to most predictors of health, Washington State Hispanic children should be fairing much better than children in Arizona. The main purpose of this dissertation research was to explore possible explanations for this unexpected situation.

Research Question

Main question: Why does Arizona have better health outcomes for Hispanic children than Washington State despite having consistently lower health rankings in all other areas?

Health status ranking is a methodology used to review and analyze state health indicators. The review and analysis, conducted for 25 years, is a partnership between United Health Foundation, American Public Health Association, and Partnership for Prevention. The data is taken from several sources, including the United States Departments of Health and Human Services, Commerce, Education, Justice and Labor to

name a few (America's Health Ranking, 2016). Among the main areas for consideration are children's health are access to care, state Children's Health Insurance (CHIP) programs, immunization rates, birth rates, infant mortality, food security and Women, Infant and Children (WIC) programs, among others.

Health outcomes for children can be complex and impacted by more than one variable. There is often overlap between areas that explain health ranking. For instance, addressing an issue in child health may be influenced by issues such as poverty, parent's education level, transportation, and access to care. In turn, there may be policies that could also affect poverty, access to transportation, jobs, education and/or access to clinical care, thereby influencing child health. In some ways, it is a circular argument. Appendix B gives an overview of selected children's health status indicators from the Data Resource Center (2008). Following is a more detailed comparison of the differences of each state.

The main hypothesis guiding this study is that the difference in health status of Hispanic children in the two states can be explained in part by the presence or absence of culturally sensitive health programs. A related hypothesis is that culturally sensitive health programs are more likely to be developed when there is a critical mass of a particular demographic population. Indeed, the literature indicates that it may take a critical mass of a targeted community to mount the resources and support to make necessary changes in policy and programs to achieve a desired outcome.

Health Status

Health status ranking is a methodology frequently used to review and analyze state health indicators. The review and analysis, which conducted for 25 years, is a

partnership between United Health Foundation, American Public Health Association, and Partnership for Prevention. The data is taken from several sources, including the United States Departments of Health and Human Services, Commerce, Education, Justice and Labor to name a few (America's Health Ranking, 2016). Some of the main areas for consideration were children's health are access to care, state Children's Health Insurance (CHIP) programs, immunization rates, low birth rates, infant mortality, food security and Women's, Infant's, and Children's (WIC) programs among others. Many health indicators were analyzed and reviewed for each state. Overall health ranking was reviewed as part of this review, which is important to understand when considering child health indicators.

Health status ranking for children can be complex and affected by more than one variable, because there is often overlap between the areas to explain health ranking. For instance, addressing an issue in child health influenced by issues such as poverty, parent's education level, transportation, and access to care illustrates the overlap. There may be policies that could also influence access to transportation, jobs, education and/or access to clinical care, thereby influencing child health. In some ways, it is a circular argument. Appendix B gives an overview of selected children's health status indicators from the Data Resource Center (2008). The next section consists of a more detailed comparison of the differences between the two states.

The Context of the Study: Washington State and Arizona

Washington has an overall Hispanic population of 11 percent and for Arizona the Hispanic population 29 percent. How each state addresses the needs of communities is instrumental in the health status of their Hispanic population. Following is a discussion of Arizona and Washington that provides a general overview of each state.

Washington State

Washington became a state in 1889, making it the 42nd state to enter the Union. Early in its constitution, it made provisions for the relationship between government and its citizens. The Washington State webpage posted a philosophy that indicates the government is there to be accessible to serve the citizens and help them achieve an optimum healthy lifestyle. In 1993, prior to the Affordable Care Act, Washington passed its own health insurance reform legislation, indicating a desire to provide healthcare coverage for Washington residents. Washington also recently filed an Amicus Brief with the U.S. Supreme Court in support of the Affordable Care Act (Kliff, 2012). This indicates that Washington supports the new federal health care legislation, the Affordable Healthcare Act, which has the intent to provide healthcare coverage for all.

Arizona

Arizona was the 48th state to enter the Union and its constitution reflects its youth and desire for local control and a minimal role for the federal government. It established the initiative, referendum and recall sections to allow citizens to intervene if they believed elected officials were not doing what the electorate wanted. Early in its constitution, Arizona made provisions for the relationship between government and its citizens. Arizona's constitution reflects the belief in small government and local control

of policy issues. Arizona was the last state to become a part of Medicaid, which is a program to provide health care to low income individuals and families.

Demographics

Washington State has a population of 6,724,540 residents. The median age is 37.3. Persons under 5 years of age make up 6.5% of the population, under 18 make up 26.3 %, and persons 65 and older make up 12.8% of the population. The majority of the population (77%) is white. African Americans represent 3.6%, Asians, 7.2%, Hispanic 11.2%, and American Indian and Alaska Natives, 1.5% (Table 1). Ninety percent of their population is high school graduates or higher as compared to 86% of the U. S. population, and 32% have bachelor's degrees or higher. The median household income for Washington in 2013 was \$59,308 (U.S. Census Bureau, 2013). The uninsured or underinsured rate is 14%. Of those that are uninsured, 5.9% are under 18 and 19.8% are adults 19-64; 65% of families with no insurance have at least 1 full-time working member; 57% are male, 43% female; and 68% are white.

The population in Arizona is 6,392,107. In Arizona, 7.1% of the population is under 5 years of age, 26.6%, of the population, is under 18, and 13.8% of the population is 65 and older. The median age is 35.9. The majority of the population is white at 87.4%, African Americans 4.1%; Asians, 2.2%; Hispanic 28.8% and American Indian and Alaska Natives 5.1 (Table 1). Eighty-six percent of their population is high school graduates and 15.2. percent have bachelor's degrees or higher. The median household income for Arizona in 2010 was \$49,674 (U.S. Census Bureau, 2010).

Table 1

Comparison of Arizona and Washington Population/Ethnicity

State	White	African American	Asian	Hispanic	American Indian	Total Population
AZ	4,667,121	259,008	135,658	1,895,149	314,482	6,166,318
	(87.4%)	(4.1%)	(2.2%)	(28.8%)	(5.1%)	(100%)
WA	5,196,362	240,042	481,067	755,790	103,869	6,724,540
	(77%)	(3.6)	(7.2)	(11.2%)	(1.5%)	(100%)

(U. S. Census 2010)

The variables identified in Table 2 below show a difference in selected demographics that according to the literature may have an impact on children’s health. The number of persons under 5 and 18 illustrate the child population in the state. Median income and unemployment rate may demonstrate the ability of the parents to access health care for their children. The uninsured/underinsured rate shows a difference in insurance rates. However, the main factor affecting child health status is median income. Moreover, when parents need to work several jobs or jobs that do not allow time to engage in the community or their children’s school, the health of those children are likely be impacted.

Table 2

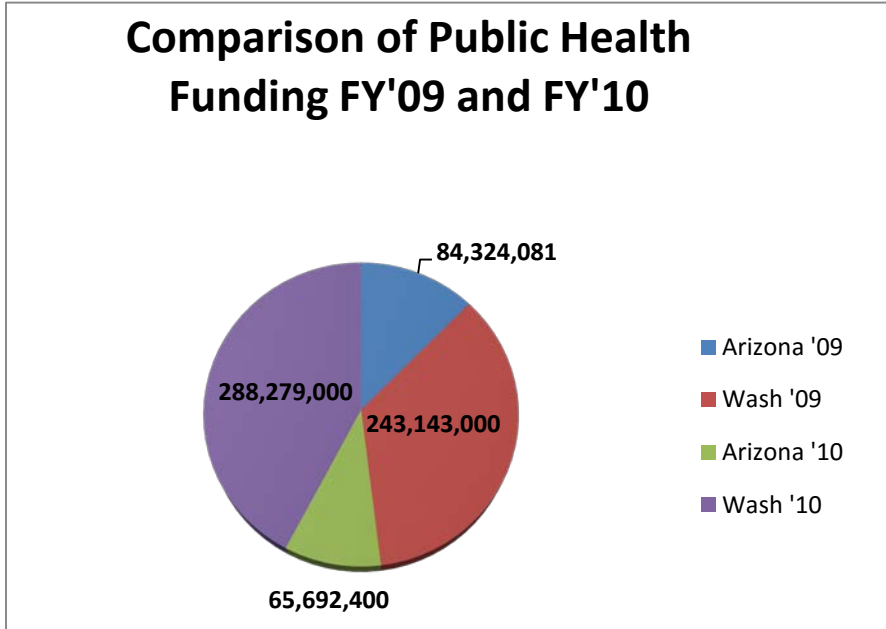
Comparison of Selected Demographic Characteristics

Variables	Arizona	Washington
Persons <5	6.9%	6.5%
Population <18	26.6%	26.3%
Uninsured/under	19.5%	12.6%
Median Income	\$49,674	\$65,588
Unemployment Rate	10.5	10.0

Trust for America's Health, 2010; *Department of Labor, 2010, **U. S. Census

Examining public expenditures, a significant difference that stands out is the amount of public health spending per state. Arizona's public health spending for FY'09 was \$ 84,324,081 and for FY'10 was \$65,692.400. Washington's public health spending for FY'09 was \$243,143,000 and FY'10 it was \$288,279,000. Considering population size, Washington State spends \$36.48 per capita and Arizona State spends \$12.78 per capita. The difference is approximately 3 to 1. Figure 1 below shows the differences between the two states in the amount of their public health spending. Washington does a biennial budget and Arizona does an annual budget. Therefore, two fiscal years were included in each state. This difference in public health spending is another factor which may explain the differences in child health programs in each state.

Figure 1



While this is overall public health funding spending for each state, it is difficult to identify specific spending for children's health because of the variety of administrative structures for children's health. Funding is not the only factor in determining health, but with this disparity in funding between the two states, it is a significant factor. Public health funding, however is a key financial indicator that helps determine the health of a state.

Social cohesion was explored as an indicator of the interest or ability of residents to engage in their community and public policies that affect their community. The amount of civic engagement may be a factor in policies requested and implemented related to individual health and more specifically children's health; therefore making it difficult for children in the community to be healthier. According to the literature, civic health and engagement may have a significant impact on the health of a community,

which in turn would affect children's health. It indicates the level of volunteerism, neighbors interacting, social cohesion and how engaged the communities are in the policies that have an impact on their day-to-day lives. Washington, ranked as twelfth overall has a significantly higher rank related to civic engagement than Arizona which is ranked at forty-second (Arizona Civic Health Index, 2010).

There are limitations in determining the differences in outcomes based on the data from the state rankings. There may be other explanations for program design and implementation. For instance, Schneider and Ingram (2009) believe the success of program implementation depends largely on informing and empowering target communities. Cultural competence is also important in program design and implementation. This will be explored further in the literature review.

Children's Health Priorities

There are global standards for children's health that both states should work to achieve. The World Health Organization (WHO) identified several priorities in children's health worldwide. They include such conditions as congenital anomalies, injuries, and non-communicable diseases. In addition, injuries such as traffic accidents, burns, drowning, burns and falls are among the priorities because they are among the top three causes of death of children. In addition, the increase in the number of overweight children is an issue as well as the increase in malnutrition (WHO, 2014).

Many child health programs come with federal mandates and federal funding; however, some states still have better health outcomes than others. The states have a great deal of control on the implementation of mandates in states, such as the policies that put the programs in place and the administration and delivery of the programs. Along with

the policy considerations, does contributing more state dollars to the federal funding enhance the programs targeted to improve children's health? Following is a discussion of global child health priorities and United Programs designed to meet some of those priorities.

Priorities

According to the Commonwealth Fund, there are variations in how states perform related to six areas in the system. These six areas should be the standard for the measure of the effectiveness of children's health programs and status in Arizona and Washington. State child health system performances have six areas and are as follows:

1. High Performance is possible—Two states, Iowa and Vermont fit this category. They have systems that provide quality, equitable care while controlling costs. They have both provided programs with expanded children's access to care. The Commonwealth Fund states "This analysis indicates that such policies make a difference." (Commonwealth Fund, 2008)
2. Leading states consistently outperform lagging states on multiple child health indicators and dimensions—One of the dimensions is a low un-insurance rate for children. States in this category are Iowa, Vermont, Maine, and Hawaii to name a few. Arizona is listed among the states in the bottom quartile along with states such as Texas, Louisiana, Mississippi and Florida.
3. There is wide variation in children's access to care and health care quality across the United States—The number of children who are uninsured ranges from 5% in Michigan to 20% in Texas. Children with regular medical and dental preventive care range from 75% in Massachusetts to 46% in Idaho. The

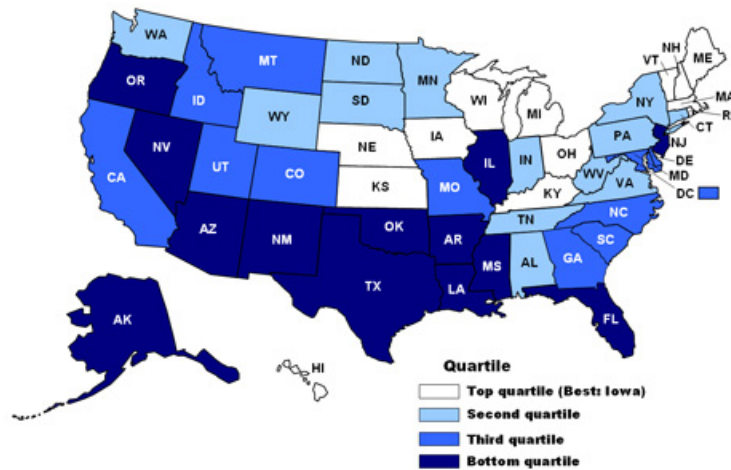
number of children hospitalized for asthma ranges from 33/100,000 in Vermont to 314/100,000 in South Carolina.

4. Children's access to medical homes primary care providers who deliver health care services that are easily accessible, family-centered, continuous, comprehensive, coordinated, and culturally competent varies widely across states. Research shows that medical homes are an effective way to improve health care quality and reduce disparities by race, insurance status, and income.
5. Across states, better access to care is closely associated with better quality of care. Seven states Massachusetts, Iowa, Rhode Island, Ohio, Vermont, Alabama, and Wisconsin are national leaders in giving children access to care and ensuring high-quality care.
6. Child health systems have a pattern of regional differences in performance. For instance, New England and the North Central states have good indicators in terms of access, quality and equity of children's health care. Western and southern states have lower health care costs. (Commonwealth 2008)

The Commonwealth Fund illustrates some of the regional differences. Washington is in the second quartile and Arizona is in the bottom quartile when it comes to overall children's health as shown in Figure 2 below. However as stated previously Arizona is performing better than Washington with Hispanic children.

Figure 2

Figure ES-2. State Ranking on Child Health System Performance



Source: The Commonwealth Fund calculations based on state's rankings on access, quality, cost, healthy lives, and equity dimensions.

(Commonwealth Fund 2008)

Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program is a federal program designed to meet the health needs of children. Although, there are specific federal guidelines, the federal government allows the states to have flexibility in the design of their state program. CHIP makes it more possible for children and specifically Hispanic children to have more access to health care to addresses the above mention priorities is critical when addressing their health care needs.

There are specific benefits prescribed by the federal government for the implementation of the CHIP programs in each state. Below is the listing of the prescribed benefits as listed on the Medicaid website (2016).

Benefits

The Children's Health Insurance Program (CHIP) provides comprehensive benefits to children. Since states have the flexibility to design their own program within Federal guidelines, benefits vary by state and by the type of CHIP program.

Medicaid Expansion Benefits- Medicaid Expansion CHIP programs provide the standard Medicaid benefit package, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, which includes all medically necessary services like mental health and dental services.

Separate CHIP Benefits- Options States can choose to provide benchmark coverage, benchmark-equivalent coverage, or Secretary-approved coverage. Benchmark coverage is based on standard Blue Cross/BlueShield provider options, state employees' coverage plan, HMO plan that has the largest commercial, non-Medicaid enrollment. They must also include what is called benchmark-equivalent coverage with includes inpatient and outpatient hospital services, physician's services, surgical and medical services, laboratory and ex-ray services and well-baby and well-child care, including immunizations. They may also have Secretary-approved coverage, which is any other health coverage deemed appropriate and acceptable by the Secretary of the U. S. Department of Health and Human Services.

To be eligible for CHIP payment, each state must submit a Title XXI plan for approval. States can design their CHIP program in one of three ways:

1. **Separate CHIP:** a program under which a state receives federal funding to provide child health assistance to uninsured, low-income children that meet the requirements of section 2103 of the Social Security Act.

2. **Medicaid expansion CHIP:** a program under which a state receives federal funding to expand Medicaid eligibility to optional targeted low-income children that meet the requirements of section 2103 of the Social Security Act.
3. **Combination CHIP:** a program under which a state receives federal funding to implement both a Medicaid expansion and a separate CHIP.

State and Federal Funding for CHIP

Like Medicaid, CHIP is administered by the states, but is jointly funded by the federal government and states. The Federal matching rate for state CHIP programs is typically about 15 percentage points higher than the Medicaid matching rate for that state (i.e., a State with a 50% Medicaid FMAP has an "enhanced" CHIP matching rate of 65%). Every state administers its own CHIP program with broad guidance from CMS. States can design their CHIP program in one of three ways: 1) Medicaid expansion; 2) Separate Child Health Insurance Program; 3) The combination of the two approaches (Medicaid.Gov, 2013).

Shone, et al (2003) found that CHIP enrolled a significant number of minority children. There were some baseline racial and ethnic disparities, with Black and Hispanic children being worse than white children with many sociodemographic factors. Even after demographic factors were controlled, the disparities still existed. There may need to be specific programs and strategies to address these disparities. Continued monitoring would be necessary to track the progress of lack of progress in the health of Hispanic children.

Arizona and Washington CHIP Programs

The Children's Health Insurance Program (CHIP) in Arizona has a 200% FPL rate for children admitted into their CHIP program and is administered by the Medicaid agency the Arizona Health Care Cost Containment System (ACHCCS). However, Arizona's program suspended in 2010 and just reinstated for the new fiscal year in 2016. Washington has a 201-300 percent FPL for children in their CHIP program.

Washington's CHIP program is administered by its public health agency, the Washington Department of Health. The Arizona delivery model is 100% managed care. Whereas Washington is primarily managed care but allows a primary care fee for service model for children in rural areas, where there is only one or no managed care providers. Below is the state CHIP program information as posted in the State Health Reports at Medicaid.gov (Medicaid.Gov. 2012).

In addition to the CHIP program administered through the Washington Department of Health, there is the Children's Administration that also has Child Safety and Protection, Foster Parenting, Adoption, and Adolescents. To note a difference here, adoption and foster parenting in Arizona is through the Department of Economic Security, which is separate from health. Washington also has a Child Profile Health Promotion System. "The system is set up to specifically to interact with children and their families. The system sends age-specific information on child health and safety by email or mail to families. The information reminds families about well-child checkups, gives information on nutrition, growth and development and other health topics" (Washington Department of Health, 2016).

Other states' CHIP programs, such as Hawaii, Tennessee, and Utah were reviewed. Each one had the main components of the federally mandated CHIP program. In addition, services generally delivered through a managed care model. The primary differences were where they were housed, whether in the state public health agency or social service agency. There were also differences in whether all programs housed in the same agency. Some states such as Arizona had their children's programs across multiple agencies. This could make coordination a challenge in delivering the most effective children's health programs. Several states with successful CHIP programs are listed below. Most of them have above average child health status indicators. However, they still have challenges with reaching the Hispanic community. The overall children's health status and the Hispanic children's health status are listed below:

Table 3

Selected Comparison of Children's Health Status

State	Total Child Health	Hispanic Child Health
UT	90.1	65.0
HI	86.7	83.8
WA	85.8	66
TN	84.3	57.3
AZ	80.7	70 (NSCH, 2008)

Community Health Centers (CHC)

Community Health Centers (CHC) are another avenue to offer health care services to children. They are non-profit clinics located in medically underserved areas

all over the United States funded by the Bureau of Primary Care, in the Health Services Resources Administration. The CHCs share a mission of “making comprehensive primary care accessible to anyone regardless of insurance status” (Arizona Alliance of Community Health Centers, 2016). CHCs provide services on a sliding fee scale. All states have one Primary Care Association whose mission is to help promote primary care in that state. Arizona has 21 CHCs. The primary care association is The Arizona Alliance for Community Health Centers. Washington has 26 CHCs. Their primary care association is The Washington Association of Community & Migrant Health Centers (WACMHC, 2016). Community Health Centers are required to offer a set of services in their community. The services are as follows:

1. Basic primary care related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology
2. Diagnostic laboratory and radiology services
3. Preventative health services including prenatal and perinatal care, immunizations, pediatric screenings, family planning services, and preventive dental care
4. Care for acute and chronic conditions
5. Pharmaceutical services as appropriate
6. Referral services
7. Patient case management, including counseling, referral, and follow-up services
8. Services that enable patients to access the health center, such as outreach, transportation, translation and interpreter services

9. For the uninsured, a sliding fee schedule that takes into account the patient's family size and income (Arizona Alliance of Community Health Centers, 2016)

When asked regarding specific guidance on child health and child health program delivery, Essen Otu, Director of Diversity, Mountain Park Community Health Center, Phoenix, AZ stated: "Although we are required to provide access to children, there is also a great deal of flexibility in how FQHCs accomplish that." (E. Otu, February 18, 2016). There are a number of children's advocacy organizations that also address children's health. Through the interview process, organizations in the two states were identified and how these organizations work to improve children's health.

Women, Infants, and Children Supplemental

Feeding Program (WIC)

The Women, Infants, and Children (WIC) program is a supplemental feeding program with prescribed food benefits. It is designed for pregnant, breastfeeding, and postpartum women, infants and if under nutritional risks, children under the age of five. The program provides the formula for babies and if the mother is breastfeeding supplemental healthy foods for the mother. Children at risk, either of malnutrition or obesity, may also receive assistance. WIC is an important program related to children's health because of the potential to influence positively the childhood obesity rate. As with adults, obesity is a risk factor for other health conditions. Considering a 1-19 obesity scale in which a score of 19 is the worst, the childhood obesity rate for Hispanic children in Arizona is 13, whereas, in the state of Washington, the rate of obese Hispanic children is 19(NICH, 2008). Education and breastfeeding support are provided to participants.

This is a program funded by the United States Department of Agriculture. Both Washington and Arizona have this program which administered by their respective state public health agencies. There are strict criteria for eligibility based on the federal poverty level (FPL). Below is the list of income guidelines. Both Washington and Arizona have program guidelines that state they provide services up to 185% of FPL (Arizona Department of Health, 2016 and Washington Department of Health, 2016).

Table 4

WIC Income Eligibility Table by Family Size Effective April 7, 2015

	Weekly Household Income	Monthly Household Income	Yearly Household Income
2	\$567	\$2,456	\$29,471
3	\$715	\$3,098	\$37,167
4	\$863	\$3,739	\$44,863
5	\$1,011	\$4,380	\$52,559
6	\$1,159	\$5,022	\$60,255

Source: ADHS, 2016

CHAPTER 2: LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

Culture

Culture influences all aspects of our daily life, whether consciously or unconsciously. When interacting with others it is important to be aware of their culture and cultural beliefs as well as our own. Maville and Huerta (2013) note that “culture is a holistic phenomenon that it is more than the sum of its parts and it affects everything including thoughts and behaviors” (p. 91). They also see culture as starting in the womb and continuing throughout one’s life to where a unique pattern of ingrained patterns, attitudes and behaviors are developed. Leininger (2002) defined culture as “the learned, shared and transmitted knowledge of values, beliefs and lifeways of a particular group that are transmitted inter-generationally and influence thinking, decisions and actions in patterns or certain ways” (p. 47). Cross (1989) states that culture encompasses a pattern of the thoughts, beliefs, religion and other aspects of a group. A common in theme in these definitions is that culture is learned, shared, and everywhere.

The CLAS (1998) document developed by the Office of Minority, Department of Health and Human Services states:

Culture defines how health care information is received, how rights and protections are exercised, what is considered to be a health problem, how symptoms and concerns about the problem are expressed, who should provide treatment for the problem, and what type of treatment should be given. In sum, because health care is a cultural construct, arising from beliefs about the nature of disease and the human body, cultural issues are actually central in the delivery of health services treatment and preventive interventions.

“By understanding, valuing, and incorporating the cultural differences of America’s diverse population and examining one’s own health-related values and beliefs, health care organizations, practitioners, and others can support a health

care system that responds appropriately to, and directly serves the unique needs of populations whose cultures may be different from the prevailing culture” (CLAS, 1998, p. 5).

The Institute of Medicine (2003), states that health disparities, which reflect cultural differences, as well as other factors such as income, threaten to hamper some of the efforts to improve the nation’s health. This creates a challenge in reaching, serving, and improving the health status of some populations. Maville and Huerta (2013) point out that everyone is influenced by culture and the impact of culture extends into health arenas” (p. 96). With the increasing diversity of the United States, it is increasingly more important to address the need to accept culture and cultural diversity as a means to improve the health and health status of individuals and groups in our communities.

Conceptual Framework

The conceptual framework used for this research is based on the work of Terry Cross and his cultural competence continuum (1989). The Cultural Competence Continuum provides a framework to examine the differences between the two states. The analysis of the interviews suggests that cultural competence might be a critical factor in explaining the differences between the two states. According to Cross (1989), cultural competence should be viewed as a goal that systems strive to achieve. Systems that are culturally competent have professionals and agencies that are culturally competent.

Cross (1989) also states that systems must recognize that minority families make different decisions based upon their cultural differences. Systems must recognize these differences in order to provide effective healthcare and treatment. This conceptual framework addresses the question of Hispanic children’s health status in Washington and Arizona because it covers several areas of significance. The framework addresses many

ways the system or agencies do or do not address cultural competence adequately. Cross (1989) defines the five levels of the cultural competence continuum as follows:

1. Cultural Destructiveness – This level is the least culturally competent. Individuals or agencies at this level tend to be very negative even to the point that programs may border on cultural genocide.
2. Cultural Incapacity – Agencies are not intentionally culturally destructive, but also do not intentionally include minority groups. They can be paternalistic at this phase. Also, they may redirect resources or discriminate based upon whether the clients “know their place”.
3. Cultural Blindness – This is at the midpoint of the continuum. At this point agencies may believe that culture makes no difference. They have a well-intentioned liberal policy, but that leads to programs being ineffective except to those minorities most assimilated into the system.
4. Cultural-Pre-Competence – Agencies at this level have acceptance and respect for difference, continuing self-assessment, attention to differences, continuous education, and various models of service delivery to meet the needs of minority communities.
5. Advanced Cultural Competence – This is the highest end of the continuum. At this level culture is held in high esteem. Agencies seek to advance knowledge, conduct research, and hire staff that specializes in culturally competent practice.

Agencies should be self-aware to know and understand where they are on the continuum and provide what is necessary to continue to grow on the continuum and

improve their placement. These two states were viewed through this lens of cultural competence, explaining the differences in health status among Hispanic children.

This study of Hispanic children's health will focus primarily on culture and cultural competence. In addition, some emphasis will be on policy and the influence of cultural competence or the lack of on policy and implementation. All of these variables may have an impact on the health status of Hispanic children.

Cultural Competence

The overall framework of this study is a discussion of Cross's (1989) Cultural Competence Continuum and other approaches to culture and cultural competence. Cross (1989), has defined cultural competence as "a set of behaviors, attitudes and policies that come together in a system, agency or profession and enable that system, agency or profession to work effectively in cross-cultural situations" (p. 17). Culture encompasses all the learned behaviors of an individual or group. Competence is used to demonstrate the capacity to function effectively (Cross, 1989). Therefore cultural competence in a system of care that "acknowledges and incorporates- at all levels- the importance of culture, the assessment of cross-cultural knowledge and the adaptation of services to meet culturally unique needs" (Cross, 1989, p. 17). Cultural competence includes all elements of systems and whether they have the capacity to meet the needs of cultures different from their own or of those that may be different from the "dominant" or "mainstream" American culture.

According to Cross (1989), cultural competence has five elements that support a system being culturally competent. The five elements are that systems:

1. Value diversity

2. Have the capacity for cultural self-assessment
3. Are conscious of the dynamics inherent when cultures interact
4. Have institutionalized cultural knowledge
5. Have developed adaptations to diversity (Cross, 1989)

A system must assess itself in with regard to the five elements of cultural competence. Self-awareness of the system is critical to moving forward on the cultural competence continuum and achieving the elements of cultural competence. Then, beyond assessment, systems must have an intentional effort of understanding of the issues associated with cultural competence, and provide training to the workforce to adequately achieve cultural competence. The system must plan, organize and implement actions that will assist in in providing culturally competent care to those they serve. Another factor to consider with cultural competence is the health care workforce.

Healthcare Workforce

Workforce diversity refers to the variety of backgrounds of people in the labor pool (Sher-Lewis, 2001). Reich and Reich (2006) also state that working with populations different from their own, the provider should take the time to learn as much as possible about the culture of the patient. To become culturally competent, health care workers must first be aware of their own culture, as well as the culture of the patients receiving their care (Cross, 1989; Huerta and Maville, 2013; CLAS, 1998). This awareness of self should then be used to work with the patient to learn how best to treat him or her. Workforce diversity is associated with cultural competence. When the workforce is more diverse, the patients can receive care from providers that is more appropriate and acceptable by the culture of the patient. Not all healthcare providers

need to be an expert, but all of them should be sensitive and aware of what they do not know.

The workforce provides a constant challenge to determine the ratios of workers to patients, the diversity of workers, as well as identifying which healthcare workers are needed. Another area affecting the workforce to consider is location of the population versus the location of the health care providers. Consideration must be given to the aging of the population which will impact health care needs and the type of healthcare workforce needed as the population ages. In addition, the aging of the healthcare workforce especially nursing adds to the challenge of retaining workers and need for more workers to come into health professions (Health Resources and Services Administration, 2010).

Barriers to Culturally Competent Care

Several barriers to culturally competent care are identified in the literature. Some of these barriers as identified by Betancourt, Carillo, and Green (1999) include:

- Lack of diversity in health care leadership and the healthcare workforce
- Systems of care poorly designed for a diverse patient population
- Poor cross-cultural communication between providers and patient

Cultural competence or the lack of it on the part of health care providers is a factor that can be an asset or a barrier that can influence the health of individuals and groups. The lack of diversity of health care providers is critical and is considered as a barrier to cultural competence. Health care providers must have a command of the language in order to communicate effectively and provide the best care to their patients. Lack of communication may include barriers other than just language. It includes the

awareness of the health care professionals of their own culture and beliefs and understanding how it affects the care given to their patients. This may also influence the trust between patient and provider if the patient perceives that the provider is not familiar with or accepting of the differences in culture. The patient perception may then influence the perception of the care and patient willingness to comply with help promotion and other health care advice given by the provider.

Another barrier to consider with culturally competent care is the issue of the size of the community or the critical mass of a community. “Larger interest groups have more total resources; they are generally more likely to have the possibility for a successful collective action” (Oliver and Marwell, 1988, p. 6). These authors go on to state that this especially true when high costs are involved which could include health care. A large group might be able to organize with only 5 percent of its resources to achieve a goal, whereas a smaller group might require 100 percent of its resources and still not achieve the desired success (Oliver and Marwell, 1988, p. 6).

In addition, the vulnerable population model may inform the analysis of culture and cultural competence. Aday (1993) states that looking at the issues of access to health care may be incorrect; that our focus may be too narrow. The Vulnerable Populations model examines health indicators looking at more than access to care but also social status, risk factors, education, environment, race and other forms of the vulnerability of a community. For instance, individuals living in a poorer community are more vulnerable and may have less access to all kinds of resources leaving them to be at risks for poorer health status and outcomes (Flaskerud and Wilson, 1998).

Cultural Competence and Health Outcomes

Based upon the data between the two states, Hispanic children in Arizona should be significantly behind Hispanic children in Washington when it comes to health status. Instead, outcomes for Hispanic children in Arizona are a few percentage points better than children in Washington. The interviews and field research show that culturally sensitive programs may explain the difference between these two states. The field research showed that Arizona had more culturally targeted outreach programs related to health, particularly at the local level. In addition to the mandates from the federal government (CLAS), there are research articles that demonstrate that targeted outreach can improve health outcomes for ethnic communities. Research related to culturally competent interventions is discussed below.

Tucker, et al (2014) conducted a community-based study on adults with type-2 diabetes. Most of the participants were Hispanic and African American. The study showed that a culturally sensitive, empowerment focused, community- based health promotion program holds much potential for improving health outcomes among racial/ ethnic minority and low- income adults with type 2 diabetes “(Tucker, et al, 2015 p. 305). The study was relatively small, so it was recommended that a larger study would present even greater results. Betancourt and Green (2010) also found that “targeted interventions focusing on specific patient populations are the approach that is most likely to have an impact” (p.584).

Anderson et al (2010) conducted a systematic study of culturally competent health care systems. The belief was that if clients did not understand the instructions given them by their providers because of language or culture the outcomes would not be as expected.

The results were inconclusive, but they recommended further research was necessary. One of the community-based organizations in Arizona expressed the challenge when parents did not understand treatment or follow-up care for their children, causing challenges in proper treatment or the requirement of continued treatment for the children. This of course contributes to increased health costs, unnecessary additional treatment for the children and additional stress for their families.

One study not specific to health, showed the significance of culturally significant interventions. Jackson, Hodge and Vaughn (2007), conducted a meta-analysis of culturally sensitive interventions to determine if the interventions had an impact on high-risk behavior among African American youth. The results were that African American youth with targeted cultural sensitive interventions participated in significantly fewer high-risk behaviors than those that did not receive the intervention. Lastly, in a commentary, Hayes-Baustista (2003) stated that if we understood the relationship between culture and health, that perhaps many lives could be saved.

The contribution of this research is to demonstrate that the primary difference in Washington and Arizona with the health status of Hispanic children may be the lack of targeted health programs to reach that community. The possibility that this is an issue in health care is supported by the literature.

Policy

Stanhope and Lancaster (2006) define policy as “a settled course of action followed by a government or institution to obtain a desired end” and then argue that “policy distinguishes the options from which individuals and organizations make their health-related choices” (2006, p.109). In other words, health policy is public policy that affects the services, options, access to care, and costs of health care to the population.

Public policy is critical in determining what governments decide not to do, and it also makes a significant statement as to what governments choose to do. Public policy can be regulatory, or it can address the distribution of resources and/or collecting of resources such as taxes or all of these at the same time (Dye, 1972). Another way to look at public policy is as dependent or independent variables. Public policy is viewed by how it influences the environment or how the environment affects public policy. In addition, public policy can be viewed from a political science approach as stated by Biernier and Clavier (2011). From this view, public policy is a process (and not an event) in which determinants of public policy are considered.

As states determine the array of health services to offer to their citizens, although they prefer less federal regulation they should consider the recommendations of Schneider and Ingram (1989). Those recommendations would allow them to customize their programs and at the same time meet the needs of their communities.

States with a stronger economic base have better health outcomes. This indicates why some of the poorer states in the United States have worse child health status than the more affluent states, as the difference between Hawaii with the number one health ranking, as ranked by the United Health Foundation (2008) and Mississippi with the 50th

health ranking. The median income for Hawaii is \$67,402 and for Mississippi, it is \$39,031 (U.S. Census, 2013). This is almost a \$30,000 difference, which may have an impact on the health status rankings. Marmott (2006) concludes that people living in states with lower average incomes have worse health outcomes than individuals living in states with higher average incomes. This implies that healthy individuals are necessary for a healthy economy and health policies may do well to capitalize on this relationship as well as a healthy economy that promotes healthy individuals. It can also be said that a healthy economy is necessary to have healthy individuals. As investments are made in children's health, investments are made toward our future by moving towards a healthy, working adult population. With regard to children, it is important to remember that health can also affect their ability to grow and learn, so health policy is critical to their growth and development.

Children's Health Policy

When discussing policy related to children, it is also important to look at larger policies related to the health and health related policies in general. The involvement of parents, the understanding and interaction with policy makers and health programs also have a direct effect on the health of their children. Therefore, the following literature review will focus on overall health policy as well as health policies related specifically to children.

Currie and Reichman (2015) observe, "we can't think exclusively about health policy when considering policies to promote child health" (2015, p. 4). They contend that parents' income and education are protective factors. This again makes the connection with a healthy economy affecting health. Children's policies are often a combination of

many policies patched together between federal, state, and local policies. Some policies target access, others target specific diseases, and the health of the mother before and during pregnancy. Some focus on poorer children and others are more general (Currie and Reichman, 2015). This makes it challenging when analyzing specific health policies related to children.

Flores and Tomany-Korman (2009) stated that minority children tend to have more problems related to health, the ability to use health services as well as access to health care. They also found that certain disparities were specific to minority children. Lau, Lin, and Flores (2010) also found that minority children have more health problems. Specifically, they identified that Hispanic children had particular difficulty with the disparity of limited access to a personal doctor or nurse. However, regarding the Hispanic population, Hunt, Schneider, and Comer (2004) discuss that acculturation is often seen as a variable related to health disparities in minority communities. In the Hispanic community, the level of acculturation may adversely relate to health status. In other words, a less acculturated Hispanic immigrant may be healthier.

In a study of 887 families, Lave et al (1998) found that when children had access to health insurance that there were positive health outcomes. In addition, the families did not use the system excessively, but were appropriate in the utilization of health care services. Medical homes are identified as important factors. The literature shows that children with a medical home or regular place to receive health care have better outcomes than those without a medical home (Commonwealth Fund, 2008). Bethell et al (2010) stated that children with health insurance fair better with health status. She states that even with health insurance that children with private insurance fair better than children

with private health insurance. The problem with care coordination is that varies across the country. Lau, Lin, and Flores (2010) state that there should be ongoing monitoring of interventions for these disparities in minority children.

Model programs should include more than just access to medical care, but will also include mental and behavioral health care as well as support for the parents to provide for their children. This is broad-based but includes such areas as appropriate housing, environment, a living wage, and access to care. In a more recent study, Berdall, Friedman, McCormick, and Simpson (2013) found that Hispanic children have made great progress in many measures of health, even though there are still disparities in income and access to care. Currie and Reichman conclude that “health and health policy should be viewed broadly and consider policies beyond those that focus narrowly on access to health care” (2015, p. 8). Currie and Reichman (2015) also recommend that there is the focus on decreasing the fragmentation of children’s health to minimize overlooking the children in children’s health care programs.

Community-Oriented Programs

Another area of policy that needs consideration is in the area of community-oriented programs and community based research. When comparing the Mission Statements between the two public health agencies, Washington seems to put more value on the opinion of the public. Moreover, Washington and Arizona both have Public Health Improvement Plans, but Washington’s plan articulates a more inclusive approach where they work closely with the public in designing programs that meet the needs of their community. Washington shortened the title to the “Partnership”, indicating a partnership

with the community. Arizona has a strategic plan that has more emphasis on the department leading in the community and less emphasis on partnership.

There are several ways to describe community inclusion when having health programs in the community. Sometimes it is named community- oriented or community-based. When the community is included “a partnership approach that is equitable involves community members and organizational representatives all aspects of the research process” (Israel, et al. 2001, p. 192). The similarity between all of these titles is that the community is included. In the past, some programs were developed and conducted without community input from the target community. As the result of the success of the Healthy People (HP) 2010 objectives, where inclusion of community participants was required, the HP 2020 advisory committee stated in their report that community participants are critical to meeting program goals (HP, 2020). Wallerstein and Duran (2010) also found that community involvement in is promising in the effectiveness of interventions. However, there are still challenges in understanding the how and type of partnerships and participation that are most effective to enhance the integration of science and practice.

Sometimes health planners and researchers describe communities that are hard to reach as a barrier to community inclusion. Usually this means that the population is hard for health care workers and researchers to find, meet, talk with and serve (Eng, Parker and Harlan, 1997). However, without community inclusion programs will not achieve the desired result. Initially it appears that programs and research move more quickly and easily without community inclusion because community inclusion may slow down the process. To include communities requires flexibility in schedules, extra effort for the

public health professional, or a change in meeting location, such as workplaces for migrant farm workers. Language may also be a barrier as identified in the Cultural and Linguistically Appropriate Services (CLAS) standards. (U. S. Office of Minority Health, 2001) To help address these issues, some communities developed lay health worker programs to allow members of the community to reach out and work with the community to provide and address specific health disparities and eliminate barriers to care. (Eng, Parker and Harlan, 1997) Passive participation is the opposite of the partnership approach in which all are involved in assessing, planning, and implementing needed community changes (Ndirangu et al 2008, Timmerman, 2007).

There is no evidence in the literature that agency-driven program planning and implementation works best. To the contrary, Christopher, et al (2007) discusses the importance of including community members when conducting research or program development targeting a community. Without input from the community program design may not be effective in getting the desired results, such as eliminating the health disparity. Community inclusion takes more time and a change in approach and practice to include community in agency plans. However, without the community, the plans may not be as effective as desired. There is a saying in some communities, not about me without me. This would indicate the importance felt by the communities of including the community activities whether it is program planning or research (Kretzman and McKnight, 1993). Cashman et al (2008) also discussed the importance of including communities not only on the front end of planning, but also during the data analysis phase. Cashman et al, (2008) found that although the roles and skills of the community

were different from the researchers, they were complimentary and helped with the eventual interpretation of the data.

Community Trust

Some communities may be distrustful of governmental agencies. Using community members as active members of the team help them feel engaged, included and valued, therefore more likely to provide input and follow through with the health programs. In many communities, such as American Indians and African Americans, they are suspicious of health-based research and programs because of negative history. American Indians have participated in many research projects and have been portrayed in ways that they did not approve or agree. African Americans still discuss the effects of the Tuskegee syphilis study (Thomas and Quinn, 1991). However, with Hispanics, the history may be different. The challenge may be related to immigration and language issues. The community may not be as comfortable coming forward and expressing their opinion and/or participating in research and program development in their communities (Bergmark, Barr, and Garcia, 2010). “Latino immigrants confront many barriers to accessing medical care in the U.S., including lack of information, difficulty making appointments, cost, lack of insurance, transportation, lack of cultural competency, language, and long waiting times” (Bergmark, Barr, and Garcia (2010). A study conducted by Bergmark, Barr, and Garcia (2010) found that many Hispanics, although not close to the border of Mexico often return to Mexico for health care. They found that although it was a great distance it was worth the travel because they felt the care was better and that the provider “had their best interest at heart” (Bergmark, Barr, and Garcia, 2010). They also found that they did not make trips specifically for health care, but would

visit a health care provider during a trip to visit family. This means that Hispanics may not have been practicing prevention or that conditions were in the later stages when diagnosed.

Christopher et al (2008) defined two levels of trust that must be addressed to engage communities in research and program implementation. The first level includes:

- Acknowledge personal and institutional histories
- Understand the historical context of the research
- Be present in the community and listen to community members
- Acknowledge the expertise of all partners
- Be upfront about expectations and intentions

The second level includes:

- Create ongoing awareness of project history
- Re-visit the first-level recommendations with potential new partners
- Match words with actions

Christopher et al, (2008) found that trust is important to establish, but that it may be different in each community. Addressing these levels of trust is critical in developing relationships with a community as a best practice, and to have the best information and outcomes for a program.

Public policies can affect health in numerous ways. The IOM (2011) and Macinko and Silver (2012) discuss three types of public health laws and policies that affect health:

1. Infrastructural: So-called “enabling” public health statutes, which typically specify the mission, function, structure, and authorities of the state or local public health agencies (also known as health departments).

2. **Interventional:** Federal, state, or local law or policy designed to modify a health risk factor.
3. **Intersectoral:** Federal, state, or local law or policy implemented by a non-health agency for a primary purpose other than health, but which has intended or unintended health effects. (IOM, 2011)

These public health laws define the type of access to health care, financing, and eligibility for health services for children. These laws help to define the different approaches to health policy of the states, particularly in light of Arizona's de-funding its CHIP program. States have discretion when determining the types of health care services, such as children's health insurance and prevention programs, maternal and child health programs that are available to their respective populations.

Economic Impact on Policy

Economics have a great impact on the health care of children. There are disagreements in the literature regarding funding for health services, which drives the economic policy related to health. Marvis, Chang, and Cosby (2008) state that wealth equals good health. As policies are developed, they affect employment or unemployment. They also influence health. Marvis et al. have noted that "...improving health has a substantial economic return and is thus a productive investment" (2008, p. 46.). Public policies related to job creation and minimum wage may influence health outcomes.

As observed in the initial analysis between Arizona and Washington, it was found that Washington's budget for public health spending is 3 times that of Arizona. Mays and Smith (2009) found that there is an inverse relationship between public health spending and medical care spending. The more money spent on public health, the less need for

medical care spending because of the prevention component of public health spending. Singh (2014) states although it may be difficult to make a definitive association between public health spending and health, financial investments in health have the potential to improve the health of a community. Mays and Smith, (2011) found a substantial improvement in mortality rates with an increase in public health spending. To the contrary, Marton, Sung, and Honore (2015) found that an increase in public health funding causes an increase in morbidity and in some instances an increase in mortality from diseases such as heart disease. Even so, Singh (2014) supports the notion of higher funding for public health services. There is a tension between whether spending alone is a factor in health outcomes. Evidence shows that both may be necessary to achieve positive outcomes.

The IOM (2011) identified the importance of timing when it comes to introducing laws and policy in order to be most effective in improving the public's health (IOM, 2011). In the area of health policy, Sharkansky (1982) believes that although states have a lot of latitude over how they spend money on services that they spend only a fraction on administrative services, which would include health. As already discussed, in 2010 Washington ranked 22 for state public health spending with \$36.48 per capita. Arizona, on the other hand, ranked 46 for state public health spending with \$12.78 per capita. That is a significant difference in spending between the two states: Arizona spends only one-quarter of what Washington State spends in public health. This may be a demonstration of the constant tension that often exists between funding health and reducing the state budget. However, the significance of the relationship between health and economics is often overlooked. The healthier the citizens of a state, the more they can contribute to the

economic health of a state. Economics and economic policy also have an impact on health outcomes.

Public policies related to job creation and minimum wage may impact health outcomes. According to the IOM, from an economic standpoint, the cost of not providing adequate care has an impact on overall healthcare expenditures (IOM, 2003). Those without insurance often use hospital emergency rooms for health care or wait until they are very sick to seek care. This is a much more expensive and less optimal form of health care. This could have a huge impact on the health of children.

Cost, access, and quality have long been considered major factors in health policy. The federal and state governments and consumers want to help providers ensure quality health care. Health information technology capabilities, such as e-prescribing, may help to improve access and quality while decreasing the cost of health care (The Forum, 2009). Much of our country's health system focuses on treatment after the fact and not much attention given to prevention or health promotion. The Prevention Institute believes that this focus on treatment and not prevention has a negative impact on the prosperity of our nation by not investing in resources that address determinants of health (Prevention Institute, 2008). Again, this investment in health, especially children's health can make a significant investment in the future of a state and nation.

CHAPTER 3: METHODOLOGY

Background and Introduction

The original purpose of this study was to identify what has kept Washington overall healthier than Arizona. However, during the course of the study, there was an unexpected and counterintuitive finding. As a result of this finding, this research focused on the differences of the health status of Hispanic children in Washington State and Arizona. Although overall Washington State residents are healthier than Arizona residents, the Hispanic children of Arizona have a better health outcome than the Hispanic children of Washington State. This study proposed further exploration of the data of Arizona and Washington, with a brief review of other states. The intent was also to determine what policy changes are necessary for a state like Arizona to improve its child health ranking, particularly with Hispanic children. To further the examination, health administrators in the public sector (State and County health), federally funded community health centers, other partners and recipients of the child health services were interviewed in each state. There is a set of questions that asked of each interviewee. The list of interviewees is found in Appendix B. The list of questions for the interviewees is in Appendix C. The first four questions are related to structure, state administration, and policy related to the setup and funding of children's health programs (Appendix C). Questions five through nine are related to cultural competence and outreach to the Hispanic community. Questions nine through fourteen related to more general related to quality, success, and challenges of the program. The state agency administrators were asked all fourteen questions. Directors of the county health departments and community health centers answered questions five through fourteen (Appendix C). The questions

focused on services and outreach to the community which were identified by the IOM as important areas for research. The IOM (2011) identified areas such as looking at social factors and health relative to policies as areas for research. In addition, economic and political factors that help to understand the relationship between policy and health were identified as important. Therefore, this study provides a description and possibly generates theory that can inform policy makers.

Conceptual Framework

This study is a comparative case study research that uses the Cross (1989) Continuum of Cultural Competence model as the conceptual framework. By using a comparative case study model there can be control for the similarities allowing for the differences to explain the research area and to examine the factors influencing children's health in Washington and Arizona. Case study research allowed the researcher to analyze the cases utilizing both quantitative and qualitative data (Exworthy, 2011). Yin (2009) defines case study research as "an empirical study that investigates contemporary phenomena within a real life context, when the boundaries between the phenomenon and context are not clearly evident and in which multiple sources of evidence are used" (p. 18). Case studies are best used when the researcher has a "how" or "why" question and has minimal or even no control over the variables (Exworthy, 2011). Eisenhardt (1989) also states that the case study research can provide three additional outcomes: it can provide a description, test theory, and generate theory. The case study informs how to explain the differences and perhaps how other states can improve their health ranking. Washington and Arizona were selected because as stated previously, there is a why

question related to the differences in health ranking between these two states and how this carries over to the health of Hispanic children.

A comparative case study is an iterative process. Therefore, throughout the analysis, more variables and observations materialized further describing the differences between these two states. The research focused on identifying differences in cultural competence and public health policy between these states.

Another aspect of case study research focuses on qualitative data. Key policy makers were interviewed to help inform the discussion and description of the two states. The interviews generated additional information to further explain why these differences may exist. Based on some of the theories discussed and the approach to decision making, the interviews helped to inform what priorities or programs have the greatest impact on health status; particularly policies regarding public health funding. Is the general funding or the targeted funding that makes the difference? The interviews may help determine if policy or policymaking matters when it relates to health status and health ranking.

The case study helped to explore the differences in health status among Hispanic children in Arizona and Washington. The researcher believed that a better understanding of the differences would help to improve the health of Hispanic children not only in the states of Washington and Arizona, but across the country as a whole. The research questions used to understand and study these differences found in Appendix C.

Research Design

This section describes the research methodology and why the comparative case study method was selected. In addition, this chapter discusses a) the sample; b) the research questions; c) the method of data collection; d) how the data was analyzed and

synthesized and; e) the limitations of the study. The qualitative research design was used for this research as opposed to quantitative research because of the complexities of the issue of health status. Quantitative research would not elicit the rich information obtained through interviews and interpretation of policy implementation. Quantitative versus qualitative would have given frequencies of occurrences, numbers but no explanation behind the numbers.

In the initial review, it was already determined that the health status of Hispanic children was lower in Washington than Arizona. The quantitative data did not explain that phenomenon; therefore, the use of qualitative research was the method selected to provide analysis and description to the health status data. The intent was to bring out the rich meaning behind the data to help distinguish the differences in the states.

There was already data to determine that there were differences in the health status of Hispanic children, but no clear explanation as to the why. The case study is an intensive analysis of a problem or situation. Merriam (1998) describes case study as follows:

A case study design is employed to gain an in-depth understanding of the situation and meaning for those involved. The interest is in the process rather than outcomes, in context rather than a specific variable, in discovery rather than confirmation. Insights gleaned from case studies can directly influence policy, practice and future research. (p. 19)

This research was well suited for Merriam's (1998) criteria because the intent was to find a better understanding of the differences in health status and not just the mere fact that the differences existed. Purposive sampling was used to identify the samples for this study. Purposeful sampling is seen as a series of choices to identify the sample and where research will be conducted. The research sample is tied to the objective and research

questions. Individuals that were directly involved with the delivery or policy making related to health care of Hispanic children were sought in both states. Two main criteria guided the selection of participants:

- Should work in official positions providing health care to children in general and Hispanic children in particular
- Should work in either in State government, a community health center or an official community-based organization.

The research sample included eighteen individuals, nine from each state. They included administrators in State Health Departments, State Medicaid Agencies, Local (County) Health Departments, Community Based Organizations, and public universities. The individuals were not of the same rank or position in their respective organizations. All of the initial requests went to agency heads who selected the individuals that would participate in the research. The case study focused on health agencies to seek to understand the state's position on providing health care to Hispanic children. In seeking to understand the research questions were devised that fit into the conceptual framework. Some of the information needed was related to agency budget, structure, program, policies and outreach to the Hispanic community.

Following is the summary of steps used in the research that will be discussed in more detail after this summary list.

1. Research of program budgets and agency policies was conducted prior to the literature review.
2. A literature review was conducted prior to help inform the interview questions and process to conduct the research.

3. A proposal defense was conducted and Institutional Review Board (IRB) approval was obtained to proceed with the research. Potential participants were contacted by email, including the including the approved consent which described the research.
4. Semi-structured interview questions were asked of the eighteen individuals in the two states of Washington and Arizona.
5. The interview data was transcribed by the researcher after each interview and then deleted.
6. After the transcription, the data was analyzed and placed into categories. Further analysis was conducted within the identified data categories.

The background research included a comparison of state demographics, state budgets, state programs targeting children and culturally considerations in the provision of health care. The primary source of the data was secondary data obtained from U S Census data, health-ranking data from the Centers for Disease Control and Prevention (CDC), America's Health Ranking, and the United Health Foundation. CDC determines the health ranking data for each state by compiling and analyzing morbidity, mortality, and other health-related data to determine the health status and health ranking of each of the fifty states (CDC, 2013). In addition to the indicators identified above additional indicators to explore are children's health policies in each state. As stated previously Washington State explored the possibility of universal health care as early as 1993.

Although the Affordable Healthcare Act (ACA) has now passed, Arizona suspended adding new enrollees to the states' CHIP program, KidsCare from 2010 until 2016. Some legislators have indicated that they are exploring methods to block the ACA.

Some legislators perceive the ACA as an entitlement and that there is too much government interference. The tables below identify the differences and variables that identified as having an impact on children's health. The analysis between these two states explored the variables further.

Data Collection Process

Each of the participants was contacted by email with a copy of the approved consent and a letter outlining detailed information on the research. The approved consent outlined the participants' role in the research, their rights to opt out at any time, that agreeing to the interview was their consent to participate in the study, and that anonymity would maintain throughout the research. In addition, the participants were informed that the interviews would be recorded and transcribed verbatim by the researcher. The transcriptions were maintained with anonymous identifying information. After being transcribed, the interviews were deleted.

After contacting each of the participants, dates were set for the interviews. The data was collected primarily via face-to-face interviews. The researcher traveled to Olympia, Washington, the capital of Washington where many of the program administrators were located. The researcher was in Olympia, Washington for three days based on the interview schedule conducting face-to-face interviews. Through the process of interviewing, other individuals were identified that had additional input to the research. Some of these were contacted while in Washington, others were not available and those interviews were conducted by telephone at a later date. All of the interviews in Arizona except two were conducted in person. These were conducted by telephone as a request of the interviewees. The interviewees were asked the same questions. (Appendix C). Of all

of the individuals contacted only one refused, but the researcher was able to obtain the information through other sources, such as the organization's website and other interviewees.

The interview method was selected as the best method to obtain the information for the research. It was determined that the interview method would be used to allow the most detailed information related to the research. The format of open-ended questions allowed for a rich mix of information and dialogue to elicit a person's perspective that otherwise may have been omitted. The interview also allowed for follow-up questions if necessary.

The interview method allowed the researcher to get information from the interviewee's or subject's point of view. It also allowed for the understanding of the subject's perception. It is an "attempt to understand the world from the subject's point of view, to uncover their lived world" (Kvale and Brinkmann, 2009, p. 1).

Challenges and Limitations

The interview method has several strengths, but it also has some challenges. To begin with as Bloomberg and Volpe (2012) have noted "first, not all people are equally cooperative, articulate, and perceptive" (p. 121). They also state that "interviews are not neutral tools of data gathering; they are the result of the interaction between the interviewer and the interviewee and the context in which they take place" (Bloomberg and Volpe, 2013, p. 121). As stated previously, the requests were made to agency heads, however, the actual interviews were held with various individuals within the organization based on the person identified as being available or having the most information

regarding the research area. It was found that there was varying degrees of knowledge, openness, and willingness to participate.

Some of the challenges of the data collection were the large amounts of data and because some of the interviewees did not always have answers to the questions, they answered either in generalities or did not address the question at all. The process of data analysis was to review the data and create categories that resulted from the analysis of the answers. The categories were as follows:

1. Funding and Structure
2. Programs and Practices
3. Outreach and Engagement
4. Challenges
5. Accomplishments
6. Good Practices

The data was placed in the appropriate category with alphanumeric codes. Based upon these categories the researcher was able to move forward with the analysis and to make conclusions and recommendations. The data categories will be discussed further in the findings.

Limitations of the study include 1) that the study is not broadly generalizable. This case study looked closely at two states Washington and Arizona. The results were specific to these two states. Although, some of the recommendations may be considered by future researchers and programs directed towards Hispanic children, overall the research results pertain primarily to these two states. Other limitations of the study were: 1) the nature of the study and analysis is based on the understanding, insight and

interpretation of the researcher and; 2) the willingness of the interviewees to be open and transparent when answering the interview questions. In addition, the research sample was limited. The data collected was limited to those individuals involved in the program and willing to participate in the research. In sum, this chapter focused on the process of contacting the interviewees, the interview process, and organization of the data. In addition, there was a discussion of the challenges of data collection and the limitations related to the methodology of generalizability of the outcomes.

CHAPTER 4: FINDINGS AND ANALYSIS

This chapter will report and discuss the data obtained from the interviews with administrators and other health care advocates in Washington State and Arizona. The chapter is organized into six sections: 1) Agency Funding and Structure; 2) Programs and Services; 3) Outreach and Engagement; 4) Challenges; 5) Accomplishments; and 6) Good Practices. There will be a focus on the discussion of the findings captured during the interview process of health administrators in Washington State and Arizona. The chapter will also focus on the analysis of the findings. The analysis will follow the findings in each section. The discussion supports the conceptual framework of this dissertation presented in a previous chapter.

The implications of this information could inform attitudes, knowledge, and beliefs related to providing health care to and the health status of Hispanic children. The information obtained could inform current and future program administrators on good practices to help design and deliver services to Hispanic children and their families, and improve the health status of these communities.

Table 5 below summarizes the findings from the interviews. A full discussion and analysis of the findings follow.

Table5

Summary of Findings from Interviews

Category(as mentioned by interviewees)	Washington	Arizona
Agency Funding And Structure	<ul style="list-style-type: none"> • \$36.48 per capita public health spending • State Health Department, • Local Health Departments – semi autonomous • Federally Qualified Community Health Centers • Community-based Health Organizations • Research programs at State University 	<ul style="list-style-type: none"> • \$12.78 per capita public health spending • State Health Department • Local Health Departments – autonomous • Federally Qualified Community Health Centers • Community-based Health Organization • Research programs at State University
Programs and Services	<ul style="list-style-type: none"> • No specific health programs targeting Hispanic children at the state level. • Minimal number of targeted program for Hispanic children at the local level 	<ul style="list-style-type: none"> • System of community-based programs, including the use of Promotoras (community health workers) Works with a

	<ul style="list-style-type: none"> • Community-based level majority of targeted programs at community health centers. 	<p>counterpart health department in Mexico.</p>
Outreach and Engagement	<ul style="list-style-type: none"> • Outreach and engagement at local level, 	<ul style="list-style-type: none"> • Moderate outreach and engagement at State level. Most outreach through CHCs and CBOs
Challenges	<ul style="list-style-type: none"> • Reaching the community • Cultural Sensitivity 	<ul style="list-style-type: none"> • Social determinants of Health • Delivering Quality Care • Quantity of people needing help
Accomplishments	<ul style="list-style-type: none"> • Legislature funding of specific Program through the University 	<ul style="list-style-type: none"> • Public Value • Strong leadership
Good Practices	<ul style="list-style-type: none"> • WIC • Health care funding and policies • Did not mention Promotoras 	<ul style="list-style-type: none"> • WIC • Community Trust • Community Health Centers/Staff Diversity • Promotoras

Approach to healthcare provision	<ul style="list-style-type: none"> • Universal 	<ul style="list-style-type: none"> • Targeted
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Agency Funding and Structure

Funding for the agencies in each state generally comes from the Federal government, the state government, grants and fees for services. The state health departments in both states serve primarily in administrative roles. They provide minimal direct personal health care services and most of the services they offer are not necessarily culturally specific. As one administrator from Arizona noted “We provide services in general, not specific to any group.” This position was also present in Washington. They serve primarily as oversight and a pass-through for federal health dollars to the local health departments and other organizations that are eligible to receive federal monies for health services. Another administrator from Arizona mentioned, “Although we are the department of health services, we are not services. In our bureau, we are part of the division of prevention so all of the things in our bureau are prevention or surveillance.” Likewise, an administrator from Washington stated, “funding comes to Department of Health and they contract with the local health departments to do the front work”.

As stated previously, Washington State allocates significantly larger budgets into health than Arizona. In the fiscal year 2009, Washington’s public health spending was \$243,143,000, whereas Arizona’s public health spending for the same year was \$84,324,081. Both Washington and Arizona receive large amounts of funding from the

federal government either in the form of Block Grants or Medicaid funding. Washington is a Medicaid expansion state, stated one administrator from that state. Arizona is also an expansion state, although this was not mentioned specifically during the interviews.

One of the ways that Washington State is different from Arizona is that Washington states proudly that they are willing to increase state funds to support Medicaid. They perceive having access to care as important to improving their health statistics. One of the ‘Washington State administrators explained,

Almost every time Medicaid had raised the federal matching ability we have raised the state funding to match that. So back in 1989 or 90 when women went to 180% of poverty we went there. With children 250% of poverty we went there, now uncovered adults has gone to 139% we have raised that. So in my book, one of the things that the state has invested in that has helped our health statistics For instance we have state only funding for Medicaid programs and our undocumented people can be on that program. That investment has been something that the state has done has paid off related to health statistics” (Washington State Administrator).

To the contrary, around 2010, Arizona decreased the portion of the state health care budget funded with only state dollars to support indigent health care. This indigent health funding specifically supported health care to low-income adults. In addition, in 2010 due to challenges with the state budget, the Arizona legislature chose to eliminate the funding for the state Medicaid program for children called Kids Care. When Arizona removed funding, it was the only state in the nation without a CHIP program. The funding was reinstated in May 2016 after much debate and negotiation. There was a period of six years with no CHIP program in Arizona.

Both states have local (county) health departments that are independent of their respective state health departments, meaning that the local health departments function

independently with minimal state oversight. Each local health department reports to their own local bodies of government, such as their local boards of health. Also in both states, the local health departments do minimal direct personal health care health services. They are involved more in population-based services, such as disease prevention, immunizations, food safety, epidemiology, and health education. One administrator from Washington State when discussing the services provided and the structure of one of the main local health departments that provide services to Hispanic populations stated the following. “Yakima has a large Hispanic population. It is a little strange organization; they gave up maternal child health (MCH) and at the hospital takes on most of it. They do more specifically targeted programs for that population.”

There are also Community Health Centers (CHC) in each state. Both states have a Community Health Center Association in which the centers are paying members. The Associations do not provide direct services to communities but rather provide administrative services to the community health centers. The Associations have more of a role of providing leadership and advocate for the funding and services that are delivered through the community health centers.

The community health centers by regulation are very representative of the areas that they serve. The boards of each of these centers must have a least fifty percent (50%) representation of the community that they serve as board members. The funding for the CHCs comes from the federal and state governments as well as grants and fees. One Arizona community health center administrator states:

About our operating budget eighty million dollars (\$80Million) about eight million dollars (\$8Million) is federal from our Health Resources Services Administration (HRSA) grant. Our best prayer is reimbursement, Arizona

Healthcare Cost Containment System (AHCCCS) and Medicaid. It is our largest patient population. About seventy percent (70%) of our population is AHCCCS eligible.” (Arizona Community Health Center)

In addition, several community-based organizations (CBO) are more at the grassroots level. Generally, the funding is via federal and state grants and/or fee for service. The CBOs generally developed as an outgrowth of a perceived need of the local community. Therefore, many of their programs are community driven and will look different from community to community. A CBO administrator from Arizona stated

First of all, we are Self-sufficient we have a variety of things that we do. First, we own and operate a rural health clinic. One source we own and operate is a training center, a vocational and technical training center, nationally accredited, by the accrediting bureau of rural health education schools....”

Lastly, in each state, there are University Centers with a focus on health in the Hispanic community. In Arizona, it is the Southwest Interdisciplinary Research Center (SIRC), hosted by Arizona State University. In Washington, it is the Latino Center for Health, hosted by the University Washington. These Centers focused primarily on health research and program development in their respective communities. Funding is either by grants or by monies from the state legislature.

A National Institute of Health Grant (NIH), primarily funds Arizona’s center. Other monies to fund Arizona’s center is some state and community-based dollars to support the evaluation and partner contracts. Arizona also has a P-20 research grant for diabetes titled “Every Little Step Counts” which focuses on adolescents and their parents to prevent diabetes. They also have a program titled “Keeping it Real”, a program to teach accurate culturally relevant nutrition information.

Washington's Latino Center receives the majority of funding for the center in Washington from their state legislature. "We're fortunate last June to receive \$500,000 from the legislature who recognized not only our potential, but the importance of our mission," stated a Latino Center administrator. The legislature approached the Latino Center to receive the funding. Currently, the Latino Center's major focus is on mental health issues in the Hispanic community with an emphasis on adolescent mental health.

Whereas in both states the basic organizational and funding structures are the same. Each state has a structure that includes State Health Departments, State Medicaid Agencies, Local/County Health Departments, Community Based Organizations and University programs. Each of the organizations has similar functions with the budgets coming from similar agencies, primarily state and federal governments. One outstanding observation, however, is that even with what they have Washington is more willing to expand and fund services to residents of their state. Their attitude is that having more access to health services is important in maintaining good health status indicators in their state. As more areas are explored, it will determine if funding and structure make a significant difference in the health status of Hispanic children in these two states.

Analysis of Funding and Structure

In Washington and Arizona, the state health departments have very similar programs. In both cases, a great deal of funding comes from the federal government with additional monies from the state government.

The local health departments provide services at the local level related to food safety, surveillance, immunizations, maternal child health and other population-based services. This work is done through the thirty-four local health departments in

Washington and the fifteen local health departments in Arizona. They are not specifically designed to address the cultural differences in their communities with the exception of primarily the WIC programs.

Both states also have a system of community health centers funded by the federal government that delivered a great deal of the direct and personal health services to the community in general also benefitting the Hispanic Community. Overall, the community health centers are placed in communities to offer health services to the poor and underserved. Both states had community health centers that were also specific community health centers that target the migrant Hispanic communities. Arizona's Hispanic population is dispersed throughout the state with some areas of concentration in the larger cities. Washington's Hispanic population tends to be concentrated in Yakima County in eastern Washington, although they are beginning to live permanently in other areas of the state. Some of the administrators in Washington talked about the Hispanic community as a migrant community and as though they were not aware that the Hispanic community was becoming more permanent members of the state no longer a migratory community.

In addition, in both states, individuals at the state level seemed not be as knowledgeable about the Hispanic community as those at the local or community level. This seems to be a consequence of the overall structure, where the state administrators were more involved in policy rather than direct contact with the community. This structure also has an impact on the policies that are made that influence the community. If the community does not connect to the policy makers, then the policies may not be the

most beneficial to the community. Policies are developed to help some and ignore others (Schneider and Ingram, 1997).

One interesting difference between the states is that although overall the state administrators knew less about communities, the individuals at the state level in Arizona were much more aware of the Hispanic population, where they were, and that there were some types of programs to address health needs of Hispanic children. In Washington, the Hispanic population was almost an afterthought. Although the questions raised in the interviews were related to Hispanic children, interviewees initially spoke in generalities before getting to the Hispanic community. Hispanics in Washington were much viewed as migrant groups who did not have a stable and strong community in the state by many of the state administrators.

The Washington administrators were reserved in some of their discussions of activities at the local level. There was not much elaboration on programs or activities, rather a very high-level description. It was unclear to the researcher if it was because of the lack of information or lack of comfort in sharing information. The interviewees in Arizona were more likely to expound on their services and programs than the interviewees in Washington. One of the possible explanations for this difference could be that the investigator was from Arizona and did not have a working relationship with the Washington interviewees as with the Arizona interviewees. Conversely, the local officers had many specifics about program and community, but not as much information about the flow of money or program planning from the state. It was not unexpected that the locals were more familiar with their communities and did not discuss the members in their community as an “other” or them in the way same at the state discussed the local

community. There seemed to be a disconnect between the state and the local communities. However, when talking to some of the locals in both states, they were much more aware of the stability of the Hispanic population, that multi-generations had begun to stay in the state, and were not as migratory as in the past. The locals saw much more of a need to design programs targeting as well as engaging the Hispanic community. The health departments in both states talked of having community-based programs, not particularly targeting a specific cultural or ethnic group, which is not surprising with such a high level, policy view that the state workers demonstrated.

In addition, there are programs related to the health of the Hispanic community from Universities within each state. The Universities both have centers that provide research related to the Hispanic community. The Center in Washington currently focuses primarily on mental health. An interesting observation during the interviews is a recommendation by the state administrators in Washington that I speak to the University. No one recommended during the interviews in Arizona that someone from the University program be interviewed. Rather, it was included to have a comparison between university programs targeting the Hispanic community.

Both states also have Medicaid programs. In Washington, it is called Apple Health and in Arizona, it is called the Arizona Health Care Cost Containment System (AHCCCS). Both are Medicaid expansion states. The Medicaid administrator in Washington, as well as other health administrators in Washington, mentioned several times that at every opportunity to increase access and benefits to Medicaid in their state, they took advantage of it. They were proud of the fact that the state was open to putting

money into providing health care for low-income families and ensuring that they had access to care.

On the other hand, during the course of this research, Arizona had just reinstated the funding back into the Children's Health Programs (CHIP) called Kids Care, which had been unfunded for six years prior due to budget cuts. This meant that many children in Arizona were without health care. Washington State has expanded Medicare and children's health funding in recent years. This funding is not specific for Hispanic children, but because of its availability, all children benefit.

Programs and Services–Findings

Both states have programs such as Maternal/Child Health, Women's Infants and Children's (WIC), Tobacco Cessation, Physical Activity, Vaccine, HIV/STD, Preparedness, and Food Safety. Both states receive Title V Maternal Child Block Grant funding from the Federal government.

While describing the MCH block grant funds a state administrator explained their MCH program as follows: "Though and yet in our division, we have Bureau of Nutrition and Physical Activity and WIC for instance and breastfeeding support a lot of things for children...then health systems development has Federally Qualified Health Center and Tobacco and Chronic Disease covers one of our Title V measures, which is to reduce parents that smoke and children that grow up in an environment with smoke. Arguably, it is talking about services for children in a preventive manner" (Arizona State Administrator).

Some of the most targeted programs relate to Maternal and Child Health. As one of the Arizona state administrators pointed out, "we have \$2 Million for a healthy start by

itself and \$2 million for a high-risk perinatal program. We have \$10 now for the Maternal, Infant, & Early Childhood Home Visiting (MIECHV) home visiting money.”

Washington also has a program targeting infants. That program similarly does not target Hispanic infants. “Infant Case Management (ICM) and School-Based Health Care Services (SBHS). “These programs do not currently target or provide outreach specifically to the Hispanic population rather services are provided to all Medicaid children who are eligible” (Washington State Health Authority). As stated previously many of the programs and services at the state level health departments are related to prevention and surveillance. Most of the considerations for cultural competence come through language and translation of verbal and written materials.

Washington State has recognized a special concern for diabetes. One Washington state administrator stated that “Early learning in our school system and Department of Health does a lot of coordinating... looking at what are the best policies in the literature” to address health programs and policies, “so it has a very special place in our governor’s heart for diabetes prevention.” Many Hispanic communities in Arizona use Promotora models, but do not seem to be used in Washington State. As one Arizona State administrator noted:

“So our bureau is divided into five different operational offices and two supportive so we have women’s health, and because of history health start is there but it could be a few places, where health start with the Promotora model where they follow the baby after it is born”

Analysis of Programs and Services

As stated previously most of the targeted programs are at the community level. One of the community-based programs in Arizona has thirty-two programs. They have an

Early Childhood Development, early Headstart, and migrant and seasonal head start, which is from birth to five. They have the childcare partnership that goes from birth to three years, and the family childcare option that can be birth to five years. This program is the only migrant and farm working clinic in Arizona.

Some community programs also have efforts to enhance enrollment for healthcare/insurance as part of the head start mandate to see that families get a medical home. A Community-based organization in Arizona discussed the requirements that they have to meet when providing services to Hispanic children. This was particularly related to ensuring that the children have access to a medical home.

“We have certain deadlines. We have either 30, 60 or 90 days to get them a medical home. If they don’t have insurance we work with them to find a health center, state insurance. We don’t get any money from them; we just work to help them not only for the enrolled child but also for the entire family. They don’t get onto the system, will supply applications and may help fill it out, but don’t do it for them.” (Arizona CBO)

One of the CBOs in Arizona is very active in assessing the community to determine needs and services. “I have been very progressive in terms of assessing the needs of the community. Looking and monitoring population health in our rural health clinic seeing if there are interventions that need to be emphasized, diabetes, and chronic disease management.” This particular CBO is based near the Arizona-Mexico border. They feel strongly that consistency is central in working in the community.

As discussed previously, trust is important to establish when working in the community. The following statement from a CBO administrator in Arizona demonstrates that they are working to establish trust and commitment to the community. The CBO’s administrator stated, “although the grant is done, they keep them”. This is a

demonstration to the community that the CBO is committed to providing quality services and plan to stay in the community.

We have been here providing medical services since 2003 so the community knows us very well and the community workers are part of the community and they are institutionalized as part of the agency whether we have a grant or not... once the grant is done, we keep them. And we continue the commitment to do whatever educational topic or assessment that we said that we were going to do so they are a part of the agency. So they are known very well and are engaged in the community,” (Arizona CBO)

Although many of the programs are not designed with specific cultures in mind, most of the programs offered in both states provide educational and other written materials in both English and Spanish. However, one local health administrator in Washington stated because the Hispanic population doesn't read, so it's more important to provide verbal communication.

“We have benefited in expanded health care. Apple Health offers greater opportunity for the community to seek health care. The community has been there for decades so awareness of language and culture are acknowledged in programs. Health insurance has helped to get healthcare” (Washington State Administrator).

CHIP (Child Health Insurance Program) is one of the federal programs that have been designed to address child health issues. The federal government mandates that specific guidelines are met for the CHIP programs. Each state has latitude in how they will implement CHIP. Many of them have successful CHIP programs. Most of them have above average child health status indicators. However, they still have challenges with reaching the Hispanic community, although they describe their CHIP program as one that builds partnerships. They also state that the plan is to work together to address the public health needs of the public. (Washington Department of Health, 2016)

States have discretion when determining the types of health care services that are available to their respective populations. Therefore, health policy could be influenced based on the ideology that the policymakers hold. For example, if a policy maker believes in a minimalist approach with the “state”, providing services, they would provide very little health care or develop policies that discourage individuals from requesting government services.

Outreach and Engagement–Findings

Most of the outreach and engagement and cultural competence were evident at the local level. There were various efforts involved such as going door to door to engage community members.

We do a lot of door to door; since 1997 we have done Nuestros Niño’s our children outreach campaign in which we go...it’s sort of like a census track program based a tracking system that we learned from Mexico that we learned from the state health department in Mexico that do a campaign outreach so we do this and we go door to door. The use of media to share information in the United States and for those areas bordering with Mexico information is also shared in Mexico. We do advertising we use the media the Hispanic newspaper, Yuma Daily Sun, TV - Telemundo, we’re getting ready to do a big health fair we’re using these traditional media. On the Mexico side there is a big electronic sign when crossing the border when you can see it while you stand for the 30 minutes or hour wait, so we use that to notify people of our services (Arizona CBO).

Washington also uses media to reach out to engage the community. “When we send out health messages, we use such media as radio. They have a large newspaper, but the Hispanic community doesn’t read, so they have found radio more successful, or Word of Mouth” (Washington CBO). “The Community is no longer itinerant... more stable and staying now versus in the past” (Washington CBO). In Arizona, some of the outreach to the Hispanic community is indirect with funding through Native Health to do the outreach to the Hispanic community.

Through our partnership with native health, they are hosting focus groups for the different age categories for Hispanic and American Indian. And then the staff here works with Native Health to provide technical assistance, helping to develop the tool in terms of questions, providing data to kind of guide them so we use data to guide native health in terms of developing questions, whether they are going to do testing, how are they going to validate etc. So that is the way we are engaging them. (Arizona Administrator)

Both states are required through the receipt of the Title VMCH block grant to conduct a needs assessment. One Arizona administrator stated:

So we spent 2015 all year with an online survey asking people what they thought about the needs. We also had listening sessions and we traveled the state. We asked what does it look like, what does your community look like?"

We have some unique things and then some things from a broader strategy. From a broader strategy we always paid attention to everything to the importance of diversity in hiring and who we are serving probably 75% of our employees identifies as Hispanic or Latino that makes a difference in terms cultural adaptability and understanding and linguistic sort of ability to access care in a language that you are comfortable with. Some of the unique strategies are not necessarily unique. We got promotoras. We got classes whether they are classes for diabetic other general nutrition classes where there is a nutritionist that facilitates. Then we have things down for the kids, we have all Kids Can a childhood obesity program. That's really an effort to get kids and families to start understanding why we are asking them to shift their behaviors around diet and physical activity and I think that's probably the most specific program that deals with Hispanic youth and obesity." (Arizona State Administrator).

In addition, one of the CHCs in Arizona held a large event in the community that is put on every year with about twelve thousand (12,000) people which has a focus on Hispanic heritage. An Arizona CHC Administrator stated that

Anything from doing community events to membership in the Arizona Chamber of Commerce to find more diverse suppliers of goods and services, to identify local organizations to partner with, get informal information or just get information out are some of the methods to engage community members.

Both states have organizations interested in Hispanic issues of advocacy, self-determination as well as some with primary the focus on health care. The CHCs along

with other agencies plan to soon be working on large population health issues related to cultural influences, social determinants of health. This will be a large focus for the next 10 years. A Washington University administrator when describing health programs in Washington stated:

We have ongoing relationships with what we call the six (6) leading Latino-serving agencies that we meet with quarterly. Some of the Latino-serving organizations are the Washington State Commission on Hispanic Affairs since 1971 and the Latino Community Fund of Washington. One of the Universities programs receives the majority of funding from the National Institutes of Health (NIH) with contributions of state and community dollars to fund the evaluation section of the University program.

A general philosophy and I think our public health programs are really good too. We have regional health districts across the state, but I think they are underfunded; I would like to think they need so much more money, so much more staff. Those visiting nurse programs are fantastic to help the early first steps program that is almost not existent anymore, the parent nurse partnership another really valuable Public Health program a lot of work with kinship another program that is really powerful in this state they just don't have enough staff enough money to do these strong public health programs.

Washington State has a continuing experience growth in terms of the Latino population and that is not going to change. If you go to eastern or central Washington Yakima County, there are now school districts that are now primarily Latino in terms of children.

A Washington state administrator described their nutrition programs as follows:

In terms of nutrition, I would say that it is more of a population-based approach rather than specific to Hispanics. I would say that most of our programs are, but we do try to translate into Spanish if we are doing any kind of education, but can't think of anything special right now. We're working more at a level to remove barriers that prevent people from being healthy. We are working more at that level now. Our local health departments may have more specific programs, but most of them are now working with their boards moving in the same direction.

Outreach and Engagement–Analysis

In my interviews with state administrators, I noticed a higher perception of a “they” attitude in Washington than in Arizona when discussing the Hispanic population as shared by several administrators. Yakima County has the largest Hispanic population in the state. A Washington State administrator described Yakima County as “It is a little strange organization; they gave up MCH and at the hospital takes on most of it” was somewhat of a value judgment. Rather than the perspective that the decisions made were community lead decisions that put the health department in a better position to serve the community needs. They described it as strange that the health department was responsive by targeting programs to the community needs.

Many efforts targeting the Hispanic and other minority communities tend to come as mandates by the federal government. There may be advocacy groups formed, however, their impact is less that what can be leveraged by the federal government, especially with the association of dollars allocated with the mandate. It may be a result of policy, but more importantly, it is how policy is interpreted. Most of the federal guidelines direct the programs to incorporate cultural competence. However, each state or organization sees it differently. Actually, at the state level, providing general overarching programs are interpreted as not discriminating against any person or group, but when in practice the opposite may occur. By being culturally neutral, programs may discriminate against people of color and, particularly in the context of this research against Hispanic children.

Organizations and policies need to be intentional about efforts. It is not enough to have general policies that relate to the population as a whole. When this is done cultural nuances are overlooked and/or omitted and the dominant group tends to be

overrepresented. The Program implementation, except in those areas directed by the federal government such as WIC, tends to be colorblind, or culturally neutral. Whereas being culturally neutral may be a good practice overall in not showing partiality when dealing with various cultures it may not be as beneficial when designing and delivering healthcare. According to Sharkansky (1982), states have a great deal of latitude on how they spend money on services, a standardized approach to analyzing state health policy could be useful in decision-making. The results may contribute to the literature on the best use of health dollars to improve health status and health ranking.

Challenges–Findings

This section will focus on the challenges identified by the interviewees when delivering health services to the community in general and the Hispanic community in particular.

“Social determinants there are things we have sort of have more control and some things we don’t so that is sort of the upstream battle for us how do we continue to identify what the real issues and challenges for our patients and challenges for our communities how do we identify those opportunities them or what impact in different ways look like and how does that impact our way to implement this preventative care model that we what are these barriers and determinants that deter people from being healthy we have done a good job to try to tackle and acknowledge them there are just some that we can’t touch because they are just so big. What are these barriers that elude people from being healthy? We’re always trying to push it. (Arizona Community Health Center Administrator)

This community health center worked with the community to develop a playground allowing the community to have a place to gather and play. The administrator continued to describe future plans to engage the community.

With this whole playground and the whole gateway clinic I think that was one of our more recent kind of different effort to impact the community differently how to approach physical activity differently and sort of pushing that needle with our next project in Tempe and health and wellness kind of campus that incorporates space for community gatherings, physical activity and multi-age spaces and that sort of thing but I think I biggest challenge is trying to do what we do with the

knowledge that we have in delivering quality care there are still some things that prevent us from sustaining those things” (Arizona Community Health Center Administrator)

“I think cultural sensitivity with the target population that you are serving. Have to be sensitive needs to the family and the entire needs of the population it’s not just health but food, jobs, address all of those needs.” (Washington State Administrator)

Another challenge is “to build trust and confidence in those delivery systems in Washington” (Washington State Administrator). Another challenge identified was the home visiting program budget is the greatest challenge. “There is definitely more need than money” (Washington State Administrator).

One of the Arizona CBO administrators identified the number of people that need help as a great challenge. Another challenge with the Hispanic community is having a parent or a medical guardian to buy in and to understand what is in the best interest of the child. The lack of understanding also impacts the whether or not there will be adequate follow-up and follow through. “Say we get them to go to the health visit. If they have to be sedated or get lab tests, the families then don’t follow up” (Arizona CBO administrator). One unique challenge is Arizona related to the diagnosis and treatment of asthma in Hispanic children was identified. For instance, of the Arizona CBO administrators discussed that the number of children receiving a diagnosis of asthma had decreased, but the number of children presenting with asthma symptoms and receiving asthma medications had increased. This was a specific disconnect for them with the physicians. The plan was to pursue further to attempt to determine why there was such a change in medical protocol. These challenges then influence the quality of care that the child gets and again may fit into the Vulnerable Populations model.

Challenges–Analysis

Some areas present both challenges and accomplishments. Washington is good about providing Medicaid and Medicaid expansion for the communities but is limited in targeted programs, outreach or education for the Hispanic community. Arizona, until recently had discontinued the CHIP and recently did a Medicaid expansion, but they are rich with targeted outreach to Hispanic families and their children. Perhaps a combination of both will produce quality results. Based on the discussion this combination of targeted cultural appropriate programs with funding is an example of best practice.

Whereas Washington has generous overall funding and policies related to health, they do not direct monies or programs that target Hispanic communities unless directed by the federal government. They especially have not adapted or implemented best practices regarding health for Hispanic children. They develop policies that are excellent in supporting the health of the majority population, but it does not necessarily meet the needs of cultural competence for minority populations, especially Hispanics. Washington has an excellent record for funding health. They were involved early in the expansion of Medicaid services while Arizona was slower to implement the expansion. To that end, they eliminated funding for the Children’s health insurance program until spring 2016, Washington although slow in recognizing the need to target specific strategies to improve the health of Hispanics, has provided additional funding of \$500,000 to direct toward research on Hispanic health care. Washington State is just beginning to realize that they have a permanent and not migrant Hispanic population. Arizona, because of the proximity to the border has had many years to work with and perfect strategies to address

the Hispanic population. Although, Arizona allocates fewer dollars including the CHIP program, because of experience they have a slightly better record with Hispanic children.

Hispanics seem to be more concentrated in the eastern part of Washington in Yakima County and they more dispersed in Arizona. It seems that in Washington they are mostly forgotten if you do not live in the area of concentration. Whereas in Arizona, the Hispanic population has reached a critical mass with a large presence in the state. It is readily apparent that the Hispanic population is significantly distributed throughout Arizona, and must be considered in health policy decisions at the state and local level.

Another challenge identified was the number of people needing service and the lack of funding to provide services to those in need. This goes back to the discussion related to the approach of the two states, where Washington is willing to add more money to the budget for health care and Arizona is more conservative or resistant to adding to the budget. As stated previously, states have a great deal of latitude in how they spend money. It is a matter of the will of the people and policy makers where the money is budgeted. Lastly, follow up and understanding of health instructions was seen as a challenge. That is where it becomes important that programs are designed with the community in mind. Some of the standard practices of giving instructions for follow-up may not work in all communities. It may require more labor to ensure that they understand the instructions, the importance of following the instructions, and the impact it could have on their child's health.

Accomplishments–Findings

When discussing accomplishments, there was a variety of responses. “I think it is definitely public value. When you bring something to the community that is valued by

the community that really hits home, then the community is very active and they are advocates.” (Arizona CBO) “We have strong leadership which I think has made all the difference in our ability to sort of grow and to serve the community...I think that’s what really gives us the edge” (Community Health Center). “We have earned trust of the community” (Arizona CBO Administrator).

Accomplishments–Analysis

Neither state identified a significant number of accomplishments in their states. Some of the specific accomplishments were programs such as WIC and Headstart. WIC having a strong presence in those communities was an accomplishment. Both states found their WIC programs to be successes or accomplishments in their communities. One of the reasons is that WIC “works hard to make it culturally relevant” for the communities they serve. (Arizona State Administrator) The Home Visiting program is a great accomplishment in terms of infant health, not just the Hispanic community as again most state-level programs do not specifically target cultural or ethnic communities.

One of the community-based organizations in Arizona described community trust as one of its accomplishments. Christopher et al, (2008) found that it was necessary to establish trust, but that it may be different in each community. Establishing trust would be critical in developing relationships with a community and for providing the best information and outcomes for a program. Molinari et al (2008) observed when individuals feel they live in a quality community their health is also better. Therefore, having trust in a community could lend itself to individuals feeling that they live in a quality community positively influencing the health of the community. The importance of public value as stated by one of the CBOs also feeds into the perception of a quality

community. If the community is valued, they tend to have positive attitudes about their community. An Arizona CBO also identified staff as an accomplishment and good practice, “staff because most of them are Latinos and are Spanish speaking. They speak the language and they understand the culture.” Language was identified as one of the strengths of many of the programs. However, as also stated by one of the interviewees from a Washington university program, “just because the person can speak the language does not mean that they are culturally competent, but it is definitely a start.”

Good Practices–Findings

One area that Washington State has recognized is the need to address mental health for children. “In about 2004-2005 in this state, there was a determination made by the state to implement best practices for children’s mental health and at that time a committee was established with academics that would identify what are the salient practices that we want to implement and require to be implemented across the state”(Washington State University Administrator). “We’re fortunate...the legislature recognized not only our potential, but the importance of our mission” (Washington State University Administrator). They are now currently in the process of hiring an executive director and moving into new office space. They work with faculty affiliates to hold strategic forums with elected officials, government officials, community leaders of community organizations and researchers to address the health needs of the Hispanic community.

Another organization was identified as having good practices is Chicanos Por la Causa in Arizona. They have Headstart working with children as young as 6 weeks old. They have areas where there is seasonal work. They are able to assess the health status of

the children as well as a developmental aspect. They have a component that focuses on children with special needs, looking specifically at mental and behavior health needs of the children.

An Arizona administrator stated the following when describing good practices:

From my perspective, there are three (3) really good federal programs one is WIC, It is spot on, nutrition is so important. The other program would be CHC because it is community-based and the way that they are organizationally structured they have to have fifty-one percent (51%) of their board has to be members that are using the services and then just the focus on the community and services they provide are really excellent. The third is the head start program. They invest in not just the kids but the families. Teaching them how to advocate in the school just the growth you see in those programs is really amazing. When they partner which they usually do, the community is better off. (Arizona State Administrator)

Along these lines, another Arizona State administrator stated:

Well, for instance, the whole idea of Health Start is to reflect the community you live in. I have to say that some do better than others. Being a border state I have to say it is a little easier. It's a majority/minority so in our programs what we did 2 years ago require all program managers and to take CLAS standards. We are also going to start making that a requirement in our contracts. We haven't been as successful, but were getting better at including the community at the local levels.

The Arizona State administrator continues to describe good practices as follows:

So what we do have through our office of children's with special health care needs, because we are not a part of Children's Rehabilitative Services (CRS) anymore, the focus of that office is the transition from childhood to adulthood. That's the biggest thing. Docs don't know how to manage adults with chronic health conditions such as cystic fibrosis. The children used to die at thirteen now they live to adulthood and docs don't know how to manage. But for the children themselves and their families we have a program called raising special kids helping them to be advocates and how to speak. We have some money to pay some compensation to families for the time they spend on these committees. (Arizona State Administrator)

One concern with identifying good practices was they often do not include ethnic groups. A University of Washington Administrator stated:

It makes sense, however; the best practices that were identified were not responsive to ethnic minority communities including Latinos. There were no persons of color on that committee making decisions on what best practices were to be sanctioned and legitimized across the state. In terms of best practice approach we have to understand that evidenced practices traditionally have not included communities of color at the table in terms of definition, measurement, and implementation and so their appropriateness and relevance to communities of color, Latinos are questionable. And it needs to be questioned rather than universally thought to be generalizable. What has been thought about as best practice has not been demonstrated to be a best practice among communities of color. I think some best practices obviously there is a sense of having linguistically competency needed to build the workforce so that there is an existing pool of bilingual-bicultural providers. It should also be considered that just because someone is Latino does not make them culturally astute and responsive.

Good Practices–Analysis

The University in Washington and two CBOs in Arizona discussed the importance of community inclusion when designing programs directed at the Hispanic community, but none of the other interviewees specifically discussed community inclusion. There were a number of good practices identified during the interviews. Some of them were occurring in their state, others identified were in other states but were considered among some of the best practices addressing the health of Hispanics. Some such programs were “Count on Me Kids” a school-based curriculum delivered weekly in thirty to forty -minute sessions over six weeks. Storyboards used in each session to demonstrated the skills and tools needed to make healthy decisions and resist peer pressure. On these storyboards, black, white, and Hispanic characters represented children from different backgrounds. (SAMSHA, 2016)

In Washington, their history tends to be more progressive in their approach to providing services to their communities. It appears that the policies or recognition of the

communities has not kept up with the reality. One of the CBOs in Arizona stated that community trust was one of the accomplishments of their community.

Chicanos Por la Causa, in Arizona (CPLC) was identified as having the Headstart program working with children as young as 6 weeks old. They have areas where there is seasonal work. CPLC is able to assess the health status of the children as well as address the developmental aspect of the children's health status. CPLC also has a component that focuses on children with special needs. They also address mental and behavioral health needs of the children. Headstart is a national program that has been proven to give children a good beginning for school readiness. What this program also does is include families in helping to prepare the children. The program is able to model good behavior and provide education to families which will support the children as they progress through school. The importance of this program in Arizona is that it is conducted in an organization that specifically targets Hispanic and migrant Hispanic families. The program was described as culturally appropriate with staff knowing the language and the culture of the families that they serve. Several administrators in Arizona mentioned the Headstart program. "When they partner, which they usually do, the community is better off." (Arizona Administrator)

One of the interviewees from Washington indicated that one concern is with identifying "good practices was that often the good practices are developed and implemented made without including ethnic groups. "It makes sense, however; the best practices that were identified were not responsive to ethnic minority communities including Latinos. There were no persons of color on that committee making decisions on what best practices were to be sanctioned and legitimized across the state" (Washington State Administrator)

It was a strongly held belief by most of the interviewees at the local, community and university level that the targeted communities must be included when designing good

practices. One Washington interviewee at the University stated the importance of implementation cultural competent programs including a linguistically competent workforce.

Not including community members in planning for the community is definitely identified as not a good practice. It has been stated that by doing that, there may be unintended consequences. Schneider and Ingram (1997) state that if the community is not included in design pre-conceived and possible incorrect elements may be included in the policy that can negatively affect the target population.

The concentration of Hispanics in certain areas of the state can make outreach easier, more targeted efforts, but it can also be a challenge because of the potential for isolation. As the Hispanic population continues to grow, the outreach and program development must expand to reach the community in such a way that isn't necessary when they are all in one area, all are migrant, or first generation. As they become more permanent members of the community, their needs will change as should the policies that reach out to them.

Policy makers and program administrators should be intentional about efforts to impact cultural differences. It is not enough to have general policies that relate to the population as a whole, but rather according to Cross (1989) and CLAS, it is important to have targeted culturally competent policies. When this is done cultural nuances are overlooked, omitted and the dominant group tends to be overrepresented. The way the implementation programs except in those areas directed by the federal government such as WIC, is colorblind. WIC specifically allows food choices to be culturally relevant.

Whereas being colorblind may be a good practice overall, when dealing with various cultures it may not be as beneficial when designing and delivering healthcare.

In Washington, their history tends to be more progressive in their approach to providing services to their communities. It appears that the policies or recognition of the communities has not kept up with the reality. One of the CBOs in Arizona stated that community trust was one of the accomplishments of their community health programs targeting the Hispanic and is significant in reaching any community.

Arizona tends to look for what is right in how they approach policies and practices, whereas Washington State tends to look for what's fair. Arizona is more legalistic in their approach. People should deserve to receive services, which feeds into the theory of Schneider and Ingram (1997). Perhaps Hispanics fulfill a narrative of public opinion, and are therefore affected by policy design of that opinion. The approach to policy design shows who is important and where the emphasis will be placed in the community. O'Toole, (1987) states that policy structures and relationships between targets and agencies have significant implications for democracy. "It is implied that policies are designed for target groups and communities with intended outcomes in mind. These outcomes may have unintended consequences"

Schneider and Ingram (1997) state the way people are treated can either prompt mobilization of the group or they may feel alienated and choose to withdraw. This could be another unintended consequence and have significant implications for the Hispanic community because some of them already may be distrusting of governmental agencies. Using community members as active members of the team may feel engaged, included

and valued, therefore more likely to provide input and follow through with the health programs.

In many communities, such as American Indians and African Americans, they are suspicious of community-based research and programs because of negative history. American Indians have participated in many research projects portrayed in ways that they did not approve or agree. African Americans still discuss the effects of the Tuskegee syphilis study (Thomas and Quinn, 1991).

Again as stated in the literature, Hispanics have a different history and may have challenges participating or expressing their opinion related to program development and policy. (Bergmark, Barr, and Garcia, 2010). Additionally, Bergmark, Barr and Garcia (2010) found that Hispanics would make a visit to healthcare providers while in Mexico visiting family members. The visit to Mexico was not specifically for healthcare reasons. This could mean that they may not have been practicing prevention or that conditions were in the later stages of the disease when diagnosed. One of the CBOs in Arizona has addressed this issue by having a reciprocal relationship with health care organizations on the Mexican side of the border. They share information allowing them to provide coordinated care to individuals as they live and move on both sides of the border. They even provide health messages at the port of entry to the United States allowing the important health information to be read by those entering the United States from Mexico.

Hispanics are the largest minority group in Washington. In Arizona, they are also the largest minority group, soon to be a majority minority (Arizona State Administrator). Therefore, it is very important to include and engage the Hispanic community in the

improvement of the health status of Hispanic children as well as the health of each state overall.

Community-based Research is necessary to help inform programs related to improving health status. Therefore, it is important to have community participation about research to inform health programs targeting a specific community. Arizona's close proximity to the border created the necessity to address the health care needs of a permanent Hispanic population was evident decades ago. Therefore, although the State sees itself as serving all and not a particular cultural or ethnic group, more community organizations have developed to address issues and concerns of Hispanic children. During the 1980s, Arizona was in that position of being culturally neutral. It took a while with the increasing diversity of the state before they realized that their culturally neutral approach did not work with all groups. According to the CLAS Standards as the U. S. population is becoming more diverse. This means that health care providers are interacting with people from many different cultures. This in turn demonstrates the need for more diverse providers and culturally appropriate outreach to communities served. It is important that organizations realize this as they provide health care to individuals from various cultural groups. In this regard CLAS states:

Because culture and language are vital factors in how health care services are delivered and received, it is important that health care organizations and their staff understand and respond with sensitivity to the needs and preferences that culturally and linguistically diverse patients/consumers bring to the health encounter. Providing culturally and linguistically appropriate services (CLAS) to these patients has the potential to improve access to care, quality of care, and, ultimately, health outcomes" (CLAS,2001, p. 1).

With the development of the CLAS standards, Washington, and many other states realized that targeted, culturally specific interventions were necessary and not the

culturally neutral care as provided. As Washington recognizes the growing numbers of permanent, not migrating Hispanic populations, remaining in the state, they will do the same. They have demonstrated their willingness to offer access to care, in the past and present. They will probably continue to do so in the future with the Hispanic population.

As one administrator from Washington State pointed out,

Washington State has a continuing experience growth in terms of the Latino population and that is not going to change. If you go to eastern or central Washington Yakima County, there are now school districts that are now primarily Latino in terms of children. In terms of nutrition, I would say that it is more of a population-based approach rather than specific to Hispanics. I would say that most of our programs are, but we do try to translate into Spanish if we are doing any kind of education, but can't think of anything special right now. We're working more at a level to remove barriers that prevent people from being healthy. We are working more at that level now. Our local health departments may have more specific programs, but most of them are now working with their boards moving in the same direction.

To sum up, this study found some similarities and differences between the two states. There are similarities in relation to organizational structures, and in the challenges faced in both states while attempting to serve the diverse cultures various communities demonstrate the challenges that both states face. One of the primary differences can be found in health funding. Washington has a significantly higher health budget than Arizona. A second difference, partly related to the previous one, is that Washington State is consistently among the top of the nation in health rankings and Arizona is at the bottom. A third difference is that although Washington has always had much better health status indicators than Arizona, Arizona does better specifically with Hispanic children. One of the practices that appear to be significant to explain this difference, is that although Arizona has a lower budget, it appears to have more community inclusion, outreach, and culturally appropriate programs that target the Hispanic community in

general with influences Hispanic children. This may be related to a fourth difference between the two states which is that Arizona has a significantly higher Hispanic population than Washington. While neither state has a plethora of programs to address health care needs of the Hispanic population, Arizona has some that seem very promising because they consist of community-based programs.

CHAPTER 5: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This research consisted of a comparative case study of the states of Washington and Arizona. This research reviewed child health data in order to assess child health status. Based upon the review of the data it was determined that Arizona had somewhat better health status outcomes for Hispanic children than Washington State, despite higher spending and substantially better outcomes for adults in Washington. Overall, Washington has a more progressive approach to the provision of health care and funding for health care. Washington spends about three times more for their health care budget than Arizona. As discussed in the findings, Washington administrators state they make general health policies that allow access for everyone. Arizona has more of a small government approach and is less inclined to offer broad health care programs. In 2010, Arizona defunded the state CHIP program for six years creating a deficit in available health care for some children. Taking into account all these different factors, one would speculate that all children in Washington, including Hispanic children would have better health outcomes than Arizona. However, that was not the case.

Indeed, in the most recent health status comparison report of children that included a comparison of minority children (2010), Arizona's health status for Hispanic children was slightly higher than Washington (68.1 v. 66). This was an interesting finding because Washington State has significantly better health status indicators than Arizona in many other areas. The literature shows that newer Hispanic immigrants have better health outcomes, and with Arizona being a border state, this could be a factor in the health outcomes of Hispanic children. A newer, younger generation may be part of the

explanation. Another part of the explanation may be found in the features of the healthcare services themselves.

The research also consisted of an exploration into the differences between Arizona and Washington State, with particular attention to state policies, public health spending, administrative structures, community involvement and program implementation related to children's health. Several areas became apparent that may explain the differences in health status of Hispanic children in Arizona and Washington. There areas were social determinants of health, funding and cultural competence.

Social determinants of health were mentioned by a community health center administrator in Arizona when discussing challenges. Social determinants of health demonstrate the overlapping social and economic structures that impact most health disparities. These structures include areas where people live, society, health services, economic factors and other resources (Healthy People 2020, 2014). A critical mass of relevant knowledge has accumulated, documenting associations, exploring pathways and biological mechanisms, and previously unavailable scientific foundation for the role of social factors in health (Braveman, 2011).

In order to analyze the phenomenon of Hispanic children's health in Arizona and Washington, the Cultural Competence Continuum developed by Cross (1989) proved to be useful as a conceptual framework. The Cultural Competence Continuum has levels ranging from cultural destructiveness to advanced cultural competence. These levels represent the intent to do harm to a specific target group, to complete active awareness and actions to be aware of cultural variances. Following is a more comprehensive

discussion of the Cultural Competence Continuum and the assessment of Arizona and Washington State related to the Continuum.

Cultural Competence Continuum

Washington State was determined to be at the level of Cultural Blindness to Cultural Competence. Arizona was assessed to be at Pre-Cultural Competence to Cultural Competence.

The findings were based upon the interviews conducted during the course of the research. Based upon the responses and that many of those interviewed in Washington referred to the community as either being migrant or located in the eastern part of the state, it appears that Washington State has yet to realize that they have a stable Hispanic population, rather than a migrant community. Arizona, because of its proximity to the border has had many years to work with and perfect strategies to address the Hispanic population. Although Arizona allocates fewer dollars including the CHIP program, because of experience they have a slightly better record with Hispanic children. Arizona's proximity to the border, may also account for the somewhat better health status for Hispanic children. The Hispanic paradox (Bostean, 2011) found that first generation Hispanics generally have better health outcomes than subsequent generations.

An example of Cultural Blindness by a Washington State Administrator was that Washington State develops general policies that apply to everyone. They do not develop specific policies for cultural groups. They want everyone to have access to healthcare. This is admirable and suggests Washington's progressive approach to the provision of healthcare and a willingness to serve their entire population. This also suggests cultural blindness according to Cross's (1989) Continuum in that no harm is meant, but that

cultural differences are not considered when developing policies and programs. However, administrators at the local level, especially in Yakima County in Washington were much more aware of the need to address cultural differences in order to reach the Hispanic community.

At the state level in Arizona they discussed awareness of the cultural differences. In the WIC program they adjusted the food vouchers to accommodate cultural differences in food choices. For example, whole wheat tortillas became one of the allowed food selections based upon including the desires of the Hispanic community. Arizona administrators also discussed travelling the state to include input from the community, including the Hispanic community as they developed the plan for the Maternal Child Health Block. Also, at the community health center level, it was stated by some administrators that seventy-five percent of their staff was Hispanic and/or bilingual.

Additionally, because of proximity to the Mexican border, experience showed that many residents received health care in Mexico. Based on this experience a community-based organization worked with their counterpart in Sonora, Mexico to allow the community to receive health care in both Arizona and Mexico. Further an agreement was developed to allow for the sharing of information to assure proper care and treatment and continuity of care. Washington administrators were not aware of this practice of returning to Mexico to receive healthcare occurring in their state.

Several assessment tools have been developed based on the Cross (1989) Cultural Competence Continuum. One such tool is the Cultural Competence Self-Assessment Questionnaire: A manual for users (CCSAQ) was developed by Mason (1995). This tool assessed organizations on two levels: administrative and provider services. In addition,

there was an additional assessment of the community demographics. The survey questions, on a Likert scale, assist agencies in determining their level of cultural competence.

Each survey is divided into the following categories: Knowledge of Communities, Personal Involvement, Resources and Linkages, Staffing, Organizational Policy and Procedures, and Reaching out to Communities. The results of the assessment are compared with the intent assisting in the identification of training needs. The Cultural Competence Continuum as well as the CLAS report suggests that training can help staff become more culturally competent. The CCSAQ allows agencies to identify needs of staff, provide the necessary training to improve the cultural competence of the staff. Conducting a self-assessment is one of the elements identified by Cross (1989) as an indication of cultural competence. One area of tension with the provision of cultural competence is economic and because of the resources needed for assessments and training.

Community Trust and Public Value

Community trust can be considered as one of the other areas that influence healthcare outcomes. If a community does not trust the healthcare providers they may not access the services that are offered. The Hispanic population is sometimes particularly concerned regarding immigration issues and is often reluctant to access any services including healthcare.

In Washington State the Hispanic community is still viewed as a migrant community that lives “over there” in Yakima County by those at the state level. This would suggest that the Hispanic community may not be included in discussions related to

health care programs and policies. Christopher, et al (2008) indicates that one way to build trust in a community is to be present in the community and listen to community members. In addition, each person's expertise is acknowledged. If the community is viewed as migrant, the effort to engage them may be limited if at all. This lack of inclusion affects the level of trust and may influence accessing services by the Hispanic community. The interviewees in Arizona at all levels discussed various methods to include the Hispanic community whenever possible. Examples from Arizona include a statewide needs assessment to determine the needs of the state including the Hispanic community related to Maternal-Child Health Needs.

In addition to trust of the community, one community-based administrator in Arizona stated that public value was important when delivering services to the community. She stated that the Hispanic community valued the work that the community-based organization (CBO) was doing. The community was willing to receive the health information and services provided to them, because they put a value on it. She believed that this came about because of the trust the community had in the CBO and the workforce at the CBO.

Diversity of Staff

Workforce issues are also an area that may contribute to access to care and health outcomes for the Hispanic community. The CLAS report indicates that "hiring a diverse staff does not automatically guarantee the provision of culturally competent care" (p. 9). They state further that organizations must ensure that education and training is offered to staff at all levels including subcontractors. The cultural competence of the staff is important because they interact with patients from many countries of origin and cultures.

As stated by a university administrator from Washington State,” it is not enough to just be a member of the community. You need to also understand the language and cultural nuances.” This statement further illustrates the recognition of the importance of education and training at a state level. The CLAS report also recognizes the importance of linguistics as an important cultural competence measure in the provision of health care services.

The lack of a culturally competent workforce may also contribute to some members of the Hispanic community having a preference to receive health care in Mexico. Bergmark, Barr, and Garcia (2010) found that some patients may feel more comfortable receiving care in Mexico. One of the ways that Arizona is attempting to bridge this gap is with the cross-border agreement that a community-based organization in Arizona has with the Mexican health department in Sonora, Mexico. The agreement to share health information is approved by the patients. This allows them to maintain continuity with the patients regardless of which side of the border they receive their care. Arizona also utilizes Promotora, lay health workers from the community, to help increase the diversity of health services providers.

Diversity of Programs

Arizona has several successful programs designed specifically to reach the Hispanic community. One such program was the Headstart program run by an Arizona CBO. Many of the Community Health Center administrators in Arizona spoke of specific community programs held throughout the year targeting the Hispanic community. This same Arizona CBO also discussed the importance of having the trust of the community, which helps to engage and empower the community.

The results of the interviews suggest that Arizona is more aware of the need for programs and policies to be written targeting specific communities to increase their effectiveness. In the 1980s-1990s, Arizona also struggled with the issue of applying the same program and strategies to all communities. This was seen as the fairest approach, not showing favoritism to any one group. However, with the increase of the Hispanic population (critical mass) there was an awareness of the need to change and embrace strategies to address the health care needs of the Hispanic community in Arizona.

One example of this targeted outreach relates to childhood obesity. Washington has a higher Hispanic childhood obesity rate than does Arizona. Washington's Hispanic childhood obesity is 19, the worst and Arizona is 13 (NICH, 2008). To address this concern the Arizona WIC program, while working with the Hispanic community developed specific strategies directed towards the Hispanic community to address childhood obesity. By engaging with the community, Arizona was able to incorporate certain types of health foods that were also culturally competent, such as whole-wheat tortillas. Engaging the community has the potential to allow individuals to enjoy culturally appropriate eating and managing their weight. One does not have to negate the other. This example of working with the Hispanic community illustrates that "power should be shared" (Stanhope and Lancaster, 2006, p. 402).

Arizona has programs that are more specific for Hispanics. Indeed based upon the cultural competence continuum model, it seems that Arizona has a higher level of culturally appropriate programs. Washington has progressive health policies and generous health care funding with the approach that the policies are set to assist everyone. Policies can be very impactful on the public based on the wording,

interpretation, and implementation of a policy. Based on cultural blindness, Washington does not appear to have targeted policies or targeted programs to meet the needs of the Hispanic children in their state. With cultural blindness there is no malice or intent to do harm, but more of a lack of awareness or failure to see the importance of targeting strategies.

Most of the interviewees in Washington spoke of the Hispanic population as a migrant community that lives in a certain part of the state that was mostly agricultural. Based on these interviews, the Hispanic community was not as engaged and perhaps more socially isolated than Hispanics in Arizona. The discussion of Hispanics in Arizona by the interviewees demonstrated an awareness of the population and the need to address the needs of the Hispanic community. There is a significant difference in the percentage of Hispanics as part of the population in each State, Arizona 28% and Washington 11%. Some of this may also be attributed to the lack of a critical mass of Hispanics in Washington.

Critical Mass

Smaller groups have to use more of their resources to organize, engage and impact policies than larger groups because the larger groups have more resources to draw upon (Oliver and Marwell, 1998). Therefore, it makes it more difficult for them to impact or change policies and practices. Their lack of ability to work with the majority community because of limited resources may also influence the trust that they have in the community, which then reinforces the notion that they have little impact on change. There is a significant difference in the percentage of Hispanics as part of the population in each States, Arizona 28% and Washington 11%. That population size may contribute to the way in which the populations are perceived. Oliver and Marwell, (1998) state

The problem of collective action is not whether it is possible to mobilize every single person who would be benefited by a collective good. It is not whether it is possible to mobilize everyone who would be willing to be mobilized. It is not even whether all the members of some organization or social network can be mobilized. Rather, the issue is whether there is some social mechanism that connects enough people who have the appropriate interests and resources so that they can act (p 6).

They also state that some of the subsets of communities and social networks are active and viable.

It is whether there is an organization or social network that has a subset of individuals who are interested and resourceful enough to provide the good when they act in concert and whether they have sufficient social organization among themselves to act together (Oliver and Marwell, 1988, p 6).

In Washington State, the Hispanic population has been a migrant population for an extensive period. It may have been difficult for them to connect or maintain a social network to advocate for their health issues. As the population becomes more stable, they may gain more of an ability to advocate and see changes in programs and services designed for them. It has to do with the ability to connect. If the Hispanic population is still primarily a migrant community, this would minimize or present challenges to their ability to connect compared to the larger more stable Hispanic population in Arizona. In Arizona, they are less likely to be a migrant community and have become an established part of the community as well as the public and policymaking bodies. Washington from a community standpoint is more engaged, has more voter turnout, and more volunteerism than does Arizona, but is relatively equal with Arizona on the measure of talking to neighbors. Social cohesion and civic engagement is higher in Washington. This illustrates that members of the community are integrated into the community. However, this may be less evident with the Hispanic community in Washington State than Arizona.

Betancourt, Green and Carillo (2003), state “demographic changes that are anticipated over the next decade magnify the importance of addressing racial/ethnic disparities in health and health care as groups currently experiencing poorer health status are expected to grow as a proportion of the total U. S. population.(p. 295). A basic framework that is simple can facilitate targeted interventions. Given the strong evidence for sociocultural barriers to care at multiple levels of the health care system, culturally competent care is important (Betancourt, Green and Carrillo, 2003, p. 295).

Washington has an excellent record for funding health, and was early in the expansion of Medicaid. Arizona was less so. Arizona, in fact, eliminated funding for the Children’s health insurance program until spring 2016. On the other hand, Washington although slow in recognizing the need to target and develop specific strategies to improve the health of Hispanics, has recently provided funding of \$500,000 to direct toward Hispanic health care. So we find that Washington State is good about providing Medicaid and Medicaid expansion for the communities, but is limited in targeted programs, outreach or education for the Hispanic community. Arizona is rich with targeted outreach to Hispanic families and their children. Perhaps a combination of both will produce quality results. There is a tension between resources and cultural competence. Where we see that resources alone do not guarantee cultural competence, resources are needed to do the recruitment, hiring, retention and training of culturally competent staff. States should be aware of this tension and budget accordingly to ensure a culturally competent staff.

One recommendation that arises from this study is that as policymakers and administrators design programs targeting Hispanic communities, they have to be intentional about their efforts. It is not enough to have general policies that relate to the

population as a whole. When this is done cultural nuances are overlooked, omitted and the dominant group tends to be overrepresented. The five elements outlined by Cross (1989), identify the need for agencies to value diversity and to build the capacity to address diversity. In Washington, except for the programs directed by the federal government such as WIC, many of the healthcare programs and services are developed for the general population, without consideration of cultural differences. This suggests from the interviewees perspective a limited capacity to understand or value diversity. Not considering diversity makes a programs colorblind/culturally neutral. Whereas being colorblind/culturally neutral may be due to good intentions, it may not be beneficial when designing and delivering healthcare for diverse populations.

Another area that needs additional examination is that Arizona was not accepting new enrollees in their CHIP program. Would that have an impact on the health of Hispanic children in Arizona after the initial child health data was collected? The lack of access is one of the areas that still negatively impacts Hispanic children. Another difference is in public health spending and child health programs other than CHIP in each state. Continued monitoring of these two states may uncover significant program and policies as both states move towards being more inclusive of the Hispanic community in their state.

The interviews seem to indicate that cultural competence may be an explanation for the differences. However, the Hispanic paradox may be an alternate explanation for the differences in health status of Hispanic children. Somewhat better health outcomes for Hispanic children in Arizona may be consistent with a higher representation of first generation Hispanics in Arizona than in Washington. This may be in addition to, or

instead of, a lack of cultural competence. It may be appropriate to conduct further research on the ‘Hispanic paradox’ to explain the differences in health status between the two states.

In addition, it would be informative for each state to do a cultural competence assessment of their programs, services, and staff to identify how they can improve the delivery of services to the community. A cultural competence assessment, such as the CCSAQ, could be used to help Arizona and Washington identify how to improve service to communities of color in general and the Hispanic community in particular. A cultural competence assessment would help them identify strategies, education or other factors that would help them become better agencies all around. The assessment would also allow each state to determine their capacity for diversity and how well they are adapting as the culture of the communities they serve.

A state’s health status and health ranking can have a significant impact on society as a whole. As Macinko and Silver (2012) observed, “categorizing and assessing different provisions of state policies is a complex task, made even more difficult by the absence of standardized methods.” (p. 1697). This study suggests that the development of targeted, culturally competent approaches to health care is necessary to improve the health status of population groups.

Focusing on the health status of children is particularly important as we view children’s health status through a public health lens. The primary focus of public health is population-based care and prevention. Therefore, the concern for the entire community is to improve health and prevent disease. To achieve or maintain good health status for a community, it is important to focus on the health of the children as they develop into

adulthood. Healthy children tend to become healthy adults, thus keeping our communities healthy. A healthy community could have a very positive economic impact for a state because of less money going to the health care of its citizens.

In conclusion, the interviews suggest that both Arizona and Washington value diversity, but Arizona's agencies seem to be more conscious of the dynamics of the diversity in the state. Indeed, based upon the interviews, Arizona appears to be more aware of the dynamics of cultures interacting and to have made adaptations to some of their programs and services based upon their institutional knowledge experience. Applying these elements of the Cross (1989) Cultural Competence Continuum may help to explain the differences in the health status of Hispanic children in Arizona. A recommendation would be to explore this area further in these states, to find out to what extent cultural competence is critical in the provision of quality and relevant health programs and services.

The literature on the topic claims that cultural competence should be system-wide and valued throughout the agency, and that agencies should have the capacity to assess themselves and provide ongoing training as necessary. Moreover, agencies should be able to adapt as their population changes. This is particularly important when providing services to communities of color. Having said that, cultural competence matters but so do resources. Indeed, resources are necessary to provide the proper training to address cultural issues in the community and should not be underestimated. The challenge is how and where the resources are used. The planning should be intentional and include participation from the targeted community. Planning which includes the community may require more time and effort, however "planning for cultural competency involves

assessment, support building, facilitating leadership, developing resources, and setting goals and action steps. While this process is not unique to the development of cultural competence, it is particularly well suited to the effort because of the scope and complexity of the issues” (Cross, 1989, p. 76).

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APPENDIX A

STATE HEALTH RANKING 1990-2014 ARIZONA AND WASHINGTON

Year	AZ	WA
1990	29	14
1991	29	16
1992	28	14
1993	24	15
1994	27	13
1995	25	16
1996	29	10
1997	36	10
1998	33	10
1999	33	9
2000	29	8
2001	29	8
2002	28	11
2003	26	11
2004	23	15
2005	25	16
2006	29	18
2007	29	15
2008	27	13
2009	27	11
2010	31	11
2011	27	9

2012	26	12
2013	28	14
2014	29	13

(America's Health Rankings, 2010)

APPENDIX B
LIST OF INTERVIEWEES

Washington Department of Health

- Director Community Programs
- Health Systems Quality Assurance
- Community Relations and Equity
- Children's Administration Assistant Secretary
- One county health department director
- University Administrator

Washington Association of Community and Migrant Health Centers

- One community health center director by recommendation

Arizona Department of Health

- Public Health Prevention Services
- Office of Children's Health
- Health Systems Development
- Arizona Center for Health Disparities
- One county health department director
- University Administrator

Arizona Alliance of Community Health Centers

- Special Populations Coordinator
- One community health center director by recommendation

APPENDIX C
INTERVIEW QUESTIONS

1. What is the state budget for children's health programs?
2. What percent of the state budget is allocated for children's health?
3. How are your children's health programs funded? Federal? State? Combination?
4. How are child health programs implemented in your state?
 - 4.1 What is the organizational structure?
 - 4.2 Are they all in one agency or distributed across multiple agencies?
 - 4.3 What is the admission process/criteria?
 - 4.4 Is your program the basic federal program or have additional benefits been added? If so, what are they?
5. How do your programs integrate with the community and community programs?
 - 5.1 Does the community have input into the program development and administration?
6. What outreach efforts are in place to enroll children, especially Hispanic children in public or private insurance programs?
7. How does your program address cultural issues, especially with the Hispanic community? What specific strategies do you use to reach the Hispanic community?
8. The data shows that asthma and obesity are two health challenges impacting Hispanic children. What efforts are in place to address these two health issues or other health issues?
9. What efforts are in place to ensure cultural competence for Hispanic families seeking healthcare, i.e. language, providers, health promotion/education materials?
10. How do you determine quality of care?
11. What would you describe as the most important factor in the success of your program?
12. What are the greatest challenges in your program?
13. Is there anything that you would like to share that I did not ask?
14. Is there anyone else that you would recommend I speak with regarding the state's child health program?