March 2009

Equal Treatment?

Seattle Hospitals Put to the Test

Washington CAN
WASHINGTON COMMUNITY ACTION NETWORK

NORTHWEST FEDERATION OF COMMUNITY ORGANIZATIONS

Taking Action
Making Change

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Introduction

INEQUITABLE OUTCOMES, INEQUITABLE ACCESS

Racial and ethnic disparities in health outcomes constitute a crisis, one that requires the attention of health care providers, policymakers, and communities alike. In Seattle and across the nation, people of color suffer from higher rates of mortality and illness from asthma, diabetes, cancer, heart disease, and a range of other diseases than their white counterparts. Compared to babies born in Seattle to white parents, twice as many African American babies and four times as many Native American babies die before their first birthday.[1]

This report asks the question, what role do hospitals play in addressing health inequity in Seattle? We recognize that many differences in health outcomes are a result of socioeconomic factors outside of the health care system, such as neighborhood air quality, access to living wage jobs, educational opportunity, and safe homes and workplaces. Some disparity can be attributed to access to insurance coverage, as people of color in Washington are two to three times more likely to be unable to afford health insurance than their white counterparts.

Nevertheless, health care institutions play a critical role in exacerbating or minimizing health disparities. For many people who are sick, health outcomes depend on real and perceived health care options, geographic access to care, cultural and linguistic competency of health care providers, and fears about cost and debt. These factors take on different dimensions for people of color, who on average have fewer health care options in their communities, are less likely to be insured, and face cultural, linguistic, and geographic barriers to care.

It is everyone's responsibility to ensure equitable access to health care and to work to minimize unequal health outcomes. Hospitals, and especially nonprofit hospitals that have a charitable obligation and receive tax benefits, have a particular role to play in minimizing health disparities. While some Seattle hospitals meet this standard, others fall short. This report analyzes the policies and practices of Seattle hospitals[2] to determine how hospitals are serving, or failing to serve, people of color in our city.

Methodology

The research for this report was conducted through literature reviews; analysis of public data sources, including county, state, and federal sources; and multiple community-based research methods.

Data Collection and Analysis:

The problem that this report addresses is the inequitable distribution of health care services in the city of Seattle, and the corresponding disparities in health outcomes for people of color. Baseline data on health inequity and health disparities in Seattle is derived from U.S. Census data, cross-referenced with health indicator data as collected by the King County Public Health Department. Researchers also analyzed the role of specific hospitals in providing care to underserved communities by analyzing hospital data on charity care provision and Medicaid patient loads. This data is self-reported on an annual basis from hospitals to the Washington State Department of Health, and through Internal Revenue Service Form 990s. Data was the most recent available at the time of this report's compilation.

Community-Based Survey Research:

This study seeks to understand the barriers to adequate health care for underserved populations, particularly people of color, that lead to inequitable health outcomes. Researchers sought to understand and quantify the experiences and perceptions of people from underserved communities as they related to health care access. Based on health outcomes data, researchers identified two zip codes with poor health indicators, 98118 and 98114, for survey collection. In partnership with the Washington Community Action Network, researchers conducted 200 door-to-door surveys of people of color and limited-English speakers in these zip codes. Surveys were collected by trained staff and volunteers, and respondents answered a series of questions about barriers to health care, including perceived and actual barriers to access to care at Seattle hospitals.

Methodology
(cont.)

Site-based and Telephonic Testing Projects:

This study also seeks to measure where hospitals are succeeding and falling short in providing access to limited-English speakers and people in need of financial assistance, both of whom are disproportionately likely to be people of color. Working with the research team, trained community volunteers completed in-person and telephonic testing protocols at Seattle hospitals. To create robust data, researchers completed 77 phone testing protocols and 24 site visits, including visits to multiple departments and entry points for services and information, and at different times during the day. These tests were conducted in non-medical settings for ethical reasons, and because many interactions with health care institutions relate to questions about billing, financial assistance, follow-up care and treatment options, and other general needs.

These research methods – data collection and analysis, community-based survey research, and site-based and telephonic testing projects – are the basis for the conclusions in this report. The recommendations are derived from these conclusions in conjunction with best practices research and in consultation with local, state, and national experts on health disparities.

Health Care Segregation

Geographic Barriers for People of Color

Many racial and ethnic minorities, but particularly African Americans, Hispanics, and American Indians, continue to be more likely than whites to face barriers to accessing care and receive a lower quality of care, according to the U.S. Department of Health and Human Services 2007 National Health Care Disparities Report.[3] While these gaps are improving on some measures, "across all core measures and for all priority groups, the number of measures of quality and access where disparities exist grew larger between 2000 and 2005."[4]

One factor in quality of health care for people of color is the geographic accessibility of health care facilities. An equitable health care system would ensure access to health care facilities for all neighborhoods, particularly those with greater need for health care services. The question of whether hospitals are located in the highest need areas first requires an analysis of which Seattle neighborhoods face the poorest health outcomes, followed by an assessment of whether current facilities are located to serve these areas.

Mapping Health Disparities in Seattle

The Seattle and King County Public Health Departments have tracked health outcomes according to neighborhood, and this data reveals significant geographic disparities in health.[5]

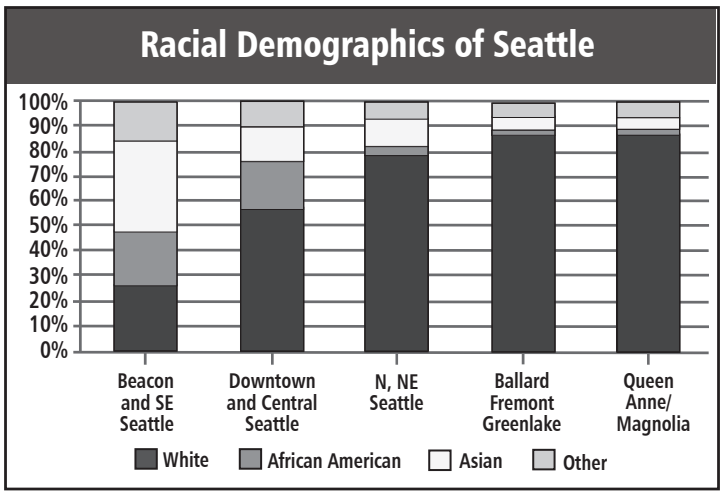

Figure 1: Source - U.S. Census

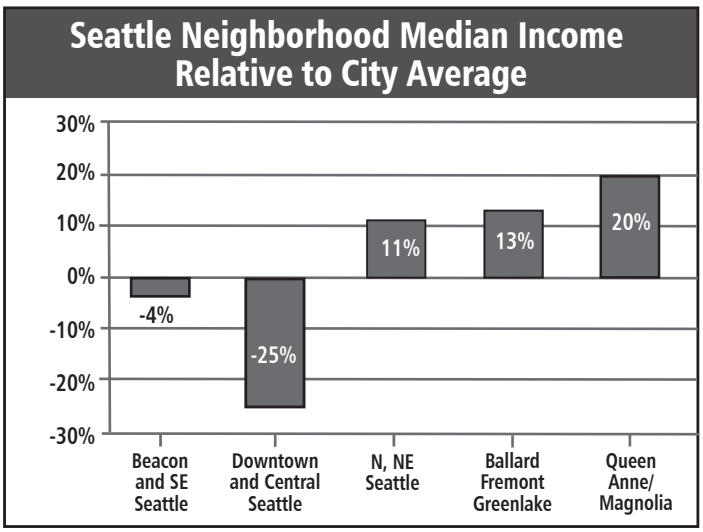

Figure 2: Source - U.S. Census

Mapping Health Disparities in Seattle
(cont.)

Overall, Seattleites in areas north and directly west of downtown Seattle are healthier than those living downtown, to the south and southeast of the city. Healthier neighborhoods have lower infant mortality, less prevalence of diabetes, less prevalence of asthma, and are more likely to have residents with health insurance.[6] These areas also have the highest concentrations of white residents and the lowest populations of people of color, are generally more affluent, and have fewer residents who report speaking a language other than English at home.[7]

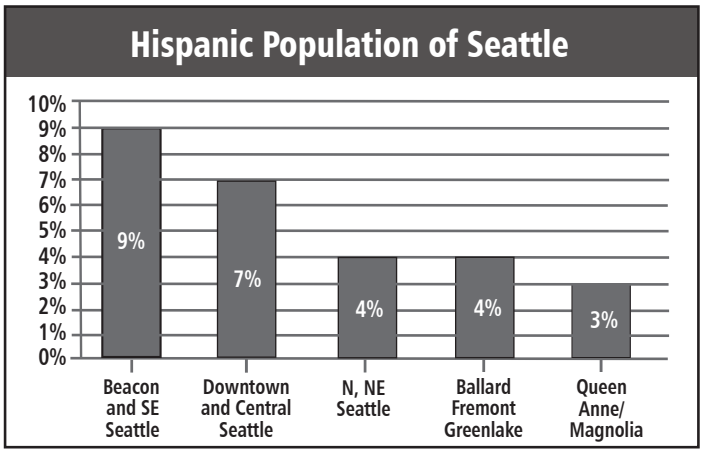

Figure 3: Source - U.S. Census

If we compare two regions of Seattle,[8] North and Northeast Seattle, and the Beacon Hill and Southeast Seattle areas,[9] we find that health outcomes correspond to race and income. In the Southeast and Beacon Hill, where almost three quarters of residents are people of color, the median income is four percent lower than the city average. North and North East Seattle are predominately white, and enjoy median income levels 13 percent higher than the rest of the city.[10] Correspondingly, these two areas experience different health outcomes in terms of several indicators, including diabetes related deaths, infant mortality, adult asthma, and life expectancy. According to every indicator, South Seattle neighborhoods with higher concentrations of people of color experience worse health care outcomes than predominantly white neighborhoods.

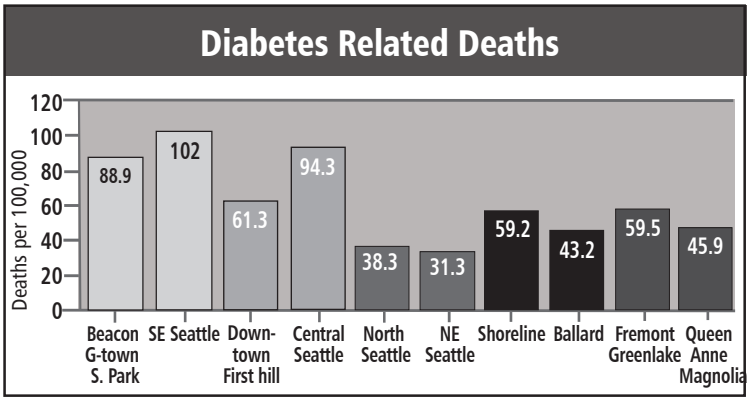

Figure 4: Diabetes related deaths per 100,000 deaths.[11]

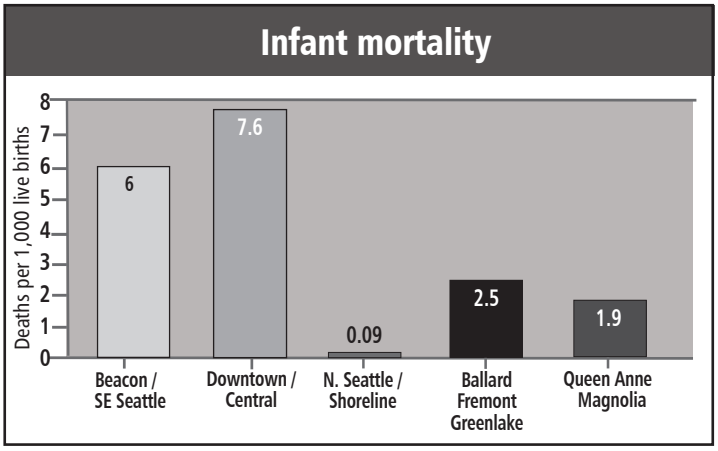

Figure 5: Infant deaths in the first year of life.[12]

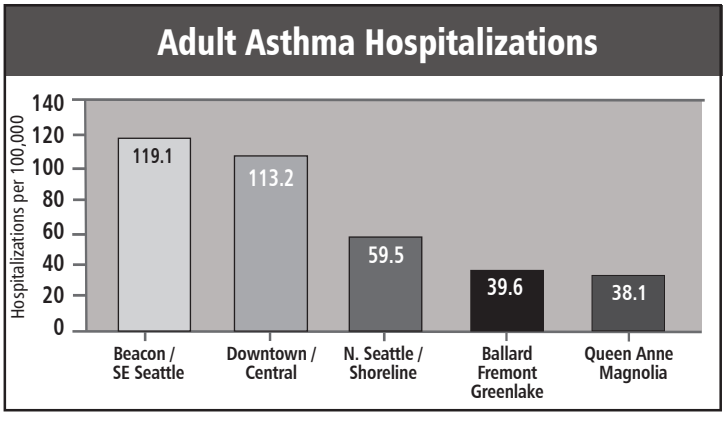

Figure 6: Adult asthma: have been diagnosed for asthma and still have asthma.[13]

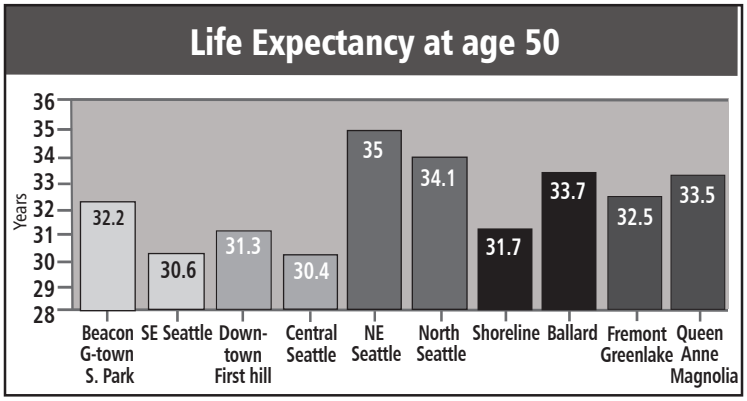

Figure 7: Life Expectancy at Age 50 is the number of years a person aged 50 can expect to live if the current age-specific death rates stay the same for his/her life.[14]

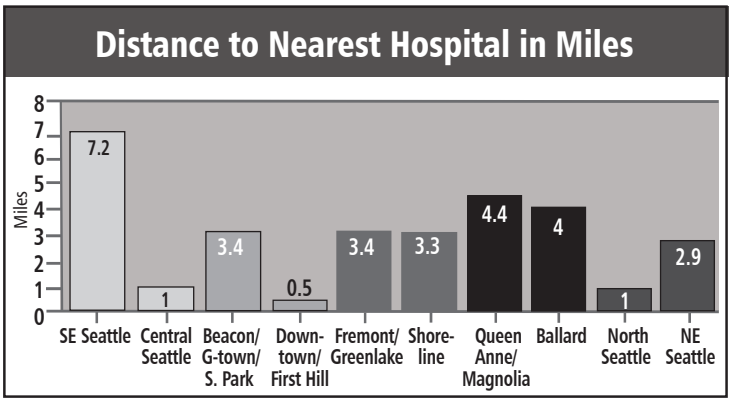

Figure 8: Distance to Nearest Hospital in Miles. This calculates the distance from a central intersection in the neighborhood to the nearest hospital.[15]

Are Hospitals Serving People of Color?

Given these disparate health outcomes, it is important to ask the question, what role are Seattle hospitals playing in mitigating or exacerbating race-based health disparities? In an equitable health care system, hospital facilities would be located where the need is greatest. A geographic analysis of the locations of hospitals and satellite clinics reveals that in general, hospitals have failed to serve Southeast Seattle, where the highest proportion of people of color live and where health disparities are greatest.

In Southeast Seattle, which of all Seattle neighborhoods has the highest percentage of people of color and where health disparities are greatest, a typical resident is more than 7 miles away from the nearest hospital, more than 2.5 miles further than the typical resident of any other Seattle neighborhood.

Conclusion:

The lack of hospital facilities in Southeast Seattle where people of color are concentrated is a cause of inequitable health care access and inequitable health outcomes. It is in the public interest to encourage hospitals that are seeking to do new construction, whether to build satellite clinics or expand facilities, to locate these facilities in neighborhoods with poor health outcomes such as the Southeast. Such expansions should be considered baseline requirements for meeting nonprofit charitable obligations, and the city and state should use the regulatory mechanisms at their disposal to ensure that new health care facilities are more accessible to people of color. The recommendations of this report provide a more thorough description of these regulatory options. Such steps will be necessary to reduce geographic barriers to health care for people of color in Seattle.

Financial Barriers to Health Care

Like geographic barriers, for many people the fear of the high cost of health care is a major barrier to receiving needed care. This is particularly true for people of color, who are disproportionately likely to be low-income or uninsured. Data analysis and community surveys demonstrate that the cost of care is a significant barrier for people of color, and hospital policies and practices play a role in mitigating or worsening this barrier.

Cost-Related Barriers to Health Care

Nationwide, African Americans and Native Americans are nearly twice as likely to be uninsured, and Latinos nearly three times as likely to be uninsured, as white residents.[16] This pattern holds true in Seattle, where people of color tend to live in neighborhoods with higher rates of uninsurance and poorer health outcomes.

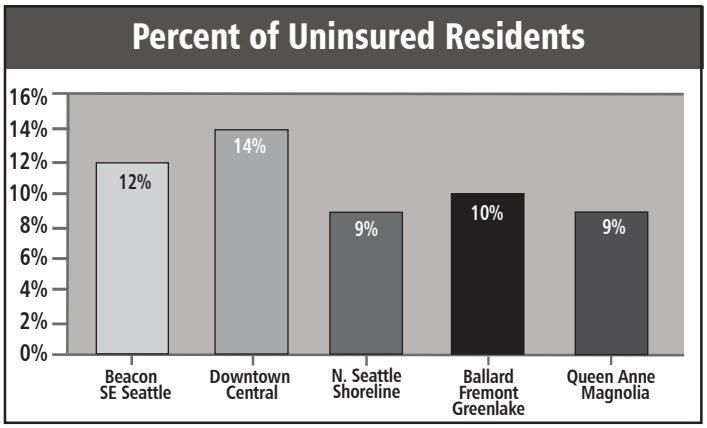

Figure 9: Percent uninsured is the number of respondents, age 18-64, who had no health insurance at the time of interview.[17]

Almost 20 percent of uninsured survey respondents reported avoiding medical care because of cost.

Fear of debt is also a barrier. Of survey respondents, 13 percent reported that they or someone else in their household has medical debt.[18] People often cannot afford to go to the hospital and are afraid to get the care they need because of the cost. Seventeen percent of respondents reported avoiding care because of fear of debt and/or having bills sent to a collections agency.[19]

The Role of Hospitals in Reducing Cost-Related Barriers: Charity Care and Financial Assistance

Hospitals should mitigate health disparities by reducing cost barriers for people of color, who are more likely to be uninsured or underinsured. Hospitals, and particularly nonprofit hospitals, have an obligation to provide accessible health care to people who cannot afford it. Medicaid covers many low-income patients, and state laws require hospitals to provide charity care – free or discounted care - to uninsured or underinsured patients who meet certain income criteria. Thus, two measures of how a hospital is reaching out to low-income patients are the amount of charity care and percentage of Medicaid patients a hospital treats.

An analysis of discharge data of area hospitals shows that some hospitals in Seattle are providing more charity care and serve more Medicaid patients than others. In 2007, Harborview Medical Center provided charity care at levels far above other Seattle hospitals. As a percentage of Harborview Medical Center's gross revenue, charity care provided amounted to 11.59 percent. Swedish First Hill and Swedish Cherry Hill were far behind at 1.41 percent and 1.69 percent, respectively. The University of Washington Medical Center provided 1.56 percent, and the Virginia Mason Medical Center came in last at three quarters of one percent.[20]

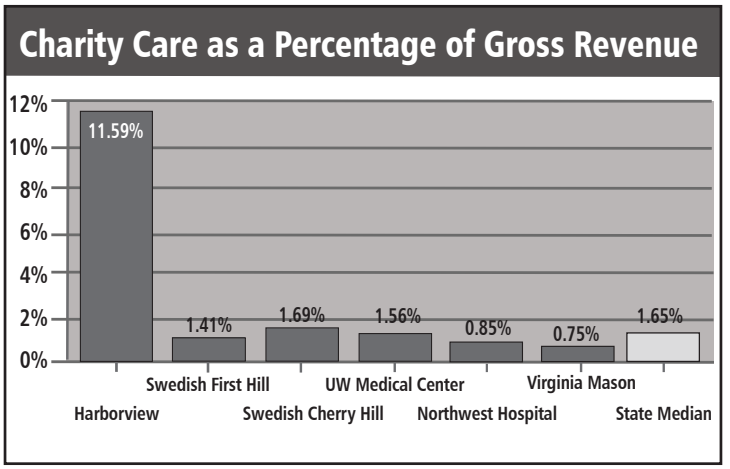

Figure 10: Source - Washington State Department of Health[21]

A similar trend was found in 2007 Medicaid revenues as a percentage of hospitals' gross revenue. Harborview again came in first at 24 percent, while Swedish First Hill and Swedish Cherry Hill were behind at 11.3 percent and 8.3 percent, respectively. University of Washington Medical Center was close behind at 17 percent and Virginia Mason lagged far behind at just over three percent. Only Harborview Medical Center and University of Washington Medical Center exceeded the state median of 14.2 percent.[22]

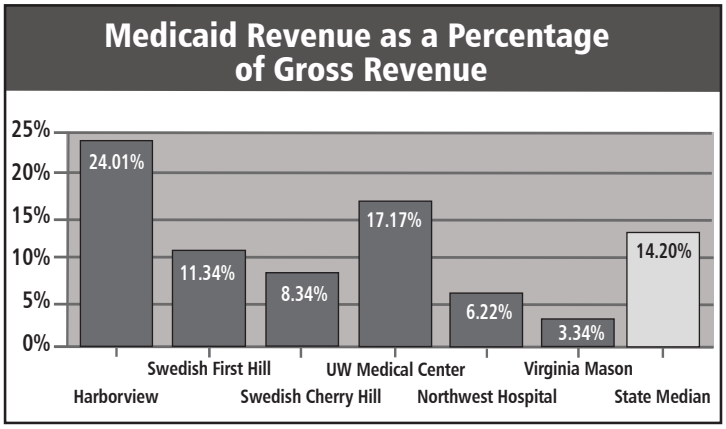

Figure 11: Source - Washington State Department of Health

A review of this data reveals that Harborview Medical Center, more than all other Seattle hospitals, is providing the most charity care and serving the most Medicaid patients. Conversely, Virginia Mason Medical Center is doing very little to make affordable care accessible to Seattle's low-income and uninsured residents.

Community survey results corroborate these findings. Of those surveyed without insurance and with incomes under $25,000, 44 percent reported going to Harborview most frequently. Thirty-seven percent reported using one of the Swedish hospitals most frequently. Of Medicaid recipients surveyed, 40 percent reported that they are most likely to receive care at a Swedish hospital, as compared with 24 percent at Harborview. Notably, despite the fact that Swedish First Hill, Harborview Medical Center, and Virginia Mason Medical Center are all within blocks of each other, only one in five uninsured respondents and only eight percent of Medicaid recipients reported attending Virginia Mason Medical Center for care.[22] These results, coupled with the fact that Virginia Mason provides less charity care and receives a much smaller amount of revenue from serving Medicaid patients, suggests that Virginia Mason could, and should, be doing much more to serve the underserved.

Harborview Medical Center's mission is to serve people who are low-income, homeless, new immigrants, and the underserved. Survey results indicate that Harborview is indeed recognized in the community as a place that you can go regardless of income, insurance status, nationality, or language. This recognition can lead to negative perceptions and/or realities. One survey respondent commented that Harborview is "overused because residents think that if you don't have health insurance, you will get care."[23] Another Seattle resident on Medicaid reported that Harborview is "overcrowded and when you are very, very ill, a minute seems like an hour."[24]

This study did not measure average wait times at hospitals. But in an equitable health care system, people who are uninsured or have language needs – disproportionately people of color – would feel comfortable accessing care at any hospital and wait times would not impact any population more than another. The fact that Harborview prioritizes caring for the underserved does not mean that other hospitals do not have a critical role to play in addressing health care disparities.

Conclusion:

While some Seattle hospitals, such as Harborview Medical Center, are providing significant care to people of color and low-income communities, others are falling short. Cost is a major barrier to health care access, particularly for people of color who are disproportionately uninsured and low-income. Hospitals that receive the generous tax-exemptions and other benefits accorded nonprofit institutions have an obligation to serve the underserved, and the clearest measures of this charitable obligation include charity care provision and service to Medicaid patients. Hospitals that are falling short, such as Virginia Mason Medical Center, should improve outreach and services to communities of color, and local and state governments should clarify these obligations and hold all hospitals to a high standard.

Language and Race

Access to Care for Limited-English Speakers

How a hospital treats people who speak languages other than English is a significant factor in access and quality of care for people of color. According to the 2000 U.S. Census, 20 percent of Seattle residents reported speaking a language other than English at home.[25] Nationwide, one in five limited-English speakers avoid seeking care altogether because they are unable to access care in their language.

The right to culturally competent health care in a person's language is written into federal law, in Title VI of the 1964 Civil Rights Act and again clarified by the Department of Health's standards for Culturally and Linguistically Appropriate Services (CLAS).[26] Yet too often, people of color who are limited-English speakers do not receive language services or culturally competent care. Hospitals play a critical role in providing access to interpreters and to translated signage and materials. Hospitals can also create welcoming environments and culturally competent staff by hiring and training a diverse and culturally competent workforce. For this study, community-based testing was used to determine whether hospitals in Seattle are meeting the needs of diverse populations and where they can improve.

Access to Interpreters and Information

Community surveys completed for this study reveal that many families depend on trained medical interpreters to receive health care. Thirty-nine percent of those surveyed reported speaking a language other than English. Of those respondents, more than half (52 percent) reported that they rely on family members to help interpret when they go for health services or they try to get by with their limited English skills. Slightly less than half (48 percent) of limited English speaking respondents try to rely on a professional interpreter at hospitals in order to communicate with hospital staff and doctors.

Telephonic and site-based testing results reveal significant barriers to care for limited English speakers at Seattle hospitals. Testers made 77 phone calls and 24 individual visits to Seattle hospitals, in both English (40%) and Spanish (60%). Overwhelmingly, the aggregate result from this testing reveals vast discrepancies in the treatment and information provided to people based on language. While 90 percent of English-speaking testers felt like the person they spoke with was knowledgeable, helpful, and answered their questions, only 16 percent of Spanish-speaking testers felt the same way. In fact, the other 84 percent of Spanish-speaking testers were either hung up on or unable to get answers to any of their questions.

When people did receive interpreters, it was not without a struggle. Northwest Hospital transferred a Spanish-speaking caller four times before connecting her with an untrained interpreter. Another caller was transferred three times and put on hold before an interpreter was provided when she called the University of Washington Medical Center. Virginia Mason placed a caller on hold for a long period of time – more than 10 minutes - before an interpreter was finally obtained. The only exception was the report of a caller who phoned Harborview's main number and was transferred just once to a very helpful and knowledgeable interpreter.

While the lack of availability of interpreter services contributes to unequal access to health care for people of color, the different treatment of potential patients based on their language, race, or ethnicity also impacts access to care. Testing results reveal a perceived difference in treatment by hospital staff for English-speakers and Spanish-speaking, Latino testers. All (100 percent) of the English speaking testers reported being treated kindly and were thanked for their questions. Conversely, 60 percent of non-English speaking testers felt like they were treated rudely, and only 40 percent reported being thanked for their questions.

Reports from testers illustrate these results. When one site visit tester to the University of Washington Medical Center called the number of an interpreter as instructed by hospital staff, the visitor received incorrect translations and rude responses from the interpreter. Staff at Virginia Mason simply pointed a Spanish-speaking visitor to a phone number to call for information, and offered no assistance. A staff member at the Swedish Cherry Hill hospital said, "I don't speak Spanish. I don't understand anything you are saying," before proceeding to hang up on the caller. An operator at the University of Washington Medical Center simply said "no" when a caller asked, "Habla Espanol?" before hanging up.

Despite these largely negative results, one hospital stood out as providing particularly helpful services to limited-English speakers. Visitors and callers to Harborview Medical Center had the highest number of successful calls and visits, and those surveyed also had good things to say about their experiences at Harborview. One individual on Medicaid said that Harborview "is a welcoming place for low-income people."[27] Another respondent who had used Harborview's services stated "refugees and immigrants like [Harborview] better, since they always have interpreters available."[28]

Signage and Translated Materials

Translated signage and materials, as well as signage indicating the availability of financial assistance, are indications of a willingness to serve underserved patients and create a welcoming environment for patients. Effective communication about the processes surrounding interpretation and financial assistance services aids in making low-income patients and patients with limited English feel more comfortable with a particular hospital.

When people enter either the main lobby of a hospital or the hospital emergency room, they are greeted by directional or informational signs that let them know where they need to go for certain services and what services are available at the hospital. The following table details the kinds of signs observed by the Testing Project in the main lobbies and emergency rooms at Seattle hospitals.

Translated Documents and Interpreter Access: Site Visit Results
(includes both Main Lobby & Emergency Room)

	Main Lobby and ER
Provided Documents On Financial Assistance: English	√ Harborview √ Swedish First Hill √ Swedish Cherry Hill √ UWMC √ Northwest √ Virginia Mason
Provided Documents On Financial Assistance: Multiple Languages	√ Harborview (Spanish) √ Swedish First Hill (Spanish) √ Swedish Cherry Hill (Spanish)
Effective Interpreter Provided in Timely Manner	√ Harborview √ Swedish First Hill √ Swedish Cherry Hill

When asked, all hospitals were able to provide documents on how to access financial assistance programs in English. However, only Harborview and Swedish hospitals were able to provide such information in other languages (Spanish). In addition, Swedish and Harborview were both able to provide an effective interpreter in a timely manner; neither University of Washington Medical Center, Virginia Mason Medical Center, nor Northwest Hospital were able to do so when visited by Spanish-speaking testers. For example, staff at Northwest hospital sent a Spanish-speaking visitor to three different departments before finally finding a radiologist who spoke Spanish to translate; a professional interpreter was never provided.

Conclusion:

Seattle hospitals are exacerbating disparities in access to health care by failing to provide meaningful access to interpreters and translated information. Some hospitals, particularly Harborview Medical Center and to a lesser degree, Swedish Medical Center, perform better than others. However, the treatment of limited-English speakers is a cause for significant concern. Hospitals should follow emerging best practices for serving diverse patient populations, some of which are highlighted in the recommendations section of this report.

Recommendations:

Hospitals can play a critical role in mitigating racial and ethnic disparities in access to health care. By providing health care at affordable prices and offering meaningful access to financial assistance, hospitals can make services more available to people of color who are disproportionately likely to be uninsured or underinsured. The location of care also matters. Locating hospitals and satellite clinics in underserved neighborhoods where people of color and low-income people live can eliminate geographic barriers to care. For many recent immigrants, who are predominantly but not exclusively people of color, language barriers create major access problems. Hospitals can address these issues by following clear federal laws and guidelines requiring the provision of care in the language that patients speak.

Conversely, when hospitals fail to address institutional barriers to quality care, they are exacerbating health inequity. Seattle hospitals can help to reduce these health disparities by addressing financial barriers and geographic barriers to access, and by ensuring all patients receive linguistically appropriate care. Providing clear and accessible charity care policies, trained medical interpretation services, and information on hospital billing services in multiple languages are key ways that hospitals can reduce disparities. However, without these proactive steps, these institutions only serve to maintain the status quo.

Health disparities constitute a crisis, and all hospitals need to pull their weight if we are to address health disparities in our city. Some hospitals carry an undue burden, while others appear not to be doing their part to welcome patients who are underserved, unable to pay, limited English speaking, and people of color. The following recommendations can help us close the gap in hospital care in Seattle.

Hospitals should:

- Review language access policies and practices, and follow recognized standards for the provision of language services. The U.S. Department of Health and Human Services has established clear guidelines for the provision of care to limited English speakers, called the National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care.[29] These standards cover culturally competent care and language services, and encourage public notification of progress toward meeting the standards. In addition, hospitals can look locally to best practices at Harborview Medical Center, which provides a high quality of care to limited English speakers, and to other hospitals in the state and around the nation that offer toll-free numbers through which people can navigate the hospital through a trained interpreter for non-medical needs.
- Improve access to financial assistance policies and practices. Many hospitals have financial assistance policies that, if implemented fairly and widely, would improve access to care for people of color. However, since many patients are not given information or assistance needed to access financial assistance programs, hospitals should thoroughly review both policies and practices and provide adequate staff training and support so that patients can access these programs.
- Create welcoming environments and culturally competent health care staff by hiring and training a diverse and culturally competent workforce. Hiring people of color and bilingual staff is one of the proven ways to improve health care outcomes for people of color. In addition, many local and national entities provide cultural competency training for health care management and personnel.
- Build new facilities and satellite clinics in underserved areas where people are experiencing poor health outcomes. To fulfill charitable obligations and to mitigate, rather than exacerbate, health disparities, hospitals must address geographic barriers to access to care. Hospitals must put the public interest above the financial bottom line, by locating in and expanding into areas where the need is greatest.

Government should:

- Use regulatory mechanisms to ensure that hospital construction and expansion projects improve access to care for people of color and mitigate health disparities, rather than exacerbate them. The state's Certificate of Need process is designed to ensure that there is sufficient need for hospital beds and services in a particular community to justify construction and expansion. The state should consider racial and ethnic disparities in access to services when reviewing CoN applications, and require projects to explain in detail how they plan to improve access to their facilities for people of color. In addition, private nonprofit hospitals receive low-cost tax-exempt bond financing through the Washington Health Care Facilities Authority for expansion, upgrade, and new construction projects. To receive this tax-exempt financing, hospitals should be required to demonstrate how the project will lead to a reduction in health care inequity.
- Require hospitals that receive tax exemptions to meet community benefits standards that are designed to mitigate health inequity. Most Washington State hospitals benefit from tax-exempt nonprofit status, with the understanding that they will provide corresponding benefits to the community. A key measure of a hospital's benefits to the community it serves is its commitment to providing charity care to low-income patients, who are disproportionately people of color. Standards for charity care provision should be strengthened to require that hospitals offer discounted or free care to uninsured patients up to 300% of poverty and that hospitals commit to ensuring that all eligible patients receive appropriate information about available financial assistance, with clear and transparent reporting and accountability measures.

ENDNOTES:

1 Seattle & King County Public Health Department, *King County Community Health Indicators, 2008 available at* http://www.metrokc.gov/health/CHI/indicators.htm

2 The following hospitals are included in this study: Harborview Medical Center, Northwest Hospital, Swedish First Hill, Swedish Cherry Hill, University of Washington Medical Center, and Virginia Mason Medical Center.

3 "National Healthcare Disparities Report 2007", U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. AHRQ Publication No. 08-0041, February 2008.

4 "National Healthcare Disparities Report 2007", U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. AHRQ Publication No. 08-0041,February 2008.

5 Neighborhoods were grouped according to zip code.
- Beacon Hill, SE Seattle – 98108, 98118,98134
- Downtown, Central District – 98101, 98104, 98121, 98122, 98144
- North, NE Seattle – 98125, 98133, 98177
- Ballard, Freemont – 98103, 98107, 98177
- QueenAnn, Magnolia – 98109, 98119, 98199

6 Seattle & King County Public Health Department, *King County Community Health Indicators, 2008 available at* http://www.metrokc.gov/health/CHI/indicators.htm

7 U.S. Census Bureau, 2000.

8 Zip codes 98125, 98133, 98115, 98177, 98105 and 98020.

9 Zip codes 98108, 98118, and 98134.

10 U.S. Census Bureau, 2000.

11 Seattle & King County Public Health Department, *King County Community Health Indicators, 2008 available at* http://www.metrokc.gov/health/CHI/indicators.htm.

12 *Ibid.*

13 *Ibid.*

14 *Ibid.*

15 Distances calculated using Google Maps, http://maps.google.com/.

16 Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2007 and 2008 Current Population Survey (CPS: Annual Social and Economic Supplements).

17 Seattle & King County Public Health Department, *King County Community Health Indicators, 2008 available at* http://www.metrokc.gov/health/CHI/indicators.htm.

18 Washington Community Action Network Seattle Hospital Survey, 2008.

19 *Ibid.*

20 Analysis of 2007 Comprehensive Hospital Abstract Reporting System (CHARS) – Hospital Inpatient Dataset, Washington State Department of Health Epidemiology, Health. Statistics and Public Health Laboratories Center for Health Statistics/Hospital and Patient Data Systems.

21 *Ibid.*

22 Washington Community Action Network Seattle Hospital Survey, 2008.

23 Washington Community Action Network Seattle Hospital Survey, 2008.

24 *Ibid.*

25 U.S. Census Bureau, 2000.

26 "National Standards for Culturally and Linguistically Appropriate Services in Health Care," U.S. Department of Health and Human Services, Office of Minority Health, March, 2001.

27 Washington Community Action Network Seattle Hospital Survey, 2008.

28 *Ibid.*

29 "National Standards for Culturally and Linguistically Appropriate Services in Health Care," U.S. Department of Health and Human Services, Office of Minority Health, March, 2001.

NORTHWEST FEDERATION OF COMMUNITY ORGANIZATIONS

The Northwest Federation of Community Organizations (NWFCO) convenes community groups nationwide on critical public policy issues. To foster public conversation of these issues, NWFCO provides research and policy analysis. Recent reports include:

- *The 2008 Job Gap: Tough Times for Northwest Families*
- *Insuring Health or Ensuring Profit?: A Snapshot of the Health Insurance Industry in the United States*
- *The Small Business Health Care Crisis in Washington: A Survey of Pike Place Market Businesses*
- *Equal Treatment? Seattle Hospitals Put to the Test*

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WASHINGTON COMMUNITY ACTION NETWORK

With over 35,000 members across the state, Washington CAN! is the state's largest grassroots community organization. Washington CAN! fights for progressive social change at the local, state, and national levels, with a focus on issues that most directly affect the lives of Washington residents. Our strength as an organization depends on our members' involvement. Our mission is to achieve economic fairness in order to establish a democratic society characterized by racial and social justice, with respect for diversity, and a decent quality of life for those who reside in Washington State.

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