PORTRAIT OF PROMISE:

The California Statewide Plan to Promote Health and Mental Health Equity

Report to the Legislature and the People of California
by the Office of Health Equity,
California Department of Public Health,
August 2015

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MESSAGE FROM THE CHAIR
OFFICE OF HEALTH EQUITY ADVISORY COMMITTEE

Widespread, systemic inequities take a toll on the mental and physical health of our state's residents. Those who suffer disproportionately from the stress of discrimination or the constraints of poverty also suffer disproportionately from heart disease, asthma, arthritis, and cancer.

As such, the health conditions of our most vulnerable populations will only improve as we address the source of those conditions. We have a responsibility and an obligation to understand the barriers that impede all of California's residents from achieving their greatest health potential – and to work together to remove those barriers.

It has taken hundreds of years of unjust social policies and practices to create the degree and magnitude of health inequities detailed in this report. Each resident, tribe, community, coalition, organization, institution, corporation, and philanthropy has inherited this legacy – and each has an important part to play as the tide is turned through a concerted, comprehensive, and sustained response. We welcome you to join us.

Sincerely,

Sandi Gálvez, MSW
Chair, Office of Health Equity Advisory Committee

ACKNOWLEDGMENTS

The California Statewide Plan to Promote Health and Mental Health Equity ("Plan") has been developed through a truly collaborative effort. Numerous individuals, agencies, and organizations have generously given of their time, knowledge, and expertise. The Office of Health Equity Advisory Committee (OHE-AC), the Health in All Policies Task Force, and the other state departments that participated in the development and review of this document ensured the process was a success.

Appreciation is extended to the following:

- Diana Dooley, Secretary of the California Health and Human Services Agency, and Dr. Ron Chapman, former State Health Officer and Director of the California Department of Public Health, for their leadership and steadfast support for the new Office of Health Equity (OHE) and this first report and strategic plan.

- Sandi Gálvez and Dr. Rocco Cheng, for serving as chair and vice chair, respectively, of the inaugural OHE Advisory Committee, and for providing leadership and guidance for the new OHE Advisory Committee (see the Office of Health Equity Advisory Committee page for a full list of Advisory Committee members).

- All the OHE staff, for their development and review of Plan documents, with special thanks to health research staff members Dr. Mallika Rajapaksa and Thi Mai for coalescing the data for the disparities report, as well as Senior Project Manager

Dr. Tamu Nolfo, who helped manage the planning and collating of ideas into the strategic plan.

- Dr. Neil Kohatsu, California Department of Health Care Services (DHCS) Medical Director; Dr. Linette Scott, Chief Information Medical Officer at DHCS; and members of the DHCS-California Department of Public Health (CDPH)/OHE data work group for their input and guidance on the disparities report.

- Jon Stewart, a technical writer who turned data into a story that everyone can understand, in the form of the disparities report.

- The Blanket Marketing Group, a design firm that had the graphic design magic necessary to make the words come alive, and TSI Consulting Partners, which facilitated the initial Advisory Committee deliberations.

- Sierra Health Foundation, California HealthCare Foundation, and Sutter Health, which provided financial and meeting support and which have been and continue to be dedicated to advancing health equity in California.

- Finally and most important, the public, for their input and contributions at OHE Advisory Committee meetings; during webinars; and through surveys, letters, and other discussions. The quality of authentic public engagement that shaped this document is to be commended.

Without the dedication and commitment of all those involved, this Plan would not have been possible. The collaboration and synergy from this diverse spectrum of talented individuals, agencies, and organizations provide great hope for what can be accomplished to achieve health and mental health equity.

OFFICE OF HEALTH EQUITY
ADVISORY COMMITTEE

The Office of Health Equity Advisory Committee (OHE-AC) is integral to advancing the goals of the office and advises on the development and implementation of The California Statewide Plan to Promote Health and Mental Health Equity. The OHE-AC comprises representatives from applicable state agencies and departments, local health departments, community-based organizations, and service providers working to promote health and mental health equity for vulnerable communities.

The OHE-AC consists of a broad range of experts, advocates, health clinicians, public health professionals, and consumers who understand the importance of the health and mental health disparities and inequities of historically vulnerable, marginalized, underserved, and underrepresented communities.

The OHE-AC works to provide a forum to identify and address the complexities of health and mental health inequities and to identify interrelated and multisectoral strategies. Additionally, the OHE-AC consults regularly with the Office of Health Equity for input and updates on policy recommendations, strategic plans, and the status of cross-sectoral work.

Advisory Committee members are:

CHAIR

Sandi Gálvez, MSW, is Executive Director of the Bay Area Regional Health Inequities Initiative (BARHII).

VICE CHAIR

Rocco Cheng, PhD, is Corporate Director of Prevention and Early Intervention Services at Pacific Clinics.

MEMBERS

Sergio Aguilar-Gaxiola, MD, PhD, is Professor of Clinical Internal Medicine and Founding Director of the University of California (UC), Davis, Center for Reducing Health Disparities; Director of the Community Engagement Program of the UC Davis Clinical Translational Science Center; and Co-Director of the National Institute on Aging's Latino Aging Research and Resource Center.

Paula Braveman, MD, MPH, is Professor of Family and Community Medicine and Director of the Center on Social Disparities in Health at the University of California, San Francisco.

Delphine Brody formerly served as Program Director for the Mental Health Services Act (MHSA) at the California Network of Mental Health Clients and is currently a member of the National Association for Rights Protection and Advocacy and of the Mental Health Services Oversight and

Accountability Commission Cultural and Linguistic Competence Committee. She also serves on the California Behavioral Health Directors Association Cultural Competence, Equity and Social Justice Advisory Committee.

Jeremy Cantor, MPH, is a Senior Consultant with John Snow, Inc., in San Francisco, California.

Yvonna Cázares is Director of Next-Level Engagement at California State PTA.

Kathleen Derby is a peer and family advocate with over 25 years of lived experience in mental health.

Aaron Fox, MPM, is Director of State Health Equity and Policy at the Los Angeles LGBT Center.

Alvaro Garza, MD, MPH, is Health Officer at San Joaquin County Public Health Services.

Cynthia A. Gómez, PhD, is Founding Director of the Health Equity Institute at San Francisco State University.

Willie Graham, MS, MTh, is pastor of Christian Body Life Fellowship Church in Vacaville, California.

General Jeff is a community activist for the underserved and unserved residents in Skid Row in Downtown Los Angeles and founder of the organization Issues and Solutions.

Carrie Johnson, PhD, is a member of the Dakota Sioux tribe and is a licensed clinical psychologist and Director of the Seven Generations Child and Family Counseling Center at United American Indian Involvement in Los Angeles.

Neil Kohatsu, MD, MPH, was appointed in March 2011 as the first Medical Director for the California Department of Health Care Services.

Dexter Louie, MD, JD, MPA, is a founding member and Chair of the Board of the National Council of Asian Pacific Islander Physicians.

Francis G. Lu, MD, is Luke and Grace Kim Professor in Cultural Psychiatry, Emeritus, University of California, Davis.

Gail Newel, MD, MPH, is an obstetrician-gynecologist who serves the Fresno County Department of Public Health as Medical Director of Maternal, Child and Adolescent Health.

Teresa Ogan, MSW, is Supervising Care Manager for the California Health Collaborative Multipurpose Senior Service Program.

José Oseguera, MPA, is Chief of Plan Review and Committee Operations for the Mental Health Services Oversight and Accountability Commission.

Hermia Parks, MA, RN, PHN, is Director of Public Health Nursing/Maternal, Child, and Adolescent Health for Riverside County.

Diana E. Ramos, MD, MPH, is the Director for Reproductive Health, Los Angeles County Public Health Department, and a practicing obstetrician-gynecologist and adjunct Assistant Clinical Professor at the Keck University of Southern California School of Medicine.

Patricia Ryan, MPA, is serving as a consultant to the California Mental Health Directors Association, having recently retired after 12 years as its Executive Director.

Linda Wheaton is Assistant Director for Intergovernmental Affairs for the California Department of Housing and Community Development and a member of the California Health in All Policies Task Force.

Ellen Wu, MPH, is Executive Director of Urban Habitat.

EXECUTIVE SUMMARY

Almost one in four children in California lives in poverty,[1] which is often associated with factors that negatively affect their health, such as substandard housing, hunger, and poor air and water quality. In California, poverty is higher among women than men and highest among Latinas and single mothers.[2] Compare the salaries of women with those of men: Women go to work on average three months per year without pay,[3] resulting in lower incomes that severely limit health-related options like sleep, nutrition, and exercise. Exacerbating these hardships, one in five women in California has experienced physical or sexual violence by her partner.[4] Through our gender lens we are also now seeing a trend that boys and young men in California are less likely to both read at grade level early on and enroll in undergraduate education through the University of California and California State Universities than are girls and young women,[5,6] and they are disproportionately impacted by school discipline, arrest, and unemployment.[7,8] Additional data demonstrates different health and mental health outcomes among people of different races, ethnicities, and sexual orientations. For example, African American families are twice as likely as their White counterparts to suffer the grievous loss of an infant,[9] due in part to the pervasive and detrimental impacts of a lifetime of discrimination on the mother's physical and mental health.[10] Such racial discrimination appears to undercut the protective benefits of educational attainment, mother's age, and marital status.[11] Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQQ) youths experience suicidal ideation, suicide attempts, and suicide completion more often than do their straight peers.[12]

Health and mental health *disparities* are the differences in health and mental health status among distinct segments of the population, including differences that occur by gender, age, race or ethnicity, sexual orientation, gender identity, education or income, disability or functional impairment, or geographic location, or the combination of any of these factors.[7]

Are the disparities described above inevitable—or preventable?

Disparities in health or mental health, or in the factors that shape health, that are systemic and avoidable and, therefore, considered unjust or unfair are defined as **health and mental health *inequities*.**[7]

In this document, the California Statewide Plan to Promote Health and Mental Health Equity ("Plan"), we present background and evidence on the root causes and consequences of health inequities in California. We explore and illustrate how a broad range of socioeconomic forces, including income security, education and child development, housing, transportation, health care access, environmental quality, and other factors, shape the health of entire communities—especially vulnerable and underserved communities—resulting in preventable health inequities for specific populations. With a better, data-based understanding of the causes and consequences of health inequities, Californians will be better prepared to take the steps necessary for promoting health across California's diverse communities and building on the great strengths that our diverse population brings.

In 2012, as authorized by Section 131019.5 of the California Health and Safety Code, the Office of Health Equity (OHE) was established within the California Department of Public Health. One of the key duties of the OHE outlined in the code is the development of a report with

demographic analyses on health and mental health disparities and inequities, highlighting the underlying conditions that contribute to health and well-being, accompanied by a comprehensive, cross-sectoral strategic plan to eliminate health and mental health disparities.

The timely creation of the Office of Health Equity (OHE) within the California Department of Public Health (CDPH) represents an opportunity, via the Plan presented here, to lessen inequities and pursue a path that leads to health, wellness, and well-being for every member of the great and diverse family of California residents.

The Plan is intended to illuminate the scope of the health equity challenge with compelling data and narrative. It makes the case that health is a basic human right, that health inequity is a moral and financial issue, and that health equity is in everyone's best interest. It also provides a brief summary of the most pervasive social determinants of health, and it offers examples of programs, policies, and practices that have begun to make a difference in the state's most vulnerable communities.

The Plan points to what California can do to capitalize on current windows of opportunity and minimize foreseeable threats. Momentum for health and mental health equity has been building in recent years, setting the stage for this important work. For example, the U.S. Department of Health and Human Services' Action Plan to Reduce Racial and Ethnic Health Disparities: *A Nation Free of Disparities in Health and Health Care*, was released in April 2011; the state's *Let's Get Healthy California Task Force Final Report* appeared in December 2012; and the state's California Wellness Plan was launched in February 2014 – each providing intersections and synergistic opportunities for moving forward with determination and focus. In addition to state and federal plans that address health and mental health inequities, nonprofit organizations have also published reports that reflect the views of stakeholders, such as *The Landscape of Opportunity: Cultivating Health Equity in California*, authored by the California Pan-Ethnic Health Network and released in June 2012.

While the OHE facilitated the process for creating this document, the outcome reflects the thoughtful participation of hundreds of stakeholders. Those who invested the most time were the 25 members of the OHE Advisory Committee, who worked alongside the public and OHE staff over the course of

three two-day meetings and for countless hours before and between those meetings. These members were chosen from 112 applications received by CDPH, a sign of both the enthusiasm and the expertise brought to bear on this endeavor.

The Advisory Committee members have been strong advocates for paying due attention to mental health in the Plan. Mental health is one aspect of overall health and, as such, should be assumed within all references to "health." However, because mental health has historically been excluded – and in many circumstances continues to be excluded – from our society's overall approach to health, it is called out explicitly throughout this document.

The Office of Health Equity staff, working with the Advisory Committee and other stakeholders, have established a vision, a mission, and a central challenge to guide the development of strategies.

Vision: Everyone in California has equal opportunities for optimal health, mental health, and well-being.

Mission: Promote equitable social, economic, and environmental conditions to achieve optimal health, mental health, and well-being for all.

Central Challenge: Mobilize understanding and sustained commitment to eliminate health inequity and improve the health, mental health, and well-being of all.

The following are the Plan's five-year strategic priorities:

Through **assessment**, yield knowledge of the problems and the possibilities.

Through **communication**, foster shared understanding.

Through **infrastructure** development, empower residents and their institutions to act effectively.

Goals for each of the strategic priorities were crafted for California overall as well as within the health field, among potential health partners, and within local communities for Stage 1 (2015-2018) and Stage 2 (2018-2020) of the Plan. In this inaugural effort, the OHE also recognized the critical need to create goals aimed at building capacity for implementation of the strategic priorities.

We have the honor of introducing the inaugural California Statewide Plan to Promote Health and Mental Health Equity, which provides both a context for why this work is of utmost importance (the report) and a road map for how to achieve it (the strategic plan). This planning process has been a truly collaborative effort. We are grateful for the insightful and broad thinking of the OHE Advisory Committee, stakeholders, and staff. Their dedication, thoughtfulness, and contributions were crucial components in the creation of this Plan.

Sincerely,

Karen L. Smith, MD, MPH
Director & State Health Officer
California Department of Public Health

Wm. Jahmal Miller, MHA
Deputy Director, Office of Health Equity
California Department of Public Health

INTRODUCTION AND BACKGROUND

This report on the California Statewide Plan to Promote Health and Mental Health Equity is the first biennial report of the new Office of Health Equity (OHE), established in 2012 under the California Health and Safety Code Section 131019.5 ("Code"). The OHE, operating within the California Department of Public Health (CDPH), is tasked, first and foremost, with aligning state resources, decision making, and programs to achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantages and historical injustice. The overriding objective of the Plan, included in this report, is to improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and inequities.

The Code instructed the OHE to seek input from the public on the Plan through an inclusive public stakeholder process and to develop the Plan in collaboration with the Health in All Policies Task Force. This was accomplished through several means, including meetings, webinars, surveys, and other correspondence. The Advisory Committee was established with a membership of 25 health experts, advocates, clinicians, and consumers representing diverse vulnerable communities and vulnerable places

across multiple fields and sectors. The Health in All Policies Task Force was represented on the committee as well. The Advisory Committee held its first meeting in September 2013. All meetings have adhered to the Bagley-Keene Open Meeting Act ("Act"), set forth in Government Code Sections 11120-111321, which covers all state boards and commissions. Generally, it requires these bodies to publicly notice their meetings, prepare agendas, accept public testimony, and conduct their meetings in public unless specifically authorized by the Act to meet in closed session.

The Advisory Committee meetings held in January, March, and May 2014 were largely dedicated to providing input into the development of the Plan. At these meetings there were presentations; full committee discussions; small group discussions involving Advisory Committee members, OHE staff, and the public; and formal public comments. Members of the public who were not able to participate on-site were able to participate via conference call.

In April and May 2014, statewide webinars were held to introduce initial drafts of the Plan, answer questions, receive comments, and allow for polling to establish priorities and partnership interests. A 61-item survey was also made available during that time for more in-depth feedback opportunities. The input from over 120 surveys and several letters was considered in the further development of the Plan.

Engagement with the public consisted of hundreds of meet-and-greets in person and occurred by phone with OHE staff, primarily with the Deputy Director, Jahmal Miller. These meetings additionally informed the Plan.

Definition of Terms

Determinants of Equity: The social, economic, geographic, political, and physical environmental conditions that lead to the creation of a fair and just society.

Health Equity: Efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

Health and Mental Health Disparities: Differences in health and mental health status among distinct segments of the population, including differences that occur by gender, age, race or ethnicity, sexual orientation, gender identity, education or income, disability or functional impairment, or geographic location, or the combination of any of these factors.

Health and Mental Health Inequities: Disparities in health or mental health, or the factors that shape health, that are systemic and avoidable and, therefore, considered unjust or unfair.

Vulnerable Communities: Vulnerable communities include, but are not limited to, women, racial or ethnic groups, low-income individuals and families, individuals who are incarcerated and those who have been incarcerated, individuals with disabilities, individuals with mental health conditions, children, youth and young adults, seniors, immigrants and refugees, individuals who are limited-English proficient (LEP), and Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQQ) communities, or combinations of these populations.

Vulnerable Places: Places or communities with inequities in the social, economic, educational, or physical environment or environmental health and that have insufficient resources or capacity to protect and promote the health and well-being of their residents.

Source: Health and Safety Code Section 131019.5.

California's Human Diversity:
Opportunities

California's population is the most diverse in the continental United States[1] and one of the most diverse in the entire world. The Latino population is the state's largest ethnic plurality, at about 38 percent of the population, and is predicted to approach majority status by 2060 (see Figure 1). That makes California only the second state in the nation, behind New Mexico, in which Whites are not the majority and where Latinos are the plurality. The state's non-Hispanic White population in mid-2014 is estimated to be a fraction of a percent smaller than the Latino population, at 38.8 percent, down from 57.4 percent in 1990. Whites are trailed by the Asian/Pacific Islander population, at 13 percent (up from 9.2 percent in 1990); African Americans, at 5.8 percent (down from 7.1 in 1990); and Native Americans, at less than 1 percent.[2]

California's human diversity goes beyond race and ethnicity. It also includes large shares of other subpopulations relative to other states, including the Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQQ) community; persons with disabilities; undocumented immigrants; and many others. For instance, according to the 2010 census, California has one of the highest percentages in the nation of married couples of mixed race or ethnicity and is among the leading states in the number of same-sex households.[3] More than 42 percent of the state's population over the age of five speaks one of several hundred languages other than English at home, with more than two-thirds of those also speaking English well or very well, while about 10 percent do not speak English at all.[4]

Diversity's Many Benefits...

California's diversity has been a source of great strength for the state's economy and cultural life, enriching California's schools, universities, communities, and industries with a kaleidoscope of skills and knowledge and with a determination to succeed. Approximately one in three small business owners in California is an immigrant,[5] and according to the Small Business Association, close to half of all small businesses in Los Angeles are owned by immigrants, who make up about 34 percent of the city's population. Statewide, almost one-third of the state's 3.4 million small businesses are owned by people of color.[6] At the national level, Latinos alone accounted for an estimated $1.2 trillion in consumer purchasing power in 2012, a market larger than the entire economies of all but 13 countries.[7]

Foreign-born individuals also make up 38.3 percent of all science, technology, engineering, and math graduates at the state's most research-intensive universities and account for 56.5 percent of the state's engineering PhDs.[8] A recent study from the University of California,

LATINOS ARE PROJECTED TO BECOME THE LARGEST RACIAL/ETHNIC GROUP AND WILL ACCOUNT FOR NEARLY HALF OF ALL CALIFORNIANS BY 2060
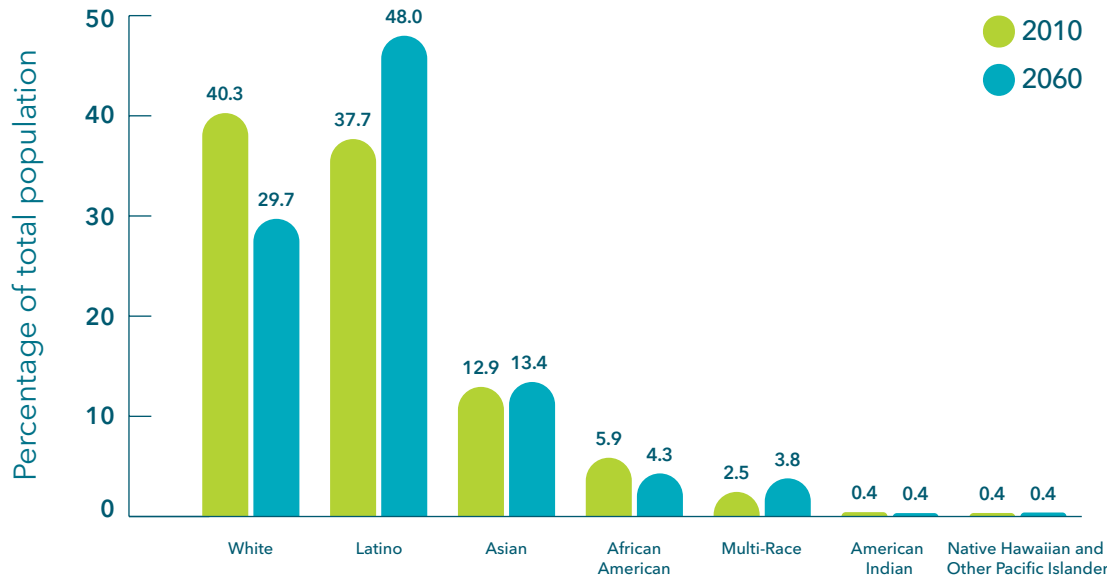

FIGURE 1: Percentage of California's population and projected population, by race/ethnicity, 2010 and projected 2060.

Source: California Department of Finance, Report P-1 (Race): State and County Population Projections by Race/Ethnicity, 2010-2060. Sacramento, California, January 2013.

Irvine, of Orange, Los Angeles, Riverside, San Bernardino, and Ventura counties looked at interrelationships among changing community factors such as racial and ethnic demographics, employment and economic welfare, housing density, crime and public safety, and land use. It found positive signs of change along all dimensions, especially rising property values in formerly homogeneous neighborhoods that have become ethnically mixed due to recent Latino and Asian immigration, reversing the trend of declining property values in the 1980s and 1990s.[9]

While immigration has already brought about powerful impacts in California, the future holds the promise of even greater change. The state's baby boomer population, which numbered 10 million in 1990, is aging into retirement over the next two decades, resulting in a steadily decreasing White share of the working age population and a rising share of workers who are Latino or Asian. The potential for the future growth of the labor force and the state's economy will increasingly depend on these younger, more diverse cohorts. The California Department of Finance projects that by 2030, the state's over-65 White population will be significantly larger than the under-25 White population, which will be only about half the size of the under-25 Latino population. Adding working-age Asians and other minority populations to the mix further illustrates the potential impact of people of color on the state's future labor force.[10]

...And Many Challenges

Despite these strengths, the great advantages of California's demographic diversity continue to be undermined by persistent, unjustifiable inequities in various social, economic, and environmental conditions that result in gaping disparities in the health of vulnerable populations, especially low-income (below 200 percent of the federal poverty level) families and neighborhoods; communities of color; the very young and the very old; and those who have experienced discriminatory practices based on gender, race/ethnicity, or sexual orientation.

These disparities in health status are a matter of life and death, shown by differences in death rates and life expectancy among the state's major racial and ethnic groups. Although the state's death rates have been steadily declining for almost all racial and ethnic groups, major gaps persist for African Americans relative to Asians and other populations as of 2010 (see Figure 2). Similarly, the state's average life expectancy of 80.8 years in 2010 masked a more than 11-year gap between Asian Americans, at 86.3 years, and African Americans, at 75.1 years.[11]

Further, life expectancy is tied to the social and environmental conditions of place – where we live, work, learn, and play. For example, residents of high-income San Francisco outlive those in the lower-income Riverside-San Bernardino area by three years: 81 to 78, respectively.[12] These neighborhood differences are particularly striking when looking within communities. In Oakland, an African American child in the low-income flatlands will, on average, die 15 years earlier than a White child who lives in the affluent hills.[12]

Similar gaps among population groups exist for numerous chronic health conditions that drive the disparities in death rates. Although death rates from stroke have declined in almost all racial and ethnic groups, the rate among African Americans remains about 50 percent higher than among some other racial or ethnic groups, mirroring similar disparities in related risks for high blood pressure, high cholesterol, tobacco use, and obesity.[12] Prevalence of diabetes is two and a half times as high among Hawaiian/Pacific Islanders as among Whites, and more than twice as high among those with a family income below 200 percent of the federal poverty level as among those with family incomes of at least 300 percent above the poverty level.[12]

While data showing the difference between aggregated populations can be useful, important disparities in health risks may be missed when looking only at this aggregated data for populations designated by large geographic areas of origin, such as Latinos and Asian/Pacific Islanders. For instance, significant gaps in rates of colorectal cancer exist among Japanese, Korean, Vietnamese, Chinese, Filipino, and South Asian Californians,[12] and so looking at only rates of colorectal cancer for Asians can be misleading and can result in missed opportunities for prevention. *(See Appendix D for information on data limitations.)*

ALTHOUGH DEATH RATES IN CALIFORNIA HAVE DECLINED, DISPARITIES PERSIST, WITH AFRICAN AMERICANS HAVING HIGHER DEATH RATES THAN OTHER RACIAL/ETHNIC GROUPS
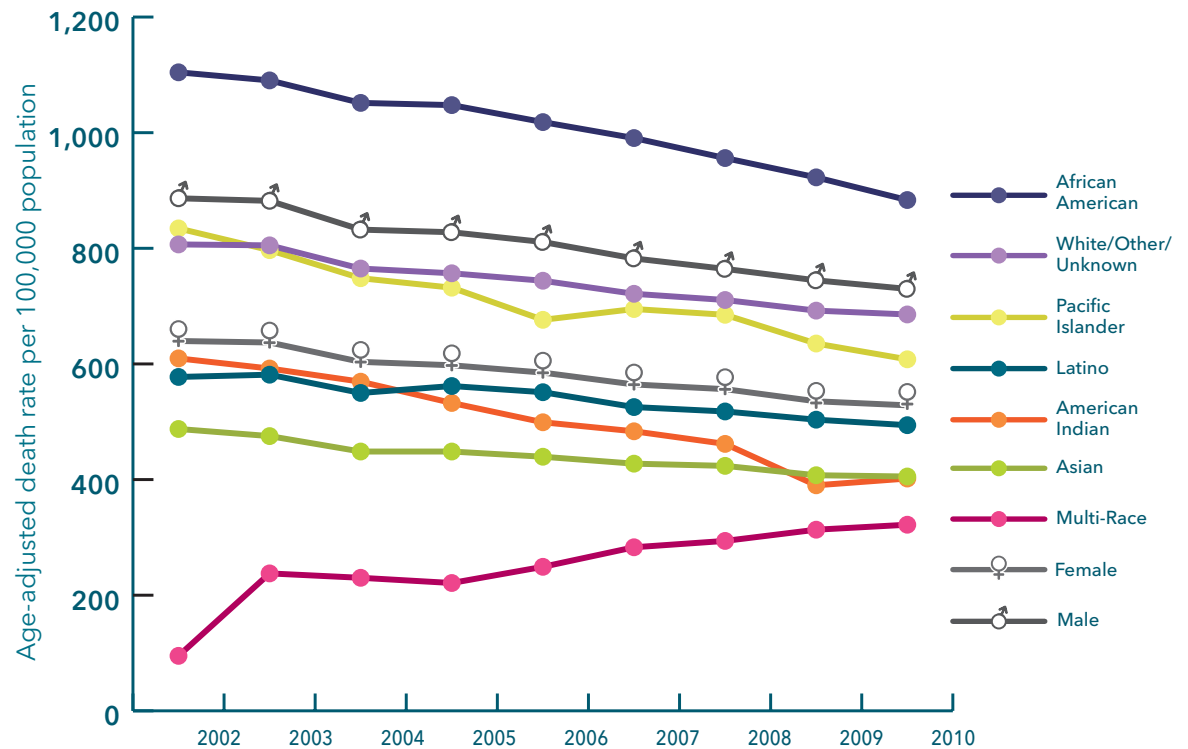

FIGURE 2: Death rates, by race/ethnicity and gender, California, 2002 to 2010.

Sources: California Department of Public Health, Death Records; and California Department of Finance, Race and Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.

Note: Age-adjusted rates are calculated using year 2000 U.S. standard population.

What Drives
Health Disparities?

One way of identifying the causes of health disparities is to examine the factors that produce and maintain healthy individuals, communities, and places. Many people assume that health is mostly a function of individuals' seeing the doctor regularly for good medical care and avoiding unhealthy behaviors, such as smoking and inactivity. However, most public health experts have adopted an upstream/downstream model of the causal factors that produce health, illness, and health disparities. In this model, factors such as medical care to maintain health or treat an illness or injury are viewed as the immediate, or "downstream," determinants of health outcomes. These downstream factors are causally related to "midstream" health determinants, such as people's genetic and biological makeup, and individual health behaviors, such as smoking, unhealthy eating, or lack of physical exercise. Further "upstream" are a host of environmental, social, and economic factors that even more powerfully influence health outcomes for entire populations. The World Health Organization (WHO) has defined these upstream factors as "the conditions in which people are born, grow, live, work, and age. These circumstances," declared WHO, "are shaped by the distribution of money, power and resources" within every level of society,[13] resulting in significant upstream health inequities and downstream health disparities that disproportionately impact low-income populations, communities of color, and other groups that are subject to racism and discrimination.

While public health researchers have differed on the relative importance of these various upstream and downstream health determinants, it is estimated that medical care, healthy behaviors, and genes and biology altogether account for only about half of a society's overall health outcomes,[14] even though downstream determinants attract the majority of health funding and expenditures.

The Social Determinants of Health

What constitutes the other 50 percent of the determinants of health and well-being is a complex interplay of environmental conditions, such as air and water quality, the quality of the built environment (e.g., housing quality; land use; transportation access and availability; street, park, and playground safety; workplace safety; etc.), and a whole host of socioeconomic factors. These latter factors include opportunities for employment, income, early childhood development and education, access to healthy foods, health insurance coverage and access to health care services, safety from crime and violence, culturally and linguistically

A PUBLIC HEALTH FRAMEWORK FOR REDUCING HEALTH INEQUITIES
BAY AREA REGIONAL HEALTH INEQUITIES INITIATIVE

UPSTREAM — DOWNSTREAM

SOCIAL INEQUITIES
Class
Race/Ethnicity
Immigration Status
Gender
Sexual Orientation

INSTITUTIONAL INEQUITIES
Corporations & Businesses
Government Agencies
Schools
Laws & Regulations
Not-for-Profit Organizations

LIVING CONDITIONS

Physical Environment
Land Use
Transportation
Housing
Residential Segregation
Exposure to Toxins

Economic & Work Environment
Employment
Income
Retail Businesses
Occupational Hazards

Social Environment
Experience of Class, Racism, Gender, Immigration
Culture - Ads - Media
Violence

Service Environment
Health Care
Education
Social Services

RISK BEHAVIORS
Smoking
Poor Nutrition
Low Physical Activity
Violence
Alcohol & Other Drugs
Sexual Behavior

DISEASE & INJURY
Communicable Disease
Chronic Disease
Injury (Intentional & Unintentional)

MORTALITY
Infant Mortality
Life Expectancy

Strategic Partnerships Advocacy

Community Capacity Building
Community Organizing
Civic Engagement

Individual Health Education

Health Care

Case Management

POLICY

Emerging Public Health Practice — Current Public Health Practice

FIGURE 3: Bay Area Regional Health Inequities Initiative (BARHII) Conceptual Framework, 2006.

appropriate services in all sectors, protection against institutionalized forms of racism and discrimination, and public and private policies and programs that prioritize individual and community health in all actions.

Significantly, in contrast to the individual-level downstream determinants, these environmental and socioeconomic determinants have population-level impacts. Understanding this is vital when designing and implementing health interventions, such as economic development programs in low-income communities, which can be targeted to specific subpopulations, communities, and neighborhoods, thus affecting thousands or tens of thousands of people rather than one individual at a time.

When a society's principles and policies work to optimize these interrelated social determinants of health on the basis of justice and equity for everyone, health is created at the levels of the individual, the community, the environment, and society at large (see Figure 4). When any combination of these drivers is lacking, the

engine that powers total health can break down, resulting in significant health inequities and disparities in health outcomes. Understanding what creates or limits the opportunity for health is essential to understanding what creates disparate health outcomes and what needs to be done to prevent them. Among other things, the solutions need to involve changes at the policy level by a broad set of public and private partners representing sectors that impact public health but may not have health at the center of their decision making, such as transportation, economic development, chambers of commerce, city planning, and others.

ACHIEVING HEALTH & MENTAL HEALTH EQUITY AT EVERY LEVEL

Transforming the conditions in which people are BORN, GROW, LIVE, WORK and AGE for optimal health, mental health & well-being.

HEALTHY PEOPLE

HEALTHY COMMUNITY

HEALTHY ENVIRONMENT

HEALTHY SOCIETY

Prevention

Mental Health Services

Culturally/Linguistically Appropriate and Competent Services

Income Security

Housing

Neighborhood Safety/Collective Efficacy

Environmental Quality

Health Care

Child Development, Education, and Literacy Rates

Food Security/ Nutrition

Built Environments

Discrimination/ Minority Stressors

FIGURE 4: Achieving Health & Mental Health Equity At Every Level

Source: California Department of Public Health, Office of Health Equity, as inspired by World Health Organization, Robert Wood Johnson Foundation, and many others.

©iStock.com/peeterv

The Deep Roots of Health Inequities

While there are many indicators of health, income and wealth play especially important roles in determining health outcomes. Income and wealth are discussed in depth in this section because of their tremendous impact on health, and the inequities in how they are distributed among California's population.

While America's constitutional principles emphasize the importance of justice and equity, its policies and practices have historically allowed some population groups disproportionately greater opportunities for building household wealth. As the poet Ralph Waldo Emerson wrote, "The first wealth is health." That saying has recently been revised to make the point that "wealth equals health," a point forcefully driven home in the *2006 Handbook for Action: Tackling Health Inequities Through Public Health Practice*. This handbook closely examined how U.S. household wealth (meaning the value of all financial and nonfinancial assets, such as real estate owned by a household, minus any debts) serves as the major determinant of health and health inequities, influencing and influenced by virtually all other upstream environmental and socioeconomic factors, including income, education, employment, housing, bank lending policies, child care, recreational opportunities, food supply, health care access, neighborhood safety, and environmental quality.[15]

If health is wealth, it follows that efforts to understand and reverse the drivers of health inequities need to begin by looking at how the policies and actions of private institutions and governments have contributed to the large gaps in wealth that mirror the gaps between the healthy and the unhealthy.

Behind the Gaps in Wealth and Health

Historically, the United States' long eras of slavery and discriminatory policies in housing, education, transportation, and economic development largely excluded people of color and other minorities from the formal economy, up until the latter half of the 20th century and the passage of major civil rights legislation. Although many of those policies, such as lending institution redlining, have been prohibited by law in recent decades, their harmful legacies persist in numerous, less obvious ways, both officially and unofficially.

For instance, it is widely recognized today that private and public bank lending policies that enabled the subprime mortgage practices during the housing boom contributed significantly to the 2007-2009 housing bust, which wiped out vast shares of homeowners' household wealth. The bust affected all but the richest few percent of the population, having much greater negative impacts on low-income households, especially communities of color. This is the result of the fact that wealth accumulation among African American and

Latino families, among other disadvantaged groups, is more recent and more concentrated in home values than for most White families, whose much greater wealth is more broadly distributed over many kinds of assets other than housing, such as stocks and bonds.[16]

A recent analysis of national annual income surveys by the U.S. Census Bureau revealed that in 2011 – two years into the so-called recovery period from the Great Recession – average African American and Latino households owned only six and seven cents, respectively, for every dollar in wealth held by the average White family. In 2011, the median net worth of households of color had fallen from 2005 levels – before the recession – by 58 percent for Latinos, 48 percent for Asians, and 45 percent for African Americans, but by only 21 percent for Whites. The same study found that the average liquid wealth – meaning cash on hand or assets easily converted to cash – of White families was 100 times that of African Americans and more than 65 times that held by Latinos.[17] This type of wealth is key to maintaining a sense of security and stability when unexpected crises occur, such as serious illness or loss of a job, as well as to being able to act on unexpected opportunities, such as building or expanding a business in response to changed circumstances. Wealth serves as both a cushion against hard times and a potential launching pad for economic growth.

The study, from Brandeis University, also examined the significant growth of the wealth gap for African American families over a 25-year period (1984-2009) and concluded that it could be largely explained by five factors: years of homeownership, household income, unemployment, education, and inheritance, all of which are deeply influenced by local, state, and federal policies that create either opportunities or barriers to wealth and health.[16]

California's wealth gaps are shown in Figure 5. White families, which accounted for just over half of total households in 2010, held two-thirds of total wealth. African American families, with 6 percent of total households, held just 2 percent of total wealth, and Latinos, with 27 percent of households, held just 16 percent of total wealth.

Public policies and private practices affecting the economy, housing, the environment, education, and other sectors are a major factor in the persistence and growth of a widening American wealth gap, which is a key driver of health inequities among low-income families, communities of color, women, children, and other vulnerable populations. Fortunately, policies are not carved in stone. They can be reshaped to address inequities and promote greater access for all people to both wealth and health. Through policy choices, government can play an important role in slowing and even reducing the growing wealth gap, thereby helping slow and ideally reduce California's growing health inequities.

HOUSEHOLD WEALTH IS UNEVENLY DISTRIBUTED ACROSS RACIAL/ETHNIC GROUPS IN CALIFORNIA

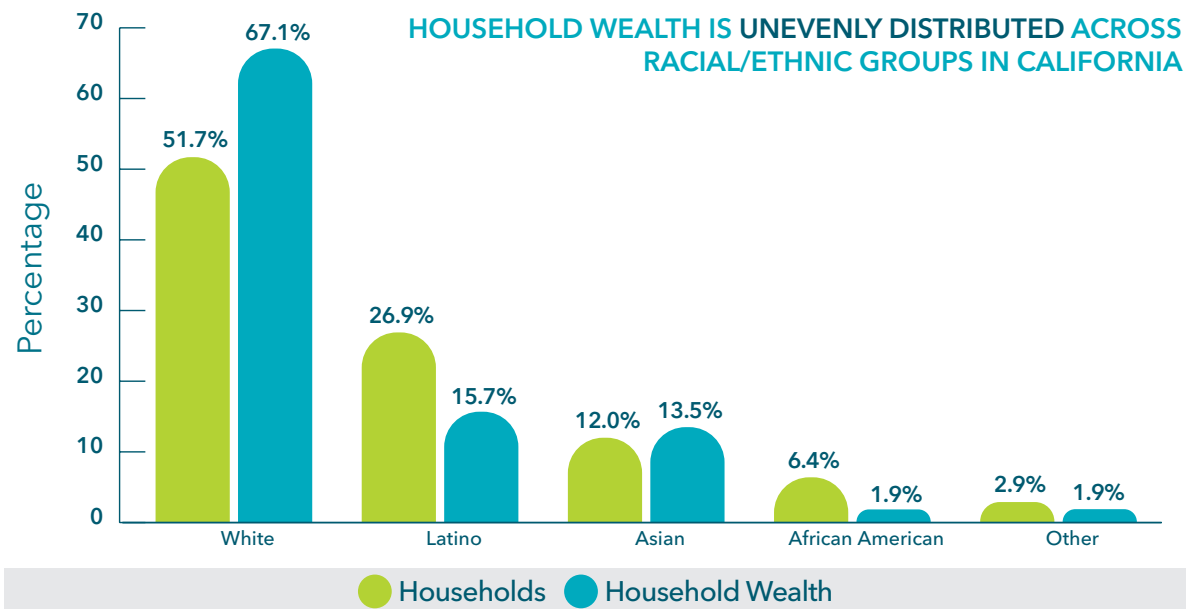|	White	Latino	Asian	African American	Other
Households	51.7%	26.9%	12.0%	6.4%	2.9%
Household Wealth	67.1%	15.7%	13.5%	1.9%	1.9%

FIGURE 5: Percentage of California's households and household wealth (net worth), by race/ethnicity, California, 2010.

Sources: U.S. Census Bureau, Census 2010, Summary File 2; and Survey of Income and Program Participation (Panel 2008, Wave 7).

Health in
All Policies

Health in All Policies is a cutting-edge approach to shaping effective public and private policies for the promotion of health and health equity. The American Public Health Association describes Health in All Policies as "a collaborative approach to improving the health of all people by incorporating health considerations into decision making across sectors and policy areas."[18]

Health in All Policies is based on the recognition that the greatest health challenges – including the health inequities described in this report – are highly complex and often interrelated. Because public health and health care institutions do not have authority over many of the policy and program areas that impact health, solutions to these complex and urgent problems require working collaboratively across many sectors to address the social determinants of health, such as transportation, housing, and economic policy.

Health in All Policies builds on public health's long and successful tradition of collaboration among government sectors, as demonstrated in such initiatives as implementing fluoridated tap water policies, reducing occupational and residential lead exposure, restricting tobacco use in workplaces and public spaces, improving sanitation, and requiring use of seatbelts and child car seats. Health in All Policies takes the idea of cross-sector collaboration further by formalizing ways to systematically incorporate a health, equity, and sustainability lens across the entire government apparatus. A Health in All Policies approach also supports collaboration across multiple sectors, ensures that policy decisions benefit multiple partners, engages stakeholders, and works to create positive structural and process change.[19]

For these reasons, a Health in All Policies approach has been embraced by the World Health Organization, the American Public Health Association, the Association of State and Territorial Health Officers, the National Association of County and City Health Officers, and other professional public health organizations. It is being implemented in a variety of ways across the United States, including by California's state government through the Health in All Policies Task Force *(see below and Appendix B for more information).*

The Case for Addressing
Health Inequities

Almost 70 years ago, both the then-new World Health Organization (WHO) and the United Nations (UN) broadly defined health as a basic human right. The WHO Constitution defines the right to health as "the enjoyment of the highest attainable standard of health," including the right to healthy child development; equitable dissemination of medical knowledge and its benefits; and government-provided social measures to ensure adequate health.[20] The UN's Universal Declaration of Human Rights in 1948 declared in Article 25 that "*[e]veryone has the right to a standard of living adequate for the health and well-being of himself [sic] and of his family, including food, clothing, housing, and medical care and necessary social services.*"[21] More recently, the focus on health disparities received a boost in 1998 when the federal government launched the Racial and Ethnic Health Disparities Initiative.[22] Subsequently, the Healthy People 2010 and

2020 initiatives moved beyond the traditional research paradigm of merely documenting the health inequities of vulnerable populations, by incorporating a commitment to actually "achieve health equity, eliminate disparities, and improve the health of all groups" as one of its four overarching goals.[23]

The case for viewing health and mental health equity as an issue of basic social justice has grown ever stronger as researchers and policy experts have learned more about the social and economic impacts of historic and continuing health disparities on the nation's large and growing vulnerable populations.

The Costs of Health Inequities

The moral case for addressing health inequities is buttressed by a strong economic argument, as reducing health inequities will yield savings in health care costs. Health spending accounted for 17.7 percent of gross domestic product

(GDP) in the United States in 2011, by far the highest share in comparison with the 34 developed nations of the Organization for Economic Cooperation and Development (OECD) and more than 8 percentage points higher than the OECD average of 9.3 percent. The United States spent $8,508 per capita on health in 2011, two and a half times more than the OECD average of $3,339, while lagging most developed nations in key measures of health outcomes.[24]

What share of that excess U.S. spending is attributable to the cost of health disparities is a complex issue, but one widely reported study in 2011 estimated that more than 30 percent of direct medical costs faced by African Americans, Hispanics, and Asian Americans were excess costs due to health inequities – more than $230 billion over a three-year period, plus indirect costs of $1 trillion in lower workplace productivity due

to associated illness and premature death.[25] That three-year total of "excess costs" due to health disparities is equal to approximately half the total of all U.S. health care spending in 2012. Meanwhile, total spending in 2012 on public health and health prevention accounts for only 2.7 percent of total health care spending.[26]

These numbers, dramatic as they may be, fail to convey the actual human costs of health disparities – lives lost prematurely and lives stunted and scarred by debilitating ill health, both physical and mental. It may be impossible to objectively assess the full dimensions of the human tragedy of health inequities and disparities, but the cost in mortalities alone is revealing. According to a National Institutes of Health 2011 study in the *American Journal of Public Health*,[27] nearly

three-quarters of a million U.S. adult deaths in 2000 were attributable to just five of the leading social determinants of health:

**Low education accounted for
245,000 deaths,**

**Racial segregation accounted for
176,000,**

**Low social supports accounted for
162,000,**

**Income inequality accounted for
119,000,**

**and Area-level poverty accounted for
39,000.**

In addition to moral arguments that health inequities are unjust, there are strong economic and social arguments that these health inequities impose avoidable costs. On an individual level, these inequities negatively impact the health and well-being of the populations that constitute the majority of Californians and that will increasingly represent over half of the nation's workforce and its taxpayers. In short, the elimination of health disparities and the creation of health security for all are vital to creating the kind of future we all want for our children and grandchildren.

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Creating Health Equity in California:
The Office of Health Equity

The Office of Health Equity (OHE), operating within the California Department of Public Health (CDPH), was created in 2012. The office continues California's multifaceted efforts to reduce or eliminate health and mental health disparities among California's vulnerable communities.

The OHE was created both to build upon the existing network of public and private sector partnerships in all economic, social, and environmental sectors that influence health and mental health and to align all state resources, decision making, and programs to accomplish the following objectives:

► Achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantage and historical injustice;

► Work collaboratively with the Health in All Policies Task Force to promote work to prevent injury and illness through improved social and environmental factors that promote health and mental health;

► Advise and assist other state departments in their mission to increase access to, and the quality of, culturally and linguistically competent health and mental health care and services; and

► Improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and achieving health equity.[28]

To carry out its work, the OHE has been organized into three operational units:

► Community Development and Engagement Unit

► Policy Unit

► Health Research and Statistics Unit

Community Development and Engagement Unit

The Community Development and Engagement Unit's (CDEU's) current focus is to strengthen the CDPH's ability to advise and assist other state departments in their work to increase access to, and the quality of, culturally and linguistically competent mental health care and services.

The primary responsibility of the CDEU is to carry on the ambitious work of the **California Reducing Disparities Project (CRDP)**, launched in 2009 to improve and increase access to care, quality of care, and positive mental health outcomes for racial, ethnic, and cultural communities. Since its creation, CRDP has provided funding for the development of

five population-specific reports for identifying and reducing mental health disparities among five target populations: African Americans; Asian/Pacific Islanders; Latinos; Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning individuals; and Native Americans.

The implementation and evaluation of local-level interventions recommended in these population reports is serving in the development of a single comprehensive strategic plan, authored by stakeholders, that brings together the community-identified lessons and successful strategies of each of the population-specific plans, identifying any similarities among them. This multiyear project aims to provide the state's mental health system with community-identified strategies and interventions that will result in meaningful culturally and linguistically competent services and programs that meet the unique needs of the five target populations.

Also part of the CRDP is the **California Mental Health Services Act Multicultural Coalition (CMMC)**, whose primary goal is to integrate cultural and linguistic competence throughout the public mental health system. The CMMC is a CRDP contractor and provides a new platform for racial, ethnic, cultural, and LGBTQQ communities to come together to address historical system and community barriers and collaboratively seek solutions that will eliminate barriers and mental health disparities. The coalition, launched in 2010, is made up of 30 members representing diverse multicultural perspectives on mental health, including those that have not been adequately represented in other efforts. CMMC members have provided extensive input into the comprehensive CRDP strategic plan.

Finally, CDEU also supports ongoing implementation of the Bilingual Services Act of 1973, which requires state agencies to provide translated materials in "threshold languages" or those languages identified by Medi-Cal as the primary language of 3,000 beneficiaries or 5 percent of the beneficiary population, whichever is less, in an identified geographic area.

Policy Unit

The work of the Policy Unit includes staff facilitation for the California **Health in All Policies (HiAP) Task Force**, which is made up of 22 state agencies, departments, and offices and is charged with identifying priority programs, policies, and strategies to improve the health of Californians while advancing the goals of the Strategic Growth Council (SGC). Executive Order S-04-10 created the HiAP Task Force in 2010, placed it under the auspices of the SGC, and called for the California Department of Public Health (CDPH) to provide facilitation. CDPH facilitates the HiAP Task Force through a private/public partnership with the Public Health Institute and several nongovernment funders. While CDPH facilitates the HiAP Task Force, the member agencies and departments contribute staff time for meetings and ongoing collaborative projects. CDPH engages HiAP Task Force members in an intensely collaborative and creative process to promote innovative strategies to improve health, equity, and sustainability. Because local governments play a major role in shaping communities and community health, the HiAP Task Force has focused on the unique role that state agencies play in supporting local action. The successes of the HiAP Task Force include incorporating health and equity principles in state guidance documents, increasing public input into key state processes, and growing collaboration across government sectors and among communities and decision-makers throughout California. *For more detailed information about the work of the HiAP Task Force, see Appendix B.*

The **Healthy Places Team** in the Policy Unit is building the [Healthy Communities Data and Indicators Project (HCI)](). The goal of the HCI is to enhance public health by providing data, a standardized set of statistical measures, and tools that a broad array of sectors can use for planning healthy communities and by evaluating the impact of plans, projects, policies, and environmental changes on community health. With funding from the Strategic Growth Council, the HCI is a two-year collaboration of the California Department of Public Health and the University of California, San Francisco (UCSF), to pilot the creation and dissemination of indicators linked to the HiAP Task Force's Healthy Communities Framework.

The Policy Unit's Climate and Health Team leads CDPH's efforts to address the health aspects of the state's efforts to reduce California's greenhouse gas emissions by 80 percent by 2050, prepare for the climate change impacts that are already occurring and plan for future impacts. The staff participate in the state's Climate Action Team (CAT), a cross-sector group of 20 agencies and departments working to develop and coordinate overall state climate change efforts. The Climate and Health team leads the CAT's Public Health Workgroup, where public health, state agency partners and diverse stakeholder groups meet to review critical climate and public health issues and work to ensure that public health and health equity are recognized and incorporated in state climate change planning efforts.

Health Research and Statistics Unit

The Health Research and Statistics Unit (HRSU) is the technical backbone of the OHE, providing and sharing research and data for OHE reports as well as baseline information for programs aimed at eliminating health and mental health inequities in California.

The unit inventories and organizes the abundant information regularly collected by other CDPH programs, state agencies, research organizations, and community-based organizations on the demographics and geography of vulnerable populations and on inequities in health and mental health outcomes, health services, and social determinants of health. It also collects existing information on interventions to reduce health and mental health inequities, allowing stakeholders to rapidly access such information.

The unit is also responsible for synthesizing and analyzing data to provide this report and subsequent biennial statistical profiles of health and mental health inequity in California, thereby providing a baseline against which progress can be measured. In addition, the unit analyzes and tracks Healthy People 2020 targets in order to monitor the state's progress toward eliminating health and mental health disparities and achieving health equity for all Californians.

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DEMOGRAPHIC REPORT ON HEALTH AND MENTAL HEALTH EQUITY IN CALIFORNIA
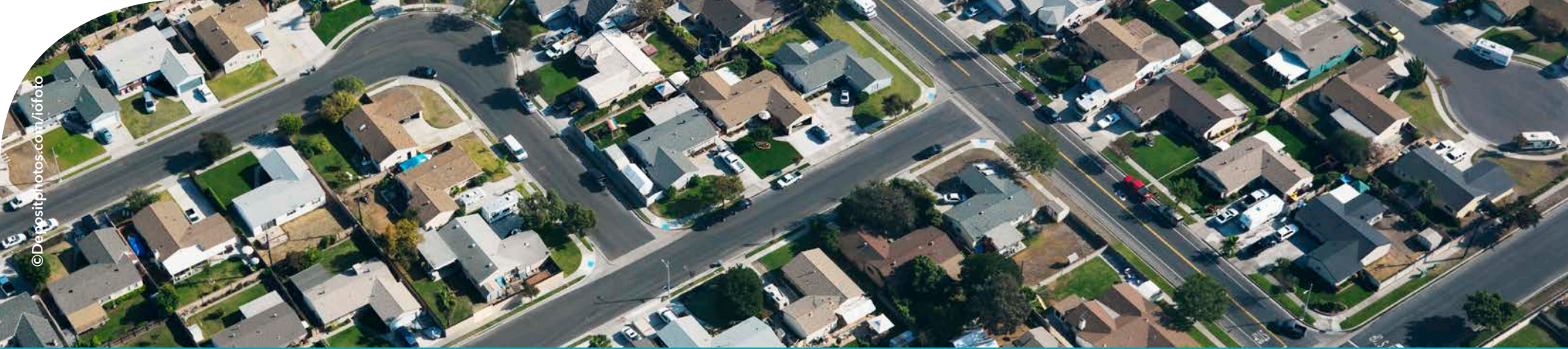
The Social Determinants
Shaping the Health of California's People and Places

As noted in the introduction to this report, the physical and mental health of individuals and entire communities is shaped, to a great extent, by the social, economic, and environmental circumstances in which people live, work, play, and learn. As explained by the World Health Organization, these same circumstances, or social determinants of health, are also "mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries."[1]

In preparing the California Statewide Plan to Promote Health and Mental Health Equity, the Office of Health Equity, working in close collaboration with other public and private agencies and advocacy organizations, has collected and analyzed a wealth of primary and secondary demographic and health data concerning the major underlying social, economic, and environmental conditions that contribute to the health and health inequities of the state's residents and their

communities. This data and analysis represent an initial benchmark to inform the current plan for addressing health inequities and disparities, as well as for measuring future progress toward the goal of reducing and eliminating these inequities and disparities.

In the following pages, we present highlights of the data and analysis relative to each of these key social determinants of health.

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Income Security:
The High Cost of Low Incomes

For many years, the relationship between socioeconomic status (SES), usually measured by income, education, or occupation, and health and mental health has been known. As individuals move up the SES ladder, their health improves, they live longer lives, and they have fewer health problems. Socioeconomic status is important because it provides access to needed resources that help people avoid risks, promote healthy behaviors, and protect health, such as "money, knowledge, power, prestige, and beneficial social connections."[1]

Several recent studies of the economic impact of poverty in the United States reveal that the nation as a whole pays the equivalent of $500 billion a year, or roughly 4 percent of U.S. gross domestic product (GDP), for the lost productivity and excess costs of health and other services associated with child poverty.[2] These studies confirm that children growing up in poverty receive less and lower-quality education, earn less as adults, are more likely to receive public assistance, and have lower-quality health and higher health costs over their lifetimes.

California Wealth and Income Disparities

Although the Great Recession of 2007-2009 hit the pocketbooks of families across the entire socioeconomic spectrum, the hardest hit included those who were already on the lower ranks of the income ladder. California families at the lowest income level (10th percentile) saw incomes fall more than 21 percent, while those at the 25th and 50th percentiles saw theirs fall about 10 percent. On the other hand, individuals in the 90th percentile experienced only a 5 percent decline, resulting in a new record level of income inequality in the state.[3]

Under the official federal poverty measure, California ranks 14th among the 50 states. However, California has the highest poverty rate in the nation when calculated according to an alternate (although unofficial) measure, known as the Supplemental Poverty Measure (SPM), which was developed by an Interagency Technical Working Group commissioned by the Office of Management and Budget's Chief Statistician to better reflect contemporary social and economic realities and government policy. The SPM factors in the cost of housing; taxes; noncash benefits; and day-to-day costs such as childcare, work-related expenses, utilities, clothing, and medical costs. This alternate method adds nearly 3 million more people to the official poverty rate, meaning that nearly one in four Californians would be considered poor.[4]

Single-Mother Households and Children Bear the Brunt of Poverty

Extreme income inequality is especially acute among California families headed by a single mother, one in three of which has an income below the poverty level. The disparity is even higher for families led by Latino, American Indian/Alaska Native, and African American single mothers *(see Figure 6)*. This suggests that the persistent (if improving) inequity in wages between men and women, with women being paid 75 percent of comparable wages paid to men,[5] is not simply a women's issue but also a serious family issue that contributes to additional inequities in quality of life for children. Almost half of the state's 2 million children age 3 or under live in low-income families.[6]

The Health Impact of Poverty

One of the highest costs of poverty is paid in the high rates of poorer health and lower life expectancy among vulnerable populations.[7] Evidence has shown a strong correlation between poverty-level income and cardiovascular disease, low birth weight, hypertension, arthritis, and diabetes.[8] One-third of deaths in the United States can be linked to income inequality, and it is estimated from data from 2007 that 883,914 deaths could have been prevented that year had the level of income inequality been lowered.[9] In addition, income-based inequities emerge

in cognitive development among infants as young as 9 months and widen as they age, leading to educational achievement gaps between higher- and lower-income peers in later years.[10] The prevalence of psychiatric disorders, including neurotic disorders, functional psychoses, and alcohol and drug dependence, is consistently more common among lower-income people.[11]

In short, one of the most beneficial prescriptions for improving people's health and closing the gaping disparities in health outcomes is to

Incubating Latino-Owned Startups In San Francisco's Mission District

In San Francisco, business incubators are normally associated with financial and technical assistance for high-tech startups looking to become the next Google. But since 2010, at a SparkPoint Center sponsored by United Way of the Bay Area, El Mercadito has helped nurture nine new microenterprises for Latino entrepreneurs impacted by economic circumstances. The center provides technical assistance, retail space, and financing opportunities from the Mission Economic Development Agency's Business Development Program and the Mission Asset Fund's Lending Circle program. Once the startups achieve sustainability, they can move into their own storefronts. El Mercadito merchants have also formed a small community of their own through a merchants association, assisting and relying on each other to achieve business success. Current businesses include Simmi's Boutique, Express Beauty and Warehouse, the Peruvian restaurant Cholo Soy, and Gallardo's Printing and Engraving, among others.

Recommended further reading from the Health Atlas for the City of Los Angeles: http://cityplanning.lacity.org/Cwd/framwk/healthwellness/text/HealthAtlas.pdf.

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ABOUT 33% OF FEMALE-HEADED HOUSEHOLDS AND 9% OF MARRIED-COUPLE HOUSEHOLDS LIVE BELOW THE FEDERAL POVERTY LEVEL

Percentage of families with children below the federal poverty level

	Latino	American Indian and Alaska Native	African American	Multi-Race	Other	Asian	Native Hawaiian and Other Pacific Islander	White	California
Female householder with children	40.9%	38.5%	35.0%	29.7%	25.5%	23.7%	23.3%	22.1%	32.8%
Married couple with children	15.3%	10.2%	7.1%	5.8%	8.2%	6.4%	8.6%	3.4%	8.7%

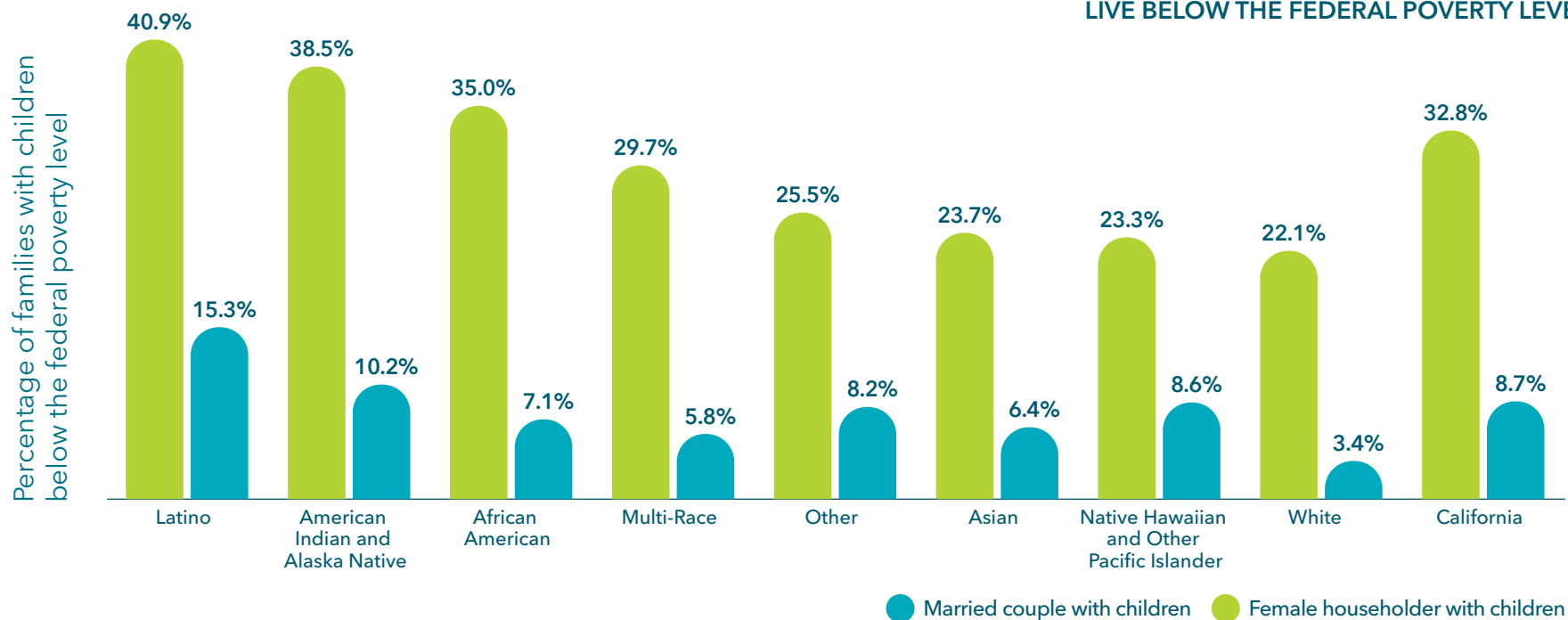● Married couple with children   ● Female householder with children

FIGURE 6: Percentage of families whose income in the past 12 months was below poverty level, by race/ethnicity, California, 2006-2010.

Source: U.S. Census Bureau, American Community Survey, 5-Year Estimates (2006-2010).

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Food Security and Nutrition

Food security, defined as stable access to affordable, sufficient food for an active, healthy life, is a basic human right.[1] Yet here in California, the nation's food-rich "breadbasket," many people experience periods when they cannot afford to put sufficient food on the table or they have to forgo other basic needs to do so. The food insecurity of California households with children ages 0 to 17 increased from 11.7 percent in 2000-2002 to 15.6 percent in 2010-2012.[2]

Chronic Food Insecurity Means More Than a Missed Meal

Adults who are food insecure have poorer health and are at risk of major depression as well as chronic diseases such as heart disease, diabetes, and hypertension:[3]

► Food-insecure expectant mothers may experience long-term physical health problems,[4] experience birth complications,[5] and be at greater risk of depression[6] and other mental health problems.[7]

► Food-insecure children have increased rates of developmental and mental health problems. They may also have problems with cognitive development and stunted growth, leading to detrimental impacts on their behavioral, social, and educational development.[6,8-14]

► Women living in food-insecure households are more likely to be overweight or obese. One possible explanation for this paradoxical correlation is that these women tend to overcompensate for periods when food is scarce by overeating when food is available.[15]

Communities of Color and Children Bear the Brunt

The pain of hunger and food insecurity impacts virtually all racial and ethnic groups and geographic regions of the state. However, low-income Latinos, African Americans, and American Indians/Alaska Natives have been disproportionately impacted by hunger and food insecurity (see Figure 7). More than 40 percent of these individuals experience food insecurity, as do more than 26 percent of all California children. Ironically, many of California's most food-insecure communities are located in the very heart of the state's agriculturally rich – and increasingly Latino – San Joaquin Valley. For example, the percentage of children in Fresno County who are food insecure is almost double that of food-insecure children in San Mateo County (see Figure 8).

Food Deserts in a Fertile Landscape

Marginalized, vulnerable communities experiencing high rates of food insecurity are not limited to the state's agricultural regions;

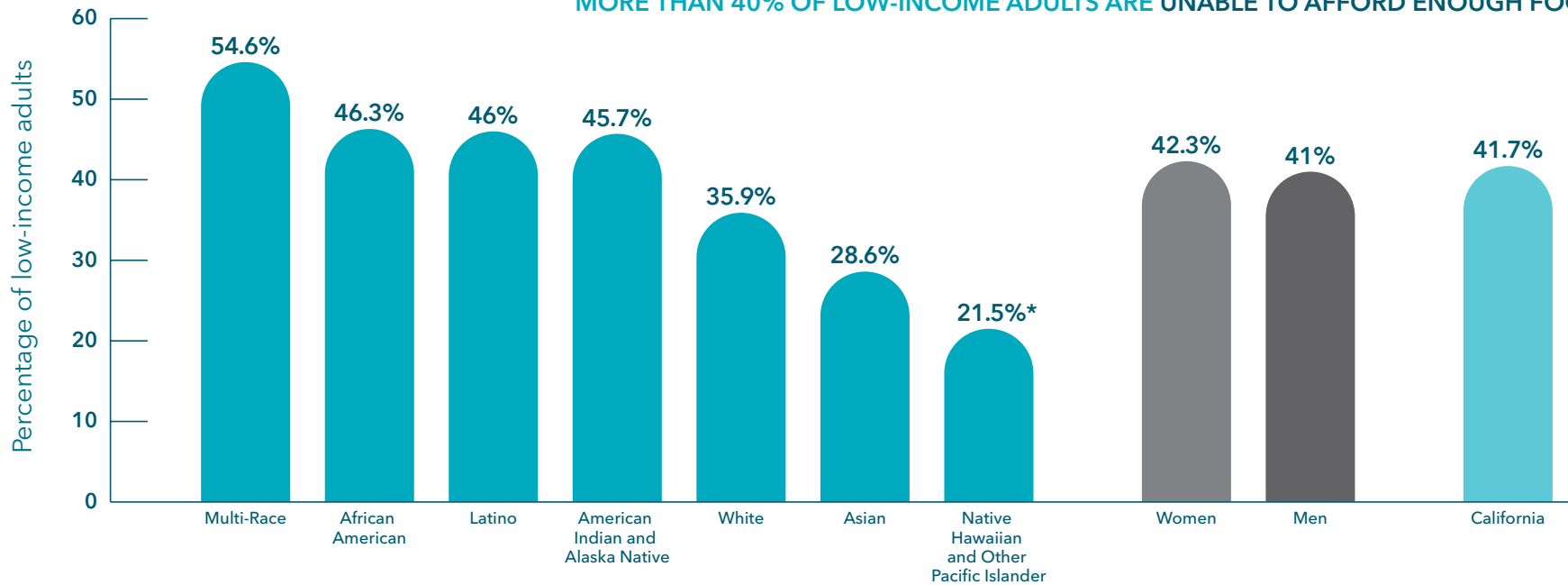**MORE THAN 40% OF LOW-INCOME ADULTS ARE UNABLE TO AFFORD ENOUGH FOOD**

Percentage of low-income adults

Multi-Race	African American	Latino	American Indian and Alaska Native	White	Asian	Native Hawaiian and Other Pacific Islander	Women	Men	California
54.6%	46.3%	46%	45.7%	35.9%	28.6%	21.5%*	42.3%	41%	41.7%

FIGURE 7: Percentage of adults whose income is less than 200% of the federal poverty level and who reported having food insecurity, by race/ethnicity and gender, California, 2011-2012.

Source: University of California, Los Angeles, California Health Interview Survey, 2011-2012.

* Statistically unreliable data.

they are also common throughout California's cities and suburban areas. Nationally, in 2010, nearly 30 million Americans (9.7 percent of the population) lived in low-income areas more than a mile from a supermarket.[16] These areas are often defined as virtual "food deserts," where fewer than 12 percent of local food retailers offer healthier food options, such as fresh fruits and vegetables, and where residents have limited means of travel to more distant full-service grocery stores.

One study found that residents with no supermarkets near their homes were 25 to 46 percent less likely to have a healthy diet.[17]

Summer Food Service Program for Low-Income Kids

The Summer Food Service Program is a federally funded program that reimburses public and private schools, nonprofit agencies, and local governments for providing free, nutritious meals to children (18 and younger) in low-income communities through the summer months when school is not in session. Participating organizations, which are reimbursed for their costs, can serve two meals or a meal and a snack each day, or up to three meals in residential camps and migrant farm worker sites. The U.S. Department of Agriculture, which sponsors the program, is working with California Department of Education officials to expand the program in California to at least 600 sites throughout the state. Nationally, about 7.5 million meals were served on a typical summer day in 2013.

Learn more at http://www.cde.ca.gov/fg/aa/nt/sfsp.asp.

1 IN 4 CHILDREN IN CALIFORNIA DOES NOT HAVE ENOUGH FOOD TO EAT

SAN MATEO COUNTY

$111,250	Median family income†
18.0%	Child food insecurity rate
9.5%	Children living in poverty
67.5%	Non-White children
60.3%	Children ages 3-4 enrolled in school
84.2%	Graduation rate

FRESNO COUNTY

$42,278	Median family income†
32.3%	Child food insecurity rate
35.5%	Children living in poverty
80.4%	Non-White children
40.8%	Children ages 3-4 enrolled in school
76.0%	Graduation rate

Child food insecurity rate (%)

- Equal to or below 22
- 22 - 26
- 26 - 30
- 30 or higher

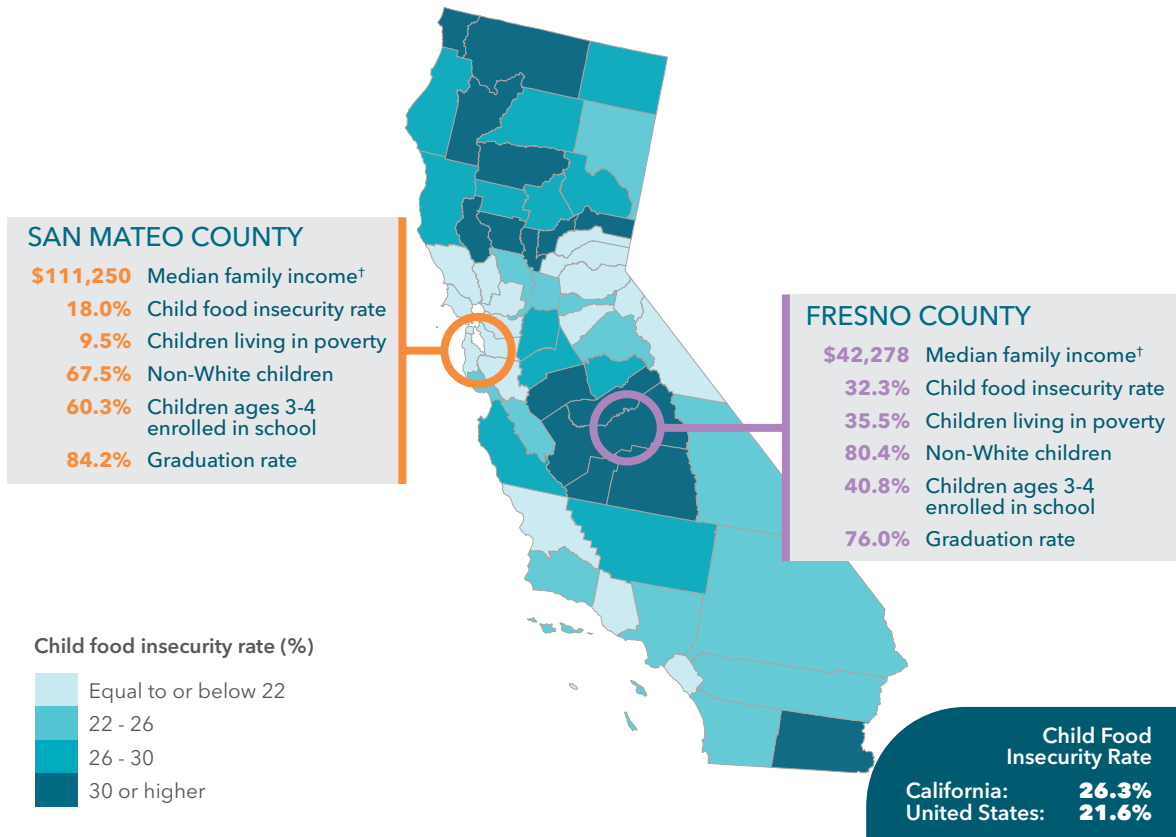| Child Food Insecurity Rate	
California:	**26.3%**
United States:	**21.6%**

FIGURE 8: Child food insecurity rate: percentage of children under 18 years old who are food insecure, California, 2012.

Sources: Feeding America, Map the Meal Gap, 2012; U.S. Census Bureau, American Community Survey, 3-Year Estimates (2009-2011) and 5-Year Estimates (2008-2012); and California Department of Education, Graduation Data, 2011-2012.
†Median family income with own children under 18 years.

A 2005 study focused on California found that for the state as a whole there were more than four times as many fast-food restaurants and convenience stores as supermarkets and produce vendors. This ratio of unhealthy to healthy food options varied substantially among counties and cities, with two counties (San Bernardino and Sacramento) and two cities (Bakersfield and Fresno) having nearly six times as many fast-food restaurants and convenience stores as supermarkets and produce vendors.[18] The communities with high concentrations of fast-food outlets and relatively high-priced convenience stores have been shown to be characterized by disproportionately high rates of obesity and diabetes, which are precursors of other chronic diseases, such as cardiovascular disease, stroke, and arthritis.

Food Councils Tackle Food Insecurity

Food councils and local, food-centered community groups have emerged as leaders of a movement to solve food insecurity and food quality concerns across California. They do this by promoting policies and education at the state and local levels that encourage and support sustainable urban and regional foodsheds, including community and home-scale gardening efforts, farmers markets, and urban agriculture. The California Food Policy Council is bringing together the food councils from the smallest counties, such as Plumas County and Sierra County, with the largest, Los Angeles County, to ensure that California's food system reflects the needs of all its communities.

Food councils address food security through policy changes that increase access to subsidized foods, like CalFresh, WIC, senior nutrition programs, and food banks. They also promote home- and community-grown food efforts; encourage economic development; and advocate for sustainable farming and fair labor practices by large-scale food producers, retailers, and the food-service industry.

Food councils are changing the foodscape of California through local ingenuity combined with community resourcefulness and resilience.

Learn more at
http://www.rootsofchange.org/content/activities-2/california-food-policy-council.

Child Development and Education:
Addressing Lifelong Disparities in Early Childhood

Many of the basic foundations for lifelong health, prosperity, and well-being are formed in early and middle childhood. That observation, increasingly recognized in policy, research, and clinical practice,[1] means that, as a society, we can minimize many of the health inequities featured in this report by focusing attention and resources on ensuring that our children – all our children – are provided with the strongest possible foundations for future success.

Getting a Head Start

In purely financial terms, early investment in childhood education is a winner. The rate of return on a $1 investment is 7 to 10 percent annually "through better outcomes in education, health, sociability, [and] economic productivity and [through] reduced crime," according to University of Chicago economist and Nobel laureate James Heckman. Over a lifetime, the return on that $1 adds up to $60

MORE THAN HALF OF THE CHILDREN IN CALIFORNIA AGES 3 TO 4 DO NOT ATTEND PRESCHOOL

Percentage of children

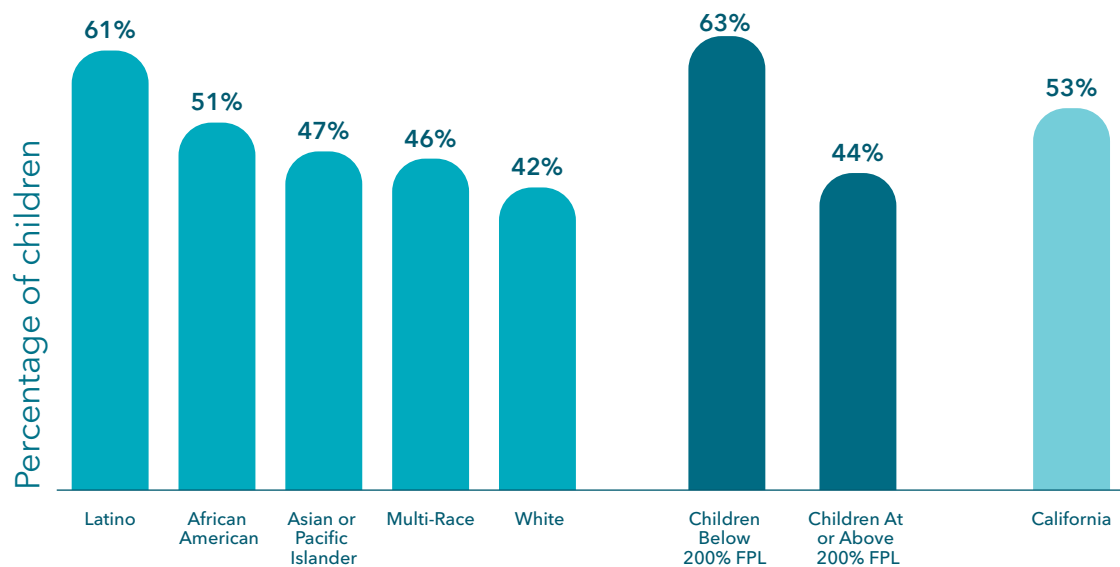| Latino	African American	Asian or Pacific Islander	Multi-Race	White	Children Below 200% FPL	Children At or Above 200% FPL	California
61%	51%	47%	46%	42%	63%	44%	53%

FIGURE 9: Percentage of children in California ages 3 to 4 who are not attending preschool, by race/ethnicity and federal poverty level (FPL), 2009-2011.

Source: U.S. Census Bureau, American Community Survey, 3-Year Estimates (2009-2011). Analysis by the Annie E. Casey Foundation, KIDS COUNT Data Center.

A HIGHER PROPORTION OF ASIAN AND WHITE THIRD-GRADERS ARE READING AT OR ABOVE GRADE LEVEL COMPARED WITH AFRICAN AMERICANS AND LATINOS

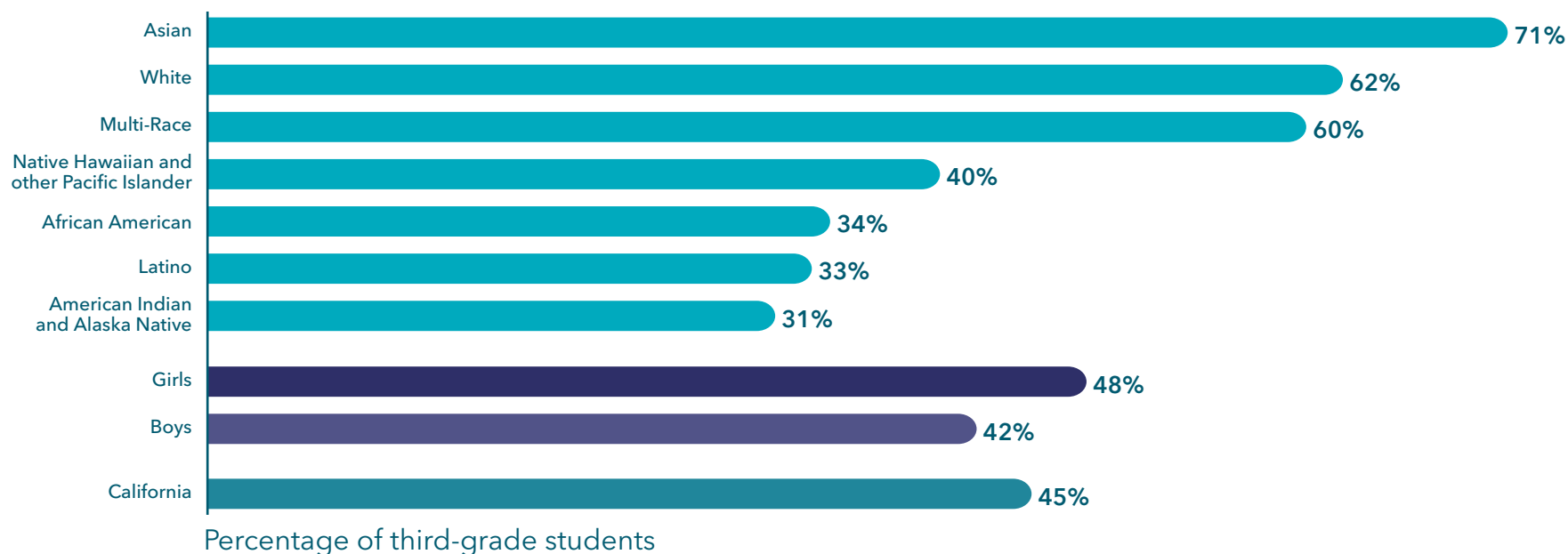| Group	Percentage
Asian	71%
White	62%
Multi-Race	60%
Native Hawaiian and other Pacific Islander	40%
African American	34%
Latino	33%
American Indian and Alaska Native	31%
Girls	48%
Boys	42%
California	45%

Percentage of third-grade students

FIGURE 10: Percentage of third-grade students scoring proficient or higher on English Language Arts California Standards Test (CST), by race/ethnicity and gender, California, 2013.

Source: California Department of Education, Standardized Testing and Reporting (STAR) Results, 2013. Analysis by www.kidsdata.org, a program of the Lucile Packard Foundation for Children's Health.

to $300.[2]

One of the most successful ways of supporting healthy early childhood development is through high-quality infant and toddler care, whether provided by parent(s) who feel prepared and supported, or by family or outside day care providers, Head Start, or preschool programs.[3] Getting ready to learn is especially important for the nearly half of all California children who live in low-income families (less than 200 percent of the federal poverty level),[4] a disproportionately large share of whom are non-White. Despite the evidence demonstrating the importance of early childhood care and enrichment, only 6 percent of income-eligible children under age 3 are served by any publicly supported program.[5] Some reasons proposed for this are transportation barriers, especially for rural areas; cultural, language, or literacy barriers; lack of awareness; and staffing or facilities issues. As shown in Figure 9, about three in five low-income children ages 3 to 4 are not attending preschool, including three out of five Latinos and more than half of African Americans.

Third-Grade Reading Proficiency as a Predictor of Future Performance

When children do not participate in early developmental and educational opportunities, the impact is seen in later educational performance. In a hopeful trend, the latest data shows that the percentage of reading-proficient California third-graders increased between 2003 and 2013 for all subgroups. However, despite this overall improvement, significant gaps remain between English learners; economically disadvantaged children (those eligible for reduced-price lunch programs); boys and girls; and some of the largest racial or ethnic subgroups, including American Indians/Alaska Natives, Latinos, and African

MALE UNDERGRADUATE STUDENTS ARE UNDERREPRESENTED IN CALIFORNIA PUBLIC HIGHER EDUCATION
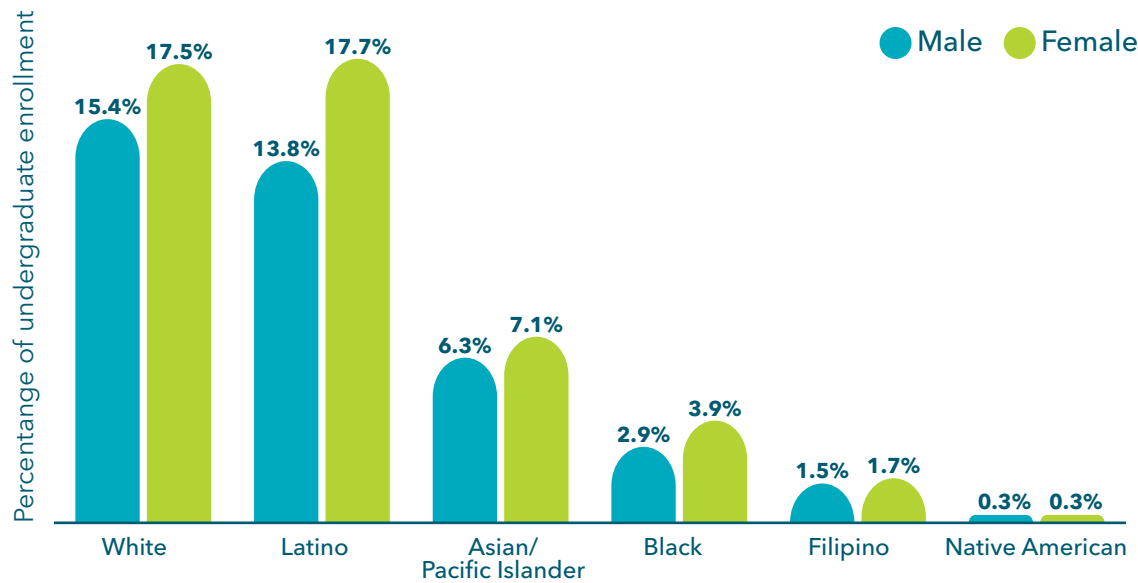

FIGURE 11: Percentage of undergraduate enrollment, by race/ethnicity and gender, California Public Higher Education, 2010.

Source: California Postsecondary Education Commission.
Note: Unknown percentage is not included in the table.

A Green Education for a Green Economy

The East Bay Green Corridor's Energy and Technology (GET) Academies were founded in 2008 to create high-quality jobs in green manufacturing and clean energy research among East Bay communities. The GET Academies, with support from the Institute for Sustainable Economic, Educational and Environmental Design, are located in nine East Bay high schools, where they are pioneering an educational curriculum in green science, technology, engineering, and math to help students graduate with the 21st-century skills and knowledge they will need to succeed in the clean energy economy. The program is designed to support the development of multiple pathways by which California's students can graduate high school, complete postsecondary education, attain industry-recognized credentials, and embark on a long and lasting career in a fulfilling, high-paying job.

Learn more at http://iseeed.org/programs/east-bay-green-corridor/.

Strong Public Support for Universal Preschool

Reflecting a growing public focus on preschool since President Obama proposed universal access to high-quality preschool for all low- and middle-income 4-year-olds, an April 2014 survey by the California Field Poll, a nonpartisan public opinion news service, registered strong voter support for extending California's transitional kindergarten to include all 4-year-olds at an estimated cost of $1.4 billion. The poll found that 56 percent of those without young children, and 57 percent of people overall, support the idea. Latinos registered the greatest support (75 percent), followed by African Americans, at 72 percent. The 2014-15 Budget Act allocates funding to support the expansion of California State Preschool Program for 3- and 4-year old children from low income families.

Sources: The President's 2015 Budget Proposal for Education. U.S. Department of Education Website. http://www.ed.gov/budget15. Accessed July 2014.

DiCamillo M, Field M. Majority of California Voters supports expanding pre-school to all four-year-olds despite its additional costs and regardless of parents' incomes. San Francisco, CA: The Field Poll; April 2014.

California State Budget 2014-2015. California State Budget Website. http://www.ebudget.ca.gov/2014-15/pdf/Enacted/BudgetSummary/FullBudgetSummary.pdf. Accessed November 2014.

Americans, compared with higher-income, White, and Asian students *(see Figure 10)*. For example, only 33 percent of economically disadvantaged third-graders in 2013 were reading at proficiency levels, compared with 67 percent of higher-income students.[6] These educational inequities start early and have long-lasting implications *(see Figure 11)*.

Similar disparities exist in terms of high school dropout and graduation rates, although here, too, there has been notable improvement in recent years. In 2012, more than 65,000 California students who started high school in 2008 dropped out – about one of every eight students. However, dropout rates vary widely by school district and among racial/ethnic groups. Generally, African American, American Indian/Alaska Native, Latino, and Native Hawaiian/Pacific Islander students have significantly higher dropout rates than Asian American and White students.[7] Research has shown that young people who do not complete high school are more likely than those with higher education levels to be unemployed, live in poverty, be dependent on welfare benefits, have poor physical and mental health, and engage in more criminal activity.[8] One national study estimated that if those who dropped out of high school in 2011 had graduated instead, the nation's economy would benefit by about $154 billion over their lifetimes.[9]

Implications for Lifelong Health

More than any other developmental period, early childhood development sets the stage for acquiring skills that directly affect children's physical and mental health – health literacy, self-discipline, the ability to make good decisions about risky situations, eating habits, and conflict negotiation.[1] These same skills influence children's health and mental health throughout adolescence, contributing to important public health and social problems, including increases in school violence, teen sexuality, and eating disorders, as well as the onset of many psychological disorders.[10]

©Depositphotos.com/monkeybusiness

The Mission Neighborhood Promise of Cradle-to-Career Education

Despite high and rapidly rising housing costs, San Francisco's Mission District remains one of the poorest in the city, with a high teen birthrate, a high dropout rate, and more than three out of four of its 12,000 mostly Latino children living in low-income housing, according to the Mission Economic Development Agency (MEDA). But big changes are coming to the neighborhood, thanks to a five-year, $30 million U.S. Department of Education grant recently awarded to MEDA to implement the Mission Promise Neighborhood (MPN). The MPN is a citywide partnership of local agencies, the school district, colleges and universities, and 26 nonprofit service providers to integrate a host of cradle-to-college-to-career services that improve academic achievement and build family wealth for the families of children at four participating Mission District schools. The MPN integrated service model builds on the success of the Harlem Children's Zone, which provides children and families with high-quality, coordinated educational, health, social, and community supports from cradle to career.

Learn more at www.missionpromise.org.

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Housing:
A Leading Social Determinant of Public Health

Housing plays a fundamental role impacting public health, from locational attributes to housing quality and affordability.[1] Stable housing (adequate, safe, and affordable) is a foundation for healthy family growth and for thriving communities.

An Unaffordable House Is Not a Healthy Home

Healthy and stable housing is one of the most basic requirements for a sense of personal security, sustainable communities, family stability, and the health of every individual. It is essential for meeting our physical needs for shelter against environmental hazards, our psychological and emotional needs for personal space and privacy, and our social needs for a gathering place for family and friends.

When Housing Becomes Unaffordable...

Cost of shelter is the largest non-negotiable expense for most families. When the cost is excessive, families fall behind on rent or mortgage payments and have little or no disposable income, often going without food, utilities, or health care.[2] For a growing share of lower- and even middle-income Californians, lack of affordable and adequate housing has made this issue a contributor to mental stress and physical illness rather than a source of health and well-being. The rising cost of housing over several decades (a trend that reversed temporarily during the Great Recession) has put even the lowest-priced 25 percent of homes in any given area out of reach for approximately half of all American families, up from 40 percent in the mid-1980s.[3] In California, the housing "affordability index"

– the percentage of households that can afford to purchase a median-priced home without exceeding 30 percent of the household income, as recommended by lending institutions – has fallen rapidly, as housing prices have rebounded since 2012. For example, in 2014, only 33 percent of California households could afford to purchase a median-priced single-family home, while 44 percent could afford to purchase a condominium or a town house. Nationally, 59 percent of households could afford to purchase a home of either type.[4] Rents are rising rapidly and rental vacancy rates are in decline, impacting lower-income households in particular, of which a third are households headed by an elderly person or a person with disabilities, and a third are families with children. The latest American Community Survey shows that almost 60 percent of all renters and 78 percent of the lower-income renters (earning 80 percent or less than the median income)

Demographic Report on Health and Mental Health Equity in California **39**

AFRICAN AMERICANS AND LATINOS ARE MORE LIKELY TO SPEND MORE THAN 30% OF THEIR INCOME ON HOUSING THAN OTHER RACIAL/ETHNIC GROUPS

Percentage of housing cost burden

	African American	Latino	American Indian and Alaska Native	Multi-Race	White	Native Hawaiian and Other Pacific Islander	Asian	California
Renters cost burdened	57.9%	55.5%	52.2%	49.1%	46.6%	46.4%	43.9%	50.4%
Owners cost burdened	51.6%	51.8%	39.6%	45.0%	36.0%	50.5%	43.4%	41.2%

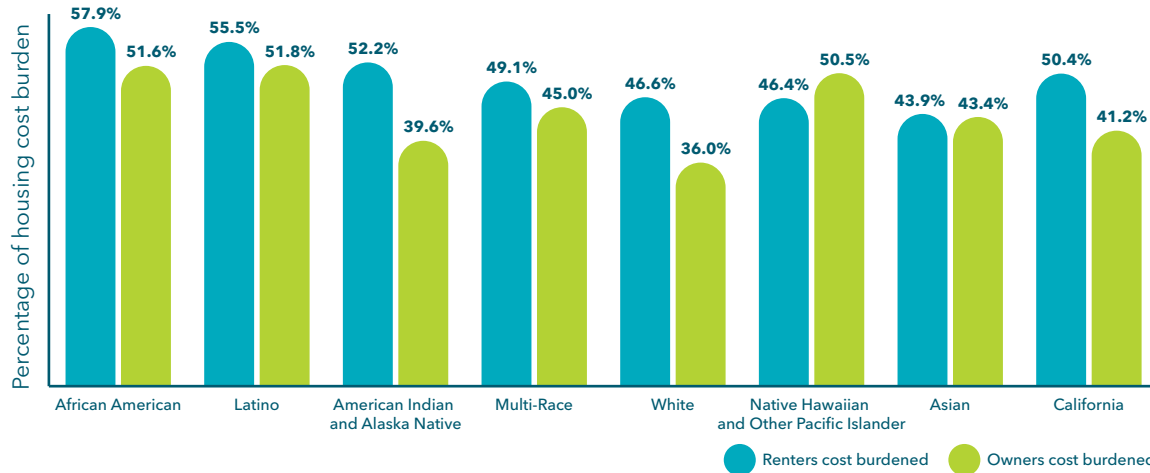● Renters cost burdened ● Owners cost burdened

FIGURE 12: Percentage of housing cost burden, by tenure and race/ethnicity, California, 2006-2010.

Source: U.S. Department of Housing and Urban Development, Comprehensive Housing Affordability Strategy, 2006-2010. Analysis by CDPH-Office of Health Equity and UCSF, Healthy Communities and Data and Indicators Project.
Cost burdened is defined as households spending more than 30% of monthly household income on housing costs.
Housing costs include monthly, gross rent (rent and utilities) or selected, housing costs (mortgage, utilities, property tax, insurance and, if applicable, home association fees).

pay in excess of 30 percent of their income for rent.[5] Households with high housing cost burdens (over 30 percent of annual income) are often referred to as "shelter poor" because they have less to spend on other essentials, such as food, clothing, and health care, and are more likely to report that their children have only fair or poor health.[6] In California, African American and Latino households are shouldering a slightly heavier burden of housing cost, with more than 50 percent of these renters and owners spending more than 30 percent of their monthly household income on housing *(see Figure 12)*.

The Color of the Housing Crisis

The affordability crisis is particularly acute in California, and it has disproportionately affected low-income and other vulnerable populations throughout the state. Home ownership rates among Latinos and African Americans are significantly below the state average and about 31 to 43 percent lower than the rate of White families *(see Figure 13)*. In addition, African American and Latino families who were recent borrowers experienced foreclosure rates during the recession that were double the rate of White families.[7] Foreclosures and rapidly rising rents have also contributed to high rates of housing disruption for economically disadvantaged families and

communities of color: African Americans and American Indians/Alaska Natives are roughly one-third more likely than the California average to experience a disruptive change of residence during a given year *(see Figure 14)*. Such unplanned changes are a source of harmful stress and disruption in families' access to health care services, education, social networks, and employment opportunities. These families will be more likely to also feel the delayed "spin-off" effects of recession, such as poor credit affecting employment and renting, or declining neighborhoods with increased crime and poverty.[8]

The barriers to healthy, stable, and affordable housing resulted in the ultimate plight of the housing crisis: homelessness.[9] With 12 percent of the U.S. population, California was home to more than 22 percent of the nation's homeless in 2013, an increase of 5,928 people from the previous year. On a single night in January 2013, 136,826 Californians were homeless. Almost seven in 10 homeless individuals in California live unsheltered (meaning they do not use shelters and are typically found on the streets, in abandoned buildings, or in other places not meant for human habitation) on any given night – the highest rate for unsheltered homeless in the nation.

Beyond Affordable Housing: Healthy Communities

A healthy home is more than an affordable house. Ultimately it must also meet at least minimum community safety and

DISPARITIES IN HOUSING OCCUPANCY EXIST ACROSS RACIAL/ETHNIC GROUPS IN CALIFORNIA
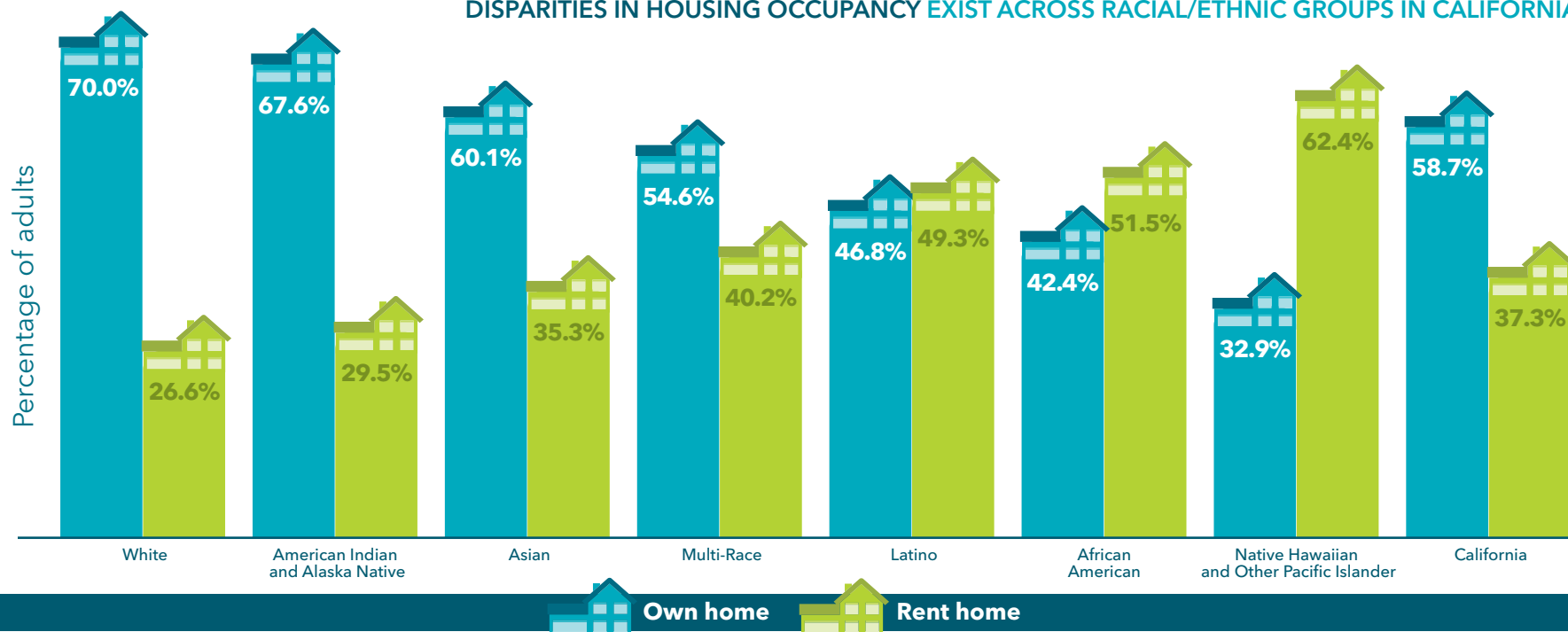
Percentage of adults

Group	Own home	Rent home
White	70.0%	26.6%
American Indian and Alaska Native	67.6%	29.5%
Asian	60.1%	35.3%
Multi-Race	54.6%	40.2%
Latino	46.8%	49.3%
African American	42.4%	51.5%
Native Hawaiian and Other Pacific Islander	32.9%	62.4%
California	58.7%	37.3%

Own home   Rent home

FIGURE 13: Percentage of adults who own or rent their homes, by race/ethnicity, California, 2011-2012.

Source: University of California Los Angeles, California Health Interview Survey, 2011-2012.
Note: Within each race/ethnic group, variable "have other arrangement" is not included, and the percentages may not add up to 100.

Building Housing and Wealth in East L.A.

The East L.A. Community Corporation (ELACC) is focused on developing housing and providing financial education for the low-income and mostly Latino residents of Boyle Heights and unincorporated East Los Angeles. ELACC's approach has four components: increasing the supply of quality, affordable housing; providing financial education for first-time home-buying and foreclosure prevention; providing related tenant services, including affordable childcare and English language tutoring; and community organizing for neighborhood cohesion and empowerment.

ELACC serves more than 2,000 residents every year and has leveraged more than $135 million of investment to the Eastside while completing more than 550 housing units serving more than 1,000 residents, with more than 300 units in various stages of development. It has mobilized a community organizing base of over 1,300 members annually and has helped over 3,000 families purchase their first homes, avoid foreclosure, establish savings, and build and sustain wealth.

Learn more at http://www.elacc.org/.

AFRICAN AMERICANS AND AMERICAN INDIANS/ALASKA NATIVES ARE MORE LIKELY TO EXPERIENCE THE DISRUPTION OF A RESIDENTIAL MOVE THAN ARE OTHER RACE/ETHNICITIES
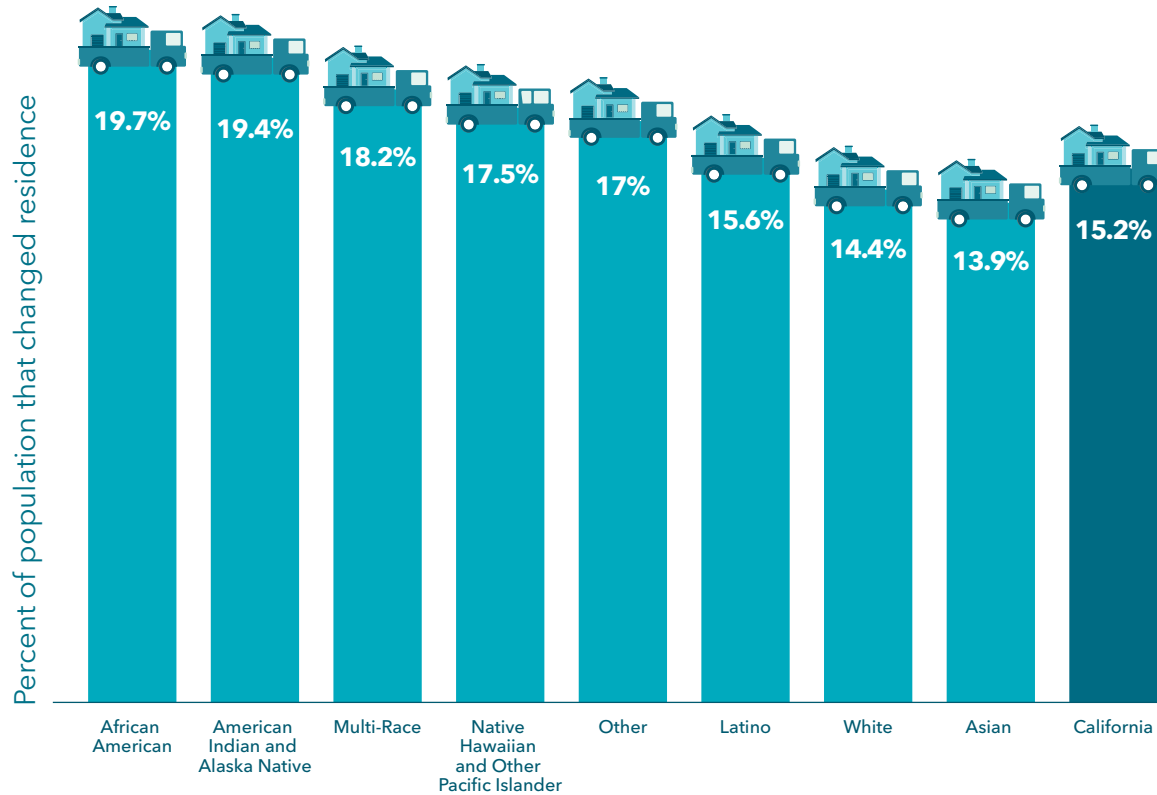

Percent of population that changed residence

African American	19.7%
American Indian and Alaska Native	19.4%
Multi-Race	18.2%
Native Hawaiian and Other Pacific Islander	17.5%
Other	17%
Latino	15.6%
White	14.4%
Asian	13.9%
California	15.2%

FIGURE 13: Percentage of population age 1 year and over who changed their residence (different house in the U.S.) from last year to current year, by race/ethnicity, California, 2006-2010.

Source: U.S. Census Bureau, American Community Survey, 5-year Estimate (2006-2010).

health standards and be part of a healthy neighborhood. That means being part of a community with parks and sidewalks and bike paths; with clean air and clean soil and clean water; with full-service grocery stores that stock affordable, healthy, fresh fruits and produce; with high-quality childcare, preschools, and K-12 schools that graduate all children; with reliable, affordable public transit for getting to work; and with decent-paying local jobs at healthy workplaces. That's the kind of healthy home we all deserve.

New Resource on Low-Income Housing from the California Housing Partnership Corporation

The California Housing Partnership Corporation (CHPC), a nonprofit organization created by the state legislature to monitor, protect, and augment the supply of affordable homes to lower-income Californians, has assisted more than 200 nonprofit and local government housing organizations in leveraging more than $5 billion in private and public financing to create and preserve 20,000 affordable homes. In February 2014, CHPC published *California's Housing Market Is Failing to Meet the Needs of Low-Income Families*. The comprehensive report includes an analysis of the enormous shortfall of homes affordable to low-income families in California, the impact of state and federal disinvestment in affordable housing, and recommendations for policy makers.

Learn more at http://www.chpc.net/policy/index.html.

Environmental Quality:
The Inequities of an Unhealthy Environment

The environment – the air we breathe; the water we consume; the soil that nourishes the food we eat; and all the natural and human-made conditions of the places we live, work, learn, and play – has a profound impact on the health of every one of us. Yet low-income families, communities of color, and certain other vulnerable populations, especially children, are disproportionately subjected to environmental perils that have been causally linked to epidemic rates of various respiratory problems, including bronchitis, emphysema, asthma, and other diseases, disabilities, and chronic health conditions.[1] Figure 14 illustrates that the pollution burden tends to be high in California's Central Valley, where Latinos and non-Whites make up a large proportion of the population.

Despite having achieved impressive improvements in overall air pollution quality in recent decades, California is still home to the top five cities in the nation for both ozone pollution and year-round and short-term particle pollution, the two sources of the most negative health effects of polluted air.[2] The state's smoggiest cities are also the cities with the highest densities of people of color and low-income residents who lack health insurance.[3]

Climate Change Threatens Even Greater Disparities

Climate change poses significant risks to the health and well-being of all Californians today and for generations to come, according to *The Third National Climate Assessment*, released in May 2014.[4] A 2009 report from the California Climate Change Center warned that current and anticipated impacts of climate change will likely create especially heavy burdens on low-income and other vuln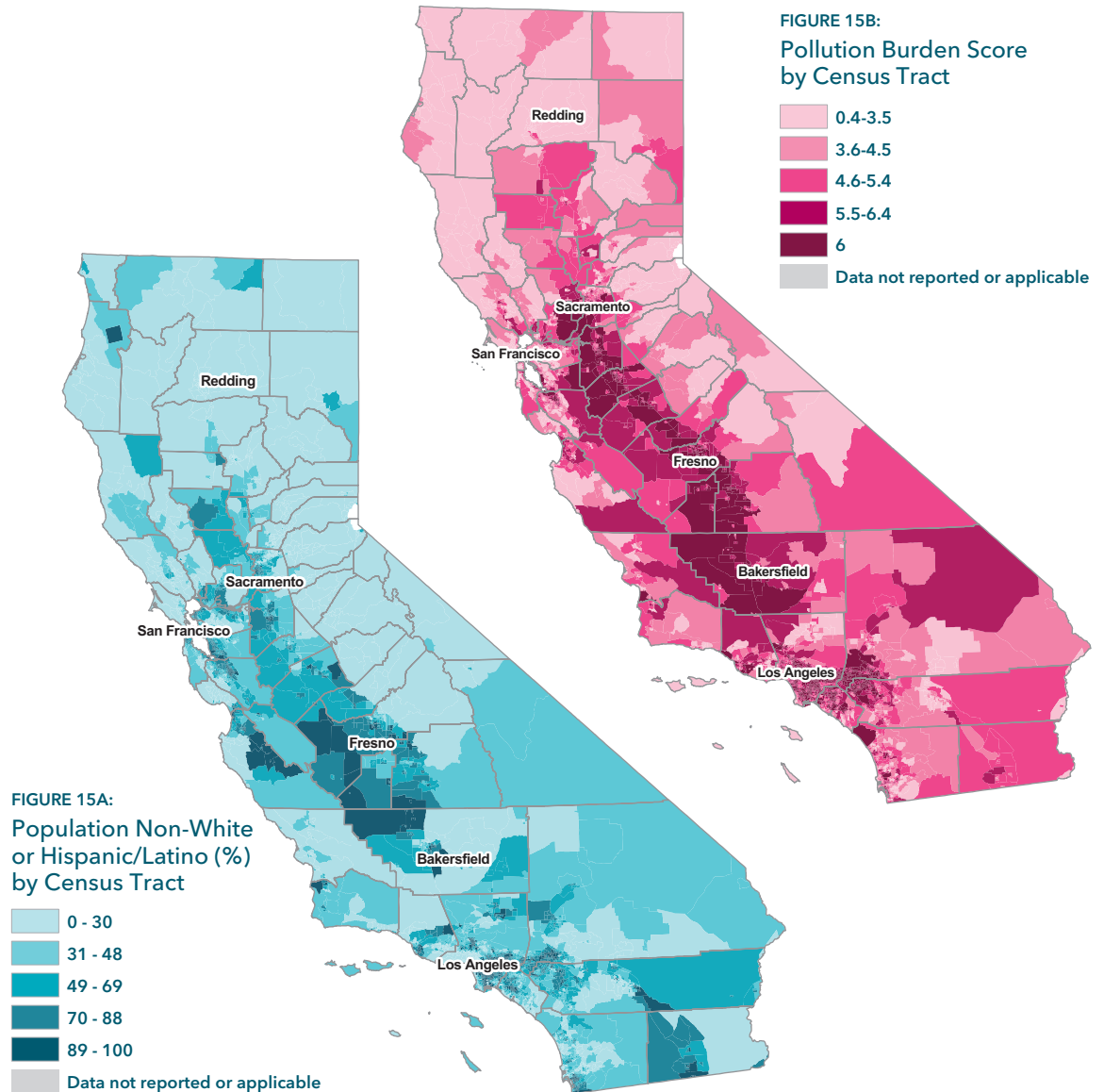erable populations: "Without proactive policies to address these equity concerns, climate change will likely reinforce and amplify current as well as future socioeconomic disparities, leaving low-income, minority, and politically marginalized groups with fewer economic opportunities and more environmental and health burdens." The report emphasized that some of the greatest economic impacts of climate change are expected to hit the state's agricultural sector, whose half million workers are predominantly Latino, and tourism-related industries, in which people of color make up a majority of the workforce.[3]

Responding to climate change through public health prevention and preparedness measures can help reduce existing health disparities and create opportunities to improve health and well-being across multiple sectors, including agriculture, transportation, and energy.[3]

Low-Income Children Are Uniquely Vulnerable

It is well established that children are more susceptible to environmental pollutants than are adults because their nervous, immune, digestive, and other bodily systems are still developing. Moreover, children eat more food, drink more fluids, and breathe more air in relation to their body weights compared with adults.[5] Exposure to high levels of air pollutants, including indoor air pollutants and secondhand smoke, increases the risk of premature death, respiratory infections, heart disease, and asthma.[6] Children living in low-income neighborhoods near heavy, energy-intensive industry; rail yards; and heavily trafficked freeways and streets in urban areas are at special risk of chronic respiratory conditions. African American children are four times more likely to be hospitalized for asthma compared with White children, and urban African American and Latino children are two to six times more likely to die from asthma than are White children.[7] Of the more than 600,000 Californians who experience frequent symptoms of uncontrolled asthma, nearly 240,000 cases are in families earning less than 200 percent of the federal poverty level, compared with 120,000 cases from families with income of 400 percent of the federal poverty level or higher.[8]

LATINO OR NON-WHITE POPULATIONS ARE MORE LIKELY TO LIVE IN AREAS WITH A HIGH BURDEN OF POLLUTION

FIGURE 15B:
Pollution Burden Score by Census Tract

- 0.4-3.5
- 3.6-4.5
- 4.6-5.4
- 5.5-6.4
- 6
- Data not reported or applicable

FIGURE 15A:
Population Non-White or Hispanic/Latino (%) by Census Tract

- 0 - 30
- 31 - 48
- 49 - 69
- 70 - 88
- 89 - 100
- Data not reported or applicable

Built Environment:
Healthy Neighborhoods, Healthy People

The built environment refers to human-designed and constructed surroundings, including everything from transportation networks (e.g., streets, freeways, sidewalks) to buildings (e.g., stores, hospitals, factories, houses, schools, office buildings) to various recreational amenities (e.g., parks, playgrounds). How we design the built environment profoundly impacts every aspect of our quality of life, especially as it relates to our physical, mental, and social health.

Influence on Access to Healthy Foods and Physical Activity

The built environment influences many aspects of a community, such as whether healthy food can be accessed and where children can safely play. An analysis of data from the California Health Interview Survey has shown that people in neighborhoods with a low number of full-service grocery stores have higher rates of obesity, and neighborhoods with fewer grocery stores tend to have more poor non-White residents than do neighborhoods with easy access to fresh fruits and vegetables.[1] The dietary link to obesity is further exacerbated because many of these same neighborhoods that lack healthy food outlets also lack safe places to be active, including walkable streets, bike paths, parks, and other recreational amenities.

Land Use, Transportation, and Health

Transportation systems and land use policies can support health and equity by influencing an individual's social connections, physical activity, and level of access to jobs, medical care, healthy food, educational opportunities, parks, and other necessities. In addition, promoting safe, active transportation (e.g., walking, biking, rolling, or public transportation) is an important strategy for promoting health and equity while also reducing greenhouse gas emissions. California's state leadership has identified healthy, sustainable transportation as a priority, and in 2014 the California Department of Transportation adopted a new goal to "promote health through active transportation and reduced pollution in communities."[2]

In California and throughout the nation, the health consequences of traffic-intensive development and transport patterns include higher rates of air pollutants, which are associated with higher incidence and severity of respiratory symptoms, and stress-related health problems and other physical ailments (e.g., back pain) associated with commuting.[3] In a car-based transportation region, people are less likely to bike, walk, or skate to school or the grocery store, thus contributing to higher rates of cardiovascular disease, diabetes, and obesity. For example, school siting and transportation planning significantly impact

how children get to school; despite the health and environmental benefits of walking and biking, the percentage of children walking or biking to school in the U.S. has dropped from 40 percent in 1969 to just 5 to 13 percent in 2009.[4] Additionally, families living in these car-based transportation regions tend to spend a higher proportion of their income on transportation costs *(see Figure 16)*, and the high burden of transportation costs can put a strain on other essential expenses such as health care, education, and food.

THE BURDEN OF TRANSPORTATION COST RELATIVE TO INCOME IS HIGHER IN RURAL REGIONS AND COUNTIES OF CALIFORNIA

FRESNO COUNTY

80%	Urban
20%	Rural
$42,278	Median Family Income‡
76.7%	Drive to Work
19 deaths per 100,00	Transportation-related fatal injury rate†

SAN FRANCISCO COUNTY

100%*	Urban
$91,294	Median Family Income‡
37.3%	Drive to Work
5 deaths per 100,00	Transportation-related fatal injury rate†

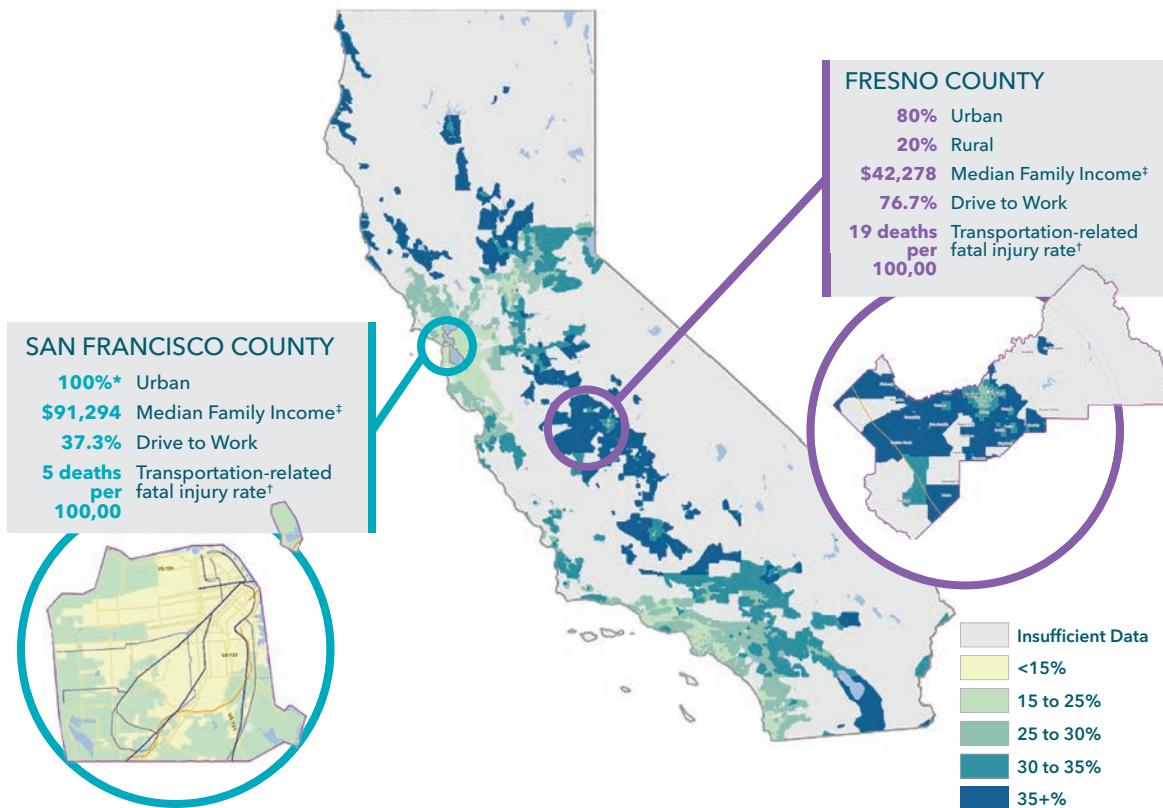Insufficient Data
<15%
15 to 25%
25 to 30%
30 to 35%
35+%

FIGURE 16: Transportation costs as a percentage of income, California, 2009.

Sources: Center for Neighborhood Technology, Housing and Transportation (H+T) Affordability Index, 2009; U.S. Census Bureau, American Community Survey, 5-Year Estimate (2008-2012); Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control, Web-Based Injury Statistics Query and Reporting System (WISQARS), 2004-2010; and University of California Los Angeles, California Health Interview Survey, 2011-2012.
†Age-adjusted death rate.
*Statistically unreliable data.
‡Median family income with own children under 18 years.

Clean Trucks, Healthier Neighborhoods

The ports of Los Angeles and Long Beach handle 70 percent of U.S. Pacific Coast cargo, and thousands of trucks spewing diesel fuel exhaust routinely passed through the low-income, immigrant neighborhoods of southwest Los Angeles each day from the port, raising cancer and asthma risks and causing injuries and traffic problems. Thanks to campaigns by a coalition of environmental, public health, and environmental justice groups, the Air Resources Board adopted a statewide regulation in 2007 and the ports adopted a Clean Truck Program in 2008; both set more stringent emission standards for port trucks. Nearly $200 million in state and local incentives aided the transition to cleaner trucks. In less than three years, these programs were responsible for cleaning up the nation's busiest drayage truck fleet and cut related air pollution in local communities by 90 percent.

Sources: Clean trucks. Port of Long Beach Website. http://www.polb.com/environment/cleantrucks/default.asp. Posted January 11, 2011. Fighting the cycle of poverty and pollution at the ports of Los Angeles and Long Beach. Coalition for Clean and Safe Ports Website. http://cleanandsafeports.org/los-angeleslong-beach/#sthash.kfSBbdib.dpuf. Accessed May 2014.

PHYSICAL ACTIVITY AMONG TEENAGERS IS ASSOCIATED WITH PLACE AND ACCESS TO PARKS

Did not go to park, playground, or open space in past month
18.4% — 29.8%

Park, playground, or open space is not within walking distance
9.7% — 18.3%

Not physically active in the past week
7.2% — 9%

Overweight/obese
14.2% — 18.5%

Bay Area Counties · San Joaquin Valley
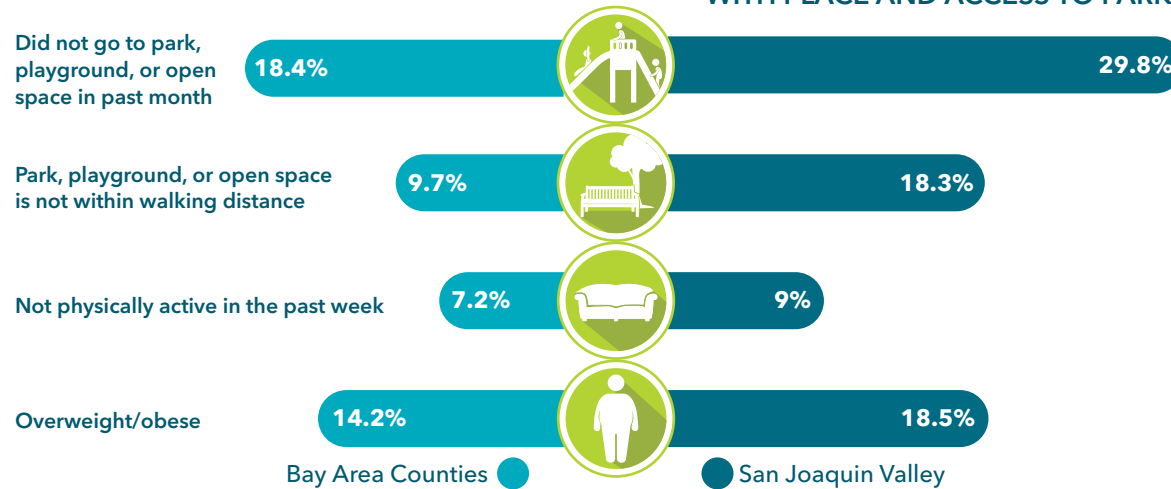
FIGURE 17: Percentage of teenagers from the Bay Area counties and San Joaquin Valley who reported not having access to parks, playgrounds, or open spaces; not being physically active; and being overweight or obese, California, 2011-2012.

Source: University of California Los Angeles, California Health Interview Survey, 2011-2012.

In addition to reducing transportation costs and the associated inequities, a focus on California's land use and transit systems can address important health inequities. People who live in highly walkable, safe, mixed-use communities with easy access to green space and public transit options have higher levels of physical activity and lower body mass indices[5,6], contributing to greater overall health *(see Figure 17)*. Strong evidence suggests that active transportation is positively associated with better cardiovascular health, lower risk of diabetes, and lower risk of hypertension. For example, the Integrated Transport and Health Impacts Model (I-THIM), developed by the California Department of Public Health, found that in the San Francisco Bay Area an increase in daily walking and biking per capita from four to 22 minutes would reduce cardiovascular disease and diabetes by 14 percent, and would decrease greenhouse gas emissions by 14 percent. The downside of this increased activity, however, would be a 39 percent increase in traffic injuries.[7] Traffic-related injuries and deaths disproportionately impact vulnerable populations such as older adults, children, communities of color, and low-income communities.[8] Investing in a range of land use and safety improvements that support active transportation could help reduce these inequities. Well-designed, well-built, safe neighborhoods and streets are essential to people's well-being, and are important strategies for promoting health and mental health throughout California.

Jobs and Healthy Food for South Los Angeles

For the 455,000 residents of South Los Angeles, the April 2014 opening of the Northgate Gonzales Market was a cause for celebration. The market, the latest addition of a local, Mexican American-owned grocery chain, gives local area residents unaccustomed access to healthy food options that have eluded this fast-food-dense area for years. It also provides 130 "living wage," permanent jobs for local people in a region with high unemployment and a large share of Mexican and Central American immigrants.

The grocery chain worked with Homeboy Industries to source and train applicants for supermarket jobs. More than 70 percent of initial hires are local residents, and more than 20 percent are African American. Eight employees were direct referrals from incarcerated youth reentry programs at either Homeboy Industries or Los Angeles County Probation.

The market's lead investor was the California FreshWorks Fund, backed by The California Endowment and other partners to finance new and upgraded grocery stores and other healthy food distribution and retail outlets in California's underserved communities.

Source: Alejandrez L. FreshWorks funded Northgate Gonzalez Marketplace brings healthy foods to South Los Angeles. The California Endowment Website. http://tcenews.calendow.org/blog/freshworks-funded-northgate-gonzalez-marketplace-brings-healthy-foods-to-south-los-angeles. Published April 15, 2014.

Health Care Access and Quality of Care:
Narrowing the Gaps

Access to high-quality health care services ranks as one of the most important overall health indicators of the federal government's Healthy People 2020 initiative. However, as late as 2011, nearly 23 percent of Americans did not have a regular primary care provider (a doctor or health center) whom they could visit when they were sick or needed preventive care or advice. As of 2012, about 17 percent of Americans under age 65 did not have any form of health insurance, a rate virtually unchanged since 2008.[1] For both measures, the national rates were higher for various ethnic or racial groups, especially Latinos.[2] In California, the uninsured rate among Latinos in 2011-2012, 28 percent, was almost double that among the White population (see Figure 18). From year to year, the largest disparities in access to care and quality of care nationally are for Spanish-speaking Latinos,[3] a fact that points to the critical importance of access to health insurance and linguistically and culturally appropriate care.

LATINOS HAVE THE HIGHEST RATES OF BEING UNINSURED FOR HEALTH INSURANCE OF ANY RACIAL/ETHNIC GROUP IN CALIFORNIA
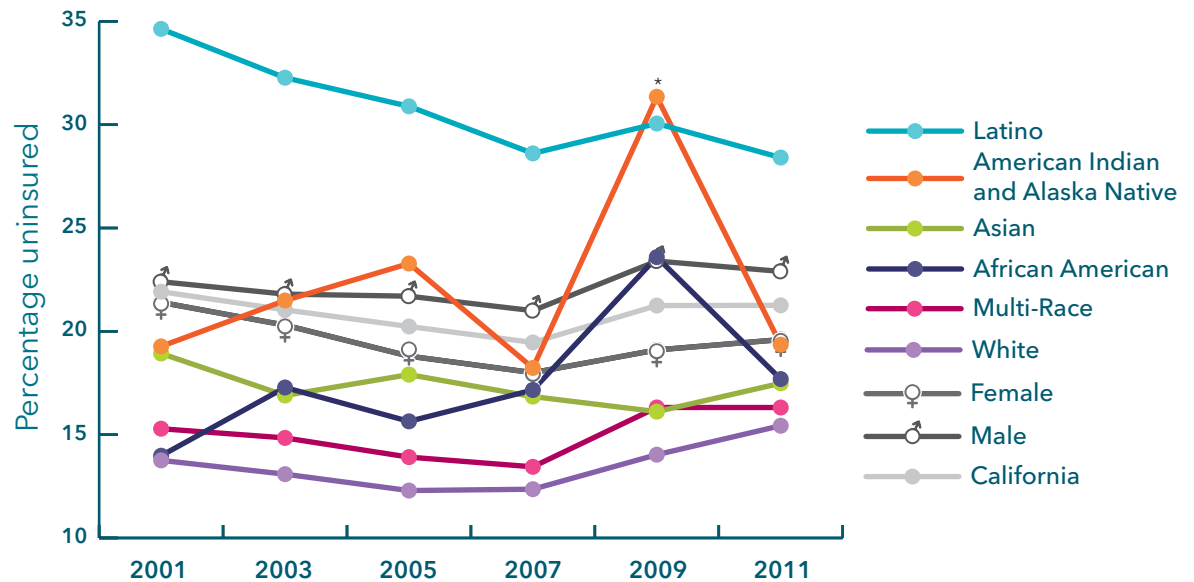

FIGURE 18: Percentage of people ages 0-64 without health insurance† during the past 12 months, by race/ethnicity, California, 2001 to 2011.

Source: University of California Los Angeles, California Health Interview Survey, 2001-2011.
Note: "Asian" includes Native Hawaiian and other Pacific Islander.
† Had no insurance the entire year or had insurance only part of the past year.
* Statistically unreliable data

Implementation of the federal Affordable Care Act (ACA) is providing expanded access to health insurance for most people. Undocumented residents are an exception to this access, aside from those who qualify for some emergency services. In California, of the 1.4 million covered California enrollees as of February 2015, Latinos accounted for 37 percent of new enrollees, up from 31 percent during the last open enrollment period.[4] This level of enrollment represents important progress, because data on the national level has shown that having insurance coverage positively affects people's ability to obtain a usual source of care and thus increases their use of preventive, urgent, or chronic health care services.[5] However, significant racial and ethnic disparities in insurance coverage in California are likely to persist, though at lower levels, due in part to observed cultural and linguistic barriers to expanded access to insurance, and in part to ineligibility under federal law (an estimated 1.1 million uninsured, undocumented California residents are ineligible).[6]

The ACA provides a number of avenues to address the health disparities linked to cultural and linguistic barriers. For example, the ACA has expanded research on health and health care disparities and created the Patient-Centered Outcomes Research Institute to oversee studies that examine differences in patient outcomes among racial and ethnic minorities. The ACA also expands grant programs to attract and retain health professionals from diverse backgrounds and directs funding to encourage service in underserved areas. The ACA provides support for the development and dissemination of curricula to promote cultural competency and supports a variety of culturally appropriate prevention and education initiatives.

Equal Access Is One Piece of Health Equity

Although insurance provides access to care, it does not ensure that everyone receives appropriate or high-quality care at the right time; nor does it fully address the remaining financial barriers to access for low-income people with insurance.[6,7] An examination over an eight-year period of 16 "prevention quality indicators" – conditions such as pediatric asthma, hypertension, and low birth weight, for which quality outpatient care, as in a doctor's office, can often prevent the need for hospitalization – concluded that African Americans consistently had the highest hospitalization rates for 14 measures. In some cases, the rates were two to three times higher than for Whites. For example, the average hospitalization rate for short-term complications of diabetes was 134 per 100,000 for African Americans, compared with 44 for Latinos, 42 for Whites, and just 14 for Asian/Pacific Islanders.[8]

California's Wide Dental Gap

Oral health, a critical though often neglected aspect of overall health, is believed to be the single greatest unmet need for health services among children. In California, the disparity in oral health between low-income and affluent children is the second worst in the nation, exceeded only in Nevada, according to a 2014 study by the Lucile Packard Foundation for Children's Health.

The report cites data from a 2011-2012 National Survey of Children's Health based on parent reports that found that 69.7 percent of California children ages 1-17 with public insurance had a preventive dental care visit during the previous year. In comparison, 83.4 percent of children with private insurance and 46.4 percent of uninsured children had a preventive visit during that time frame.

The disparity in access to dental care should narrow somewhat beginning in 2015, when dental insurance will become available as part of health insurance plans purchased through the state's new health insurance marketplace.

This survey is based on parent responses, not on claims data. These types of surveys tend to over-report utilization, partly because of faulty recall of events that may have happened a year ago.

Source: Schor E. Dental Care Access for Children in California: Institutionalized Inequality (Issue Brief). Palo Alto, CA: Lucile Packard Foundation for Children's Health; 2014.

Major disparities in quality of care also exist across the nation among cities, regions, and states. A 2013 study of quality of care received by low-income Americans found that if every state could have achieved the high-quality levels achieved by the top-performing states, an estimated 86,000 premature deaths would have been avoided, 750,000 low-income Medicare beneficiaries would not have been unnecessarily prescribed high-risk medication, and tens of millions of adults and children would have received timely preventive care.[7] California ranked 20th among all states for overall quality of care for low-income patients but was among the lower third quartile of states for prevention and treatment.

School-Based Health Centers Boost Access to Care for Underserved Families

School-based health centers (SBHCs), which bring vital primary care services into the heart of low-income neighborhoods, have more than doubled in California over the past decade, numbering more than 226 as of 2013. Serving nearly a quarter million K-12 students and their families, the clinics, financed by a variety of public and private sources, have sprung up in schools from Del Norte County to San Diego County, with large concentrations in Los Angeles and the Bay Area.

Most SBHCs are located in schools with low-income Latino and African American students—ethnic groups that are more likely to suffer health disparities due to higher rates of violent injury, poor nutrition, physical inactivity, substance abuse, and sexually risky behavior. They also have lower rates of health insurance and less access to health and mental health services.

California schools received $30 million, almost a third of the $95 million provided under the health care reform law, for creation of school-based health clinics in 2011 to 2013.

Learn more at http://www.schoolhealthcenters.org.

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Clinical and Community Prevention Strategies:
The Power of Prevention

Prevention in health is a broad concept. It can occur in health care in a range of settings and in various ways, including public health strategies to prevent the occurrence of a disease (such as antismoking campaigns), clinical strategies or treatments to detect the early stages of a disease (such as cancer screening), or clinical interventions to prevent complications of an existing disease (such as care management plans for diabetes). Prevention also includes public health activities, such as health education about risky or positive personal behavior, and changes to the larger environmental or social conditions that have an impact on health. In all these ways, prevention has long been recognized as an essential public health strategy for creating better health and promoting health and mental health equity throughout society.

Unfortunately, prevention strategies are not fully utilized in California or elsewhere in the United States. The result has been the avoidable loss of thousands of lives annually in the United States, unnecessarily high levels of poor mental and physical health, the persistence of health disparities among vulnerable populations, and inefficient use of health care dollars. For instance, a national study from the Partnership for Prevention states that a 90 percent utilization rate for just five widely recommended and cost-effective preventive services – daily aspirin use to prevent heart attacks, antismoking advice by health professionals, periodic colorectal cancer screening, annual influenza immunization for adults over age 50, and biennial breast cancer screening for women over age 40 – would save more than 100,000 lives each year in the United States. Among the 12 preventive services examined in the Partnership for Prevention study, seven are being used by about half or less of the people who should be using them. Racial and ethnic minorities are getting even less preventive care than the general U.S. population. Latinos, for instance, have lower utilization of 10 preventive services than do non-Hispanic Whites and African Americans, and Asian adults age 50 and older are 40 percent less likely to be up to date on colorectal screening than are White adults.[1] In a number of important areas, use of preventive mental and physical health strategies among disadvantaged populations significantly lags behind use among more advantaged population groups.[2]

Disparities in Clinical Prevention: Mammograms and Childhood Immunization

In California, very low-income women are more than twice as likely as high-income women in the same age bracket to not receive timely mammograms, and almost twice as likely to not receive timely Pap tests (see Figure 19).

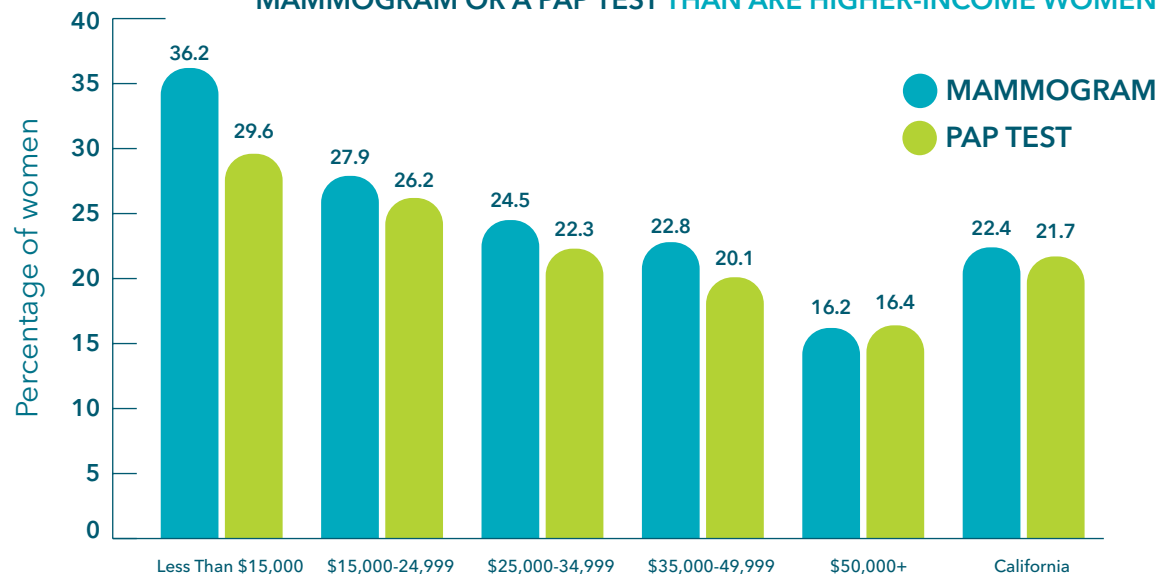## LOW-INCOME WOMEN ARE MORE LIKELY TO NOT RECEIVE A MAMMOGRAM OR A PAP TEST THAN ARE HIGHER-INCOME WOMEN

Percentage of women

Income	MAMMOGRAM	PAP TEST
Less Than $15,000	36.2	29.6
$15,000-24,999	27.9	26.2
$25,000-34,999	24.5	22.3
$35,000-49,999	22.8	20.1
$50,000+	16.2	16.4
California	22.4	21.7

FIGURE 19: Percentage of women who have not had a mammogram or a Pap test, by annual income level, California, 2012.

Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2012.

Note: Mammogram screening among women age 40 years or over within the past two years, and Pap smear screening among women age 18 years or over within the past three years.

This is especially important for African American women, who in 2010 had the highest breast cancer death rates of all racial and ethnic groups, at 33 per 100,000, compared with 24 per 100,000 for White women, though White women are actually more likely to be diagnosed with breast cancer.[3]

Another core component of preventive medicine is the recommended childhood immunization regimen. Immunizations are estimated to save, for every United States birth cohort, 33,000 lives; prevent 14 million cases of disease; and avoid more than $43 billion in direct and indirect costs. Despite progress in immunization rates, however, approximately 42,000 adults and 300 children in the United States die each year from vaccine-preventable diseases.[4] In California, students entering kindergarten must show proof of immunizations for DTaP, polio, MMR, Hep B, and varicella.[5] The dosages required for these vaccines can be taken within the first 24 months of life.[6] As shown in Figure 20, African American kindergarteners continue to significantly lag all other racial or ethnic groups in immunization rates.

Behavior-Level Prevention: Breastfeeding

Like immunization, breastfeeding has multiple health benefits for infants and children as well

AFRICAN AMERICAN KINDERGARTNERS ARE REPORTED TO HAVE THE LOWEST IMMUNIZATION RATE AT EACH AGE CHECKPOINT FOR RECOMMENDED VACCINATION
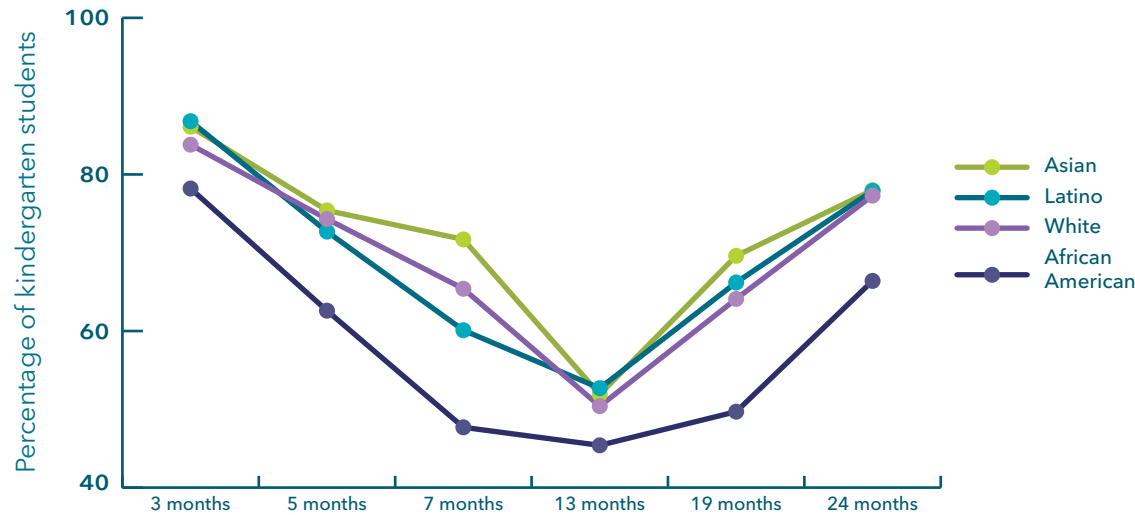

FIGURE 20: Percentage of immunization coverage among kindergarten students, by age checkpoint and race/ethnicity, California, 2010-2011.

Source: California Department of Public Health, Immunization Branch, Kindergarten Retrospective Survey Results, 2010-2011.

as mothers. It reduces the likelihood of many common infections and is associated with reduced risk of atopic dermatitis (eczema).[7] Studies estimate that 27 percent of monthly pediatric hospitalizations for lower respiratory tract infections and 53 percent of monthly pediatric hospitalizations for diarrhea could be prevented by exclusive breastfeeding.[8] Yet rates of breastfeeding beyond the first week following birth fall off sharply among California women at the lowest levels of family income, partly because low-income women are more likely than their higher-income counterparts to return to work earlier and to be engaged in jobs that make it challenging for them to continue breastfeeding.[9,10] There is a range of policy and health education strategies that can be taken to improve the rates of breastfeeding among new mothers.

Preventing Upstream Health Inequities

As this report indicates throughout, a growing body of evidence shows that many of the downstream health disparities that occur among vulnerable populations can be effectively reduced or eliminated by addressing the related upstream socioeconomic and environmental inequities.[11] Clean air and safe playgrounds, for instance, may be as effective for reducing levels of childhood asthma in low-income communities as a shot in the arm is for preventing measles. As another example,

transportation systems, which are generally not thought of as part of the health care system, can indirectly impact health by influencing physical activity opportunities. Active transportation (walking, biking, and wheeling to destinations) can help prevent obesity and improve both mental and physical health.[12,13]

Improving Childhood Immunization Rates

A 2004 study involving more than 200 randomly selected English- and Spanish-speaking families with young children in Bakersfield identified the following key barriers facing any program to improve childhood immunization rates in ethnically diverse rural communities: lack of transportation, child illness, parental forgetfulness, and fear of side effects. Among providers, the key barriers were lack of an opening for an appointment, limited clinic hours, and long lines at clinics. The report concluded that effective strategies must include reminder calls, increased transportation options, weekend clinics, and improved communication with parents.

Source: Thomas M, Kohli V, King D. Barriers to childhood immunization: findings from a needs assessment study. Home Health Care Serv Q; 2004;23(2):19-39.

Experiences of
Discrimination and Health

The United States has made progress in creating a more tolerant society, yet discrimination and inequality persist today. Discrimination, whether experienced as individual acts or at an institutional level, makes people sick.[1] Although many of the most blatant forms of discrimination have been greatly reduced since passage of the Civil Rights Act of 1964 and subsequent civil rights laws, which prohibit discrimination in workplaces, schools, public facilities, and state and local government, many groups continue to be vulnerable to both subtle and overt forms of discrimination in other social and economic sectors.[2] Numerous studies have documented the harmful mental and physical health effects of discrimination, including depression, stress, anxiety, hypertension, self-reported poor health, breast cancer, obesity, high blood pressure, and substance abuse.[3,4]

MORE THAN 40% OF AFRICAN AMERICAN WOMEN REPORTED EXPERIENCING RACIAL DISCRIMINATION, COMPARED WITH 9% OF WHITE WOMEN

Percentage of women

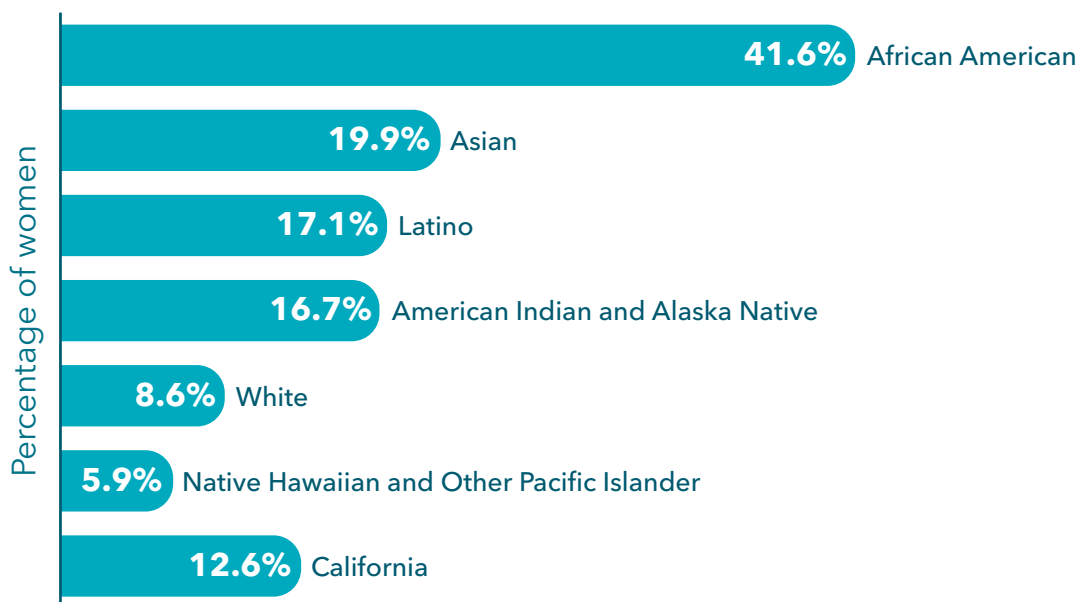|	
41.6%	African American
19.9%	Asian
17.1%	Latino
16.7%	American Indian and Alaska Native
8.6%	White
5.9%	Native Hawaiian and Other Pacific Islander
12.6%	California

FIGURE 21: Percentage of women who reported experiencing discrimination because of their race/ethnicity, California, 2012.
Source: California Department of Public Health, California Women's Health Survey, 2012.

Prejudice and acts of discrimination are experienced by members of racial and ethnic groups, and Figure 21 details how California women experience discrimination across these groups. In addition, discrimination is experienced by individuals and groups defined by age, gender, gender identification, sexual orientation, religion, and other social or personal characteristics. Individuals who are members of two or more disadvantaged groups (such as a member of a racial minority who is also disabled) are the most likely to report acts of discrimination and to experience stress and poor mental or physical health as a result.[5]

Discrimination is complex, rooted in historical racist and sexist social policy, and compounds the disproportionate burden of poor health outcomes that marginalized groups experience directly and indirectly. Therefore, efforts to

ARRESTS FOR MARIJUANA POSSESSION DISPROPORTIONATELY AFFECT AFRICAN AMERICAN TEENAGERS
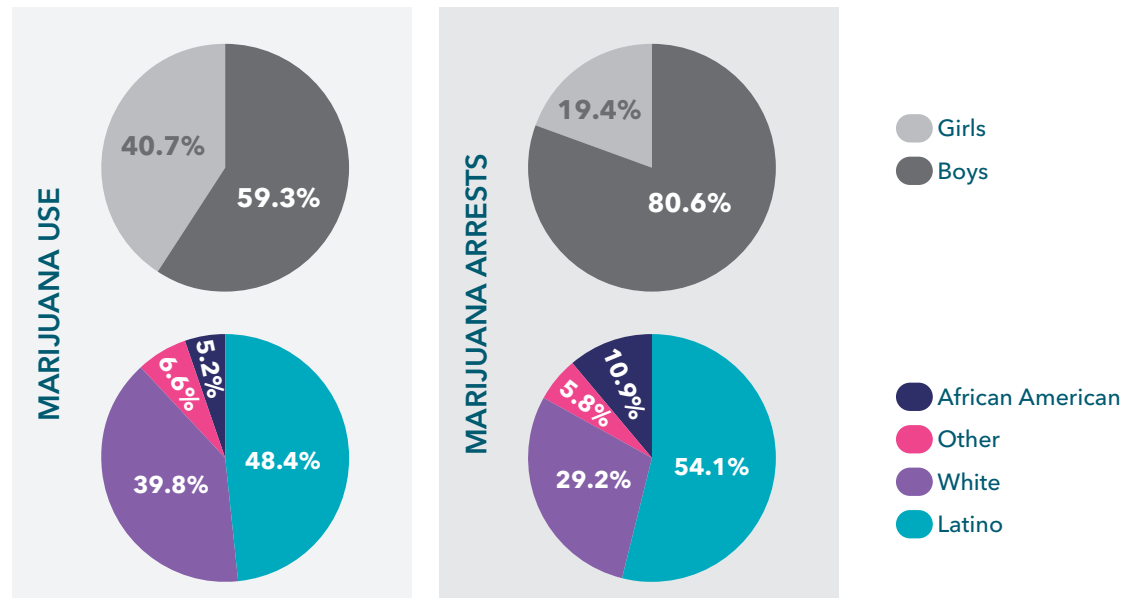

FIGURE 22: Percentage of marijuana use and misdemeanor arrests among teenagers ages 10 to 17, by race/ethnicity and gender, California, 2011-2012.

Sources: University of California Los Angeles, California Health Interview Survey, 2011-2012; and California Department of Justice, Criminal Justice Statistics Center, 2011-2012.
Note: Under California Health and Safety Code 11357b, possession of one ounce or less of marijuana for personal use is considered a misdemeanor.

Let Her Work Campaign Scores a Win

The Let Her Work campaign by Equal Rights Advocates (ERA), a statewide organization working for legal protection and policy change on behalf of the civil rights of women and girls, is focused on enabling the rising number of California's incarcerated women (most of whom are mothers) to resume their caregiving responsibilities following release. However, like men, these women face tremendous obstacles in seeking employment following their release. Many employers refuse outright to consider the application of a person with even a minor criminal record.

In partnership with the National Center for Lesbian Rights, ERA launched the Breaking Barriers: Let Her Work project to train women with criminal histories about their employment rights and promote policy changes to remove barriers to their employment. An early win for the campaign was the passage in 2013 of AB 218, which prohibits government agency employers from asking a potential new hire to disclose his or her previous criminal convictions on a preliminary employment application.

Learn more at http://www.equalrights.org/legislative-update-ban-the-box-and-let-her-work/.

achieve health equity must also include efforts to identify and correct the discrimination that persists.

How Discrimination Gets Under Our Skin

Discrimination is not just something that we cognitively or emotionally feel. Discrimination gets under our skin and causes negative physiological changes in the body. Researchers are able to measure the body's stress response to discrimination by assessing changes in blood pressure,[6,7] stress hormone levels,[8] protein markers associated with heart disease,[9,10] and more. Over time, the resulting physiological and psychological effects of discrimination start to wear down

MORE THAN HALF OF ALL HATE CRIMES ARE MOTIVATED BY RACE/ETHNICITY, FOLLOWED BY THOSE MOTIVATED BY SEXUAL ORIENTATION AND BY RELIGION OF THE VICTIM
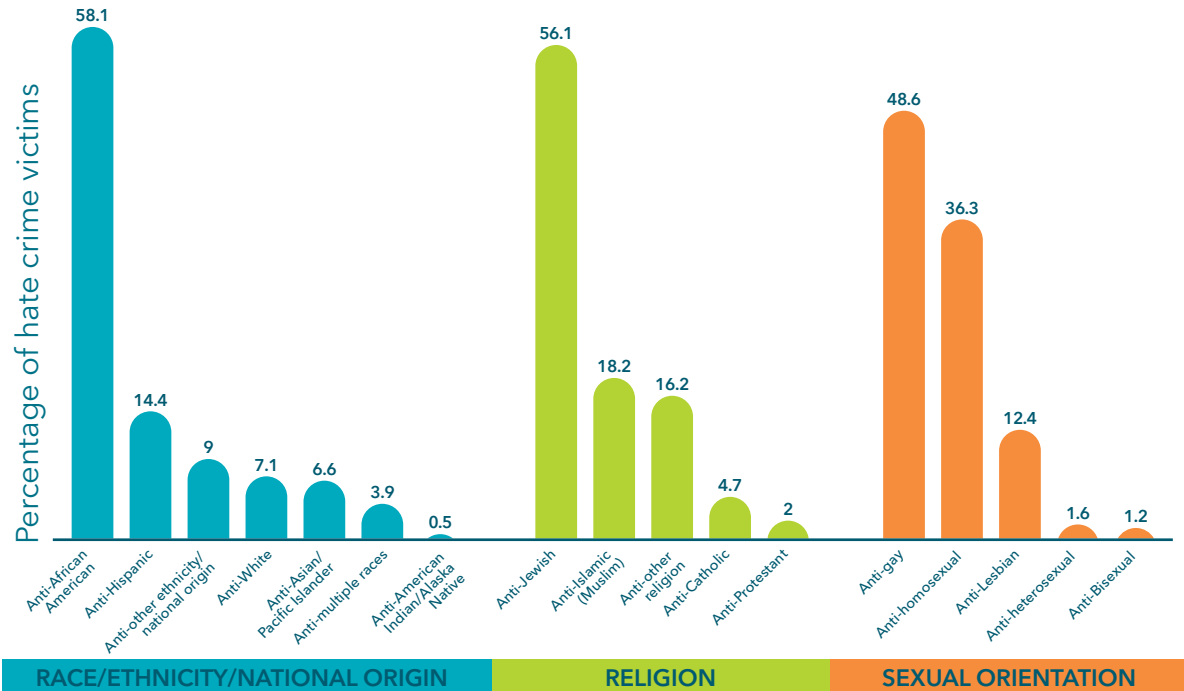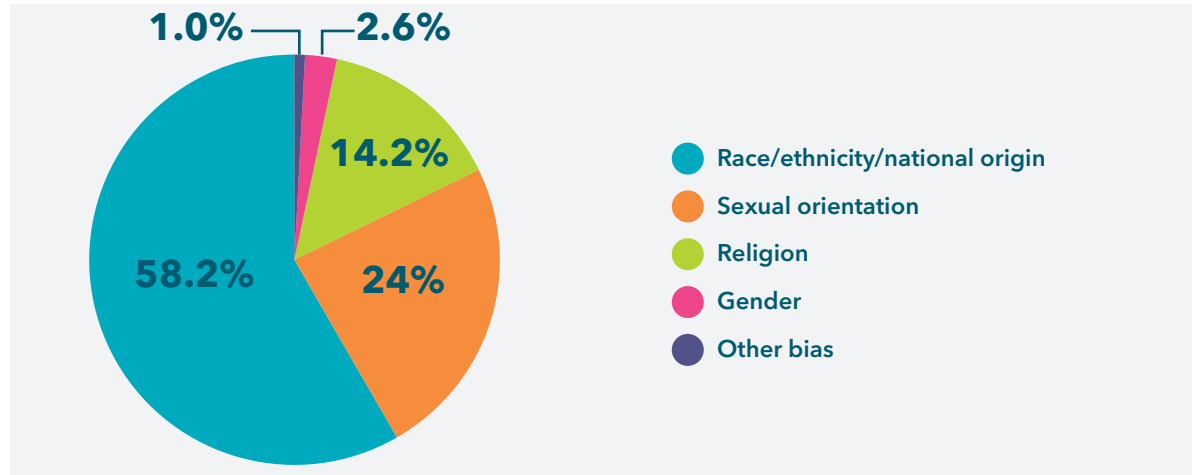

FIGURE 23: Percentage of hate crimes victims motivated by the victim's race/ethnicity/national origin, religion, and sexual orientation, California, 2012.
Source: California Department of Justice, Hate Crime in California Report, 2013.

the body. This wearing, or "weathering," effect from repeated exposure to discrimination contributes to a number of health disparities, such as the disproportionate prevalence of cardiovascular disease and low-weight births in African Americans compared with Whites.[11,13,14] Studies have shown that when comparing women with the same levels of income and education, job status, and health insurance status, African American mothers in the U.S. have lower-weight babies compared with their African-born and White counterparts, suggesting that genetic ancestry is not a strong determinant of birth weight.[12] Although this is a complex area of research, the lower-weight babies born to African American mothers can be explained in part by the stress caused by the mothers' lifelong experiences of discrimination.[13,14] This is particularly problematic because low birth weight is a strong indicator of long-term health consequences. Furthermore, according to the Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, non-White patients tend to experience discrimination at the patient-provider level and to receive a quality of care inferior to that received by their White counterparts, even when controlling for access-related factors such as income and insurance status.[15] Given the impact of discrimination, it must be addressed as rigorously as the other social determinants of health.

The Indirect Health Effects of Discrimination

Beyond the direct health effects of discrimination, complex social and political sources of discrimination have serious health consequences. These discriminatory practices include pay inequality between women and men, bank redlining practices targeted toward lower-income individuals, disproportionate arrest rates for boys and men of color *(see Figure 22)*, and lack of job opportunities and protection for those with physical and mental disabilities, among many others. In limiting an individual's or a group of individuals' ability to make a fair and decent wage, buy a home, access high-quality education at all levels, and marry and support the person of their choice, society is directly or indirectly impacting their health and overall quality of life.

Hate Crimes Declining but Still Pervasive

One way of discussing different groups' experience of discrimination is the number of hate crimes inflicted on individuals that are motivated by the victim's race, ethnicity, or other personal characteristics *(see Figure 23)*. In California, the number of victims who experience hate crimes overall has decreased 42.4 percent in recent years, from 1,815 in 2003 to 1,045 in 2013.[16,17] In 2013, hate crimes involving race, ethnicity, or national origin were the most frequent

in absolute (but not population-adjusted) terms, accounting for 609 victims (mostly anti-Black, 354 victims). Sexual orientation bias accounted for 251 victims (mostly for anti-gay bias, 122 victims), and religious bias accounted for 148 victims (mostly anti-Jewish bias, 83 victims).[17]

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Neighborhood Safety and Collective Efficacy

Across the country, when you ask people what they want their neighborhood to look like, the answers are fairly consistent. People want neighbors who care enough about the neighborhood to work together to create and maintain a healthy and safe environment, with convenient access to cultural and economic opportunities, and where their children can play, learn, and thrive in an atmosphere of trust and security.[1] In other words, they want neighborhoods that ensure access to basic goods, that are socially cohesive, that are designed to promote good physical and psychological well-being, and that are protective of the natural environment. Such characteristics are essential to community mental and physical health and health equity.[2]

Trust as a Foundation for Health

An analysis of the literature on neighborhood-level social determinants of health shows that,

among other factors, the collective health of neighborhoods is highly subject to the social relationships among residents, including the degree of mutual trust and feelings of connectedness among neighbors. For instance, residents of close-knit neighborhoods work together to create and maintain clean and safe playgrounds, parks, and schools. They exchange information on childcare, employment, and health access, and they cooperate to discourage crime and other negative behaviors, such as domestic violence, child abuse, substance abuse, and gang involvement, which can directly or indirectly influence health. Conversely, less close-knit neighborhoods and greater degrees of social disorder have been related to anxiety and depression.[3]

Unfortunately, California has many low-income neighborhoods, both rural and urban, where the opportunities or traditions for engagement

in community service are lacking. While opportunities for social engagement benefit people across the socioeconomic spectrum, lower-income adults in California are less likely to have participated in a board, council, or organization or to have worked informally to address a community problem, when compared with higher-income California adults (see Figure 24).

Unsafe Neighborhoods Produce Sick Children

Low levels of neighborhood trust and cohesion may also be related to higher rates of criminal activity in disadvantaged neighborhoods. A 2010 study from the U.S. Department of Justice found a high correlation between low household income levels and rates of property crime, such as burglary.[5] A similar relationship holds true for violent crime, as seen in Figure 25, where low-income, disadvantaged neighborhoods in the Bay Area and in South

Partying for Safe Neighborhoods

When neighbors are organized, their neighborhoods are safer. That's the concept of National Night Out (NNO). In 2013, Oakland residents hosted 670 block parties on August 6 – one of the largest NNO events in the country. When the event started about nine years ago, Oakland had only 35 parties. Each year, Oakland's mayor's office seeks to grow the number of neighborhood events and to encourage residents to take the next step and become a neighborhood watch group. The first step is simply for neighbors to get to know one another.

Central Los Angeles have the highest crime rates. The combination of high crime rates and other social factors associated with low-income neighborhoods creates barriers to healthful behaviors, such as walking and playground use; puts children at risk for poor educational, emotional, and health outcomes; and makes children more likely to become victims or perpetrators of violent crime.[5,6] Community-level crime interventions, such as well-lit, secure playgrounds; neighborhood watch organizations; and development of well-resourced teen centers to reduce neighborhood gang activity, are important components in many community-based neighborhood improvement initiatives.[7]

LOWER-INCOME ADULTS ARE LESS LIKELY TO ENGAGE IN VOLUNTEER WORK OR GET TOGETHER WITH OTHERS TO DEAL WITH COMMUNITY PROBLEMS
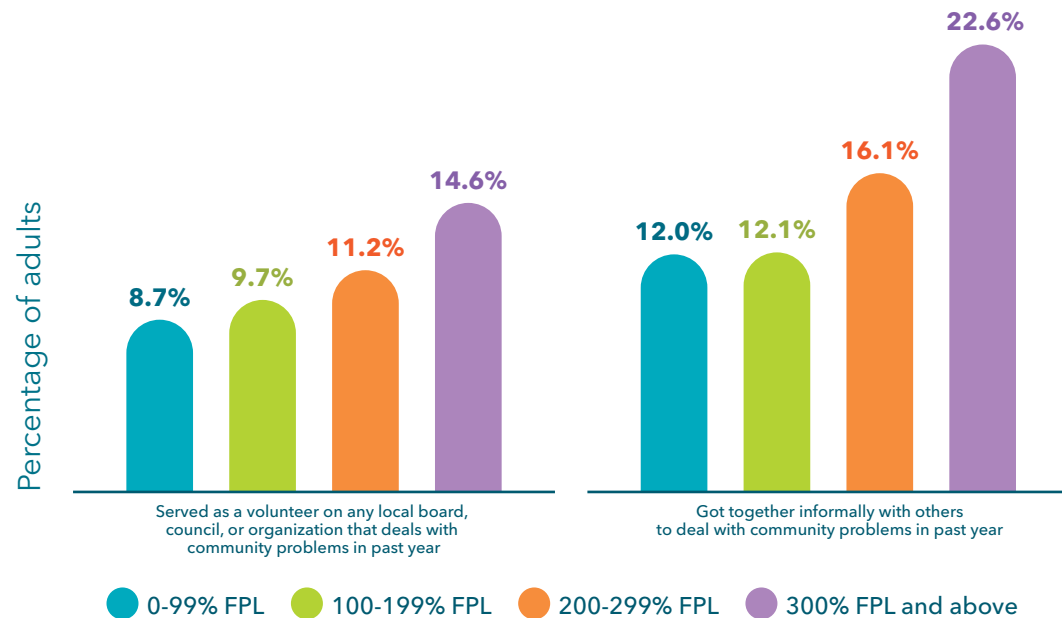

FIGURE 24: Percentage of adults who participated in community service, by federal poverty level (FPL), California, 2011-2012.
Source: University of California Los Angeles, California Health Interview Survey, 2011-2012.

Operation Ceasefire/Safe Community Partnership

Operation Ceasefire is an evidence-based strategy designed to reduce gang- and group-related homicides and nonfatal shootings. Localized versions of the Operation Ceasefire model of neighborhood gang and gun violence suppression are making headlines in 10 California cities that have seen rising rates of gun violence in recent years. In Stockton, the initiative, which operates under the name Safe Community Partnership, has been credited with helping reduce the number of homicides from 71 in 2012 to 32 in 2013. In Richmond, the city's homicide rate in 2013 was the lowest in 33 years and total crimes were more than 40 percent lower than the 2003 total. Other cities that have implemented the model in select neighborhoods include Los Angeles, Modesto, Oakland, Salinas, Oxnard, Union City, East Palo Alto, and Sacramento.

Learn more at http://www.nnscommunities.org/index.php.

Legend:
- 0 - 4.4 (lower than the state average of 4.4)
- 4.4 - 6.6 (1 to 1½ times the state average)
- 6.6 - 8.8 (1½ to 2 times the state average)
- 8.8 - 292.1 (2 times or more the state average)
- Data not reported or applicable
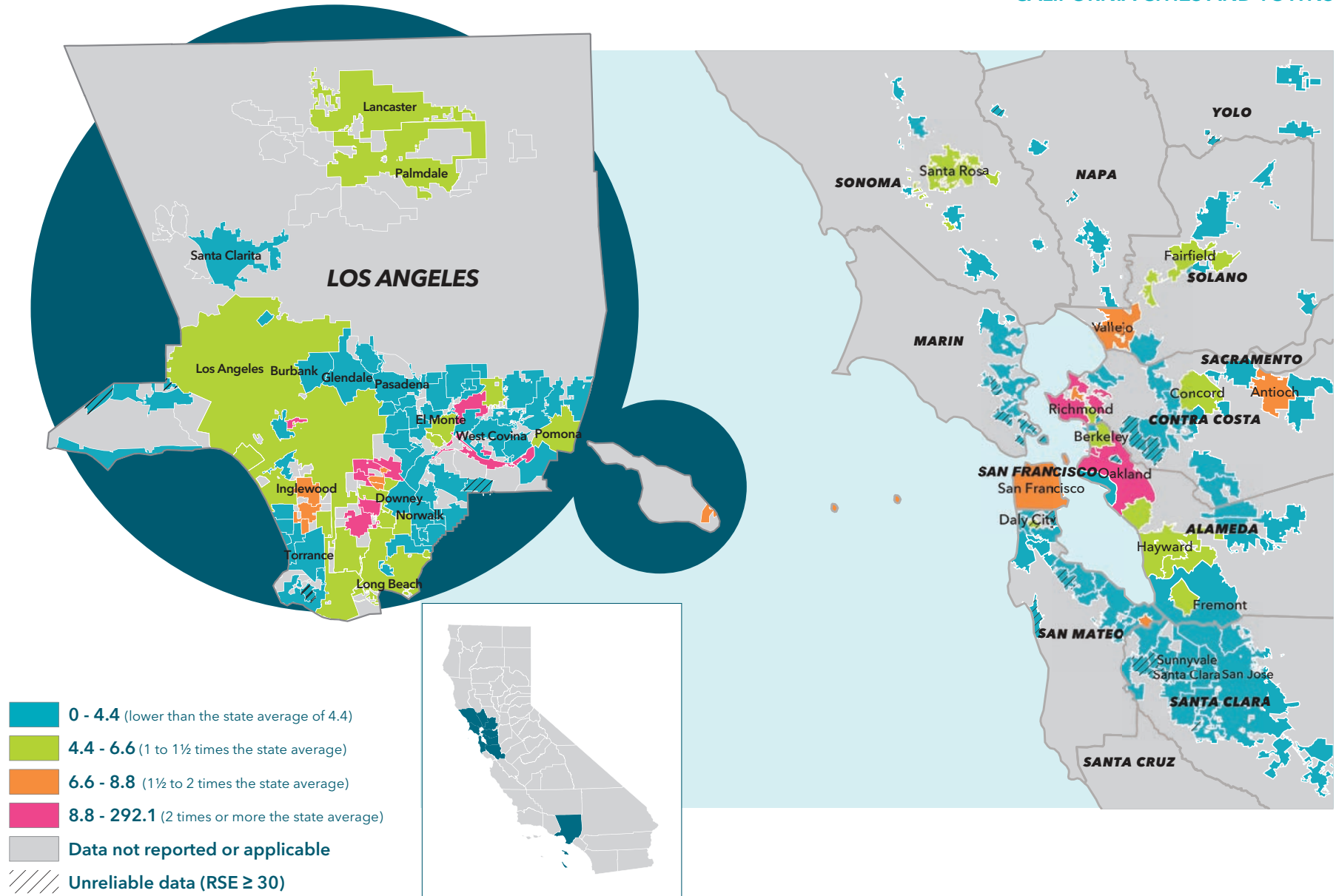- Unreliable data (RSE ≥ 30)

FIGURE 25: Number of violent crimes per 1,000 population, by cities and towns, Los Angeles County and Bay Area, California, 2010.

Source: Federal Bureau of Investigation, Uniform Crime Reports, 2010. Analysis by CDPH-Office of Health Equity and UCSF, Healthy Communities Data and Indicators Project.

Cultural and Linguistic Competence:
Why It Matters

The ability of health and mental health care providers to effectively communicate with service recipients and to understand and respond to their cultural beliefs and values regarding health, illness, and wellness is essential for providing high-quality care to every person and for reducing health disparities among all social groups.[1,2,3]

California's vast and growing population diversity represents a special challenge for the state's primary and behavioral health care providers and organizations. The state is home to more than 200 languages, with more than 40 percent of the population speaking languages other than English at home, and 20 percent, or almost 7 million Californians, considered limited English proficient (LEP) – meaning they do not speak English "very well."[4,5]

The state's physician workforce in 2012 was disproportionately White and Asian.

AFRICAN AMERICAN AND LATINO PHYSICIANS ARE UNDERREPRESENTED IN CALIFORNIA

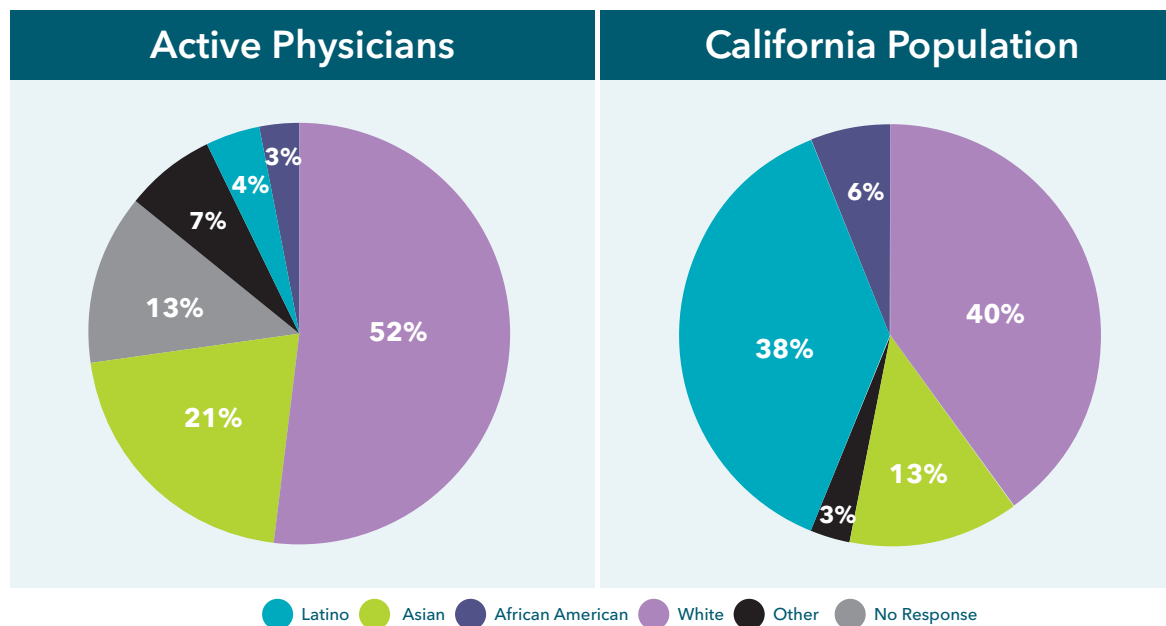Legend: Latino, Asian, African American, White, Other, No Response

FIGURE 26: Percentage of California's population and active physicians, by race/ethnicity, California, 2012.

Sources: Medical Board of California, Cultural Background Survey Statistics, 2012; and U.S. Census Bureau, Population Division, Annual Estimates of the Resident Population by Sex, Age, Race, and Hispanic Origin for the United States: 2010-2012. Analysis by California HealthCare Foundation, California Health Care Almanac, California Physicians: Surplus or Scarcity, 2014.
Note: Data includes active medical doctors (MDs).

MEDICAL SCHOOL GRADUATES

52%   48%

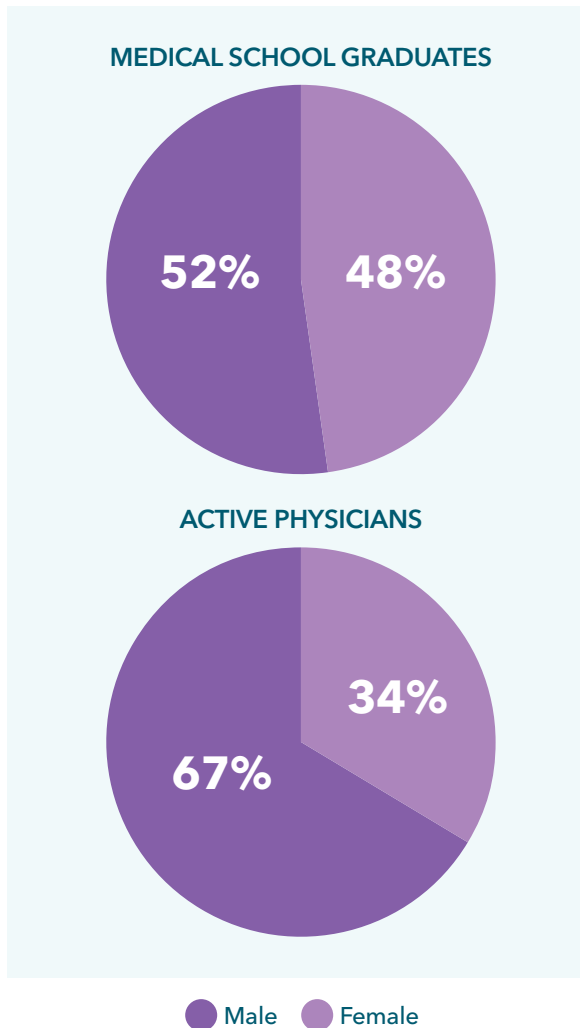### ACTIVE PHYSICIANS

67%   34%

● Male   ● Female

FIGURE 27: Percentage of California's medical school graduates and active physicians, by gender, California, 2012.

Source: Association of American Medical College, State Physician Workforce Data Book, 2013. Analysis by California HealthCare Foundation, California Health Care Almanac, California Physicians: Surplus or Scarcity, 2014.

Note: Data includes active medical doctors (MDs) and doctors of osteopathic medicine (DOs).

While White and Asian people made up 53 percent of the population in California, they accounted for 73 percent of the active physicians. Latinos, African Americans, and other ethnicities made up 47 percent of the California population but only 14 percent of active physicians *(see Figure 26)*; women are also underrepresented *(see Figure 27)*. While Latinos constituted 38 percent of the population (and close to 50 percent in many regions), Latino physicians made up only 4 percent of the physician workforce, including those in Los Angeles and the San Joaquin Valley, where Latinos are a near majority. African Americans, who make up about 6 percent of the state's population, account for just 3 percent of physicians. It is estimated that roughly nine out of 10 physicians, dentists, and pharmacists in California are either White or Asian.[6]

Impacts on Quality of Care

Although as many as 20 percent of the state's non-Hispanic White physicians are relatively fluent in Spanish,[7] significant cultural and linguistic barriers remain for many patients,

ADULTS WITH LIMITED ENGLISH PROFICIENCY (LEP) GENERALLY HAVE POORER HEALTH COMPARED WITH THOSE WHO SPEAK FLUENT ENGLISH

Percentage of adults

- Fair or poor health: 13.1% / 33.6%
- Did not have usual source of care: 17.6% / 25.8%
- Had hard time understanding doctor: 3.6% / 7.3%

● Speak English very well   ● Speak English less than "very well"

39.4% Speak English very well

60.6% Speak English less than very well

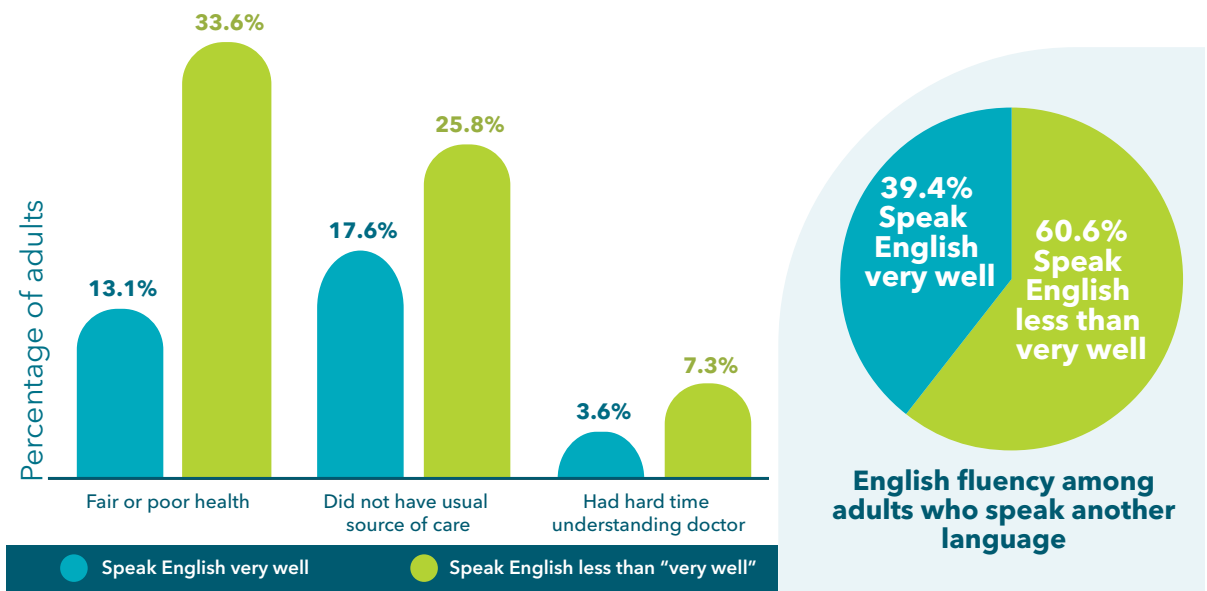**English fluency among adults who speak another language**

FIGURE 28: Percentage of English fluency levels among adults ages 18 years and older who speak a language other than English at home, by selected characteristics, California, 2011-2012.

Source: University of California Los Angeles, California Health Interview Survey, 2011-2012.

Note: Adults who reported speaking English less than "very well" includes those who reported speaking English well, not well, or not at all.

and these barriers are associated with multiple forms of reduced quality of care and decreased access to primary and preventive care.[8,9,10] The Institute of Medicine report *Unequal Treatment* indicates that U.S. racial and ethnic minorities are less likely to receive routine medical procedures and more likely to experience a lower quality of health services.[11] Racial/ethnic minorities and individuals with low household incomes are more likely than their non-Hispanic White and higher-income counterparts to experience culturally insensitive health care and dissatisfaction with health care – health care experiences that have been linked to poorer health outcomes.[12]

The persistent racial, cultural, and linguistic gaps in the health care workforce are reflected in significant health disparities between population groups with limited English proficiency and those that speak English very well *(see Figure 28)*. In order to achieve cultural and linguistic competency in California's public and private health care institutions, we must look beyond the issue of language alone and grapple with a larger challenge – that of developing a primary and behavioral health care workforce capable of providing services that are responsive to the health beliefs, health practices, and cultural and linguistic needs of California's diverse population.

Priming the Medical School Pipeline

The University of California, Riverside, School of Medicine obtained $3 million in private grant funding in 2013 to expand its existing medical school pipeline programs, aimed at broadening and diversifying the pool of students in inland Southern California applying to medical school. The program, Imagining Your Future in Medicine, will link students as young as the middle school level with pipeline initiatives at the high school, community college, and university levels. For middle school students it includes a one-week residential summer camp called Medical Leaders of Tomorrow, in which 40 to 50 educationally and socioeconomically disadvantaged students in the Inland Empire have access to presentations on science and health care topics; study skills, workshops, and training; leadership and team-building activities; laboratory and clinic tours; and college admissions information. Once students enter the pipeline, they are provided a continuous path for academic preparation and enrichment, hopefully leading to entry into medical training, particularly in primary care and short-supply specialties.

Source: UC Riverside Today, April 3, 2013.

Sharing Trained Health Care Interpreters

The Health Care Interpreter Network (HCIN), funded in 2005, by California HealthCare Foundation and others, is a national network of more than 40 hospitals and provider organizations that share more than 100 trained health care interpreters in 16 languages through an automated video/voice call center. Videoconferencing devices and all forms of telephones throughout each hospital and clinic connect within seconds to an interpreter on the HCIN system, either at their own hospital and clinic or at another participating hospital and clinic.

In California HCIN membership is offered to:

• Public, district, or University of California hospitals

• Community hospitals that are not members of hospital systems larger than three distinct acute care facilities

• Community clinics that serve the Medi-Cal population

• Health plans that serve the Medi-Cal population

Learn more at http://www.hcin.org/.

Mental Health Services:
'No Health Without Mental Health'

The World Health Organization (WHO) defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." WHO adds, "Mental health is an integral part of health; indeed, there is no health without mental health,"[1] since physical health impacts mental health and vice versa.

Mental disorders, characterized by alterations in thinking, mood, and/or behaviors that are associated with distress and/or impaired functioning, contribute to a host of physical and emotional problems, including disability, pain, or death. In fact, mental health disorders are the leading cause of disability in the United States, accounting for 25 percent of all years of life lost to disability and premature mortality.[2] In

California, suicide, which is a direct outcome of mental distress, is the third leading cause of death among individuals ages 15 to 34.[3]

Unequal Burdens

The prevalence of mental illness and problems of availability, affordability, and access to mental health treatment and preventive services are areas of striking disparities on the basis of race, ethnicity, gender, income, age, and sexual preference. Various racial, ethnic, and other minority groups and low-income individuals of all races experience higher rates of mental illness than do Whites and more affluent individuals. Further compounding the problem, these individuals are less likely to access mental health care services, and when they do, these services are more likely to be of poor quality.[4] In California, almost one in six adults has a mental health need,

and about one in 20 (and one in 13 children) suffers from a serious mental illness (SMI), according to a recent study by California HealthCare Foundation.[5] The study found that nearly half of adults and two-thirds of adolescents with mental health needs did not get recommended treatment. Other findings included significant racial and ethnic disparities for incidence of SMI, with Native Americans, multiracial individuals, African Americans, and Latinos all experiencing rates above the state average.

A notable exception to the link between race/ethnicity and mental illness is the suicide rate, which is highest among White men.[5] This is an area that could benefit from additional understanding, as White men do not report having seriously thought about committing suicide any more than their multiracial and American Indian and Alaska Native counterparts do (the data on

RATES OF SUICIDAL THOUGHTS ARE HIGHER AMONG BISEXUAL, GAY, AND LESBIAN ADULTS

Multi-Race — 17.8%
American Indian and Alaska Native — 15.1%
Native Hawaiian and Other Pacific Islander — 11.6%*
White — 11.0%
African American — 9.4%
Latino — 6.5%
Asian — 6%

Bisexual — 28.4%
Gay or Lesbian — 22%
Other — 9.5%*
Straight — 8.7%

Women — 8.9%
Men — 8.7%
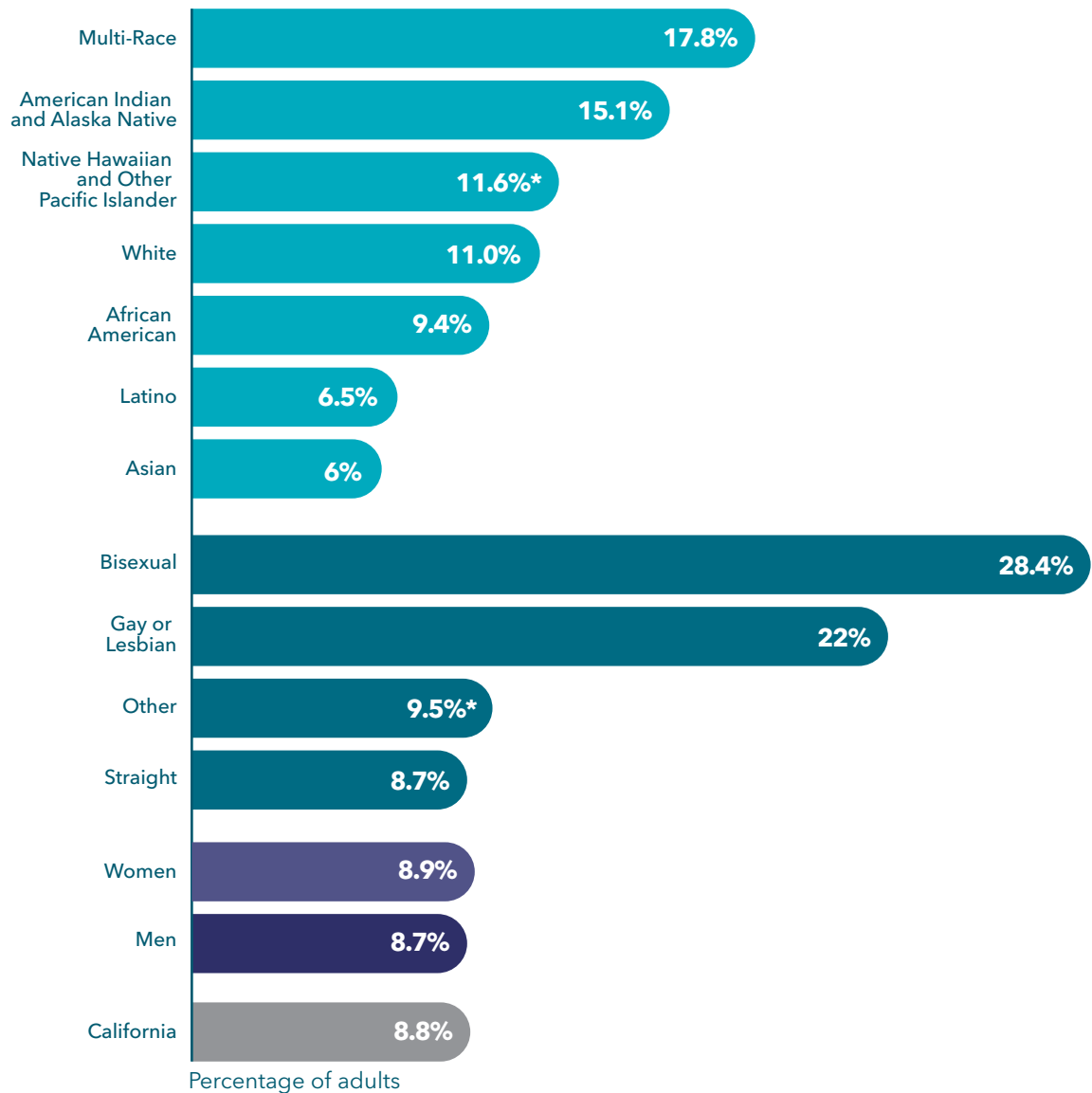
California — 8.8%

Percentage of adults

FIGURE 29: Percentage of adults who reported having seriously thought about committing suicide, by race/ethnicity and sexual orientation, California, 2011-2012.

Source: University of California Los Angeles, California Health Interview Survey, 2011-2012.
Note: "Other" includes not sexual/celibate/none.
Statistically unreliable data

Integrating Mental and Physical Health in New Minority Physicians

The Combined Internal Medicine/ Psychiatry Residency Training (IMP) Program at UC Davis Health System combines psychiatry with either family practice or internal medicine training, as well as board certification. The program, launched in 2007, is a response to the growing need to address mental and physical health needs in primary care settings, where most low-income minorities, especially Mexican Americans, first seek help for emotional problems. Most of the program's physicians-in-training come from underrepresented or culturally diverse backgrounds and plan to work in underserved settings and be future residency directors, policy makers, and thought leaders. Research shows that underrepresented minority physicians are more likely to work in health workforce shortage areas and to care for medically underserved populations, patients of their own ethnic group, and Medicaid recipients.

Source: The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand. U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, 2008.

Native Hawaiians and other Pacific Islanders is statistically unreliable). When the data is examined by sexual orientation, rates of suicidal thoughts are highest among Bisexual individuals, followed by those who identify as Gay or Lesbian *(see Figure 29)*.

Barriers to Care

Affordability of care and low rates of health insurance among vulnerable populations have been major barriers to care for certain underserved populations *(see Figure 30)*. African American, Latino, and Asian American teens who need help for emotional or mental problems are less likely to receive counseling than are White teens. About two-thirds of White teens who need counseling access it, compared with about half of African American, Latino, and Asian teens.[6] Studies show that rates of serious mental illness are more than four times as high among the lowest-income adults in California (less than 100 percent of the federal poverty level) than among those earning at least 300 percent of the poverty rate. Among children age 17 and under, serious emotional disturbance is more closely associated with family income than with race or ethnicity.[5]

Another key barrier to equity in mental health prevention and treatment is the wide cultural and linguistic gulf between underserved populations and health care and behavioral health professionals. For example, a recent University of California, Davis, study found

that up to 75 percent of Latinos who seek mental health services opt not to return for a second appointment, due largely to cultural, social, and language barriers.[7] Although mental health services must be provided in native languages of major immigrant groups, the study found Spanish-speaking professionals few and far between within Latino communities.

On the positive side, changes in state and federal legislation on mental health, including mental health parity laws and the Affordable Care Act, are expected to increase access to mental health prevention and treatment for underinsured and uninsured Californians with mental health needs. In addition, funding for California's public mental health system is getting a boost from the expansion of Medi-Cal and increased revenue stemming from passage of the Mental Health Services Act in 2004 and the Mental Health Wellness Act of 2013.[7]

ACCESS TO HEALTH INSURANCE OR A USUAL SOURCE OF CARE IS LOWER AMONG MINORITY INDIVIDUALS WITH SERIOUS PSYCHOLOGICAL DISTRESS

Percentage of people with serious psychological distress

No Insurance
- American Indian and Alaska Native: 37.0*
- Latino: 27.1
- Asian: 21.1
- African American: 16.8*
- White: 15.5
- Multi-Race: 9.7*

No Usual Source of Care
- American Indian and Alaska Native: 24.7*
- Latino: 23.4
- Asian: 20.0
- African American: 19.8*
- White: 12.4
- Multi-Race: 20.0*

Legend: American Indian and Alaska Native · Latino · Asian · African American · White · Multi-Race
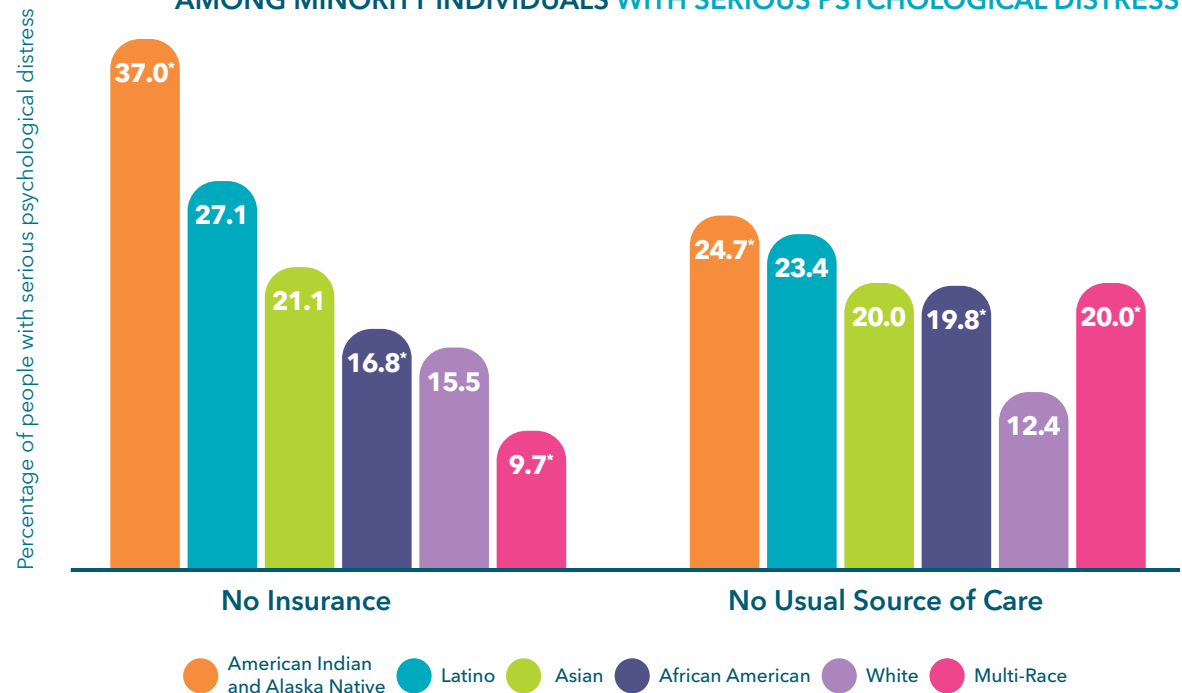
FIGURE 30: Percentage of people with serious psychological distress who reported not having health insurance or the usual source of care, by race/ethnicity, California, 2011-2012.

Source: University of California Los Angeles, California Health Interview Survey, 2011-2012.
Note: "Other" includes not sexual/celibate/none.
* Statistically unreliable data.

THE CALIFORNIA STATEWIDE PLAN TO PROMOTE HEALTH AND MENTAL HEALTH EQUITY
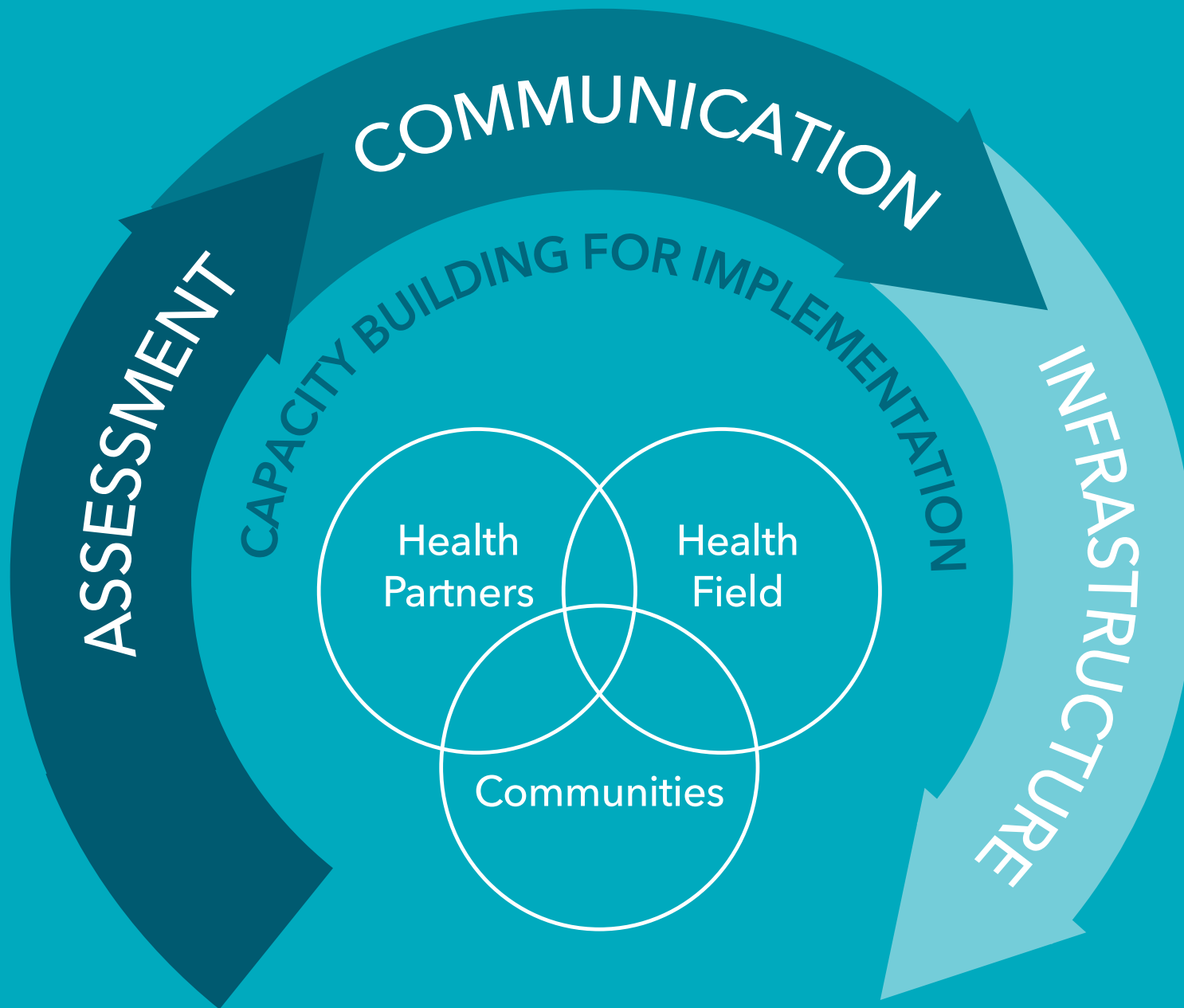
VISION

Everyone in California has equal opportunities for optimal health, mental health, and well-being.

MISSION

Promote equitable social, economic, and environmental conditions to achieve optimal health, mental health, and well-being for all.

CENTRAL CHALLENGE

Mobilize understanding and sustained commitment to eliminate health inequity and improve the health, mental health, and well-being of all.

COMMUNICATION

ASSESSMENT

INFRASTRUCTURE

CAPACITY BUILDING FOR IMPLEMENTATION

Health Partners

Health Field

Communities

Eliminate Health and Mental Health Inequities

PREFACE

We are grateful for the work of hundreds of stakeholders, as well as staff at other state departments, who have participated in the process of launching the first-ever Statewide Plan to Promote Health and Mental Health Equity. To move the Plan from a strategic conversation to a tactical one, we have embedded a set of goals to guide and support our implementation efforts.

Capacity Building for Implementation of the Strategic Priorities

As the facilitator of the planning and implementation processes, the Office of Health Equity (OHE) intends to build capacity for movement on its strategic priorities. First and foremost, we will be building mechanisms for ongoing public engagement and accountability. This will enable meaningful participation of stakeholders to engage in how the goals are prioritized, who will be involved in their implementation, and other important considerations that need to be made along the way. Mechanisms will likely include the use of both technology and personal interaction and will be designed for maximum participation and transparency.

The staff members at the OHE have had the honor and privilege of leading this planning process and will have the responsibility of maintaining accountability for its implementation. However, it should be acknowledged that the process has been highly inclusive and the content of the Plan is reflective of the hard work of the OHE Advisory Committee and hundreds of other stakeholders. This Plan belongs to all who participated in its creation and who will participate in and/or benefit from its implementation. Ultimately the OHE is the author and keeper of the Plan. As such, please note that the terminology "we" and "our" used in this Plan comes from the vantage point of the OHE, in consideration of the many contributions that have been offered in the Plan's development.

Strategic Priorities

Assessment, Communication, and Infrastructure

Health and mental health inequities have surfaced through a culmination of unjust policies and practices over multiple generations. As such, there is no one-to-one relationship in eliminating the inequities; it is a many-to-many relationship. The individuals who have been involved in developing this Plan have identified many intersecting, complementary interventions to turn the tide on the many inequities that are well documented in the accompanying report.

These interventions have as their basis; assessment, communication, and infrastructure development for California overall, as well as within the health field, among potential health partners, and within local communities. The next sections will detail our rationale for prioritizing these three intervention targets, but first we would like to describe the interventions themselves.

Assessment will yield knowledge of the problems and the possibilities. **Communication** will foster shared understanding. **Infrastructure** development will empower residents and their institutions to act effectively. This approach speaks to our intention to identify and disseminate actionable information on inequities and

disparities to develop and align sustainable multisectoral infrastructure and support.

There is growing interest in health and mental health equity, yet many do not know what this terminology means, how it impacts them and others, or why they should be involved in this work. We see an opportunity to build and strengthen the existing network of individuals, organizations, and institutions committed to promoting health and mental health equity—work that is also strongly linked to addressing the social determinants of health. Working to address the social determinants of health includes working to broadly improve the economic, service, and built environments in which people live, work, learn, and play. To expand this network, we must understand who is already engaged in this work and reach out to those who have a potential interest in engaging in it. In order to be both motivated and successful in reducing the inequities caused by the social determinants of health, partners need access to one another, models that work, and data that is relevant and user friendly. They also need as much support as they can get in building their capacity to effectively implement and sustain their interconnected, mutually advancing infrastructures.

Assessment

Readily available assessment data, including what interventions work under what circumstances, is vital to the implementation of this plan. Research and case studies on evidence-based, evidence-informed, and community-based practices for reducing health and mental health disparities and inequities, as well as issue briefs, should be used to guide our efforts. Data that allows us to see disparities at the level of social determinants of health, and that is disaggregated in ways that make our often-invisible communities visible, has been hard to obtain but is vitally important. Failing to account for a community in data means missing the opportunity to understand and address that community's unique challenges, needs, and assets. Although there are a number of major surveys conducted to help us understand our health challenges, such as the American Community Survey and the California Health Interview Survey, not all groups are covered by these surveys. There are particular data challenges for small communities and overlooked groups (e.g., LGBTQQ, people with disabilities, multiracial individuals), and our aim is to increase the availability of this disaggregated data.

In addition to collecting meaningful data, it is important to deliver data in a way that is accessible and understandable to multiple audiences, including various communities, policy makers, and health industry partners. Both qualitative and quantitative data are valuable, and we intend to capture and present both in order to best tell the story of the disparities and inequities that exist and how we are addressing them.

The Healthy Places Team in the Office of Health Equity will continue to build the Healthy Communities Data and Indicators Project (HCI). The goal of the HCI is to enhance public health by providing data, a standardized set of statistical measures, and tools that a broad array of sectors can use for planning healthy communities and by evaluating the impact of plans, projects, policies, and environmental changes on community health. With funding from the Strategic Growth Council (SGC), the HCI was initiated as a two-year collaboration of the California Department of Public Health (CDPH) and the University of California, San Francisco (UCSF), to pilot the creation and dissemination of indicators linked to the Healthy Communities Framework ("Framework"). The Framework was developed by the California Health in All Policies Task Force, with extensive public discussion and input from community stakeholders and public health organizations. The Framework identifies 20 key attributes of a healthy community (of 60 total), clustered in five broad categories: 1) basic needs of all (housing, transportation, nutrition, health care, livable communities, physical activity); 2) environmental quality and sustainability; 3) adequate levels of economic and social development; 4) health and social equity; and 5) social relationships that are supportive and respectful. Indicators are associated with each attribute, and the goal is to present the

data for each indicator for local assessment and planning down to the census tract or zip code wherever possible. CDPH will continue the work beyond the two-year collaboration as existing resources allow.

Communication

Health and mental health equity are new concepts for many – communicating what they are and what they are not to multiple sectors and fields will have major implications moving forward. The same will be true for communicating about the Office of Health Equity and the California Statewide Plan to Promote Health and Mental Health Equity. There has already been much discussion about how to communicate the strategies and for whom the Plan is intended. Ultimately a goal was added to create a comprehensive marketing and communications plan, which will address the many questions that have surfaced and inspired rich dialogue.

Communication plays a meaningful role overall and is particularly important in each of the three intervention targets – health partners, health field, and communities. While these goals are intended to stand alone, the proposed website and issue briefs will be important components of the marketing and communications plan. They will be successful when they reach their target audience with timely, accurate, actionable information. Actions may include utilizing data for decision making, replicating a promising practice, or joining others to move a particular issue forward.

So that these efforts are not taking place in isolation, we will seek to coordinate and convene those involved. We will capitalize on technology and on face-to-face interaction, utilizing the communication avenues that have already been established, such as summits and forums, and building new ones as necessary. California is a vast state, and we want everyone to be included in these efforts, so special attention will be paid to reaching the corners of the state and the individuals and communities that have historically been challenged to participate in statewide dialogue and action.

Infrastructure

We envision a robust, statewide community of people engaged in conducting their work and advocating for their needs through a health and mental health equity lens. Our vision is to have a workforce with the capacity to effectively dismantle health and mental health inequities. This will require education, training, guidance, support, and accountability at multiple levels throughout multiple sectors. It will also require strong partnerships to leverage the resources, tools, and incentives to facilitate such workforce development. We intend to bring together partners in the national, state, local, tribal, and private spheres to consider how we can capitalize on our expertise and resources to accomplish this common vision. We see opportunities for further embedding health and mental health equity outcomes into funding criteria and accompanying technical assistance.

We also see opportunities for California to benefit from the implementation efforts under way through the U.S. Department of Health and Human Services' Action Plan to Reduce Racial and Ethnic Health Disparities and other plans and entities that are addressing the needs of historically underserved communities. Many of these efforts have resources connected to the shared vision of workforce development; monitoring them and seeking a role for California and its communities will allow us to align with national and other efforts and to leverage resources when available.

Strategic Intervention Target: Health Partners

Embed Health and Mental Health Equity into Institutional Policies and Practices Across Fields with Potential Health Partners

In order to advance health and mental health equity, our work will extend beyond the traditional boundaries of public health and health care to address the other factors that contribute to overall health. These factors include educational attainment, income, housing, safe places, and clean environments. Fortunately, this work has begun with many willing partners, and many more will have the opportunity to engage. We will identify the equity practices currently being conducted across a spectrum of fields and work with both existing and new partners.

At the level of state government, exciting work is being done with the Health in All Policies (HiAP) Task Force created administratively in 2010 and accountable to the Strategic Growth Council. Pending available resources, the Office of Health Equity helps staff the HiAP Task Force in partnership with the Public Health Institute, with primary funding from The California Endowment. The HiAP Task Force is specifically identified in the statute that created the Office of Health Equity (California Health and Safety Code Section 131019.5), naming it as a partner in the creation of this statewide plan.

We will foster a HiAP approach to embed health equity criteria in decision making, grant programs, guidance documents, and strategic plans.

A key area for dialogue and action that will require the cooperation of interests across a spectrum of fields is climate change.[1] We anticipate that the most profound consequences of climate change will disproportionately impact the state's most vulnerable populations.[2] As such, we will engage in partnerships to enhance understanding of climate change and its impact on the health of Californians. There are opportunities through the Climate and Health Team in the Office of Health Equity to incorporate health equity into the state's Climate Action Team, share data and tools, and participate in cross-sector planning and consultation.

Strategic Intervention Target: Health Field

Embed Equity into Institutional Policies and Practices across the Health Field

Promoters of health and mental health equity abound throughout the health field, and they are among the first to identify the challenges in their own field. Equity policies and practices are not consistent, and learning still needs to take place around the social determinants of health and the National

Culturally and Linguistically Appropriate Services (CLAS) Standards. We will take stock of the equity policies and practices in the field to determine how widespread they are, providing a basis for subsequent engagement.

California Health and Human Services (CHHS) oversees departments, boards, and offices that provide a wide range of health care services, social services,

mental health services, alcohol and drug treatment services, public health services, income assistance, and services to people with disabilities. Initially, we will facilitate a common understanding of health and mental health equity and the social determinants of health between the departments, boards, and offices within CHHS and then extend that conversation to health, behavioral health, and social services departments

outside of the state system. Awareness may be raised through film or speaker series, online learning communities, in-person and online trainings, or other mechanisms. The OHE Climate and Health Team will be a natural resource to engage in this outreach.

There is also an opportunity to synchronize our efforts with the National CLAS Standards, which were enhanced in 2013 to move toward a health equity model inclusive of health and health care. We envision widespread assessment, technical assistance, and training to align California's practitioners with the National CLAS Standards. This attention to cultural and linguistic competence will strengthen the capacity of organizations, institutions, and systems to assess, plan, implement, evaluate, and communicate their efforts.

The health field is changing dramatically with the implementation of the Affordable Care Act (ACA), a historic health care reform law designed to improve health care coverage and access while putting in place new protections for people who already have health insurance. Under the law, health insurance coverage is becoming affordable and accessible for millions of California residents, a factor that will help reduce health disparities. The United States' foreign-born population is currently over 2.5 times more likely than native-born Americans to be uninsured. The ACA has expanded health care coverage to certain refugees and documented immigrants.[3] However, we anticipate that health coverage disparities will increase for California residents who are undocumented immigrants, and it is possible that the disparities will widen also for those residing in mixed-status households, who may fear triggering immigration investigations upon ACA enrollment. We intend to explore how to maximize coverage opportunities for California's residents while assisting those who will remain uninsured. There is great potential for partnering with health plans to pursue innovations in this area.

Strategic Intervention Target: Communities

Empower Communities in Inequity and Disparity Reduction Initiatives

Tremendous work in reducing formal and informal inequities and disparities is being conducted throughout the state, in organizations and communities large and small, rural and urban. We will gain a better understanding of this work so that it can be networked, spotlighted, elevated, and replicated. Communities that have identified effective ways to reduce inequities and disparities have much to share, and the entire state has much to learn from their successes— including how they are resourced, how they are building local capacity for sustainability, and how they are measuring their success. Our vision is to integrate these lessons statewide and to identify the partnerships and available resources that will allow that to happen.

One exciting possibility is the launch of local initiatives to increase health and mental health equity in all policies. These initiatives could build upon local, state, and national efforts to ensure that their local policies consider equity and the social determinants of health. This would be an opportunity to build alliances across local public health departments, county mental health or behavioral health departments, local social services, local mental health agencies, and other local agencies that address key health determinants, including but not limited to housing, transportation, planning, education, parks, and economic development. We have heard from stakeholders that these alliances have been difficult to forge because it is hard to make the case for common interests in a way that can be easily understood and appreciated. With this in mind, we intend to explore the feasibility of local initiatives inspired by HiAP approaches. Ideally, we will establish avenues for learning from the lessons of existing local efforts and enlist them in technical assistance for their colleagues statewide.

Such HiAP-inspired initiatives might draw from the experiences of place-based models established in other states. The Division of Community, Family Health, and Equity at the Rhode Island Department of Health has created a model for cross-program integration that includes pooled community investment grants in high-need communities called Health Equity Zones, each with a Center for Health Equity and Wellness. The model includes a statewide Healthy Places Learning Collaborative, with web-based resources, tools, and on-site technical assistance for communities; uniform contract language for all health contracts to communicate expectations for implementation of health equity work; a collaborative network of state/local stakeholders from multiple coalitions and interest groups doing cross-program, state-level strategic thinking; and an online relational mapping database of community assets and gaps to ensure that investments and partnerships result in the greatest reach and impact. We intend to further research Health Equity Zones and other place-based models to assess the feasibility of replicating them in high-need California communities.

To immediately mobilize resources to reduce health and mental health disparities, we will initially act through the California Reducing Disparities Project (CRDP) within the Office of Health Equity. CRDP Phase 2 provides $60 million dollars in Mental Health Services Act (MHSA) funding over five years to implement the practices and strategies identified in the CRDP Strategic Plan. Phase 2's focus is to demonstrate the effectiveness of community-defined practices in reducing mental health disparities. Through a multicomponent program, the California Department of Public Health plans to fund selected approaches across the five CRDP-targeted populations with strong evaluation, technical assistance, and infrastructure support components. These populations are African Americans; Asians and Pacific Islanders; Latinos; Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQQ) individuals; and Native Americans. After successful completion of this multiyear investment in community-defined evidence, California will be in a position to better serve these communities and to provide the state and the nation a model to replicate the new strategies, approaches, and knowledge. As partnerships become available, we will further seek to mobilize resources at the community level.

Two priority areas that relate to the CRDP Strategic Plan and have been identified by a range of stakeholders throughout the state are 1) the possible extension of the California MHSA Multicultural Coalition beyond 2015 and its utilization as a major advisor to the Office of Health Equity regarding the CRDP, in addition to its other purposes; and 2) the possible creation of new Strategic Planning Workgroups (SPWs) in order to continue the critical work of identifying promising practices for underserved communities not covered by the original SPWs.

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HEALTH IN ALL POLICIES TASK FORCE

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Appendix A:
Goals to Support the Strategic Priorities

The following are the Plan's five-year strategic priorities:

Through **assessment**, yield knowledge of the problems and the possibilities.	Through **communication**, foster a shared understanding.	Through **infrastructure** development, empower residents and their institutions to act effectively.

Goals for each of the strategic priorities were crafted for California overall as well as within the health field, among potential health partners, and within local communities, for Stage 1 (2015-2018) and Stage 2 (2018-2020) of the Plan. As an inaugural effort, goals have also been created aimed at building capacity for implementation of the strategic priorities.

The goals for both Stage 1 and Stage 2 are presented in the first matrix of this appendix. These goals are aspirational and will include substantial cross-sector collaboration.

We will strategize how to best implement the goals over time. The preliminary activities and resources planned by the California Department of Public Health for the implementation of Stage 1 goals are presented in the second matrix of this appendix.

KEY TO GOAL CODING:

STRATEGIES

A = Assessment
C = Communication
I = Infrastructure
CB = Capacity Building

TARGET AUDIENCES

O = Overall
HP = Health Partners
HF = Health Field
C = Communities

1 AND 2 FOLLOWING THESE CODES:

Stage 1 (2015-2018)
Stage 2 (2018-2020)

Numbers after the dot distinguish the goals from one another.

Stage 1 and Stage 2 Goals by Strategy and Target Audience

ASSESSMENT

Overall

AO1&2.1 Monitor continuously each of the goals to ensure that the Plan is progressing appropriately, and present updates at the quarterly Office of Health Equity Advisory Committee (OHE-AC) meetings and post a corresponding report online

AO1&2.2 Collect and analyze data that highlights the social determinants of health, and encourage this data for planning purposes

AO1.3 Assess health and mental health equity data shortcomings, and explore the feasibility of creating new data and/or disaggregating existing data

AO2.3 Build on Stage 1 by creating new data and/or disaggregating existing data, as feasible

Health Partners

AHP1.1 Identify the state's capacity to collect health and mental health equity practices in fields with potential health partners

Health Field

AHF1.1 Identify the health and mental health equity practices throughout state departments and state-funded programs in the health field

Communities

AC1.1 Identify how local communities are currently mobilizing to address the social determinants of health and how they are measuring their efforts toward progress

COMMUNICATION

Overall

CO1.1 Create a comprehensive marketing and communications plan for health and mental health equity, the Office of Health Equity, and the California Statewide Plan to Promote Health and Mental Health Equity

CO1.2 Build a network of communication and support for health and mental health equity work statewide, to include practitioners, community members, community-based organizations, consumers, family members/those with lived experience with mental health conditions, policy leaders, and other stakeholders

CO1&2.3 Develop, host, and regularly update an interactive, informative, and engaging state-of-the-art website with timely, accurate data; relevant research; and evidence-based and community-defined practices

CO1&2.4 Develop and disseminate issue briefs based on recommendations from the OHE-AC and other stakeholders

CO1&2.5 Provide leadership in sharing California's health and mental health equity efforts for adoption as appropriate throughout the state, nationally, and internationally

Health Partners

CHP1&2.1 Facilitate common understanding of health and mental health equity and the social determinants of health between potential health partner agencies and organizations

Health Field

CHF1.1 Facilitate common understanding of health and mental health equity and the social determinants of health between all departments that fall under California Health and Human Services (CHHS), while beginning this dialogue with key health-related state programs outside of CHHS

CHF1.2 Enhance understanding of and action on climate change as a critical public health issue that is likely to impact vulnerable populations in disparate ways

CHF2.1 Facilitate a common understanding of, and the ability to operationalize, health and mental health equity and the social determinants of health between all health, behavioral health, and social service departments inside and outside of the state system – and their grantees – through access to training, technical assistance, and leveraged funding relationships

Communities

CC1&2.1 Build broad-based community support on health and mental health equity issues through education and dialogue, heightening awareness of the social determinants of health

INFRASTRUCTURE

Overall

IO1&2.1 Partner on existing health and mental health equity summits for practitioners and policy makers

IO1&2.2 Catalyze workforce development opportunities aimed at increasing California's capacity to effectively address health and mental health inequities and disparities, starting with state employees and moving beyond the state system as resources and partnerships are secured

IO1&2.3 Recommend that health and mental health equity goals be considered during the allocation of existing funding streams

IO1&2.4 Closely monitor progress of the U.S. Department of Health and Human Services' Action Plan to Reduce Racial and Ethnic Health Disparities and of other health and mental health equity efforts that are addressing the needs of historically underserved communities, and seek opportunities to increase California's role and/or adopt successful models

IO1&2.5 Promote the use of a gender lens as appropriate when assessing health and mental health equity models to increase the likelihood of improving the often-distinct health needs of women and girls and of men and boys, particularly those of color and/or low income

IO2.6 Leverage the community support, relationships, and networks built in Stage 1 to coordinate impact on health and mental health equity issues statewide

Health Partners

IHP1&2.1 Use a Health in All Policies approach to embed health and equity criteria in decision-making, grant programs, guidance documents, and strategic plans

IHP1&2.2 Enhance understanding of climate change as a public health issue of increasing importance for the state's most vulnerable populations, and promote widespread efforts to reduce greenhouse gas emissions, achieve health co-benefits, and enhance climate resilience for vulnerable and disadvantaged communities

IHP2.3 Utilize results from the identification of health and mental health equity practices conducted in Stage 1 to make recommendations for addressing inequities and their social determinants in potential health partner practices

IHP2.4 Facilitate access to training and technical assistance for agencies and grantees of state programs on health and mental health equity, including incorporating health and mental health equity modules into current training provided by state and federal programs

Health Field

IHF1&2.1 Support the expansion of the National Culturally and Linguistically Appropriate Services (CLAS) Standards, including assessment, technical assistance, and training

IHF1.2 Explore health and mental health equity implications of the Affordable Care Act (ACA) as they relate to access, expanded coverage, and community-based prevention strategies

IHF2.2 Support health care institutions to partner with health allies (e.g., transportation and land use) to develop policies and programs that improve access to health, mental health, and health care services

IHF2.3 Utilize results from the exploration of health and mental health equity implications of the ACA conducted in Stage 1 to evaluate actionable next steps

Communities

IC1&2.1 Mobilize resources to reduce health and mental health inequities and disparities

IC1&2.2 Identify opportunities to build upon existing initiatives, implement new initiatives, replicate initiatives, and leverage local resources to increase health and mental health equity in all policies

IC1.3 Research Health Equity Zones and other place-based models to assess the feasibility of replicating or expanding such interventions at the neighborhood level in California

IC2.3 Increase the civic participation of the communities most impacted by health and mental health inequities and disparities

IC2.4 Incentivize, recognize, and publicize local efforts addressing health and mental health equity and the social determinants of health, both emerging and established

IC2.5 Connect local efforts with partners and resources to build health and mental health equity into strategic plans; train staff and volunteers; evaluate impact; and engage with funders, colleagues, and other communities

IC2.6 As feasible and appropriate, initiate or expand Health Equity Zones and/or other place-based models

Stage 1 and Stage 2 Implementation Goals

CB1&2.1. Build mechanisms for the OHE to establish ongoing public engagement and accountability on the strategic priorities, ensuring community participation in all goals at all levels of the Plan.

CB1&2.2. Strengthen the health and mental health equity workforce development pipeline by utilizing fellows and interns in the implementation of the strategic priorities, throughout the Plan's multiple partners.

CB1&2.3. Seek additional resources, including in-kind assistance, federal funding, and foundation support.

CB1&2.4. Develop and implement a process to foster public and private partnerships for all appropriate strategic priorities, including governmental, corporate, educational, research, and philanthropic institutions.

ASSESSMENT

Overall

AO1.1 Monitor continuously each of the goals to ensure that the Plan is progressing appropriately, and present updates at the quarterly Office of Health Equity Advisory Committee (OHE-AC) meetings and post a corresponding report online.

▶ The Supervisor for the OHE Health Research and Statistics Unit will provide leadership in further identifying the activities to support each of the goals for each of the target audiences in this strategy.

▶ OHE Health Research and Statistics Unit will prepare quarterly reports, and OHE's deputy director will present them at the OHE-AC meetings.

▶ AO1.2 Collect and analyze data that highlights the social determinants of health, and encourage this data for planning purposes.

▶ The Healthy Places Team in the OHE will continue to build the Healthy Communities Data and Indicators Project by: a) completing all 60 indicators identified in the research and development phase by December 2016 as resources allow, b) developing supporting materials for each indicator by December 2016 as resources allow, and c) conducting training workshops to disseminate knowledge and skills about the indicators among stakeholders by December 2016 as resources allow.

▶ Per the OHE mandate and through the Interagency Agreement with the California Department of Health Care Services (DHCS), the OHE will continue meeting with DHCS in the established Data Workgroup to discuss opportunities to coordinate data capacity.

▶ The OHE Community Development and Engagement Unit (CDEU) will continue to update and collaborate with DHCS through its Mental Health Services Division to partner, collaborate, inform, and offer technical assistance. CDEU will continue ongoing cultural and linguistic sensitivity technical assistance to DHCS such as with the Cultural Competence Plan Requirements that collect data from all county mental health plans.

▶ AO1.3 Assess health and mental health equity data shortcomings, and explore the feasibility of creating new data and/or disaggregating existing data.

▶ The OHE Health Research and Statistics Unit will work with other CDPH offices in a joint effort with California HealthCare Foundation's Free the Data project, which consists of a gateway for external data users to use one online portal for access to all our data at CDPH.

▶ The OHE Community Development and Engagement Unit will a) provide technical assistance (TA) on lessons learned and community recommendations relative to the data and disaggregation of the data (this information is documented in five target population-specific California Reducing Disparities Project [CRDP] Phase I Population Reports), b) provide TA on lessons learned and community recommendations relative to CRDP target population data evaluation efforts, and c) encourage CRDP contractors to share subject matter expertise on population-specific tools to collect culturally and linguistically appropriate data.

Health Partners

AHP1.1 Identify the health and mental health equity practices in fields with potential health partners.

Health Field

AHF1.1 Identify the health and mental health equity practices throughout state departments and state-funded programs in the health field.

Communities

AC1.1 Identify how local communities are currently mobilizing to address the social determinants of health and how they are measuring their efforts toward progress.

- Identification will be strengthened by data generated from the California Wellness Plan.

COMMUNICATION

Overall

CO1.1 Create a comprehensive marketing and communications plan for health and mental health equity, the Office of Health Equity, and the California Statewide Plan to Promote Health and Mental Health Equity

► A management-level position with expertise in both communications planning and execution will provide leadership in further identifying the activities to support each of the goals for each of the target audiences in this strategy.

CO1.2 Build a network of communication and support for health and mental health equity work statewide, to include practitioners, community members, community-based organizations, consumers, family members/those with lived experience with mental health conditions, policy leaders, and other stakeholders

► The OHE Community Development and Engagement Unit will continue California Reducing Disparities Project (CRDP) efforts, including the following: a) email regular communications through the OHE e-blast function to hundreds of stakeholders to keep them apprised of CRDP activities, b) post online and then update the CRDP contractor roster regularly, and c) encourage a continuous feedback loop from community stakeholders via meet-and-greets and an open-door policy (email/phone/at meetings in the community).

CO1.3 Develop, host, and regularly update an interactive, informative, and engaging state-of-the-art website with timely, accurate data; relevant research; and evidence-based and community-defined practices

► Subject to the availability of resources to fund such activities, the OHE Community Development and Engagement Unit will share critical outcome information associated with the following community-defined practices and evaluation efforts: a) host a CRDP webpage that is regularly updated; b) create a webpage posting of deliverable reports from the community participatory evaluation being conducted throughout Phase 2 activities; c) post online the categories of community-defined practices identified by the CRDP Population Reports; d) use a translation service contract to translate webpage information; and e) use a cultural competence consultant contract to incorporate recommendations made to the state by subject matter experts in cultural and linguistic competence, with the goal of improving culturally and linguistically appropriate mental health web information.

CO1.4 Develop and disseminate issue briefs based on recommendations from the OHE-AC and other stakeholders

► The OHE Community Development and Engagement Unit will support CRDP contractors in sharing issue briefs with their communities.

CO1.5 Provide leadership in sharing California's health and mental health equity efforts for adoption as appropriate throughout the state, nationally, and internationally

Health Partners

CHP1.1 Facilitate common understanding of health and mental health equity and the social determinants of health between potential health partner agencies and organizations

► The HiAP Task Force will a) hold quarterly meetings to engage nonhealth state agencies in developing collaborative approaches to promoting health, equity, and sustainability; and b) hold at least three collaborative learning sessions to provide leaders and staff at potential health partner state agencies with opportunities to explore the links between health and mental health equity and the social determinants of health.

Health Field

CHF1.1 Facilitate common understanding of health and mental health equity and the social determinants of health between all departments that fall under California Health and Human Services (CHHS), while beginning this dialogue with key health-related state programs outside of CHHS

CHF1.2 Enhance understanding of and action on climate change as a critical public health issue that is likely to impact vulnerable populations in disparate ways

► The OHE Climate and Health Team will a) work with local health departments, OHE-AC members, health equity and environmental justice advocates, and stakeholders in the public health and mental health arenas to build capacity to incorporate climate change issues into training and strategic planning;

b) offer online trainings, presentations, and resources to enhance awareness and understanding of climate change, with a focus on health equity; and

c) utilize the CAT Public Health Workgroup as an educational forum in which to raise climate and health equity issues, needs, and strategies with a variety of stakeholders.

Communities

CC1.1 Build broad-based community support on health and mental health equity issues through education and dialogue, heightening awareness of the social determinants of health

► The OHE Community Development and Engagement Unit will continue CRDP efforts to meaningfully engage diverse community stakeholders by a) meeting with local stakeholders around the state to hear concerns and feedback that will continue meaningful dialogue and build upon community engagement momentum, and b) collecting data pertaining to mental health equity outcomes, inequities, and community participatory evaluation processes.

INFRASTRUCTURE

Overall

IO1.1 Partner on existing health and mental health equity summits for practitioners and policy makers.

▶ The OHE Community Development and Engagement Unit will encourage CRDP contractors to participate in health and mental health equity summits to share population-specific, community-defined practices and recommendations relative to CRDP efforts.

IO1.2 Catalyze workforce development opportunities aimed at increasing California's capacity to effectively address health and mental health inequities and disparities, starting with state employees and moving beyond the state system as resources and partnerships are secured.

▶ CDPH has a Public Health Management Team that is committed to movement on this goal.

IO1.3 Recommend that health and mental health equity goals be considered during the allocation of existing funding streams.

▶ CDPH has a Public Health Management Team that is committed to movement on this goal.

IO1.4 Closely monitor progress of the U.S. Department of Health and Human Services' Action Plan to Reduce Racial and Ethnic Health Disparities and other health and mental health equity efforts that are addressing the needs of historically underserved communities, and seek opportunities to increase California's role and/or adopt successful models.

▶ OHE will monitor external health and mental health equity plans.

IO1.5 Promote the use of a gender lens as appropriate when assessing health and mental health equity models, to increase the likelihood of improving the often distinct health needs of women and girls and of men and boys, particularly those of color and/or low income.

▶ OHE will coordinate with gender experts and stakeholders to assist in the assessment of viable health and mental health equity models.

Health Partners

IHP1.1 Use a Health in All Policies approach to embed health and mental health equity criteria in decision-making, grant programs, guidance documents, and strategic plans.

▶ The HiAP Task Force will embed health equity as a key consideration in five decision-making processes, grant programs, state guidance documents, and/or strategic plans.

▶ The OHE Community Development and Engagement Unit will continue participation on the State Interagency Team Workgroup to Eliminate Disparities and Disproportionality (WGEDD), which has a special interest and a history in developing and implementing a racial impact tool to assist state agencies in making decisions that do not adversely impact vulnerable populations.

IHP1.2 Enhance understanding of climate change as a public health issue of increasing importance for the state's most vulnerable populations, and promote widespread efforts to reduce greenhouse gas emissions, achieve health co-benefits, and enhance climate resilience for vulnerable and disadvantaged communities.

▶ The OHE Climate and Health Team will a) incorporate health equity into the state's Climate Action Team and into specific climate mitigation and adaptation plans and policies; b) develop and share data and tools to identify climate risks, health impacts, and vulnerabilities in the state's diverse communities and populations for use in multi-sectoral planning efforts; and c) participate in cross-sector planning and consultation on climate mitigation and adaptation efforts that promote health equity and enhance the resilience of vulnerable and disadvantaged communities.

INFRASTRUCTURE

Health Field

IHF1.1 Support the expansion of the National Culturally and Linguistically Appropriate Services (CLAS) Standards, including assessment, technical assistance, and training

► The California Wellness Plan's second goal is "Optimal Health Systems Linked with Community Prevention." The OHE will work closely with the other CDPH offices implementing the objectives in Goal 2 that speak to CLAS. In particular, the OHE Community Development and Engagement Unit will continue to update and collaborate with DHCS to share in learning opportunities and provide technical assistance related to cultural and linguistic competence.

IHF1.2 Explore health and mental health equity implications of the Affordable Care Act (ACA) as they relate to access, expanded coverage, and community-based prevention strategies

► CDPH's partners on the California Wellness Plan are interested in focusing on a) building on strategic opportunities, current investments, and innovations in the Patient Protection and Affordable Care Act; and b) prevention and expanded managed care to create a systems approach to improving patient and community health. OHE and other CDPH offices will continue partnering with Covered California to ensure that the uninsured are moved into programs for which they are eligible.

Communities

IC1.1 Mobilize resources to reduce health and mental health inequities and disparities

► The OHE Community Development and Engagement Unit will oversee $60 million in resource allocation through the California Reducing Disparities Project over a four-year period.

IC1.2 Identify opportunities to build upon existing initiatives, implement new initiatives, replicate initiatives, and leverage local resources to increase health and mental health equity in all policies

► Through the implementation of CRDP Phase 2, community-based promising practices and strategies will be identified, implemented, and evaluated, utilizing a robust community-based participatory approach to demonstrate the effectiveness of community-defined practices in reducing mental health disparities. This will position community-defined practices for replication and additional resource acquisition.

IC1.3 Research Health Equity Zones and other place-based models to assess the feasibility of replicating or expanding such interventions at the neighborhood level in California

► The OHE Health Research and Statistics Unit will initiate research on Health Equity Zones and other place-based models.

Stage 1 CDPH Preliminary Activities and Resources for Implementation

All goals will be led by the OHE Deputy Director.

> **CB1&2.1.** Build mechanisms for the OHE to establish ongoing public engagement and accountability on the strategic priorities, ensuring community participation in all goals at all levels of the Plan.

> **CB1&2.2.** Strengthen the health and mental health equity workforce development pipeline by utilizing fellows and interns in the implementation of the strategic priorities, throughout the Plan's multiple partners.

Additional CDPH Activities and Resources: The California Epidemiologic Investigation Services (Cal-EIS) Fellowship and the Preventive Medicine Residency Program (PMRP) are two postgraduate programs that train epidemiologists and physicians. The Cal-EIS Fellowship's and the PMRP's mission is to build the public health workforce by training well-qualified candidates in preventive medicine and public health practice. Fellows and residents receive training that addresses health equity and social determinants of health, conducted through preventive medicine seminars. Focused discussions on these topics help build trainees' awareness of these issues and develop related competencies as they prepare for careers in public health. The training results in adding skilled epidemiologists and public health physicians to the state (and local) workforce (e.g., research scientists, public health medical officers, local health officers and administrators). If resources were identified for placement opportunities, Cal-EIS fellows and PMRP residents could be placed in local health departments or state programs and could train with a focus on health and mental health equity. During fellows' and residents' placement, major projects and activities could be developed that have a specific focus in this area, and fellows and residents could be utilized to help implement the strategic priorities.

> **CB1&2.3.** Seek additional resources, including in-kind assistance, federal funding, and foundation support.

> **CB1&2.4.** Develop and implement a process to foster public and private partnerships for all appropriate strategic priorities, including governmental, corporate, educational, research, and philanthropic institutions.

Additional CDPH Activities and Resources: The California Wellness Plan's fourth goal was established, due to external partner input, as "Prevention Sustainability and Capacity." Our partners are interested in focusing on a) collaborating with health care systems, providers, and payers to show the value of greater investment in community-based prevention approaches that address underlying determinants of poor health and chronic disease; b) exploring dedicated funding streams for community-based prevention; and c) aligning newly secured and existing public health and cross-sectoral funding sources to support broad community-based prevention. Partners selected the short-term strategy of Wellness Trust creation, with dedicated streams of funding for community-based prevention at the local, regional, and state levels.

Appendix B:
Health in All Policies Task Force

The California Health in All Policies Task Force ("Task Force") provides a venue for 22 state agencies to develop collaborative approaches to promote health and health equity outcomes across California. The Task Force was created administratively in 2010, out of recognition that nearly all policy fields have an impact on health, as well as the complex relationship between health, equity, and environmental sustainability.

- In order to promote health, equity, and environmental sustainability, the Task Force:

- Reviews existing state efforts and best/promising practices used by other jurisdictions and agencies;

- Identifies barriers to and opportunities for interagency/inter-sector collaboration;

- Convenes regular public workshops and solicits input from stakeholders; and

- Develops and implements multi-agency programs to improve the health of Californians.

The Task Force's initial recommendations and implementation plans were developed by the Task Force and endorsed by the Strategic Growth Council (SGC) between 2010 and 2012. As new windows of opportunity emerge, staff and Task Force members vet ideas and create new recommendations and implementation plans, pending available resources and alignment with Task Force priorities.

Following are key highlights of the Task Force that are relevant to the goals of the Office of Health Equity.

Food Security and Access to Healthy Food:

The multi-agency Office of Farm to Fork (http://cafarmtofork.com/) was created in August 2012, when an interagency agreement was executed between the California Department of Education, the California Department of Food and Agriculture, and the California Department of Public Health, drawing resources from all three agencies to "help all Californians eat healthy, well-balanced meals." The office aims to increase "access to healthy, nutritious food for everyone in the state" by "connecting individual consumers, school districts, and others directly with California's farmers and ranchers, and providing information and other resources."

The Task Force gave rise to the creation of a multi-agency Food Procurement Working Group, a successful community-supported agriculture (CSA) pilot program on state property, and a partnership with the Department of General Services and the Department of Corrections and Rehabilitation as they integrate nutrition criteria into food purchasing contracts. This will effectively improve the nutritional content of food provided to over 100,000 inmates and will also create opportunities for other agencies to purchase healthier foods.

Active Transportation:

Health in All Policies staff gathered lessons learned from the Task Force and partnered with TransForm to develop and disseminate a report called *Creating Healthy Regional Transportation Plans*, released in January 2012 and available at http://www.transformca.org/resource/creating-healthy-regional-transportation-plans. This report was disseminated to metropolitan planning organizations and other stakeholders.

The Task Force hosted an orientation workshop, Complete Streets: Designing for

Pedestrian and Bicycle Safety, for staff from nine agencies, providing an opportunity for multisectoral dialogue among agencies with a stake in creating streets that serve all users, including bicyclists, pedestrians, and people with disabilities.

The Southern California Association of Governments created a public health subcommittee to support its Regional Transportation Plan and included Task Force staff on that committee to help the region make links to health and equity as it develops policy proposals for the upcoming plan.

Task Force members are currently engaged in a creative process to renew their active transportation goals and generate new action steps based upon current and emerging opportunities.

Healthy Housing:

The Department of Housing and Community Development facilitates a multi-agency workgroup that provides resources to support local communities in harmonizing goals related to housing, air quality, location efficiency, transit-oriented development, and public health.

Parks and Community Greening:

The Department of Forestry and Fire Protection worked with the Governor's Office of Planning and Research to develop a webpage resource for local governments to use in planning for a healthy urban forest that optimizes benefits to the environment, public health, and the economy.

The Task Force supported the Department of Forestry and Fire Protection in conducting an urban forest inventory and assessment pilot project in the city of San Jose that can be used to develop and demonstrate a feasible approach for mapping the state's urban forests and quantifying the value of ecosystem services they provide.

Health in All Policies staff regularly serve as reviewers for the SGC Urban Greening for Sustainable Communities grant applications

Integration of Health and Equity into Land Use Policy:

The Governor's Office of Planning and Research is engaging health partners and the Task Force as they revise California's General Plan Guidelines, with a particular focus on health, equity, and environmental sustainability.

The California Department of Education, the Governor's Office of Planning and Research, the SGC, and the Task Force formed the Land Use, Schools, and Health (LUSH) Working Group to explore the linkages between health, sustainability, and school infrastructure and to promote these goals through the state's General Plan Guidelines, K-12 school siting guidance, and school facilities' construction and rehabilitation.

Health in All Policies staff worked with the

SGC to integrate health language into its Sustainable Communities Planning Grants Program in order to incentivize applicants to partner with local health departments and incorporate health into their planning processes.

The Healthy Community Framework, developed with input from the Task Force, has been incorporated into programs and reports such as the *2010 California Regional Progress Report*, which provides a framework for measuring sustainability using place-based and quality-of-life regional indicators.[1]

Neighborhood Safety:

The Task Force is working with the Local Government Commission and others to develop guidelines for local communities to use design elements to promote community safety while also promoting social cohesion; active transportation; and healthy, livable communities.

Detailed information about the recommendations, priorities, implementation plans, and progress of the Health in All Policies Task Force is available through a variety of documents posted on the Strategic Growth Council (SGC) website at www.sgc.ca.gov/.

Appendix C:
Glossary

Active physicians are currently licensed physicians who are not retired, semiretired, working part time, temporarily not in practice, or inactive for other reasons and who work 20 or more hours per week. (American Medical Association and Medical Board of California)

Age checkpoints are defined according to whether or not children are up to date for age- appropriate doses of DTaP, polio, and MMR vaccines at 3, 5, 7, 13, 19, and 24 months. (CA Department of Public Health)

Bisexual is of or relating to persons who experience sexual attraction toward and responsiveness to both males and females. (CA Department of Justice)

Determinants of equity are defined as the social, economic, geographic, political, and physical environmental conditions that lead to the creation of a fair and just society. (CA Health and Safety Code Section 131019.5)

Ethnic bias is a preformed negative opinion or attitude toward a group of persons of the same race or national origin who share common or similar traits in language, custom, and tradition. (CA Department of Justice)

Ethnicity refers to two "ethnic" classifications: "Hispanic or Latino" and "not Hispanic or Latino." (U.S. Census Bureau)

Food insecurity is limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways. (U.S. Department of Agriculture via Life Sciences Research Office)

Food security means access by all people at all times to enough food for an active, healthy life. (U.S. Department of Agriculture)

Gay (homosexual male) is of or relating to males who experience a sexual attraction toward and responsiveness to other males. (CA Department of Justice)

Health equity refers to efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives. (CA Health and Safety Code Section 131019.5)

Health and mental health disparities are differences in health and mental health status among distinct segments of the population, including differences that occur by gender, age, race or ethnicity, sexual orientation, gender identity, education or income, disability or functional impairment, or geographic location, or the combination of any of these factors. (CA Health and Safety Code Section 131019.5)

Health and mental health inequities are disparities in health or mental health, or the factors that shape health, that are systemic and avoidable and, therefore, considered unjust or unfair. (CA Health and Safety Code Section 131019.5)

Heterosexual is of or relating to persons who experience a sexual attraction toward and responsiveness to members of the opposite sex. (CA Department of Justice)

Homosexual is of or relating to persons who experience sexual attraction toward and responsiveness to members of their own sex. (CA Department of Justice)

Household includes all the people who occupy a housing unit (e.g., house, apartment, mobile home). (U.S. Census Bureau)

Lesbian (homosexual female) is of or relating to females who experience sexual attraction toward and responsiveness to other females. (CA Department of Justice)

Limited English proficiency (LEP) refers to those who reportedly speak English less than "very well" (i.e., those who reported speaking English well, not well, or not at all). This definition is based on the results of the English Language Proficiency Survey (ELPS) conducted by the U.S. Census Bureau in 1982.

Married-couple household is a family in which the householder and his or her spouse are listed as members of the same household. (U.S. Census Bureau)

Net worth (wealth) is the sum of the market value of assets owned by every member of the household minus liabilities owed by household members. (U.S. Census Bureau)

Pollution burden scores are derived from the average percentile of the seven Exposure indicators (ozone concentrations, PM2.5 concentrations, diesel PM emissions, pesticide use, toxic releases from facilities, traffic density, and drinking water contaminants) and the five Environmental Effects indicators (cleanup sites, impaired water bodies, groundwater threats, hazardous waste facilities and generators, and solid waste sites and facilities). Indicators from the Environmental Effects are given half the weight of the indicators from the Exposures component. The calculated average percentile (up to 100th percentile) is divided by 10, for a pollution burden score ranging from 0.1 to 10. (CalEnviroScreen version 1.1)

Poverty status is determined by using a set of dollar-value thresholds that vary by family size and composition. If a family's total income in the past 12 months is less than the appropriate threshold of that family, then that family and every member in it are considered "**below the poverty level.**" (U.S. Census Bureau)

Race refers to five "racial" classifications: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, and White. (U.S. Census Bureau)

Reading proficiency is measured by the percentage of third-graders in public schools who score proficient or higher on the English Language Arts California Standards Test (CST). In order to score proficient on the CST, a student must demonstrate a competent and adequate understanding of the knowledge and skills measured by this assessment, at this grade, in this content area. (www.kidsdata.org)

Religious bias is a preformed negative opinion or attitude toward a group of persons based on religious beliefs regarding the origin and purpose of the universe and the existence or nonexistence of a supreme being. (CA Department of Justice)

Serious psychological distress is a dichotomous measure of mental illness using the Kessler 6 (K6) series. (CA Health Interview Survey)

Sexual orientation bias is a preformed negative opinion or attitude toward a group of persons based on sexual preferences and/or attractions toward or responsiveness to members of their own or opposite sexes. (CA Department of Justice)

Usual source of care means having a usual place to go when sick or in need of health advice. (CA Health Interview Survey)

Victim is an individual, a business or financial institution, a religious organization, government, or other. For example, if a church or synagogue is vandalized or desecrated, the victim would be a religious organization. (CA Department of Justice)

Violent crimes are composed of murder, forcible rape, robbery, aggravated assault, simple assault, and intimidation. (Federal Bureau of Investigation)

Vulnerable communities include, but are not limited to women; racial or ethnic groups; low-income individuals and families; individuals who are incarcerated or have been incarcerated; individuals with disabilities; individuals with mental health conditions; children; youth and young adults; seniors; immigrants and refugees; individuals who are limited English proficient (LEP); and Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQQ) communities, or combinations of these populations. (CA Health and Safety Code Section 131019.5)

Vulnerable places are places or communities with inequities in the social, economic, educational, or physical environment or environmental health and that have insufficient resources or capacity to protect and promote the health and well-being of their residents. (CA Health and Safety Code Section 131019.5)

Appendix D:
Data Limitations

The findings in this report should be interpreted within the context of the limitations discussed in this section. First, the data limitations of vulnerable population groups and vulnerable places defined by California Health and Safety Code Section 131019.5 are still an issue. Data on sexual orientation (Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning [LGBTQQ]) and vulnerable places is limited in most data sets used in this report. For example, the American Community Survey (ACS) still does not collect data on LGBTQQ population groups. Although we attempted to capture the vulnerable places to include in this report, data is very limited in existing data sources.

Second, data on race and ethnicity is limited for some population groups. American Indian/Alaska Native, Native Hawaiian and other Pacific Islander (NHOPI), and subpopulations (e.g., Asian subpopulations such as Korean, Chinese, Vietnamese) data has to be analyzed with caution due to insufficient sample size and unstable data. For example, most NHOPI data in the California Health Interview Survey is represented as unstable due to the small sample size. Also, some data variables available in the ACS at the national level are not collected for California.

Third, data on discrimination stratified by vulnerable population groups identified in this report is limited and not available for California. Although there are numerous published journals and information for this topic available, the data is not often collected on most surveys. Even when the data is collected, usually it is considered "sensitive" data that are not available for public use.

Fourth, within the context of vulnerable population groups, mental health data is very limited in most data sets. Although there is data available on mental health, some people are not willing to answer survey questions relating to mental health issues because mental health issues are still considered a stigma or even taboo in some cultures. This data is sometimes considered "sensitive" and is therefore not available for public use.