

California Second Demographic Report Story Proposal

**Health Research and Statistics Unit
Office of Health Equity
December 9th, 2015**

Meeting Objectives

- Present the context for the second demographic report
- Present a proposal for the story of the second demographic report
- Obtain feedback on the story and timeline and reach a consensus on next steps

California Health and Safety Code

Section 131019.5

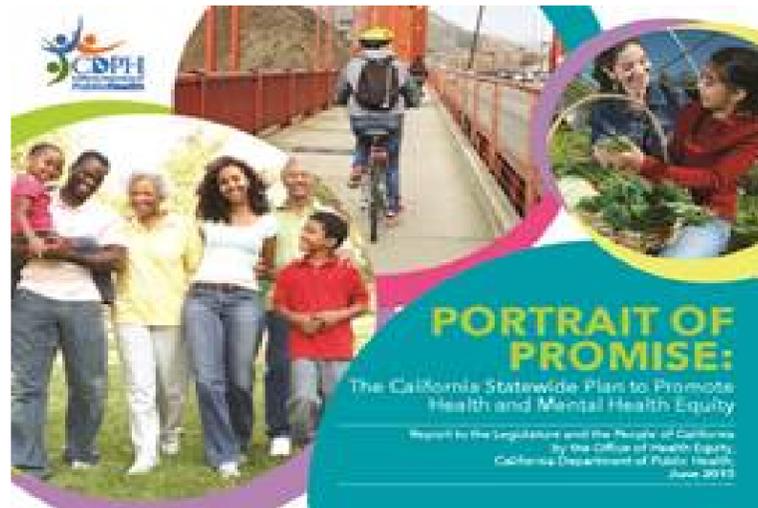
- (d) In identifying and developing recommendations for strategic plans, the Office of Health Equity shall, at a minimum, do all of the following:
 - Conduct demographic analyses on health and mental health disparities and inequities. **The report shall include, to the extent feasible, an analysis of the underlying conditions that contribute to health and well-being.** The first report shall be due July 1, 2014. This information shall be updated periodically, but not less than every two years, and made available through public dissemination, including posting on the department's Internet Web site. The report shall be developed using primary and secondary sources of demographic information available to the office, including the work and data collected by the Health in All Policies Task Force. Primary sources of demographic information shall be collected contingent on the receipt of state, federal, or private funds for this purpose.
 - Based on the availability of data, including valid data made available from secondary sources, the report described in paragraph (1) shall address the following key factors as they relate to health and mental health disparities and inequities:

The “A through N”

- (A) Income security
- (B) Food security
- (C) Child development, education, and literacy rates
- (D) Housing
- (E) Environmental quality
- (F) Accessible built environments
- (G) Health care
- (H) Prevention efforts
- (I) Ongoing discrimination
- (J) Neighborhood safety and collective efficacy
- (K) Health in All Policies Task Force
- (L) Culturally appropriate and competence services and training
- (M) Linguistically appropriate and competent services and training
- (N) Mental health services

First Demographic Report

“Portrait of Promise: The California Statewide Plan to Promote Health and Mental Health Equity”

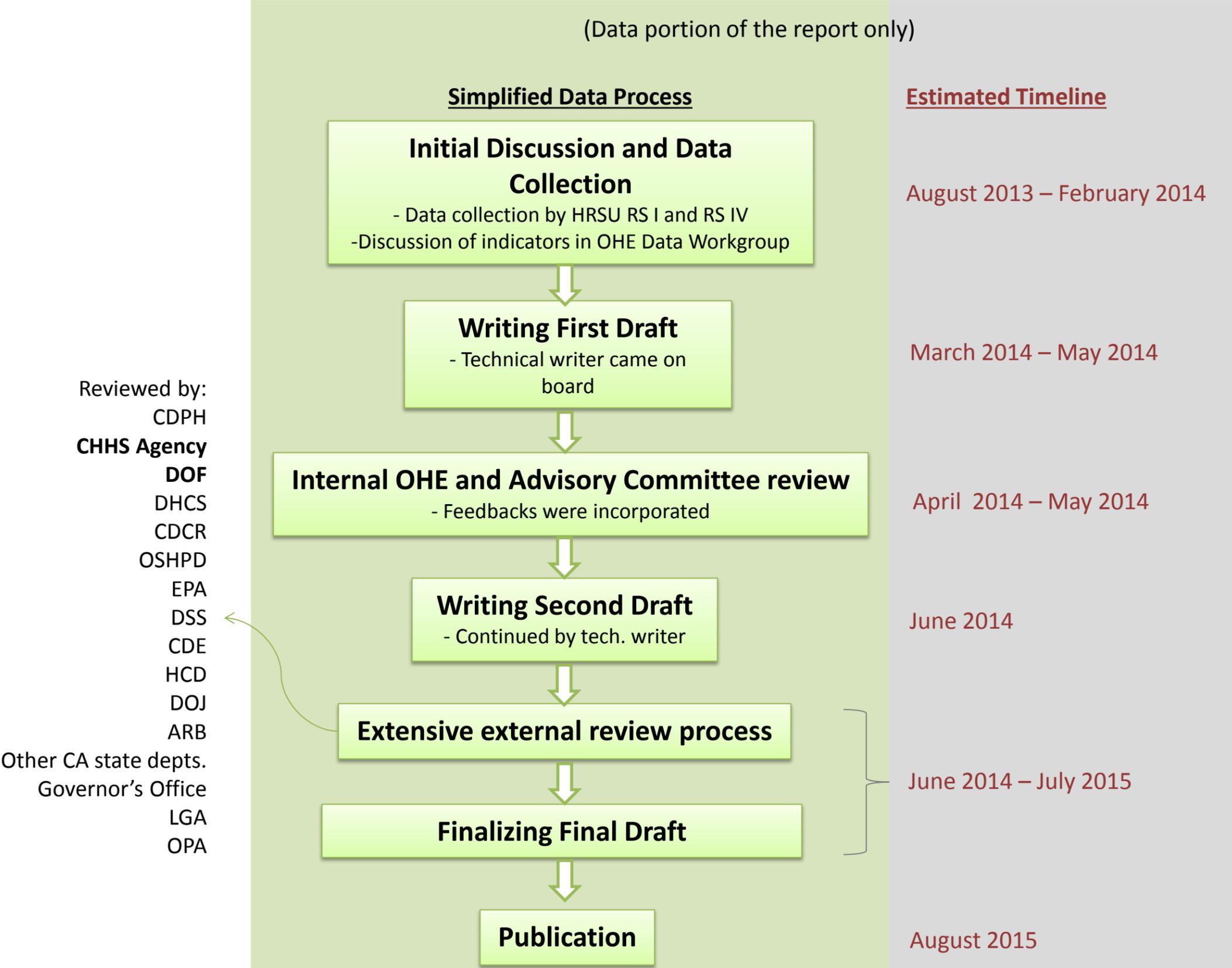


Introduces the Office of Health Equity, important concepts such as Health in All Policies and the Social Determinants of Health.

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First Report Process Flow Chart



Successes

- Better understanding of how Agency and DOF work
- Build relationship with other departments and agencies
- Constructive feedback from OHE staff, AC members, CDPH, and other state departments that shaped the demographic report
- Better knowledge of data
- Better understanding of the process of producing a state report

Challenges

- Extensive review process
- No control over the approval process timeline
- Not the ultimate decision maker
- Limited to government or government-sponsored data sources
- Sensitivity of content and language
- Shortage of staff
- Broad language of the mandate
- No precedent

Lessons Learned

- **WE NEED TO START EARLY**
- **WE NEED TO PRODUCE A SHORT AND FOCUSED REPORT**
- **UNDERSTANDING THAT THIS IS A STATE OWNED REPORT**

Context of the Second Report

- The first report presented a description and discussion of each A-N determinant at the statewide level; some of them have explicit reference to health outcomes or overall health status.

Poverty

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

<http://cityplanning.lacity.org/Cwd/framwk/healthwellness/text/HealthAtlas.pdf>

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 work toward a more equitable household income distribution.



Child Development

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

Other CDPH Reports*

* Not an exhaustive review

Examples:

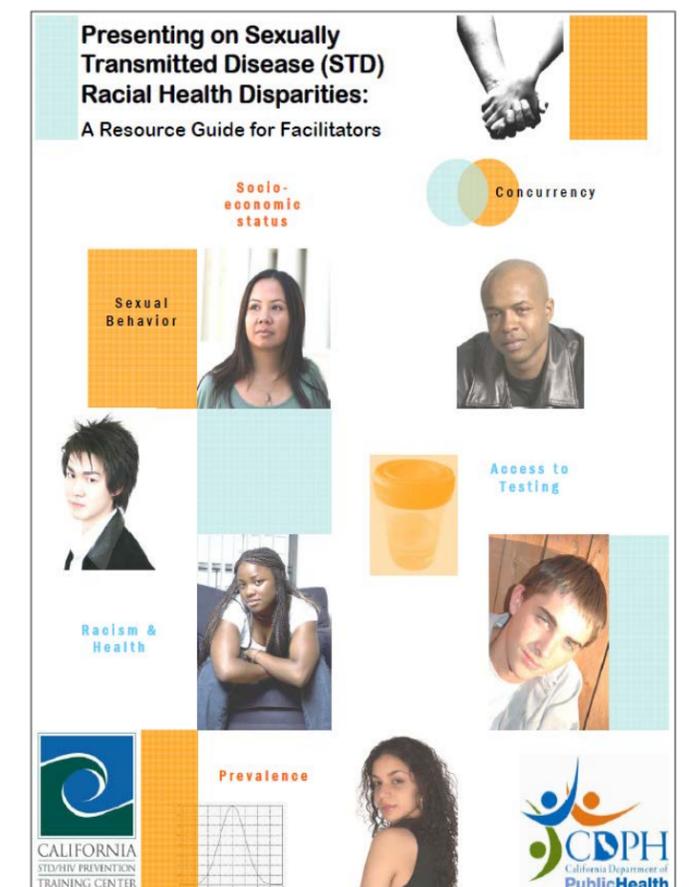
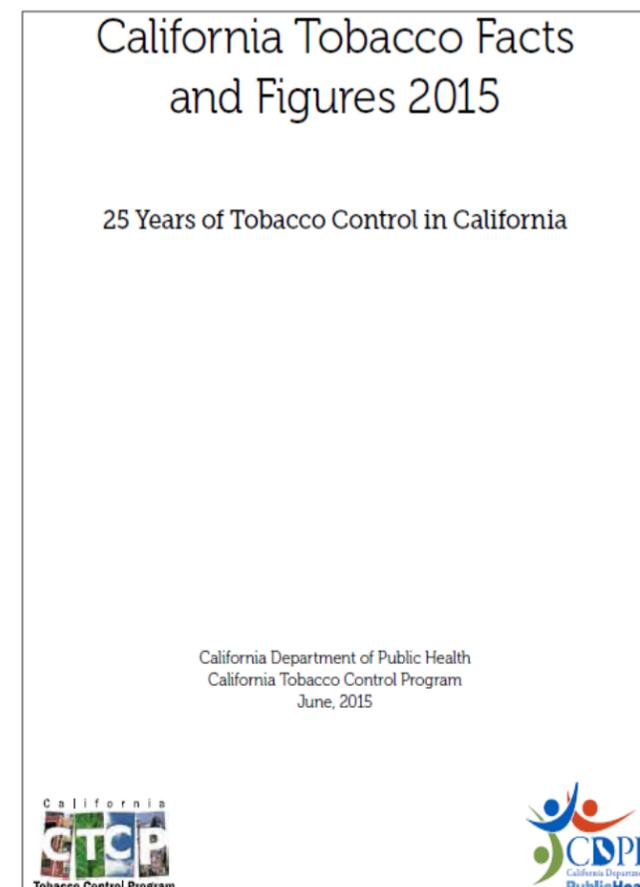
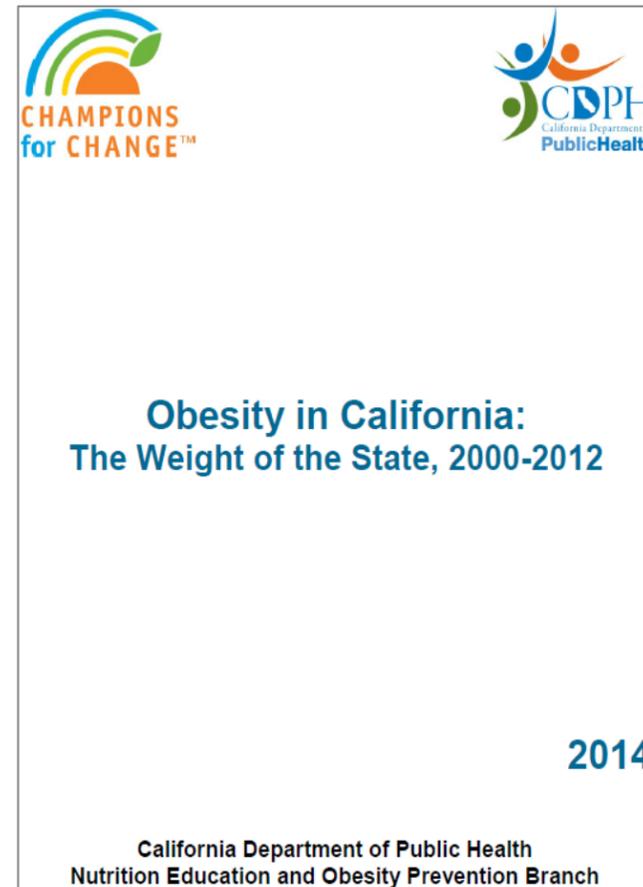
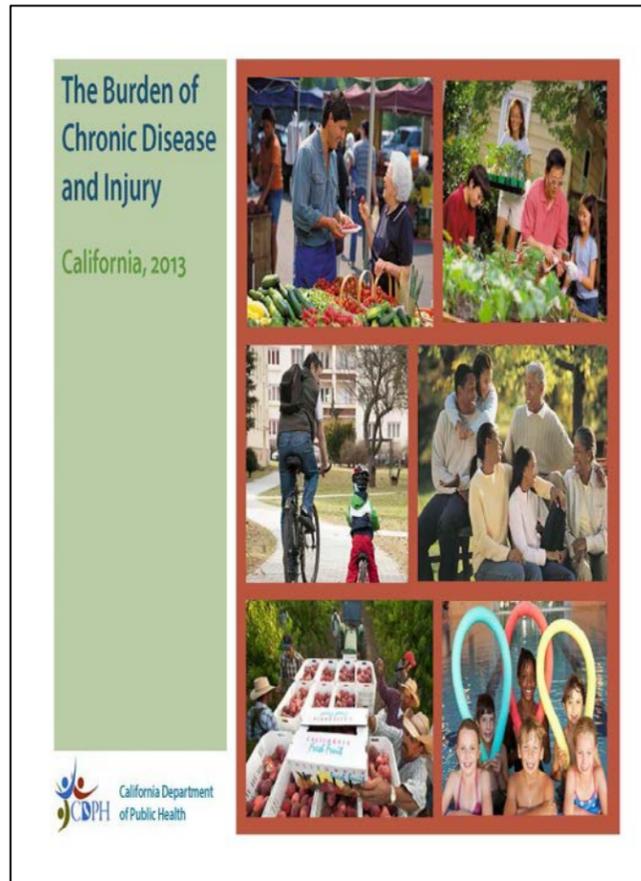


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Figure 9. Prevalence of Obesity Among Adults in California by Household Poverty Level, 2011-2012 CHIS

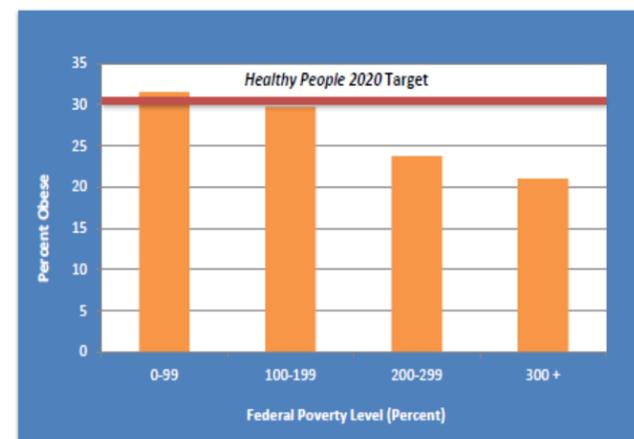
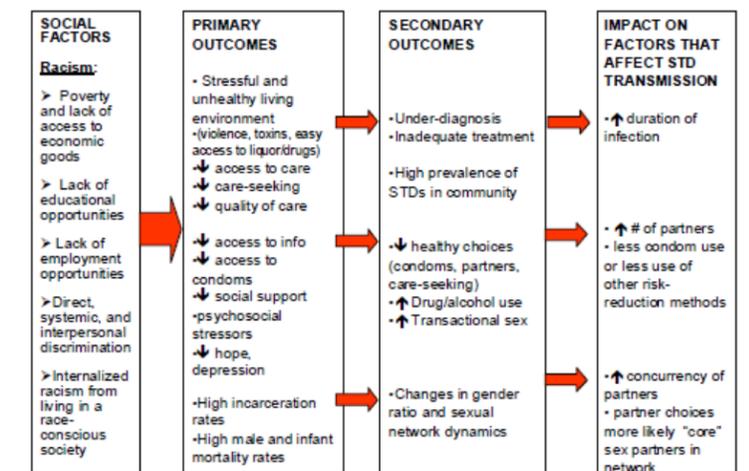


Figure 1D.3 Who are the smokers in California?

	Percent of Smokers	Population percent	Number of smokers	Population size
Sexual Orientation				
Heterosexual	94.4%	95.8%	3.5M	23.9M
Homosexual or bisexual	5.3%	3.6%	195K	903K
Not sexual, celibate, or other	0.3%	0.6%	12K	158K
Rurality				
Urban	44.9%	43.4%	1.8M	13.4M
*2nd City	28.0%	26.8%	1.1M	8.3M
Suburban	15.4%	19.4%	607K	6.0M
Town and rural	11.6%	10.5%	456K	3.2M
Own or rent				
Own home	42.7%	58.7%	1.6M	16.2M
Rent home	52.2%	37.3%	2.0M	10.2M
Have other arrangement	5.1%	3.9%	192K	1.1M
Psychological distress				
Likely in last year	15.9%	7.9%	608K	2.2M
Not likely in last year	84.1%	92.1%	3.2M	25.5M
Insurance status				
Currently insured	73.50%	83.10%	2.9M	25.7M
Not currently insured	26.5%	16.9%	1.0M	5.2M

RACISM AND STD RISK: POTENTIAL THEORETICAL MODEL



Adapted from model created by Heidi Bauer, California Department of Public Health, Center for Infectious Disease, Division of Communicable Disease Control, STD Control Branch, 2007.

What is the Opportunity?

- The first data report included in Portrait of Promise presented data on A-N as important social determinants of health in California, some of those beyond those usually included in other reports (i.e., discrimination, crime).
- For the second report we would like to recommend a more explicit presentation on how the A-N relate to the top-10 causes of disease burden and death in California.
 - This is also an opportunity to connect to existing CDPH reports/resources.
- We hope that this will help the audience discover associations between social determinants and health that might not be obvious to them, or to reinforce the complexity of factors that interact to produce particular health outcomes.

Diseases and Conditions Identified

(Review of multiple sources and OHE input)

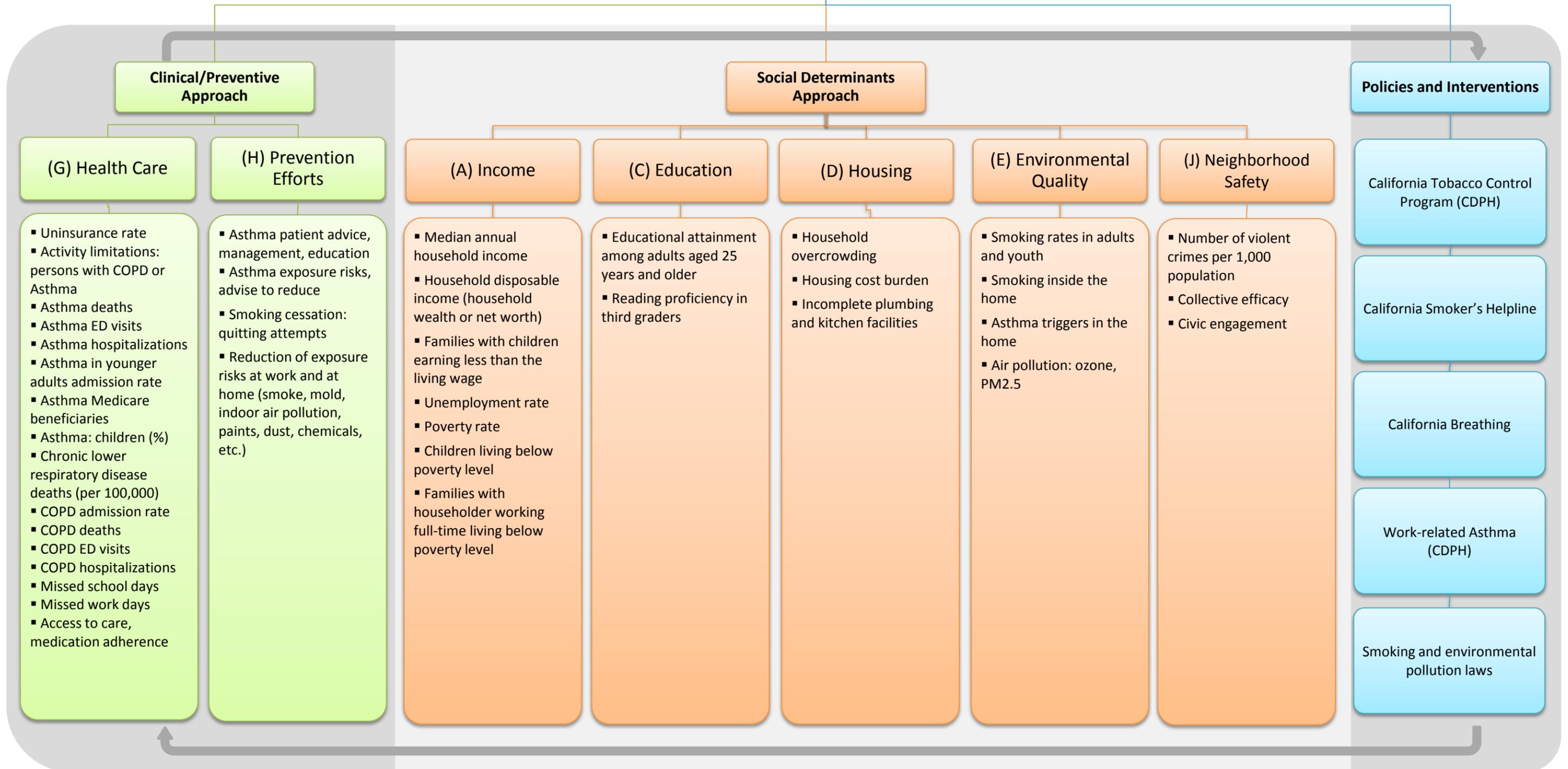
- Heart disease
- Chronic lower respiratory disease
- Mental health
 - Depression, suicidal thoughts, self-harm, psychological distress, substance abuse
- Unintentional injuries
 - Work-related injuries, falls, lower-back pain, road traffic injuries
- Cancer
 - Cervical, breast, lung, colorectal
- Diabetes
- Stroke
- Arthritis
- Influenza/Pneumonia
- HIV/AIDS

Vision for the Report

- Either in print or a web-based report, we propose two main parts:
 - Part I: Presenting the connections between diseases and conditions and social determinants based on information from literature reviews, identification of relevant social determinants indicators per condition.
 - Part II: Individual chapters for social determinants, their importance to health and California data.
- The aim is that graphs and charts would do most of the work of presenting the picture.
 - If web-based report could include other media, like videos.
- What follows are pilot ideas.

CHRONIC LOWER RESPIRATORY DISEASE

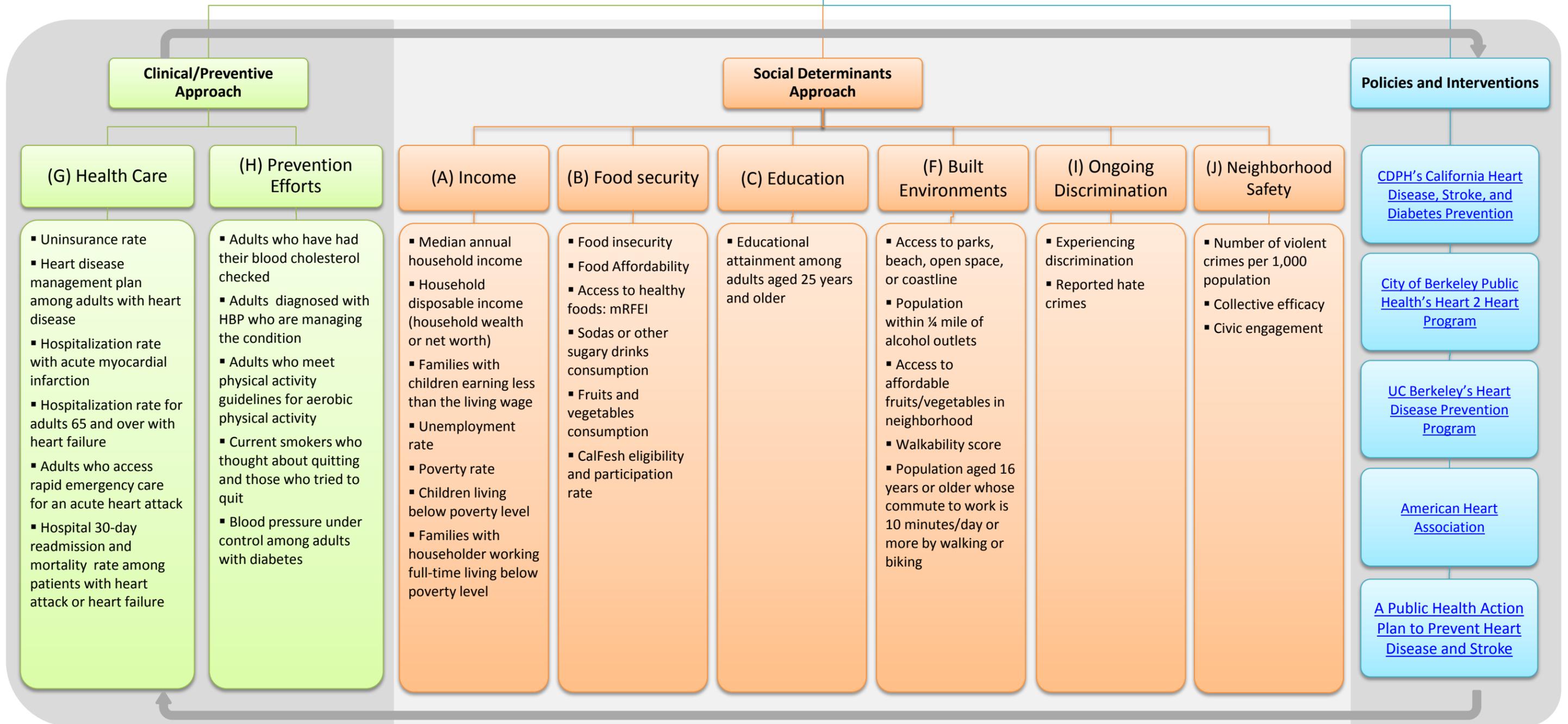
COPD and Asthma



Vulnerable Communities or Places with Higher Risk for Heart Disease:

- Racial or ethnic groups
- Age
- Occupation
- Neglected children (associated with SES status)
- Gender
- Urban vs. rural
- Immigration status
- Obesity and physical activity in adults and youth (obesity precedes asthma-comorbidities)

HEART DISEASE



Vulnerable Communities or Places with Higher Risk for Heart Disease:

- Racial or ethnic groups
- Gay, lesbian, bisexual, transgender, queer, and questioning (LGBTQ)
- Individuals with disabilities
- Lower socioeconomic neighborhoods
- Gender
- Low-income individuals
- Individuals with mental health conditions
- Homeless

INCOME SECURITY

Why is it important for health?

Income creates access to resources that promote better health, including access to health care, nutritious food, recreation, and safe housing. The large inequalities in income between the rich and the poor are correlated with lower overall life expectancy and higher risk of social isolation, stress, and poor health outcomes.

Extreme income inequality is especially acute among California families headed by a single mother. The disparity is even higher for families led by Latino and African-American single mothers. 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 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. Several recent studies reveal that the nation as a whole pays the equivalent of \$500 billion a year for the lost productivity and excess costs of health and other services associated with child poverty.

One of the most beneficial prescriptions for improving people's health and closing the gaping disparities in health outcomes is to work toward a more equitable household income distribution.

What does the data say about California?

6.9 Million Californians (or 18.4%) Live in Poverty (<100% FPL)

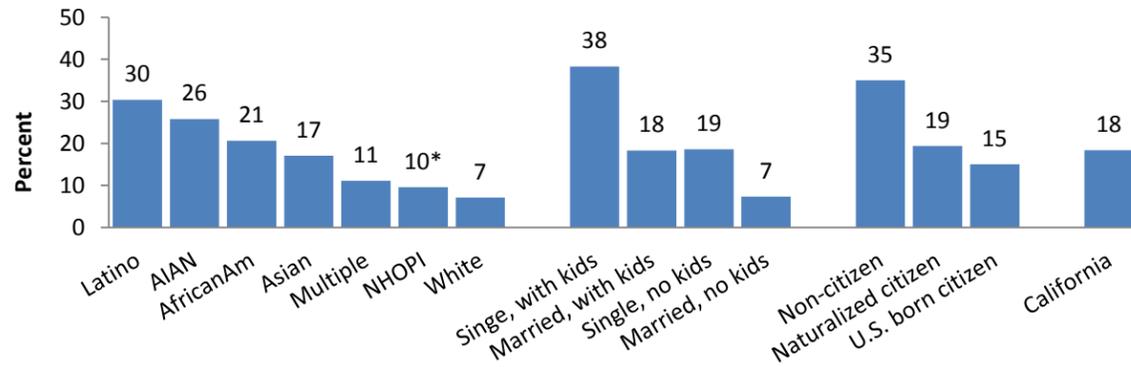
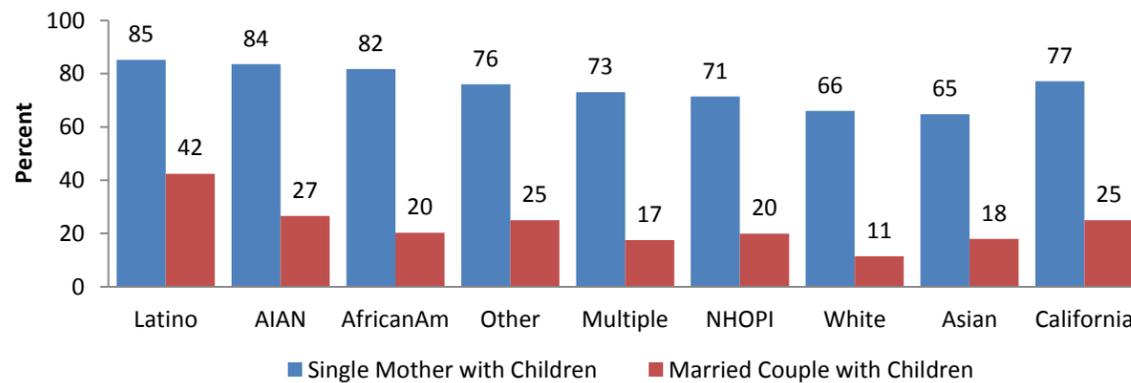


Figure 1. Percent of People Below Federal Poverty Level (<100% FPL) by Race/Ethnicity, Family Type, and Citizenship/Immigration Status, California, 2014.

Source: University of California, Los Angeles, [California Health Interview Survey](#), 2014

77% of Single Mothers Don't Earn Enough to Cover The Cost of Basic Necessities of Living



How Much You Have to Make PER HOUR to Live in California?

Single mother with children	\$26.33	\$8.00	\$18.33
	LIVING WAGE	MINIMUM WAGE	THE GAP
Married couple with children	\$22.15	\$8.00	\$14.15

Figure 2. Percent of families with children earning less than the living wage, California, 2010.

Sources: [Living Wage Calculator](#); [American Community Survey](#), 2006-2010. Analysis by UCSF/CDPH-Office of Health Equity, [Healthy Communities Data and Indicators Project \(HCI\)](#)

Men Earn More than Women at All Educational Levels

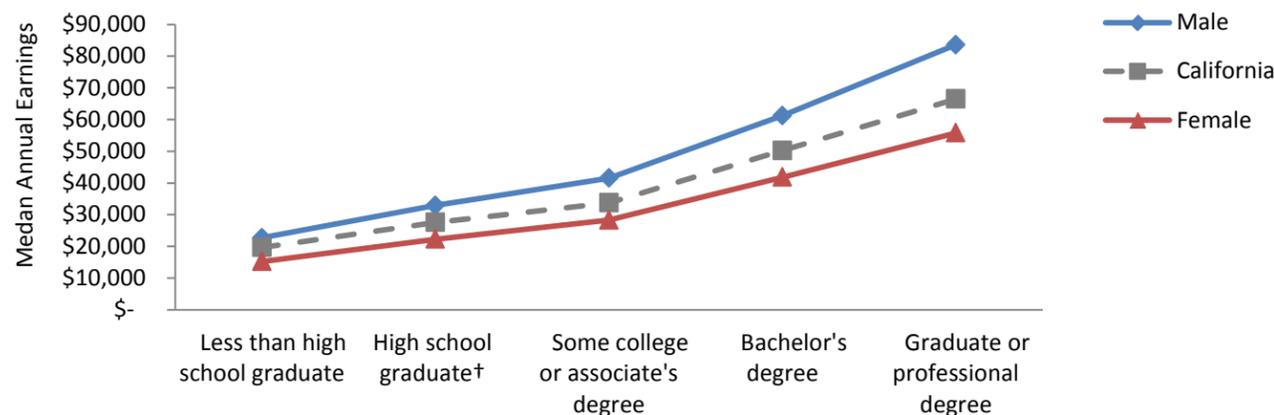


Figure 3. Median Annual Earnings by Sex and Educational Attainment for Population 25 Years and Over, California, 2009-2013.

Source: U.S. Census Bureau, 2009-2013 [American Community Survey](#), 5-Year Estimates

URBAN vs RURAL Economic Disparities



Sources: UCSF/CDPH-Office of Health Equity, [Healthy Communities Data and Indicators Project \(HCI\)](#)

How does it impact health?

It is well-documented that income and poverty are risk factors for premature mortality and increased morbidity. One-third of United States deaths can be linked to income inequality, and it is estimated that 883,914 deaths would have been prevented each year if the level of inequality was lowered.

Evidence has shown a strong correlation between poverty-level income and health outcomes, such as:

- Heart Disease
- Cancer: [Breast](#), [Cervical](#), [Colorectal](#), and Lung
- Diabetes
- Stroke
- Chronic Lower Respiratory Diseases: [Asthma](#) and [Chronic Obstructive Pulmonary Disease](#)
- Arthritis
- Mental Illness

Policies or intervention programs aim to reduce income disparities?

POLICIES:

- [Minimum Wage Laws](#)
- Equal Pay Act of 1963
- Fair Labor Standards Act of 1938
- Family and Medical Leave Act
- Child Care and Development Block Grant
- Head Start and Early Head Start
- [Medicaid under the Affordable Care Act](#)
- CalFresh, CalWORKs, and WIC
- Family and Medical Insurance Leave Act
- Schedules That Work Act
- [Healthy Families Act](#)
- Earned Income Tax Credit
- Child Tax Credit
- Temporary Assistance for Needy Families
- Workforce Innovation & Opportunity Act

PROGRAMS:

- Living Wage Campaign
- [Stanford Center on Poverty and Inequality](#)
- [Family Independence Initiative](#)
- Los Angeles Alliance for the New Economy

Notes: AIAN=American-Indian/Alaska Native, AfricanAm=African American, NHOPI=Native Hawaiian/Pacific Islander.

* Statistically unreliable ; † includes equivalency

MINIMUM WAGE VS. LIVING WAGE

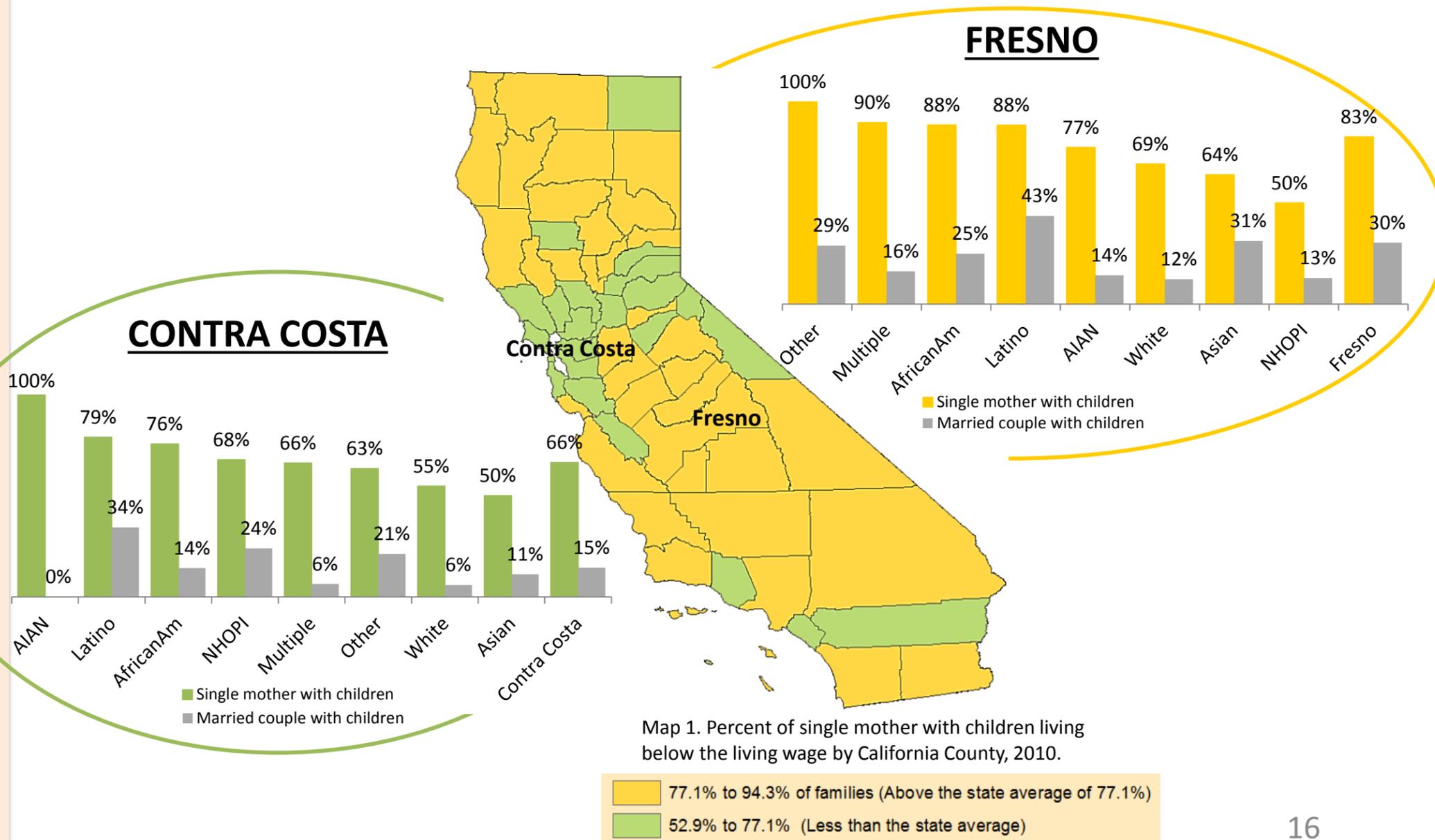
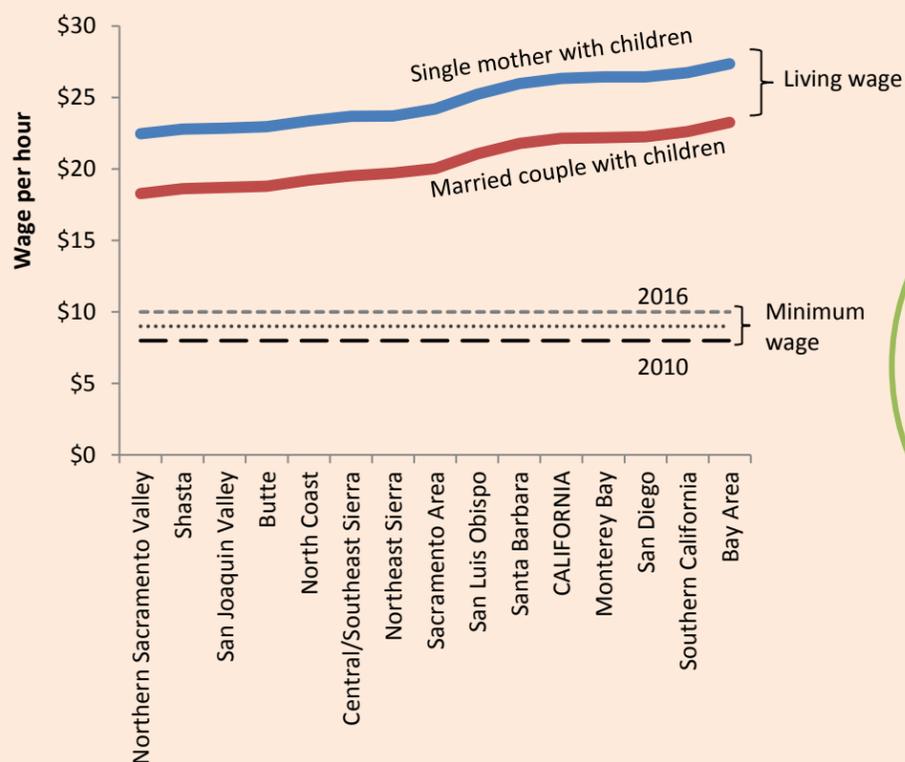
How Much You Have to Make **PER HOUR** to Live in California?

Single mother with children	\$26.33	\$8.00	\$18.33
	LIVING WAGE	CA MINIMUM WAGE	THE GAP
Married couple with children	\$22.15	\$8.00	\$14.15
Single adult	\$11.20	\$8.00	\$3.20

The living wage is the wage or annual income that covers the cost of the bare necessities of life for a worker and his/her family. These necessities include housing, transportation, food, childcare, health care, and payment of taxes. Several California studies have estimated the impacts of raising the wage rate in low-wage earners to the level of a living wage. These impacts include reduced mortality, improved mental health and self-rated health status, reduced disability at home and work, and greater educational attainment in their children.

In California, about 77% of single-mother households and 25% of married-couple households don't earn enough income to meet basic needs.

The current minimum wage in California does not provide enough money to support families with children.



Source: Sources: [Living Wage Calculator](#); [American Community Survey](#), 2006-2010. Analysis by UCSF/CDPH-Office of Health Equity, [Healthy Communities Data and Indicators Project \(HCI\)](#)

Important Considerations for the Second Report

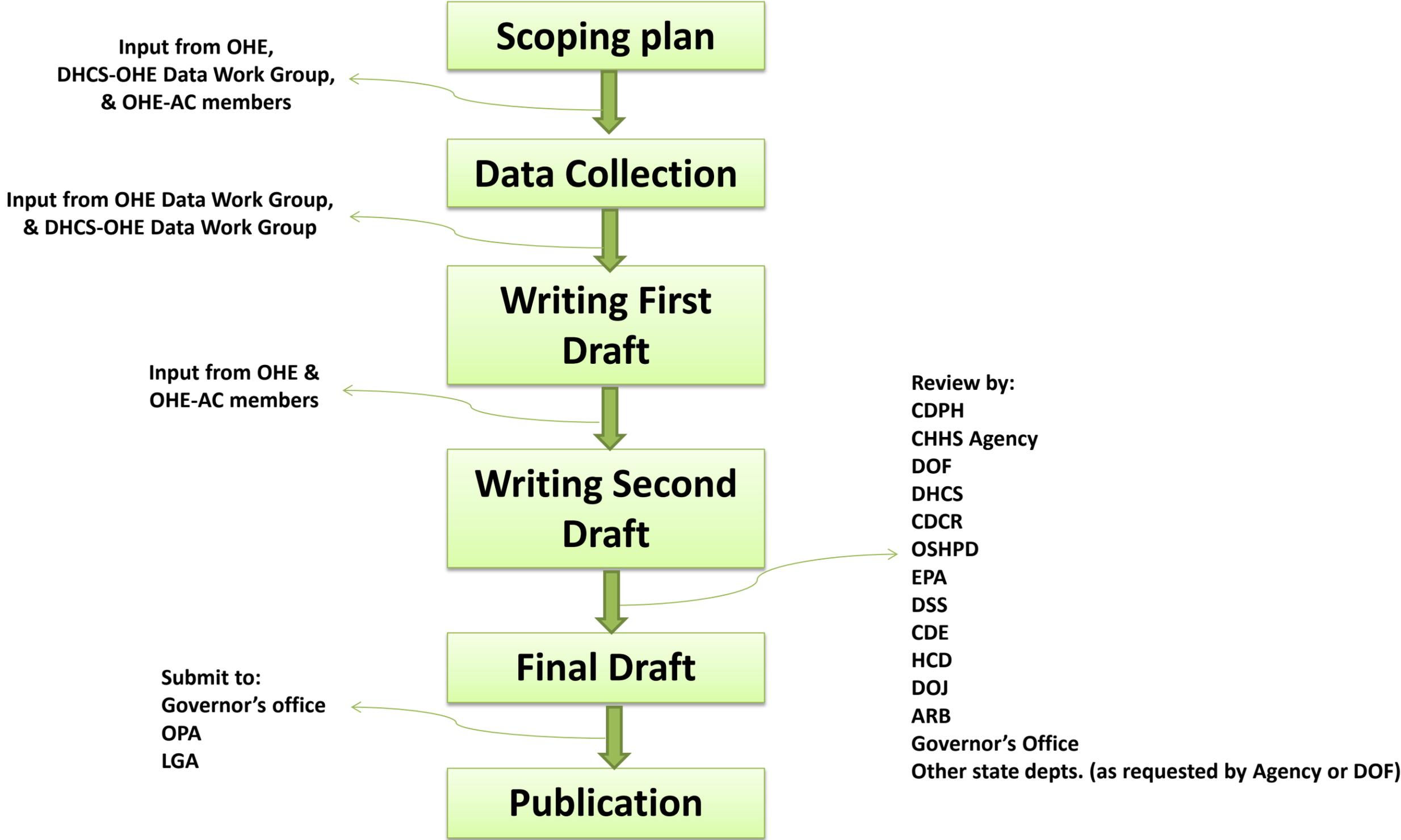
- Help our audience make the connection between the leading causes of mortality, morbidity, and injury in California, the social determinants associated with them and the impact on vulnerable communities.
- Highlight how the same determinants are associated with multiple of the leading diseases and conditions.
- Even though we want to make a link to health outcomes, keep the emphasis on A-N topics and the underlying factors that contribute to health disparities.
- Make the case that moving the needle on social determinants is also a health priority.
- Showcase the health equity lens that other CDPH programs have been using to present data, or how they use it in their programs and/or interventions.
- **The report should be short and focused**
Use data and graphics to paint a picture, think infographics and audience of all education levels.

Tentative Report Timeline

Phases	YEAR 1	August 2015 – March 2016	April 2016 – June 2016	July 2016 – August 2016
Phase I	New story approach development, feedback from OHE, AC. Literature reviews, selection of indicators based on selected criteria. Limit number of indicators: 4 per domain? 5 per domain? Create ACCESS database to document metadata/literature reviews			
Phase II	Update data on selected indicators, research data sources and reports that can be linked to health outcomes. Contact external partners (CDE, HCD, etc.) for their input on selected metrics, incorporate feedback.			
Phase III	First draft report (in the style of Burden of Chronic Disease), work with writer to develop narratives. Keep the text short, make graphs more prominent.			

Phases	YEAR 2	August 2016	September 2016	October 2016- July 2017(?)
Phase IV	First internal review of draft report, OHE and AC			
Phase V	Incorporate feedback, second draft for external review			
Phase IV	Second draft for external review is sent out to multiple agencies, feedback gets incorporated, work with DOF and CHSA to finalize report (Note: graphs/charts might need to be updated if new data is available)			
Phase VII	Publication			

Second Report Process Flow Chart



Questions for This Group

- What do you think of this story approach?
- What other opportunities do you see moving forward?
- Anything you learned from the first report process that we should consider now?

CONTACT INFO

Thi Mai, MPH

Research Scientist I – Office of Health Equity
California Department of Public Health
1615 Capitol Avenue | Sacramento, CA 95814
Office: (916) 324-0070
Email: Thi.Mai@cdph.ca.gov

Dulce Bustamante-Zamora, PhD

Research Scientist II – Office of Health Equity
California Department of Public Health
850 Marina Bay Parkway P3-101 | Richmond, CA, 94804
Office: (510) 620-3127
Email: Dulce.Bustamante-Zamora@cdph.ca.gov

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