



"GO GET IT. PERIOD."

ACHIEVING HEALTH EQUITY AT EVERY LEVEL

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Deputy Director
CDPH Office of Health Equity

Friday, April 18, 2014



25 YEARS A CHAMPION FOR HEALTH EQUITY!



- This year marks the 25th anniversary of the CDC Office of Minority Health and Health Equity (OMHHE)!
- April is Minority Health Month!
 - This year's theme is Advance Health Equity Now: Uniting our Communities to Bring Health Care Coverage to All!



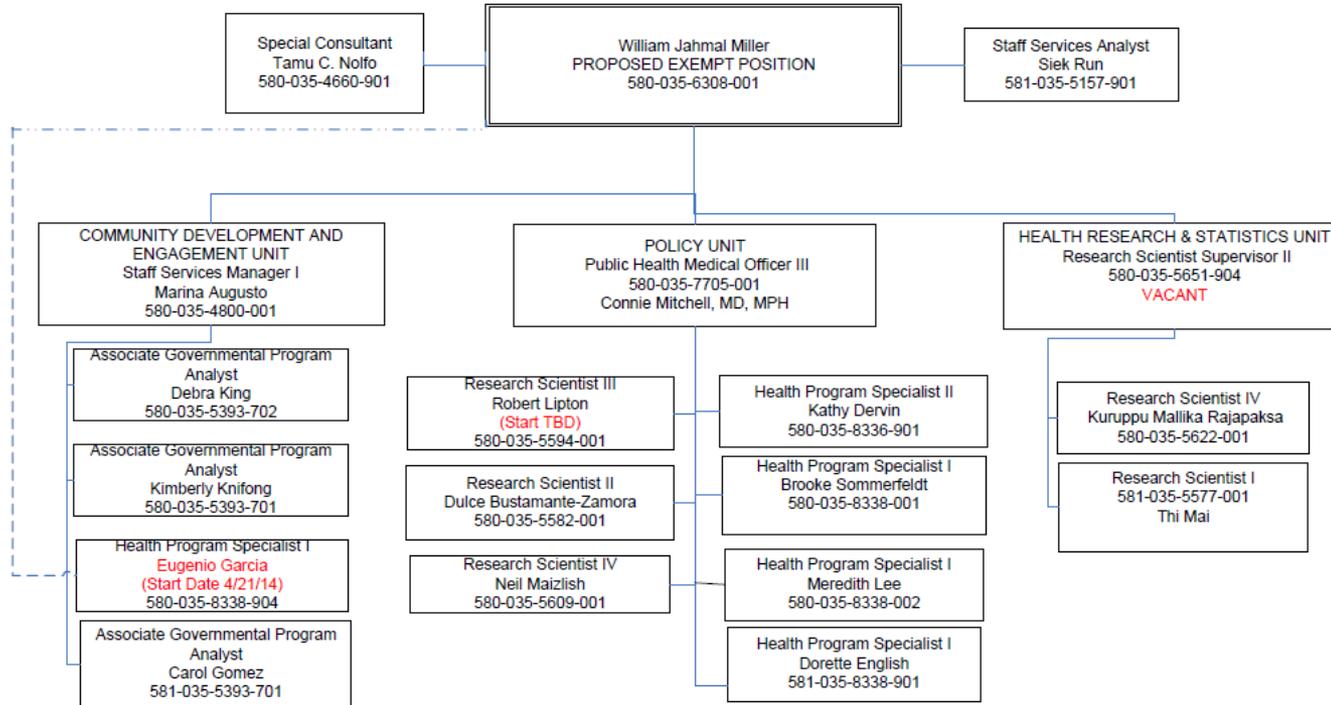
“Health equity” means efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

Health and Safety Code
Section 131019.5





California Department of Public Health Office of Health Equity



Jahmal Miller
Deputy Director

April 1, 2104



OFFICE OF HEALTH EQUITY

The Office of Health Equity (OHE) was established to align state resources, decision making, and programs to accomplish all of the following:

- ❑ 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 (HiAP) Task Force to promote work to prevent injury and illness.
- ❑ 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.
- ❑ Improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and inequities.
- ❑ Conduct demographic analyses on health and mental health disparities and inequities (updated periodically, but not less than every two years).
- ❑ Establish a comprehensive, cross-sectoral strategic plan to eliminate health and mental health disparities by July 2014. (Updated every two years).



OFFICE OF HEALTH EQUITY ADVISORY COMMITTEE



Consists of a broad range of 24 health experts, advocates, clinicians and consumers who will help advance the goals of the office and advise in the development and implementation of the OHE Strategic Plan

- **Sergio Aguilar-Gaxiola**, MD, PhD, Director, Center for Reducing Health Disparities and Professor of Clinical Internal Medicine, University of California, Davis School of Medicine
- **Paula Braveman**, MD, MPH, Director, Center on Social Disparities in Health and Professor of Family and Community Medicine, University of California, San Francisco
- **Delphine Brody**, Former Program Director of Mental Health Services Act (MHSA) Client Involvement, public policy, and self-help technical assistance for the California Network of Mental Health Clients
- **Jeremy Cantor**, MPH, Program Manager, Prevention Institute of Oakland
- **Yvonna Càzares**, Policy Manager, Gay-Straight Alliance Network
- **C. Rocco Cheng**, PhD, Corporate Director, Prevention and Early Intervention Services, Pacific Clinics
- **Kathleen Derby**, Legislative Analyst, California State Independent Living Council
- **Aaron Fox**, MPM, Health Policy Manager, LA Gay and Lesbian Center
- **Sandi Gálvez**, MSW, Executive Director, Bay Area Regional Health Inequities Initiative - CHAIR
- **Alvaro Garza**, MD, MPH, Public Health Officer, San Benito County Health and Human Services Agency
- **Cynthia Gómez**, PhD, Founding Director, Health Equity Institute, San Francisco State University
- **Willie Graham**, Pastor, Christian Body Life Fellowship Church
- **General Jeff**, Founder, Issues and Solutions and serves on the Board of Directors of the Downtown Los Angeles Neighborhood Council (DLANC)
- **Carrie Johnson**, PhD, Director/Clinical Psychologist, Seven Generations Child and Family Counseling Center at United American Indian Involvement in Los Angeles, California
- **Neal Kohatsu**, MD, MPH, Medical Director, California Department of Health Care Services
- **Dexter Louie**, MD, JD, MPA, Founding Member and Chair, Board of the National Council of Asian Pacific Islander Physicians
- **Francis Lu**, MD, Luke and Grace Kim Professor in Cultural Psychiatry, Emeritus, University of California, Davis
- **Gail Newel**, MD, MPH, Medical Director, Maternal Child and Adolescent Health, Fresno County Department of Public Health
- **Teresa Ogan**, MSW, Supervising Care Manager, California Health Collaborative Multipurpose Senior Service Program
- **José Oseguera**, Chief, Plan Review and Committee Operations, Mental Health Services Oversight and Accountability Commission
- **Hermia Parks**, MA, RN, PHN, Director, Public Health Nursing/Maternal, Child Adolescent Health, Riverside County Department of Public Health
- **Diana E. Ramos**, MD, MPH, Director, Reproductive Health, Los Angeles County Public Health
- **Patricia Ryan**, MPA, Executive Director, California Mental Health Directors Association
- **Ellen Wu**, MPH, Executive Director, California Pan-Ethnic Health Network





COMMUNITY DEVELOPMENT & ENGAGEMENT UNIT

COMMUNITY DEVELOPMENT & ENGAGEMENT UNIT: CURRENT PRIORITIES

Mission

- To strengthen the CDPH's focus and ability to advise and assist other state departments in their mission to increase access to, and the quality of, culturally and linguistically competent mental health care and services.
- The California Reducing Disparities Project (CRDP)-\$1.5m and \$60m
 - Completion of CRDP Phase I
 - Roll Out of CRDP Phase II
- MHSa Translation
- Cultural Competency Consultants Contract –multi-provider
- Allocation For Cultural Competence Regional Trainings – CA Brief Multicultural Competency Scale (CBMCS)
- Outreach and Education
- Meet and Greets/Technical Assistance
- Field Outreach
- Committee Participation



HEALTH RESEARCH AND STATISTICS UNIT (HRSU)

- HRSU is the technical backbone of OHE, researching and producing data to fulfill statutory mandated reports and to provide baseline information on disparities and inequities.
- Recruiting for Research Scientist Supervisor role
- Data Workgroup Updates:
 - Developing demographic report to make inform the OHE Strategic Plan Report on key factors. (A – N)
 - Inter-Agency Data Workgroup w/ DHCS to collect, analyze, and disseminate MediCal data.
 - Participates w/ Data Policy and Advisory Committee (Public Health Informatics)



ADDRESSING “KEY FACTORS” OR “SOCIAL DETERMINANTS” AS THEY RELATE TO HEALTH AND MENTAL HEALTH DISPARITIES AND INEQUITIES

- (A) Income security
- (B) Food security and nutrition
- (C) Child development, education, and literacy rates
- (D) Housing
- (E) Environmental quality
- (F) Accessible built environments
- (G) Health care
- (H) Prevention efforts
- (I) Assessing ongoing discrimination and minority stressors
- (J) Neighborhood safety and collective efficacy
- (K) The efforts of the Health in All Policies Task Force
- (L) Culturally appropriate and competent services and training
- (M) Linguistically appropriate and competent services and training
- (N) Accessible, affordable, and appropriate mental health services.





Policy Unit

CLIMATE CHANGE AND PUBLIC HEALTH



CALIFORNIA HEALTH IN ALL POLICIES TASK FORCE

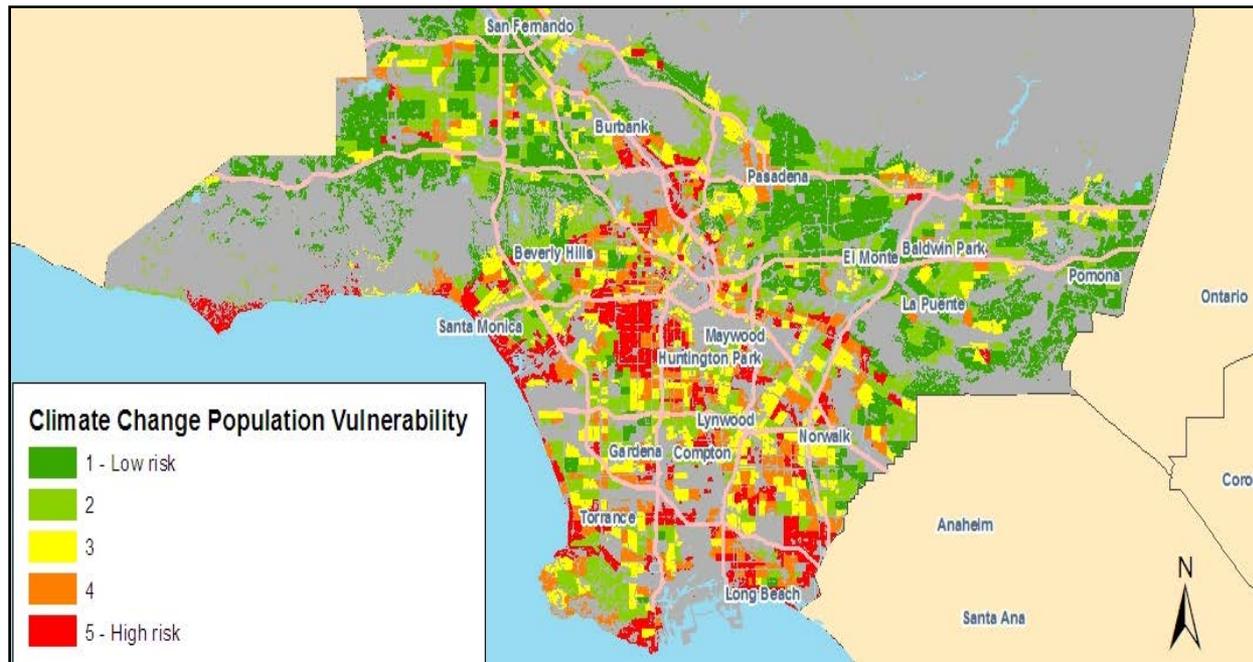


HEALTHY COMMUNITIES DATA AND INDICATOR PROJECT



CLIMATE CHANGE WILL IMPACT ALL CALIFORNIANS BUT THE MOST VULNERABLE WILL SUFFER THE MOST

- Climate change will magnify existing health inequities rooted in social determinants of health; adaptation draws on many of the same resources
- In LA County, more African Americans and Latinos live in high risk areas compared to whites and average incomes are about 40% lower



CO-BENEFITS: REDUCE GREENHOUSE GAS EMISSIONS & IMPROVE PUBLIC HEALTH

Less Sustainable	More Sustainable	Public Health Co-benefits
Fossil fuel dependent transportation	Walking, bicycling, public transit	<ul style="list-style-type: none"> ↑ Increase physical activity ↑ Air quality ↓ Major chronic disease and obesity
Energy-intensive food systems	Local food systems purveying healthy food options	<ul style="list-style-type: none"> ↑ Fruits and vegetables ↓ Cardiovascular disease from low animal protein/fat diet ↑ Educational outcomes/resilience
Urban sprawl, destruction of wetlands, habitat, and ag. lands	Compact development, open and green space, tree canopy	<ul style="list-style-type: none"> ↑ Access to physical activity and other health-promoting resources ↑ Water quality ↓ Urban heat island, noise, violence

CDPH ITHIM model :

- ↑ daily active travel from 4.4 min to 22 min
- ↓ 15% cardio-vascular and diabetes burden
- ↓ 15% decrease in car-related GHG emissions



OHE CLIMATE AND HEALTH TEAM

- Assess climate impacts on public health and vulnerable populations and promote strategies which maximize health co-benefits of climate action
 - California Climate Action Team - Public Health Work Group
 - *Preparing California for Extreme Heat: Guidance and Recommendations (released October, 2013)*
- Provide training tools, metrics, technical assistance for local health departments, regional planners and other organizations on climate and health;
 - California Climate Adaptation Strategy update “*Safeguarding California*” to be released soon
 - Climate Change Communications Strategy
- Develop plans to reduce health risks from climate impacts and enhance resilience at the state and local level
 - Building Resiliency Against Climate Effects (BRACE) Responsible for the Public Health Work Group of the Climate Action Team



OHE HEALTHY PLACES TEAM

- **Integrated Transport and Health Impacts Model (ITHIM)**
 - Modeling the health and greenhouse gas (GHG) reduction co-benefits of increasing active transportation
- **Health Community Indicator Project**
 - A standardized, core set of valid indicators that define a healthy community
 - Methods to construct indicators at different geographic scales (e.g. census tract, zip code, city, county, etc.)
 - A multi-agency plan for centralized data collection, analysis, and reporting
 - Demonstration website now up and operable for 14 indicators



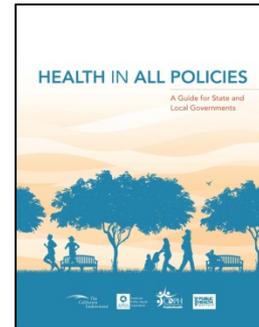
HEALTH IN ALL POLICIES

Defined

- A collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas.

Key Elements

- Promotes health, equity, & sustainability
- Supports intersectoral collaboration
- Benefits multiple partners
- Engages external stakeholders
- Creates structural or process change

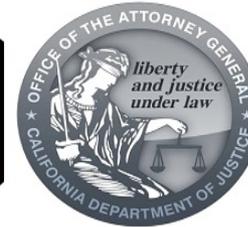


Rudolph, L., Caplan, J., Ben-Moshe, K., & Dillon, L., (2013). Health in All Policies: A Guide for State and Local Governments. Washington, DC and Oakland, CA: American Public Health Association and Public Health Institute.

<http://www.phi.org/resources/?resource=hiapguide>

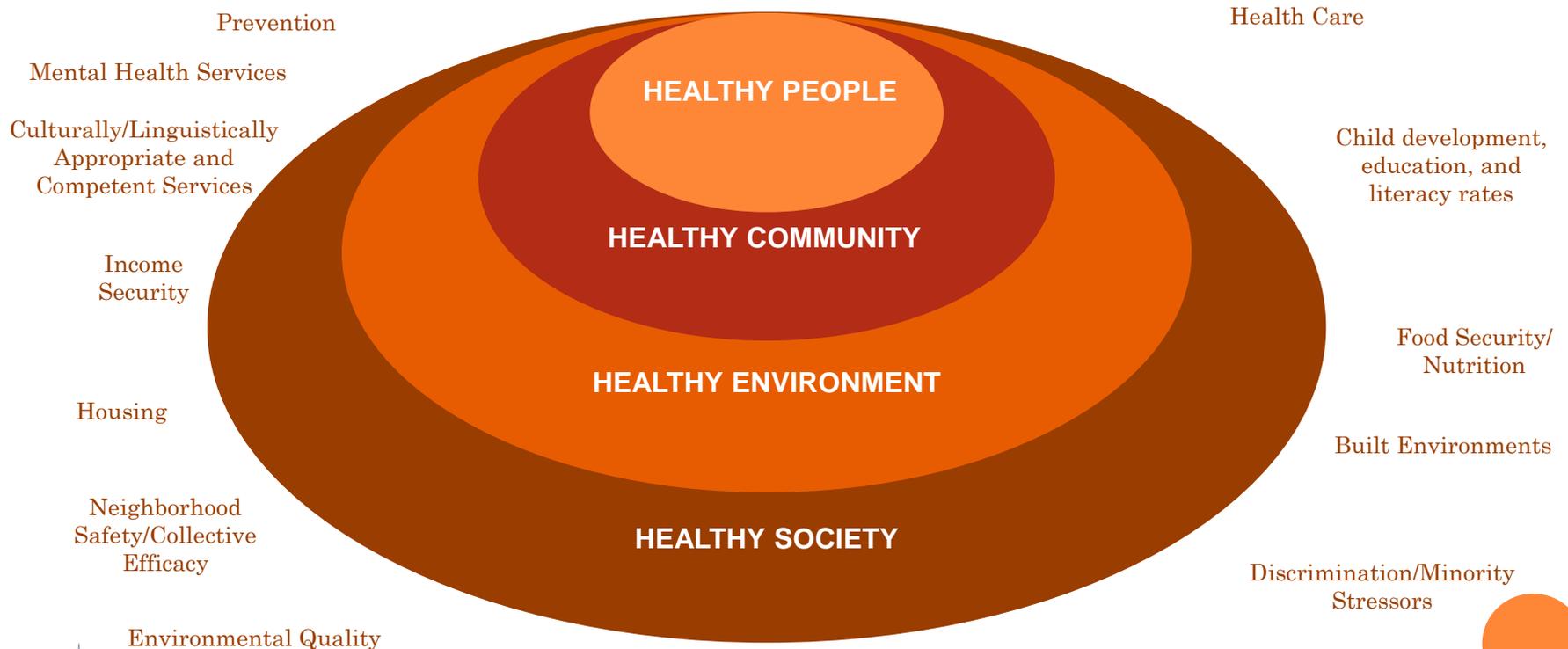


CALIFORNIA HIAP TASK FORCE



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.



“THE HAVE AND HAVE-NOTS OF HEALTH ON DISPLAY IN EAST SACRAMENTO, OAK PARK”



- Visible differences between the two neighborhoods.
- The 95819 and 95817 ZIP codes, which encompass much of east Sacramento and Oak Park, respectively, share a border.
 - Each has about 15,000 residents.
 - In 2010, Oak Park residents are more than three times as likely to go to the emergency room for asthma, diabetes or high blood pressure.



TALE OF TWO CITIES

MARIN CITY



- Statistics consistently show that Marin is one of the healthiest counties in the state and the country. But those statistics mask an uncomfortable truth: Marin also has some of the most severe health disparities in the state. Simply put: Where you live in Marin plays a role in how long you live.

MARIN CITY FACT SHEET

Total Population (census tract 1290): 2666*



People under the age of 18: 23.7%
People over the age of 65: 9.4%

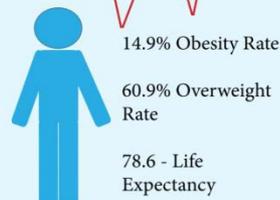
Approximately 39% of Marin City Residents live below 200% of the federal poverty level



*Marin City's Median Household Income: \$37,857

*Low income range: \$5,629-\$31,205
*County of Marin Median Household Income: \$90,962

US Census, 2010 & American Fact Finder, 2012 - *Tract 1290 does not include all of Marin City



(Human Impact Partners, 2012)

ED visits for asthma in children in Marin County

*151 - African American
*37.2 - Hispanic/Latino
*27.0 White

(Calculated per 10,000 people, OSHPD, 2010)

MARIN CITY STATS

- 2,509 Population (census tract 0604112900)
- 63% of African Americans living in poverty (at or below 185% federal poverty level)
- 7 of schools (k-8, preschools)
- 0 of public parks
- 0 of farmers markets
- 0 of supermarkets/large grocery stores
- 4 of fast food outlets near schools
- 2 of other food sources (CVS and Dollar Tree)



ROSS FACT SHEET

Total Population: 2415



People under the age of 18: 30.3%
People over the age of 65: 17.1%

Approximately 10.7% of Ross Residents live below 200% of the federal poverty level

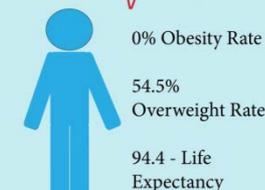


*Ross's Median Household Income: \$114,750

*Low Income range: \$66,894-114,332

*County of Marin Median Household Income: \$90,962

US Census, 2010 & American Fact Finder, 2012



(Human Impact Partners, 2012)

ED visits for asthma in children in Marin County

*151 - African American
*37.2 - Hispanic/Latino
*27.0 White

(Calculated per 10,000 people, OSHPD, 2010)

“THE PROBLEM IS CLEAR: THE WATER IS FILTHY”



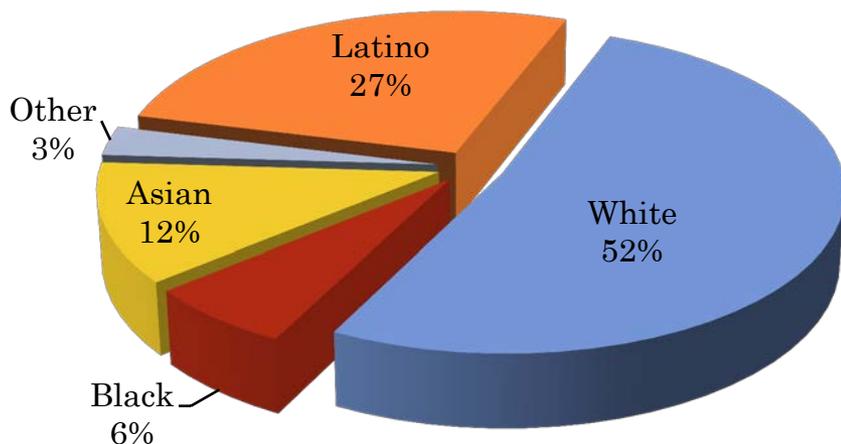
The New York Times

- “No tomes el agua!” — “Don’t drink the water!”
- Seville, with a population of about 300
 - One of dozens of predominantly Latino unincorporated communities in the Central Valley plagued for decades by contaminated drinking water.
- Today, one in five residents in the Central Valley live below the federal poverty line.
 - Many spend up to 10 percent of their income on water.

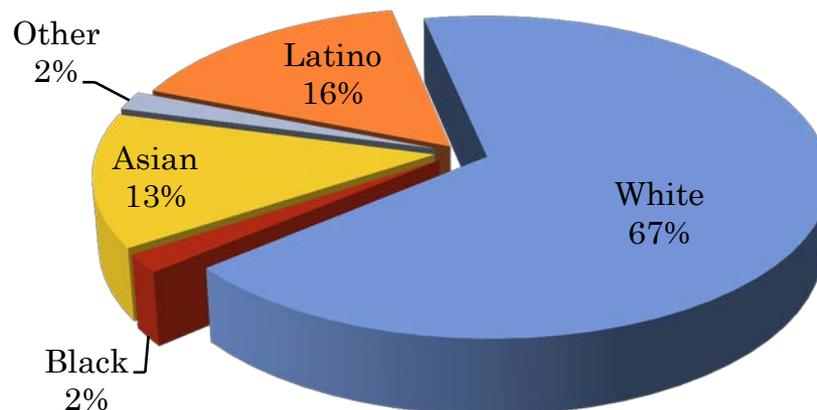


UNEVEN DISTRIBUTION OF HOUSEHOLD WEALTH ACROSS RACIAL ETHNIC GROUPS IN CALIFORNIA

Households in California by Race/Ethnicity, 2010



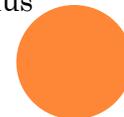
Household Wealth in California by Race/Ethnicity, 2010



African American households represent 6% of California households, but hold about 2% of household wealth.

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.

A household consists of all the people who occupy a housing unit



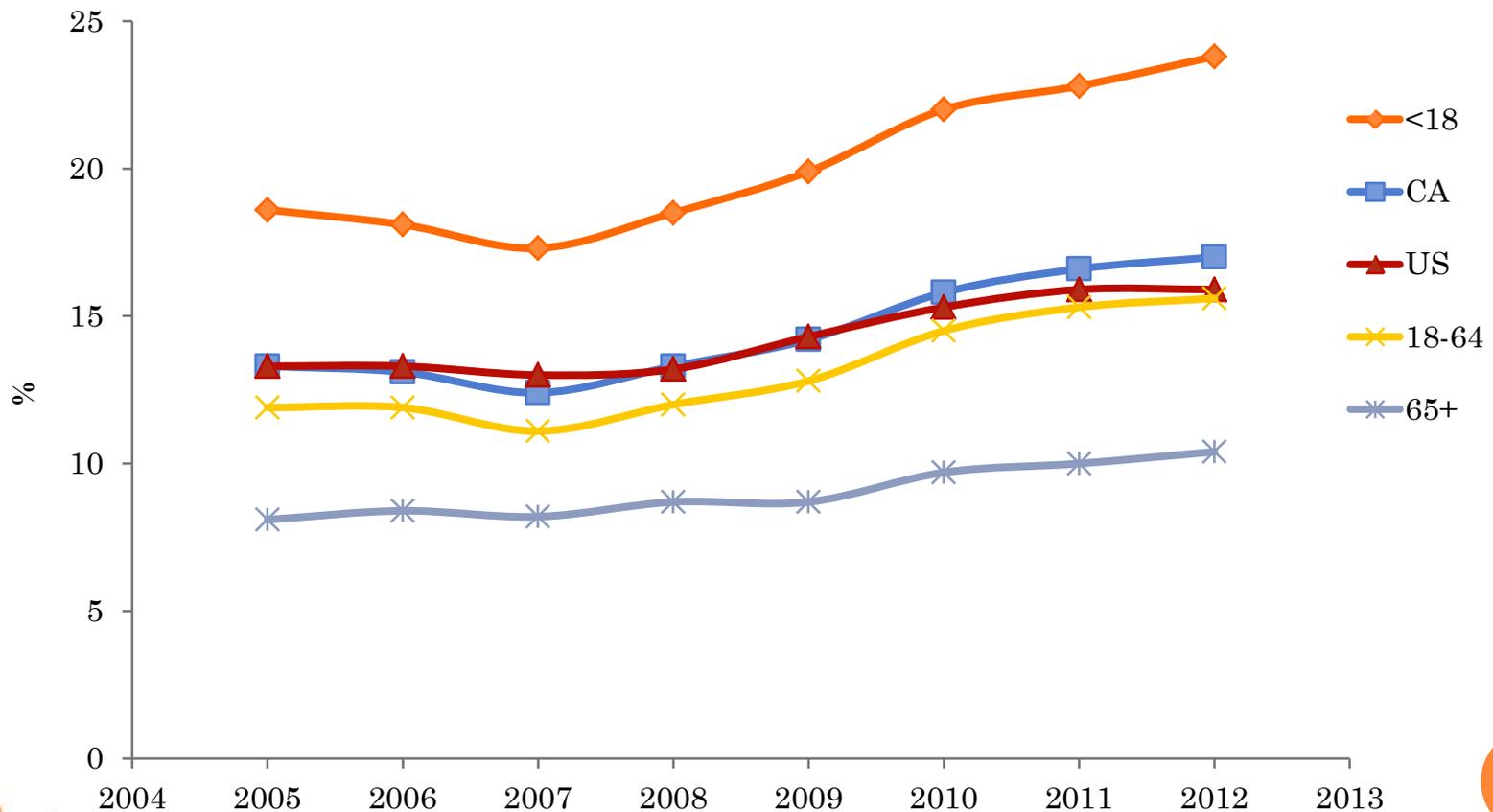
THE WEALTHIER A COUNTY IS, THE LONGER ITS INHABITANTS LIVE.



Figure 1.2: The life expectancy used is the average of the male and female life expectancies for 2009. Compiled by SFRB. Life Expectancy: Institute for Health Metrics and Evaluation, Life Expectancy US Counties, 2009.

1 IN 4 CALIFORNIA CHILDREN LIVING IN POVERTY IN 2012

Percentage of People Living Below Poverty by Age, California, 2005-2012.



Source: ACS



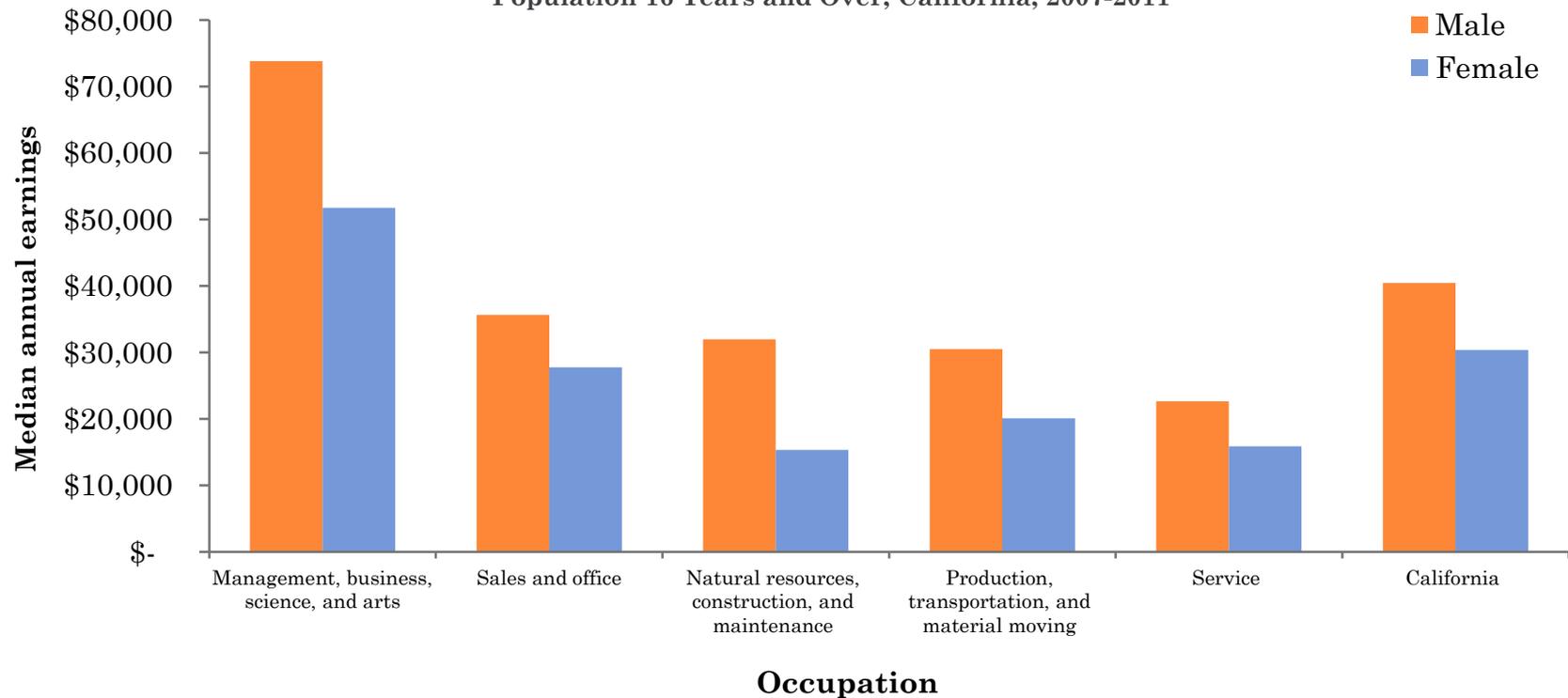
HIGHER PROPORTIONS OF LATINO AND AFRICAN AMERICAN CHILDREN LIVE IN POVERTY COMPARED TO CHILDREN OF OTHER RACE/ETHNIC GROUPS

Percentage of children living below poverty level by race/ethnicity, California, 2010-2012



WOMEN EARNED 75 CENTS ON EVERY DOLLAR PAID TO MEN.

Occupation by Sex and Median Annual Earnings† Among Civilian Employed Population 16 Years and Over, California, 2007-2011



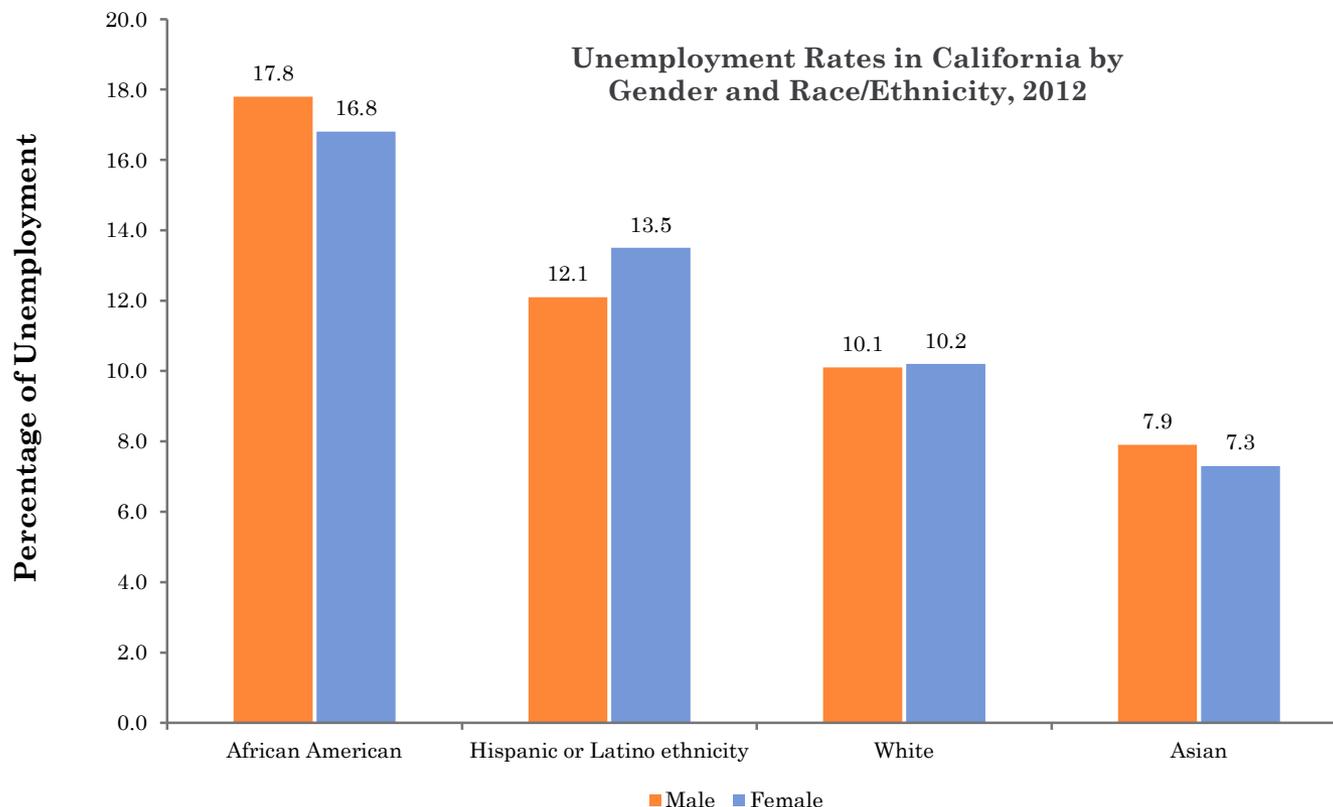
Source: American Community Survey, 5-year estimate.

† Individual earnings

Data methodology and limitation are available at: https://www.census.gov/acs/www/methodology/methodology_main/

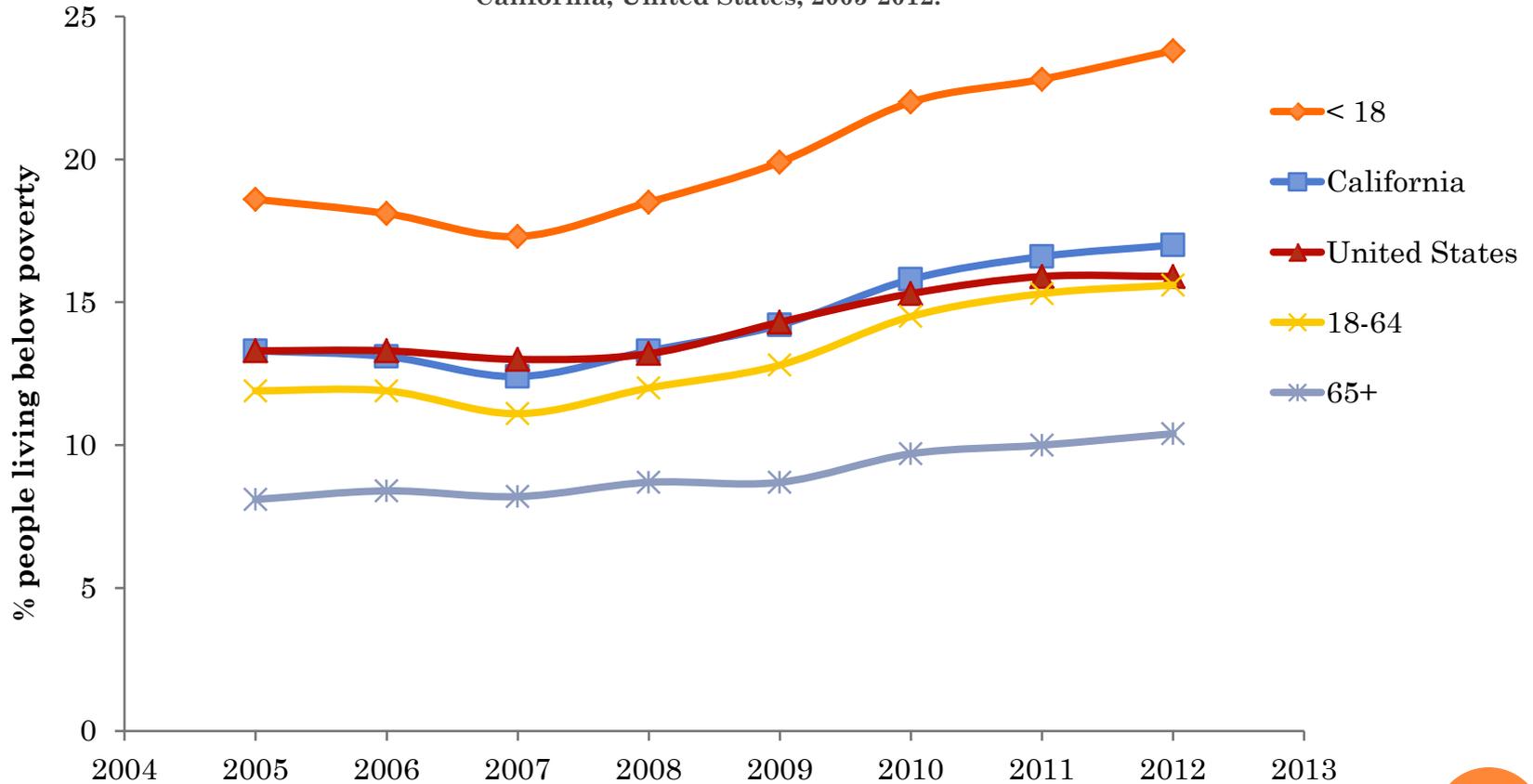


UNEMPLOYMENT RATES FOR AFRICAN AMERICAN MEN AND WOMEN ARE HIGHER THAN THE OTHER RACIAL ETHNIC GROUPS IN CALIFORNIA.



1 IN 4 CALIFORNIA CHILDREN LIVING IN POVERTY IN 2012.

Percentage of People Living Below Poverty Level by Age, California, United States, 2005-2012.



Source: American Community Survey, 1-year estimate

Data methodology and limitation are available at: https://www.census.gov/acs/www/methodology/methodology_main/



ONE THIRD OF CALIFORNIA CHILDREN ARE FOOD INSECURE.

San Mateo County

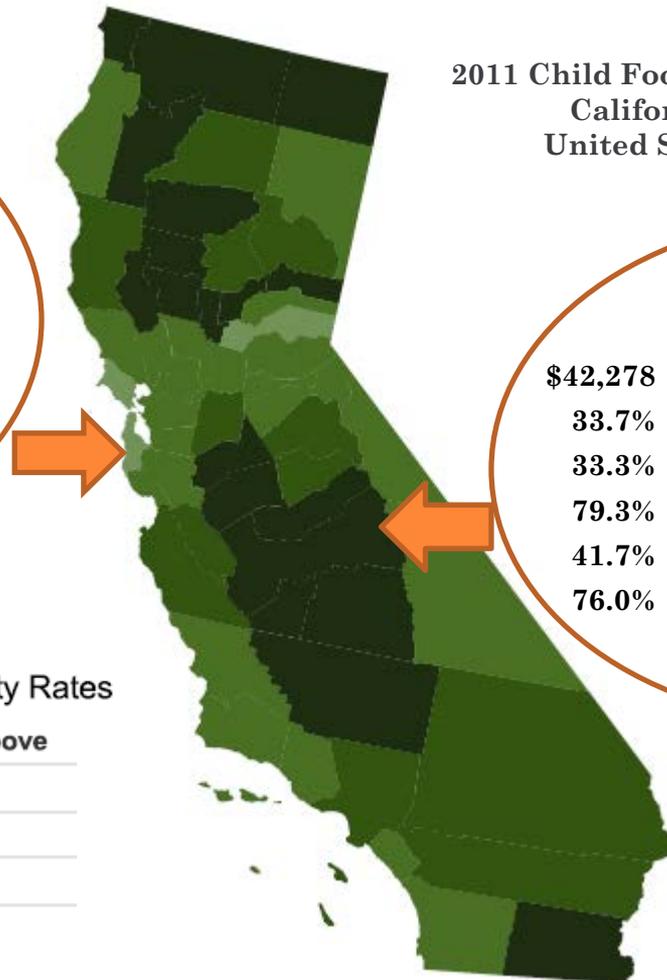
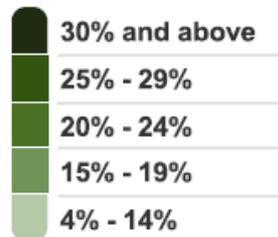
- \$111,250** Median family income†
- 17.1%** Child food insecurity rate
- 8.8%** Children living in poverty
- 65.5%** Non-white children
- 60.1%** Children age 3-4 enrolled in school
- 84.2%** Graduation rate

2011 Child Food Insecurity Rate
California: 27.3%
United States: 22.4%

Fresno County

- \$42,278** Median family income†
- 33.7%** Child food insecurity rate
- 33.3%** Children living in poverty
- 79.3%** Non-white children
- 41.7%** Children age 3-4 enrolled in school
- 76.0%** Graduation rate

Child Food Insecurity Rates

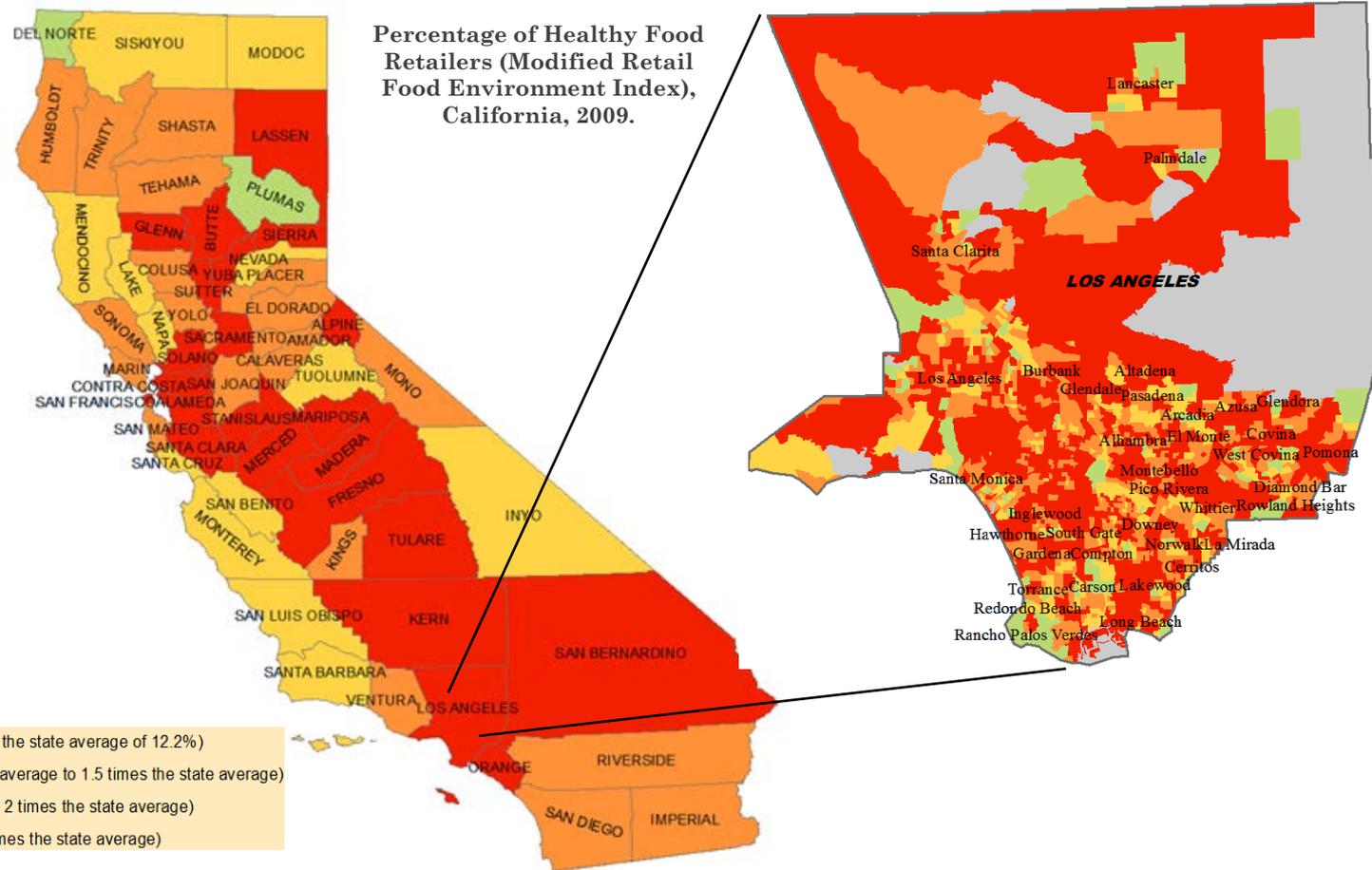


Sources: Map the Meal Gap, Feeding America 2011. American Community Survey, 3-year estimate (2009-2011) and 5-year estimate (2008-2012). California Department of Education, 2011-2012.

†Median family income with own children under 18 years.

Data methodology and limitation are available at: <http://feedingamerica.org/hunger-in-america/hunger-studies/map-the-meal-gap.aspx>, https://www.census.gov/acs/www/methodology/methodology_main/, <http://www.cde.ca.gov/ds/>

FOR MOST OF CALIFORNIA, ONLY 1.2 OUT OF EVERY 10 FOOD RETAILERS HAVE HEALTHIER FOOD OPTIONS AVAILABLE.



Sources: Centers for Disease Control and Prevention; Division of Nutrition, Physical Activity, and Obesity. U.S. Census Bureau, Decennial Census 2000. Analysis by CDPH-Office of Health Equity and UCSF, Healthy Community Indicator Projects.

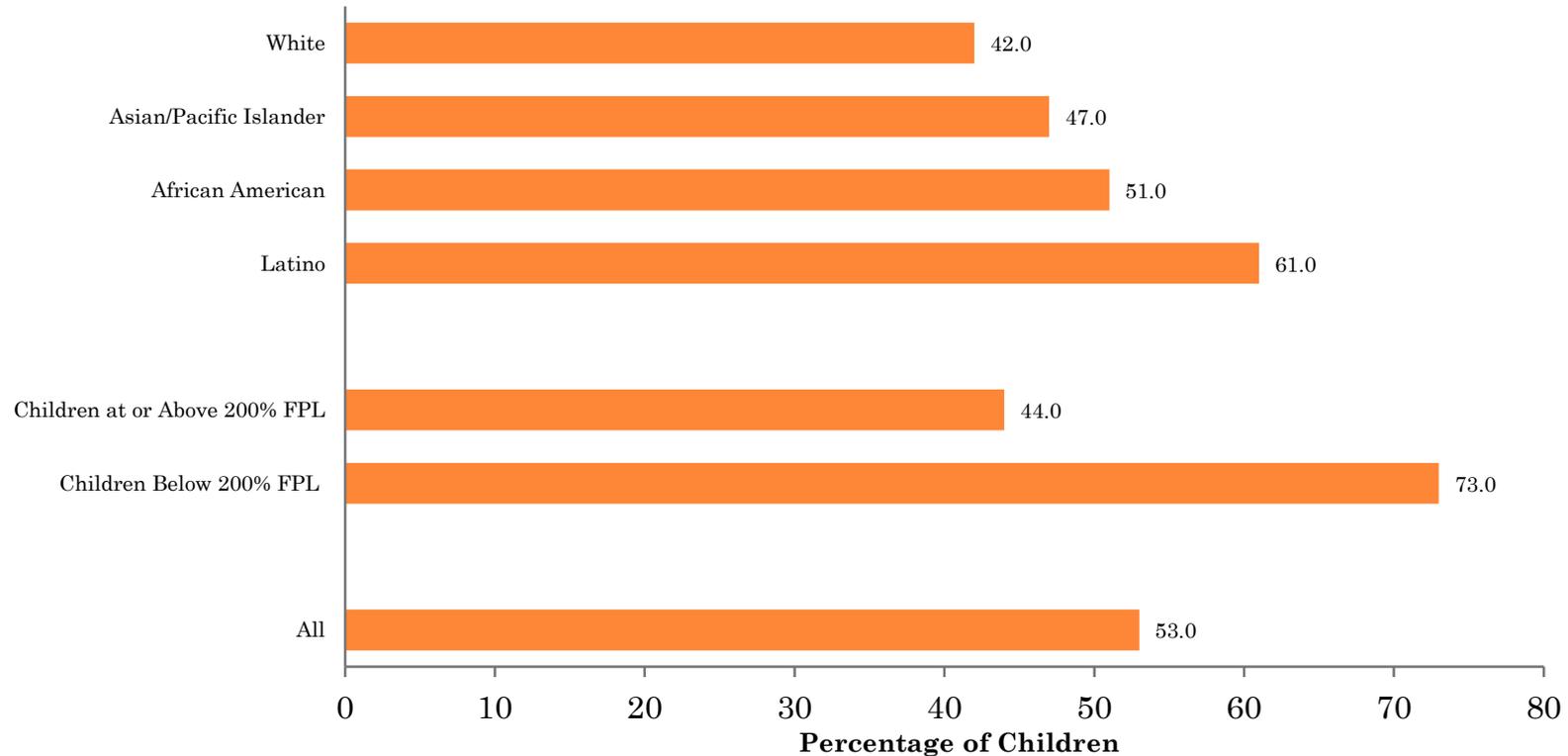
Data methodology and limitation are available at:

http://www.cdph.ca.gov/programs/Documents/HCI_RetailFoodEnvironment_75_Narrative_and_examples_11-8-13.pdf



MORE THAN HALF OF AFRICAN AMERICAN AND HISPANIC CHILDREN ARE NOT ATTENDING PRESCHOOL. 73% ARE BELOW 200% POVERTY LEVEL.

Percentage of California Children Ages 3 to 4 Who Are Not Attending Preschool by Race/Ethnicity and Federal Poverty Level (FPL), 2008-2011



Source: KIDS COUNT Data Center, Annie E. Casey Foundation, 2011.

Data methodology and limitations are available at: <http://datacenter.kidscount.org/data#CA/2/0>

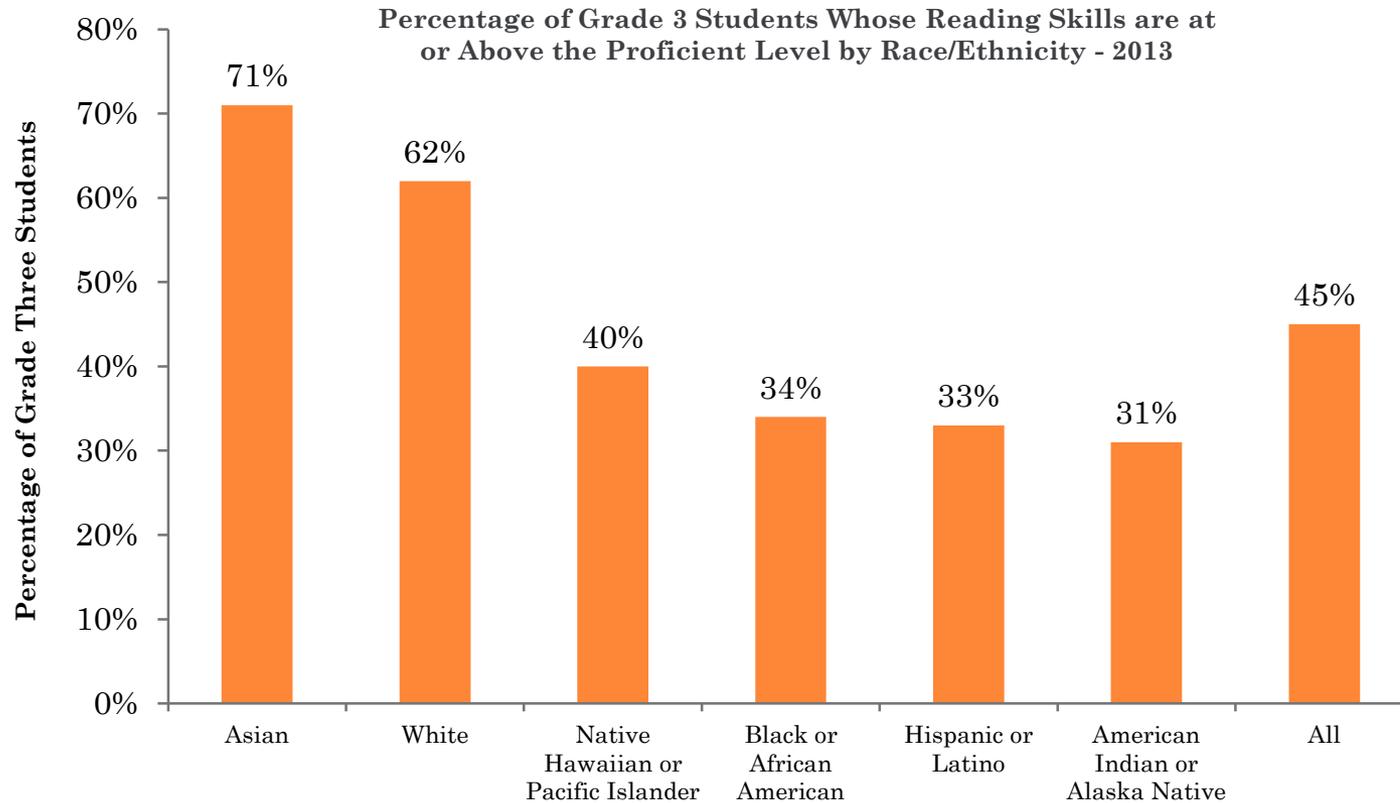
Data Source: Population Reference Bureau, analysis of data from the U.S. Census Bureau, Three-year American Community Survey, 2009-2011.

Preschool includes any group or class of institution providing educational experiences for children during the years preceding kindergarten.

Note: The share of children ages 3 to 4 not enrolled in nursery school or preschool school during the previous two months by their poverty status.



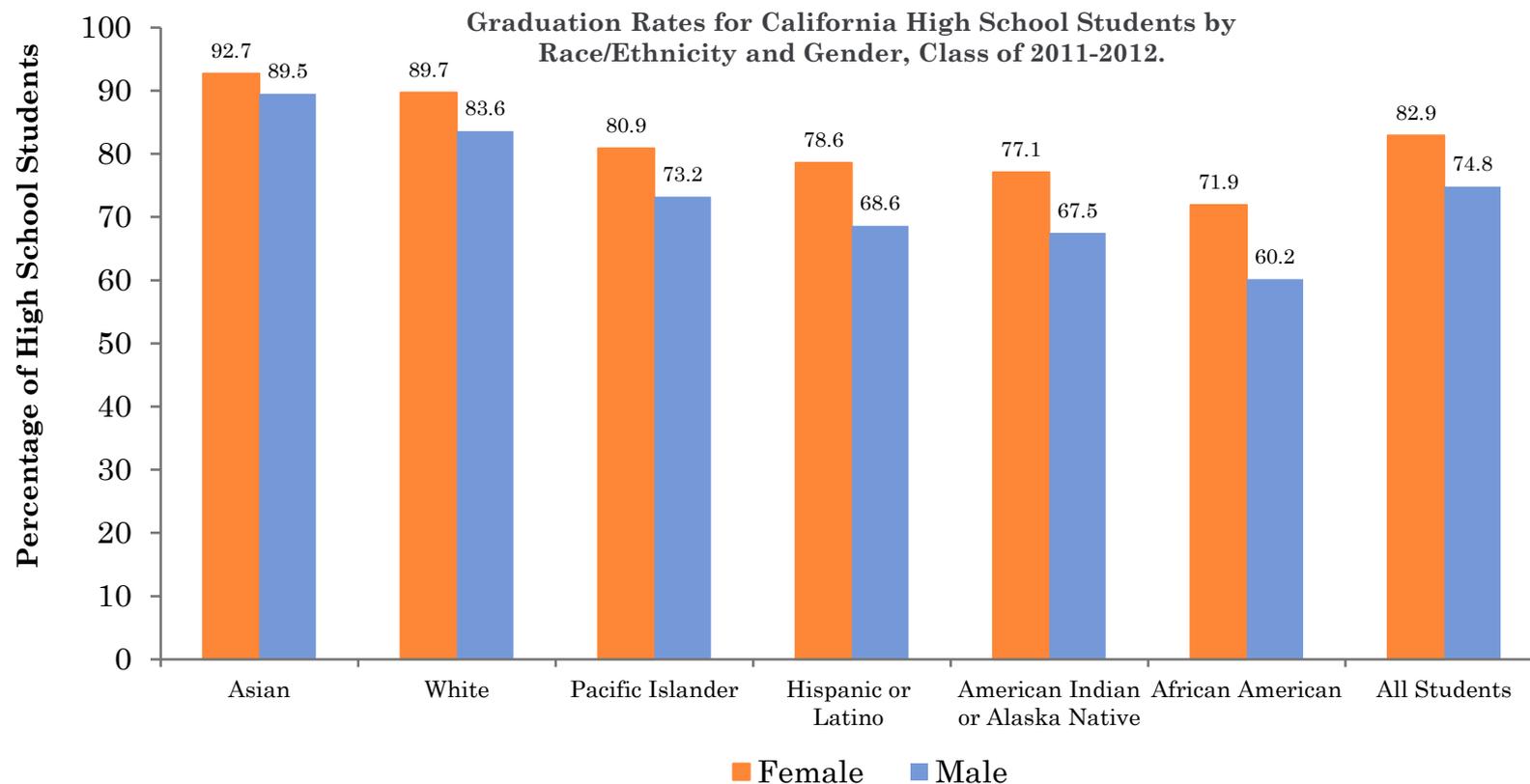
AMONG THIRD GRADERS, ONLY ASIANS AND WHITES READ AT OR ABOVE THE STATE AVERAGE PROFICIENCY LEVEL.



Source: California Department of Education, English-Language Arts Standardized Testing and Reporting (STAR) Results, 2013. Data methodology and limitations are available at: <http://dq.cde.ca.gov/dataquest/>



ONLY ASIANS AND WHITES GRADUATION RATES ARE ABOVE THE STATE AVERAGE. FEMALE STUDENTS HAVE HIGHER GRADUATION RATES THAN MALE STUDENTS.



Source: California Department of Education, Data Reporting Office.

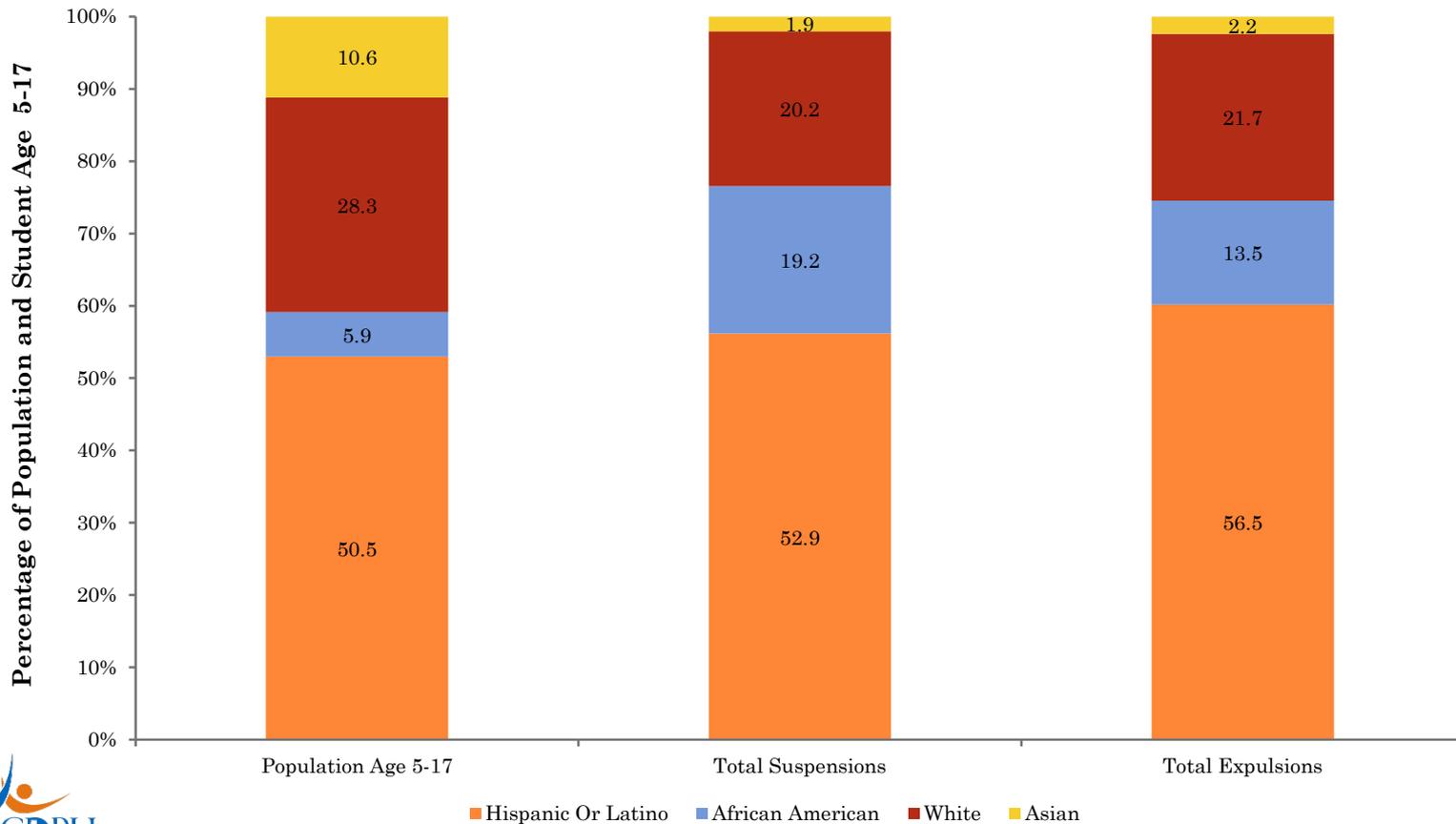
Data methodology and limitations are available at: <http://dq.cde.ca.gov/dataquest/>

Dropout definition: Either 1) was enrolled in grades 7, 8, 9, 10, 11 or 12 at some time during the previous school year AND left school prior to completing the school year and has not returned to school as of Information Day or 2) Did not begin attending the next grade (7, 8, 9, 10, 11 or 12) in the school to which they were assigned or in which they had pre-registered or were expected to attend by Information Day.

Note: Each race and ethnic group excludes percentages of "Still Enrolled high school student Rates" and may not add up to 100%.

SUSPENSION AND EXPULSION RATES FOR AFRICAN AMERICAN STUDENTS ARE MUCH HIGHER THAN THE STUDENTS IN OTHER RACIAL ETHNIC GROUPS COMPARED TO SCHOOL AGE POPULATION RATES IN CALIFORNIA.

Percentage of Suspension and Expulsion of California Students Compared to California School Age Population, 2012-2013

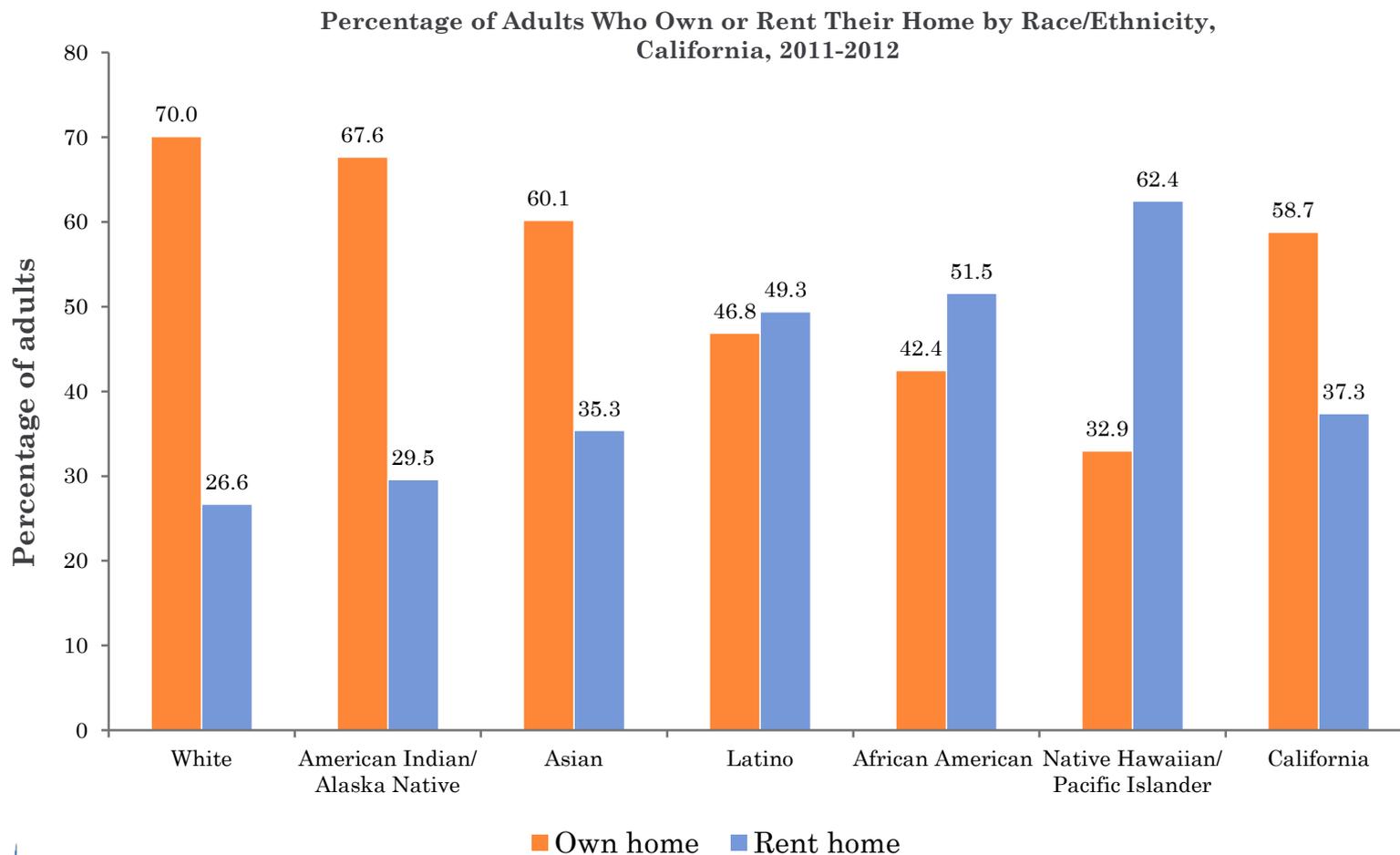


Source: California Department of Education.

Note: Other racial and ethnic population groups are not included in the graphs.



DISPARITIES IN HOUSING OCCUPANCY EXIST ACROSS RACIAL ETHNIC GROUPS IN CALIFORNIA.



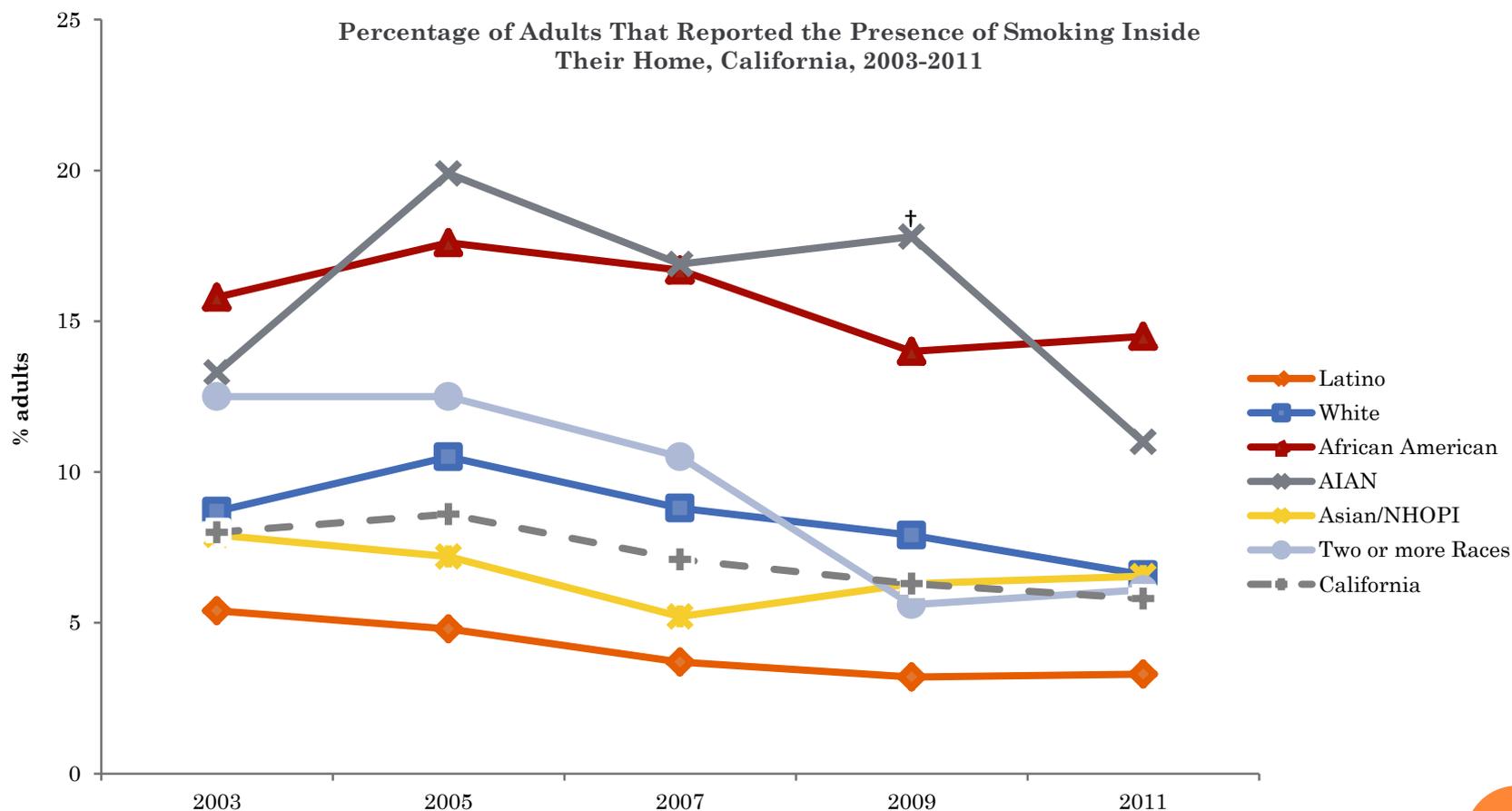
Source: UCLA, California Health Interview Survey, 2011 – 2012.

Data methodology and limitations are available at: <http://healthpolicy.ucla.edu/chis/Pages/default.aspx>

Note: Each race and ethnic group excludes percentages of “Have other arrangement” and may not add to 100%.



AFRICAN AMERICANS ARE MORE LIKELY TO BE EXPOSED TO SECONDHAND SMOKE.



Source: UCLA, California Health Interview Survey, 2011-2012

Data methodology and limitation area available at: <http://healthpolicy.ucla.edu/chis/Pages/default.aspx>

†Statistically unstable

AIAN: American Indian/Alaska Native

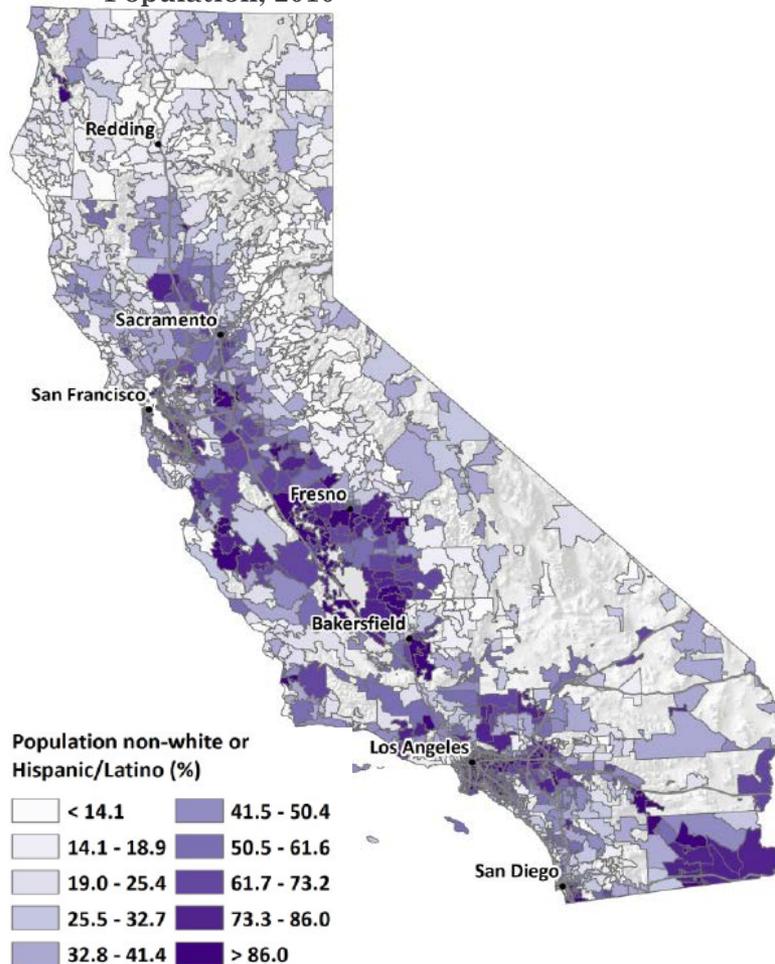
NHOPI: Native Hawaiian/Other Pacific Islander



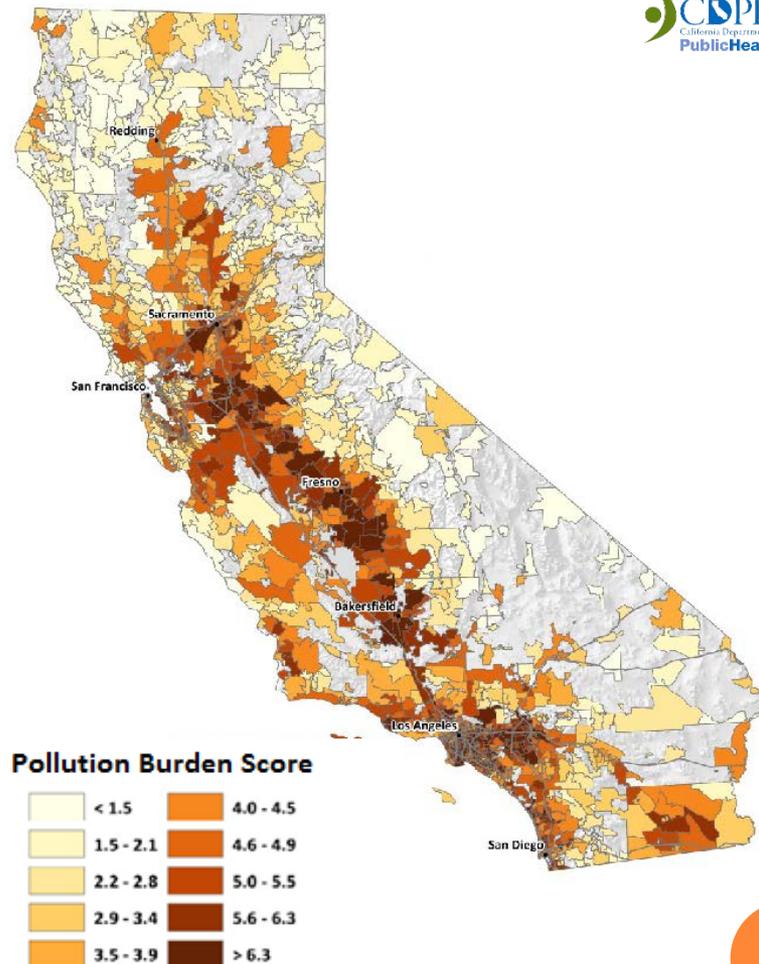
HIGH CONCENTRATION OF NON-WHITE OR HISPANIC POPULATION IN AREAS WITH HIGH BURDEN OF POLLUTION.



Non-White or Hispanic/Latino Population, 2010



Pollution Burden of California



Source: California Communities Environmental Health Screening Tool, Version 1.1, 2013

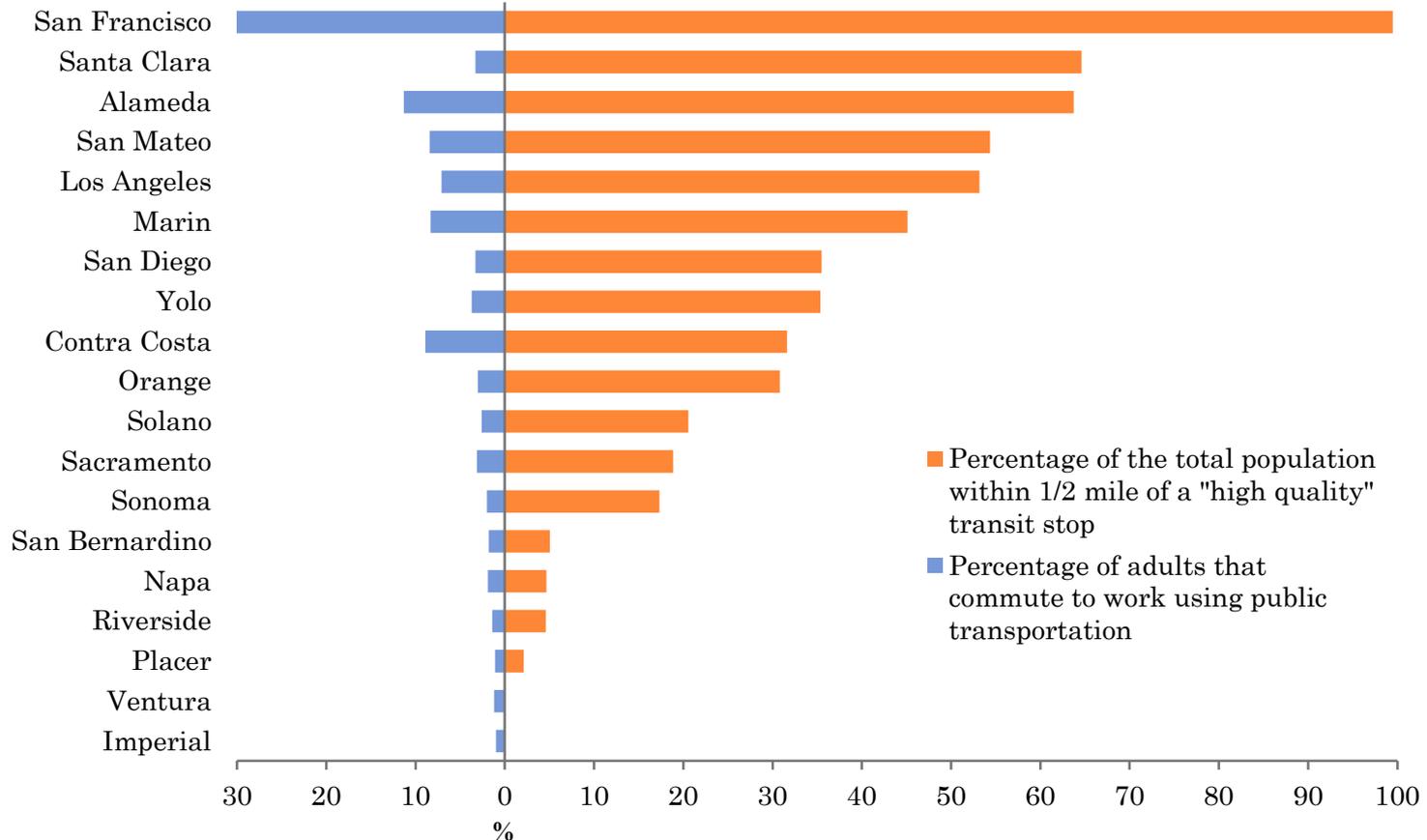
Pollution Burden scores for each ZIP code are derived from the average percentiles of the six Exposures indicators (ozone and PM_{2.5} concentrations, diesel PM emissions, pesticide use, toxic releases from facilities, and traffic density) and the five Environmental Effects indicators (cleanup sites, impaired water bodies, groundwater threats, hazardous waste facilities and generators, and solid waste sites and facilities). Indicators from the Environmental Effects component were given half the weight of the indicators from the Exposures component. The calculated average percentile (up to 100th percentile) was divided by 10 and rounded to one decimal place for a Pollution Burden score ranging from 0.1 -10, where 10 is the highest burden.

Data methodology and limitation are available at: <http://www.oehha.ca.gov/ej/ces11.html>



THE PERCENTAGE OF THE POPULATION WITH ACCESS TO PUBLIC TRANSIT AND THAT USES PUBLIC TRANSIT BY COUNTY IS LOW OVERALL IN COMPARISON TO SAN FRANCISCO COUNTY.

Public Transportation Use and Access in California by Counties of the Metropolitan Planning Organizations: SANDAG, SCAG, MTC, and SACOG

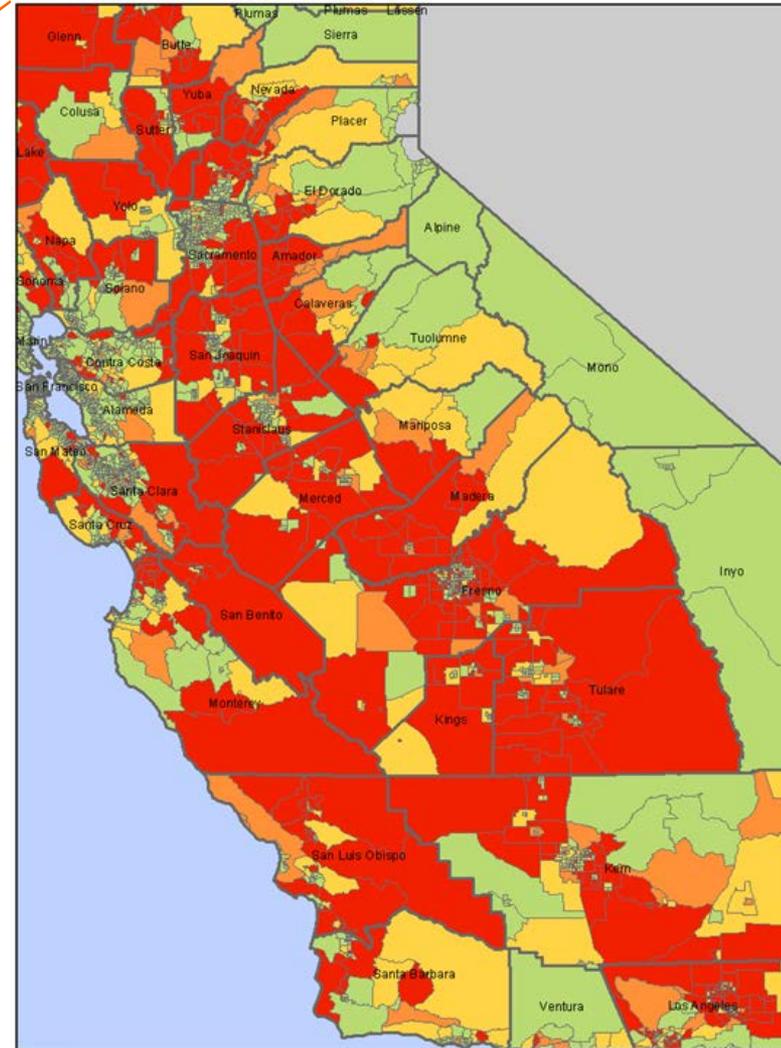
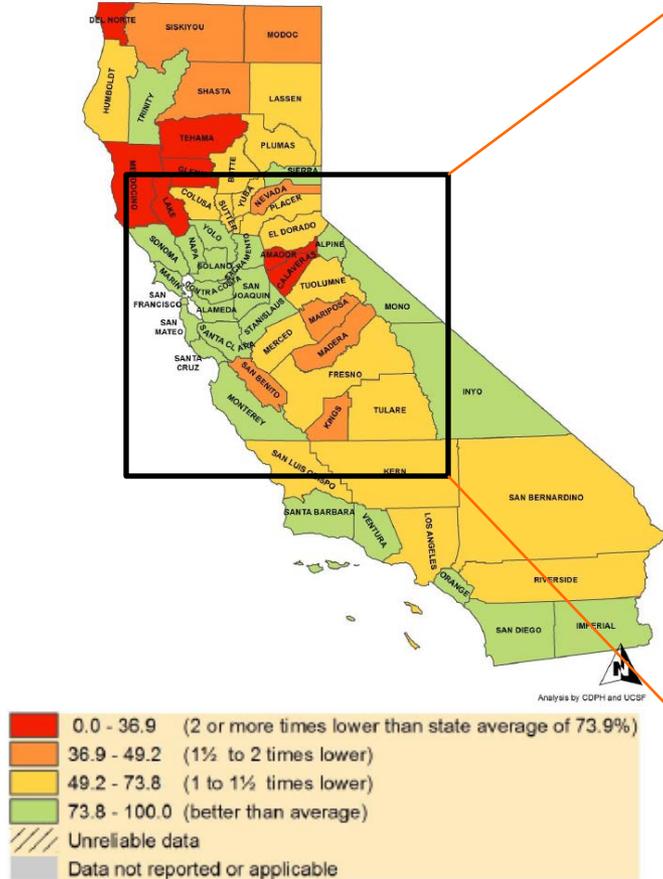


Sources: American Community Survey, 2006-2010, Southern California Association of Governments (SCAG), 2012, San Diego Association of Governments (SANDAG), 2012, Metropolitan Transportation Commission (MTC), 2012, and Sacramento Area Council of Governments (SACOG), 2008. Analysis by CDPH-Office of Health Equity and UCSF, Healthy Community Indicators Project.

Data methodology and limitation are available at: http://www.cdph.ca.gov/programs/Documents/HCI_RailFerryBus_51_Narrative_and_examples_11-26-13SoCal_MTC_Sac.pdf

ACCESS TO PARKS WITHIN WALKING DISTANCE VARIES BY COMMUNITY, BUT IT IS LOWER IN NON URBAN AREAS.

Percent of Population within ½ Mile of Park, Beach, Open Space, or Coastline, by California County, 2010.

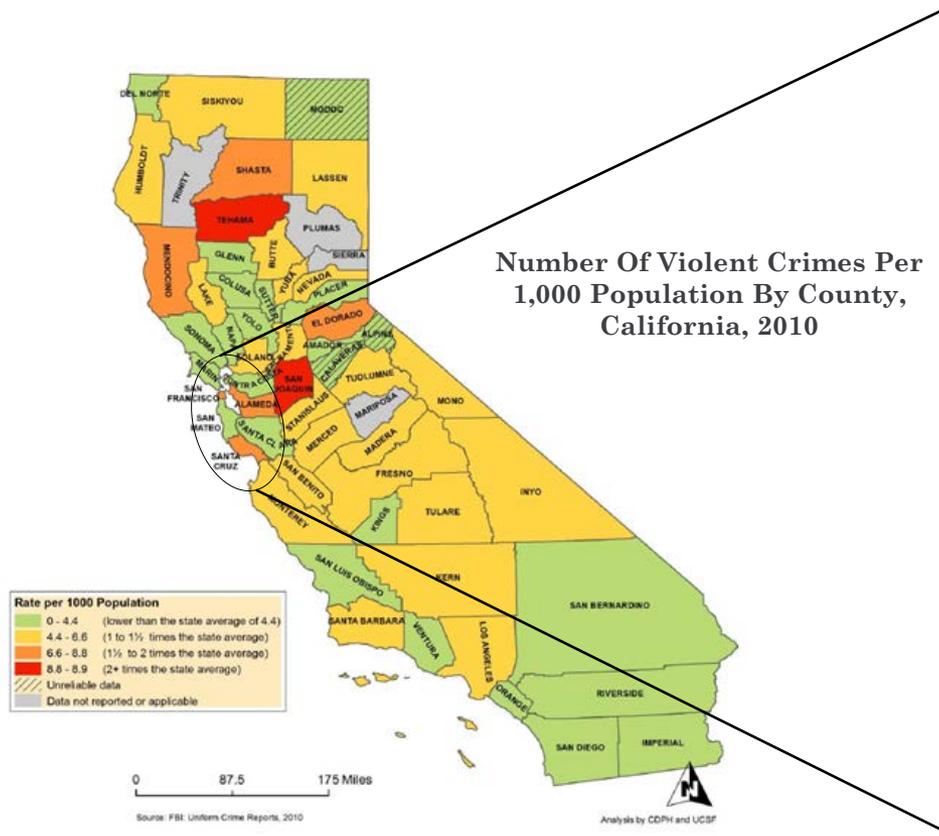


Source: CALANDS (2012), U.S. Census (2010). Analysis by CDPH-Office of Health Equity and UCSF, Healthy Community Indicator Projects.

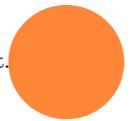
Data methodology and limitation are available at:

http://www.cdph.ca.gov/programs/Documents/ParkBeachOpen_Narrative_Examples4-12-13.pdf

CHILDREN AND YOUTH GROWING UP IN UNSAFE NEIGHBORHOODS ARE MORE LIKELY TO BECOME VICTIMS OR PERPETRATORS OF VIOLENT CRIME.

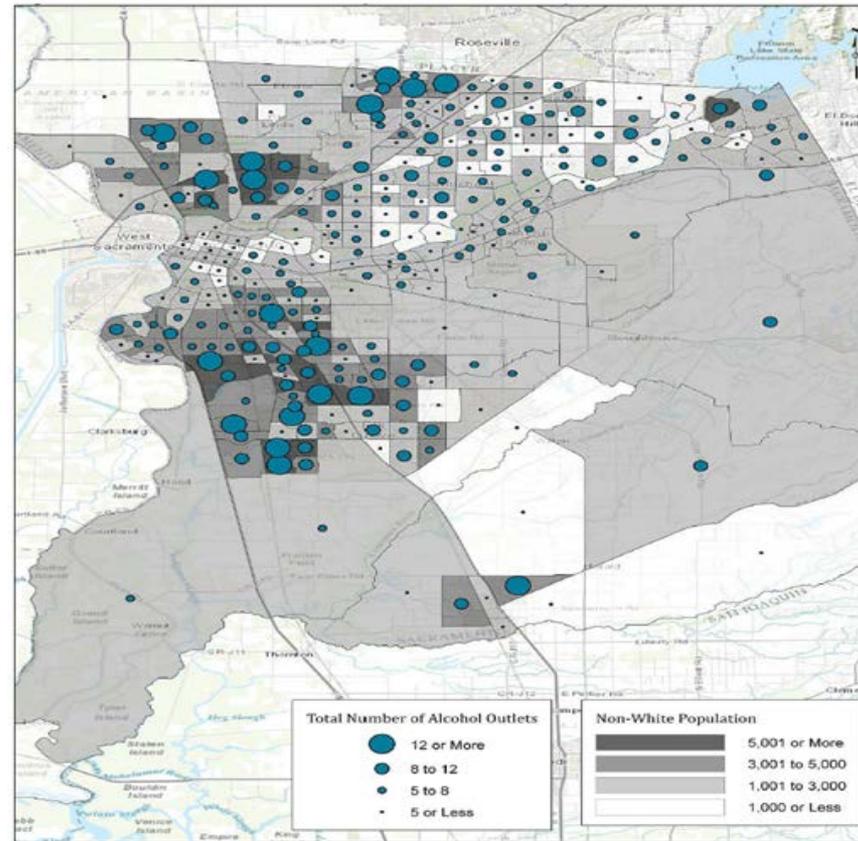


Source: Federal Bureau of Investigation: Uniform Crime Reports, 2010. Analysis by CDPH-Office of Health Equity and UCSF, Healthy Community Indicators Project.



HIGH DENSITY OF ALCOHOL SALE OUTLETS IN NON-WHITE NEIGHBORHOODS

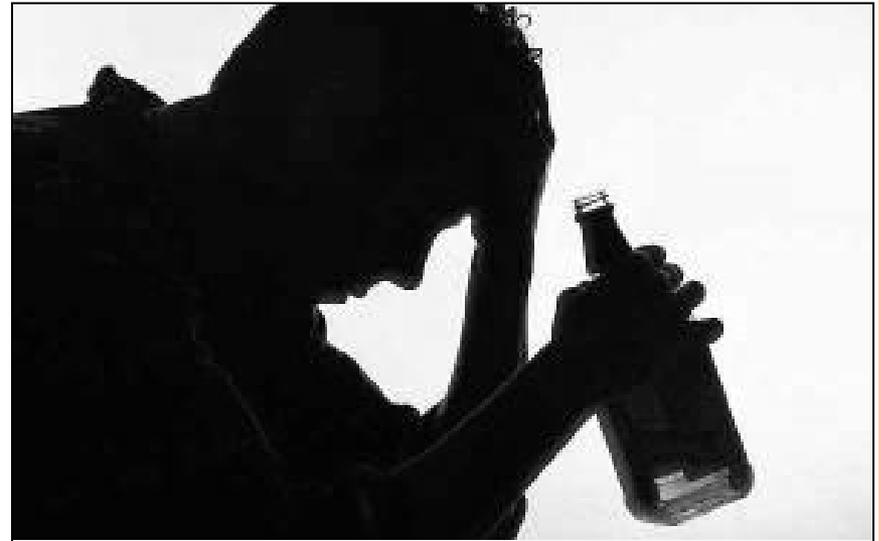
Alcohol Sales Outlet Density, Sacramento County, 2010.



Source: Alcohol Beverage Control (ABC) Retail Authorization for both On-Sale and Off-Sale outlets. U.S. Census Bureau. Racial/ethnic disparities – A data informed perspective, a 2013 report from California Department of Alcohol and Drug Programs.



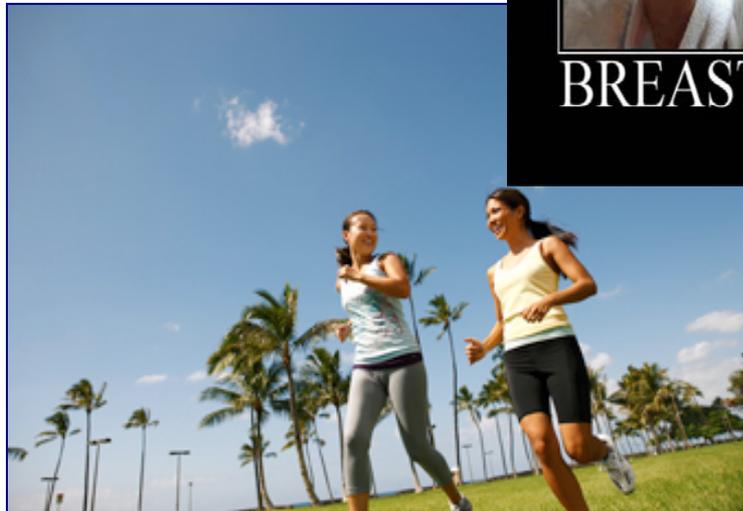
WE HAVE TO DISRUPT CURRENT DEFAULTS...



...WITH POSITIVE, HEALTHY DEFAULTS



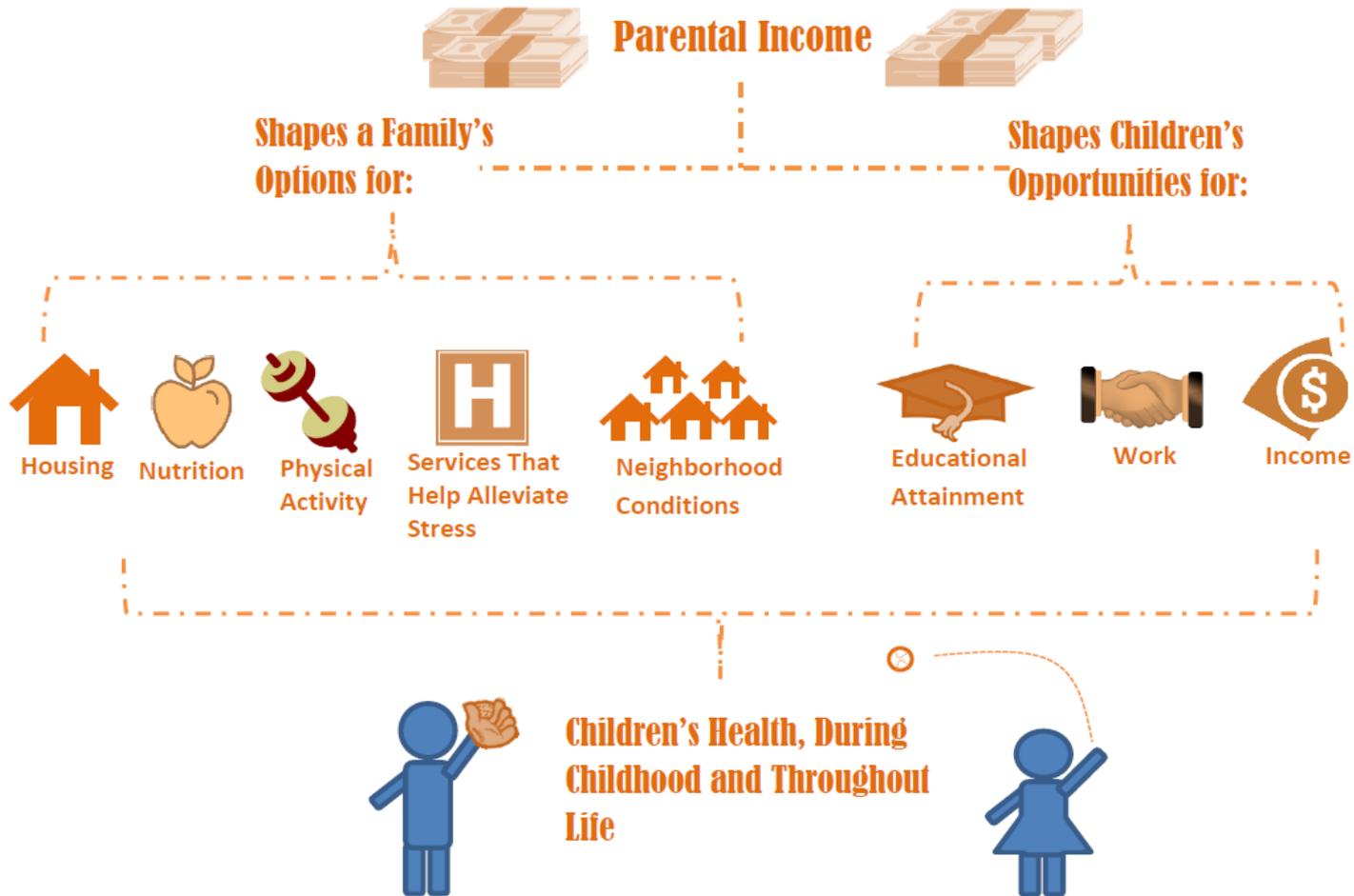
BREASTFEEDING
It Rocks!



WE MUST STRENGTHEN OUR CHILDREN & OUR FAMILIES

Fig 1.1

-Pathways to Healthier Lives-



STRATEGIC PLAN TO ACHIEVE HEALTH EQUITY IN THE STATE OF CALIFORNIA

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 achieve health equity and improve the health, mental health and well-being of all.



STRATEGIC PLAN PRIORITIES

(PROPOSED – UNDER REVIEW – STAKEHOLDER INPUT NEEDED)

- A. Identify and Disseminate Actionable Information on Disparities
- B. Embed Health and Equity into Institutional Policies and Practices Across Non-Health Fields
- C. Embed Equity into Institutional Policies and Practices Across the Health Field
- D. Empower Communities in Disparities Reduction Initiatives
- E. Develop and Align Sustainable Multi-Sector Infrastructure and Support
- F. OHE Capacity Building for Implementation of the Strategic Initiatives



HOW DO WE GET THERE?

“Go Get It. Period.”



Questions?

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