

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH EQUITY

STATUS UPDATE

**REPORT TO THE SENATE BUDGET SUBCOMMITTEE 3
HEALTH AND HUMAN SERVICES**

JULY 2012 TO DECEMBER 2012

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Executive Summary

Assembly Bill 1467 (Committee On Budget, Chapter 23, Statutes of 2012) requires the California Department of Public Health (CDPH) to establish the Office of Health Equity (OHE) to align state resources, decision making and programs to accomplish all of the following: 1) 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, including, but not limited to, vulnerable communities and culturally, linguistically, and geographically isolated communities; 2) 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; 3) 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 4) improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and achieving health equity (See Appendix A for more details about the creation of OHE, its responsibilities and definitions).

OHE is comprised of three units: Community Development and Engagement Unit (CDEU); Policy Unit (PU); and Health Research and Statistics Unit (HRSU). OHE will include a Deputy Director, who is appointed by the Governor and is subject to confirmation by the Senate. The Deputy Director of OHE will report to the CDPH Director and work closely with the Director of the Department of Health Care Services (DHCS) to ensure compliance with the requirements of the office's strategic plans, policies, and implementation activities. Currently OHE consists of fourteen positions; nine of which are filled. Additional contract positions will be added to the OHE based on recent grant funding opportunities. OHE organization chart is attached (Appendix B).

The law requires that an advisory committee be established within OHE to provide input and recommendations on issues related to eliminating mental and health disparities and achieving health equity amongst California's vulnerable population groups¹ (Appendix C gives a descriptive picture of California demographics among these vulnerable population groups). The committee will actively participate in four meetings per year and make recommendations on a broad range of health and mental related issues that address the diversity of multicultural communities in California as a whole.

OHE is also in the process of establishing an interagency agreement between CDPH and DHCS. An initial meeting will be scheduled in December to discuss activities and deliverables, with a timeline to have the interagency agreement completed by January, 2013. The law requires that the interagency agreement be established to outline the process by which the departments will jointly work to advance the mission of the office, including responsibilities, scope of work, and necessary resources.

OHE is currently supported through funding received from the Centers for Disease Control and Prevention (CDC); The National Office of Minority Health (OMH); Proposition 99 Fund/Climate Change; and Proposition 63, Mental Health Services Act.

¹ "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.

Introduction

The Omnibus Health Trailer bill for 2012-2013 [AB 1467 (Committee on Budget Ch. 23, Statutes of 2012) implements the creation of OHE within the CDPH. OHE consolidates the functions of five state-level organizations: Office of Multicultural Services at the former Department of Mental Health (DMH), Office of Multicultural Health at CDPH and DHCS, Office of Women's Health at CDPH and DHCS, Health in All Policies Task Force (HiAP) at CDPH, and Healthy Places Team at CDPH.

The Senate Budget Subcommittee 3 (Health and Human Services) requested CDPH prepare a six month report to the Budget Committee on the activities conducted by OHE for the period of July 2012 to December 2012.

Structure of the Office of Health Equity (OHE)

OHE is comprised of three units, Community Development and Engagement Unit (CDEU); Policy Unit (PU); and Health Research and Statistics Unit (HRSU). OHE will be led by a Deputy Director, who is appointed by the Governor and is subject to confirmation by the Senate. The Deputy Director of OHE will report to the Director of CDPH and work closely with the Director of DHCS to ensure compliance with the requirements of the office's strategic plans, policies, and implementation activities. Currently OHE consists of fourteen positions; nine filled and five in the process of being filled.

Staffing Priorities and Vacancies

Deputy Director

The position announcement was posted on Friday, August 3, 2012. To ensure broad distribution, the OHE Deputy Director position announcement was posted on the following web sites: CDPH, American Public Health Association (APHA), Healthcareers (HEALTHeCAREERS), California Public Health Association - North (CPHA-N), The California Conference of Local Health Officers (CCLHO), and County Health Executives Association of California (CHEAC). The position announcement was also electronically distributed to: Association of State and Territorial Health Officials (ASTHO), HiAP, CDC, National Office of Minority Health (NOMH) Region 9, National Association of County and City Health Officials (NACCHO), California Mental Health Director's Association (CMHDA), California Institute of Mental Health (CiMH), Mental Health Services Oversight and Accountability Commission (MHSOAC), California Mental Health Planning Council (CMHPC), and the California Mental Health Services Authority (CalMHSA). Additionally, the announcement was forwarded to community stakeholder groups to include: the National Alliance on Mental Illness (NAMI), Mental Health America (MHA), United Advocates for Children and Families (UACF), the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), and the California Pan Ethnic Health Network (CPEHN).

The recruitment and hiring process for the OHE Deputy Director includes the following: 1) CDPH Director screened applications and selected the top qualified candidates in November, 2012; 2) a stakeholder interview panel made up of representatives from the public health and mental health fields was selected to participate in interviews; and 3) an internal CDPH interview panel led by the CDPH Director will be convened for a final set of interviews. A first round of interviews was held in December, 2012.

Advisory Committee

An advisory committee to advance the goals of the office and to actively participate in decision making will be established by OHE. The advisory committee shall be composed of representatives from applicable state agencies and departments, local health departments, community-based organizations working to advance health and mental health equity, vulnerable communities, and stakeholder communities that represent the diverse demographics of the state. The chair of the advisory committee shall be a representative from a non-state entity. The committee shall meet, at a minimum, on a quarterly basis. Subcommittees of this advisory committee may be formed as determined by the chair.

The OHE advisory committee membership application was posted on the CDPH and DHCS websites and distributed electronically to government partners and community stakeholders on November 30, 2012. The announcement of the creation of the advisory committee was also posted on CDPH's Facebook page. To date the Facebook page has received 418 views. Additionally, CDPH Tweeted a message to 6,778 followers and DHCS sent a Tweet to 88 followers. Interested parties will have approximately four weeks to submit their applications. Upon receipt and review of the applications a team of CDPH representatives will be making final recommendations to the CDPH Director. According to the Omnibus Health Trailer Bill the advisory committee shall be established by no later than October 1, 2013.

Community Development and Engagement Unit (CDEU)

The CDEU has five positions and currently there are no vacancies.

Health Research and Statistics Unit (HRSU)

The HRSU has three positions, one of which is filled. Advertising for and recruitment of the two vacant positions began in November, 2012.

Policy Unit (PU)

PU has three positions filled: Public Health Medical Officer, Research Scientist III, and Health Program Specialist II. There is a vacant Research Scientist II position. Interviews will be held January, 2013. Additionally, the Public Health Medical Officer is responsible for four full-time and one half-time contract staff with the Public Health Institute, whose current functions involve the ongoing partnering and collaboration with the HiAP. Additional contract positions will be added to the PU due to the recent awarding of the CA Building Resilience Against Climate Effects grant from CDC.

Office of Health Equity - Unit Updates

Community Development and Engagement Unit (CDEU)

- A. California Reducing Disparities Project (CRDP): The CRDP is a key statewide policy initiative to improve access, quality of care, and increase positive outcomes for racial, ethnic and cultural communities in the public mental health system. CDEU staff support the work of the CRDP and manage seven contracts designed to identify community-defined evidence and culturally appropriate strategies to reduce disparities for racial, ethnic, and multicultural communities. The project focuses on five populations: African-American; Latino; Native American; Asian and Pacific Islander; and Lesbian, Gay, Bisexual, Transgender, and Questioning individuals. These groups are required to establish Strategic Planning Workgroups (SPWs) that will produce population specific

reports that will form the basis of a statewide comprehensive strategic plan on reducing disparities. All of the five population reports have been approved and posted on the CDPH website. Recommendations from these reports will be incorporated into a comprehensive draft strategic plan. Once finalized, the California Reducing Disparities (CRD) Strategic Plan will be used as a guide to identify new service delivery approaches from multicultural communities using community defined evidence to improve outcomes and reduce disparities. Furthermore, the Strategic Plan will serve as a blueprint to implement these strategies at the local level. A 30-day public review and comment period of the CRDP Strategic Plan will commence in December, 2012. Another key component of the CRDP is the California MHSa Multicultural Coalition (CMMC) which is designed to provide a new platform for racial, ethnic, and multicultural communities to address historical barriers and provide recommendations on embedding cultural and linguistic competence into the public mental health system. The CMMC is a pivotal component of the CRDP; as this coalition works collaboratively with all the SPWs to provide feedback into the population reports and will support implementation efforts.

- B. CRDP Phase II: The second phase of the CRDP is the implementation of the CRDP Strategic Plan recommendations at the local level. CDPH anticipates completion and release of the final Request for Proposal (RFP) by October, 2013. Public input will be gathered through three regional community forums in the Northern, Central, and Southern regions of the state. The current implementation plan for Phase II is to fund selected approaches across the five identified communities for four years with a strong community participatory evaluation component. After successful completion of this [more than] six year investment in community-defined evidence, California will be in a position to better serve unserved, underserved and inappropriately served communities and to replicate the new strategies, approaches, and knowledge across the state and nation.
- C. Translation: The Dymally-Alatorre Bilingual Services Act (1973) requires California State agencies to provide translated materials and serve monolingual customers in languages other than English. Title 9, CCR, Section 1810.410 (a) (3) defines "Threshold Language" as the primary language, as indicated on the Medi-Cal Eligibility Data System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. CDEU staff monitors a deliverable-based contract with Avantpage Inc. to provide translation and cross translation services in 12 threshold languages. CDEU utilizes this contract to provide translation and cross translation services for MHSa related documents for state and local partners. To date, CDEU has translated 15 documents into nine languages for three MHSa partners since July 1, 2012.
- D. Cultural Competency Consultants: A Master Multi-Provider County Mental Health Cultural Competency Consultant contract includes 16 cultural competence consultants to advise CDPH and OHE on cultural competence in policy, practices, and procedures to reduce disparities. CDEU staff will utilize these consultants with the RFP development within CRDP Phase II.
- E. Outreach/Education: OHE has received numerous inquiries and remains actively engaged with stakeholder groups regarding the newly formed office. OHE staff have participated in the following activities:

1. Native American Day

2. “Sharing Knowledge, Improving Lives, Community Defined Solutions for Latino Mental Health” Conference
3. California Reducing Disparities Native American Behavioral Wellness Conference
4. Statewide release of the African American CRDP final Population Report
5. Informational meetings with representatives of the following organizations:
 - National Alliance on Mental Illness (NAMI)
 - California Mental Health Directors Association (CMHDA)
 - Racial and Ethnic Mental Health Disparities Coalition (REMHDCO)
 - Research Fellow, Dr. Chung, from the Division of Culture and Art Policy at the Korea Culture and Tourism Institute
 - Four individual meetings with community stakeholders from the African American Strategic Planning Workgroup (SPW)
 - Mental Health Services Oversight and Accountability Commission (MHSOAC)
 - African American Health Institute of San Bernardino County
 - Pacific Clinics
 - University of California Davis (UCD) Center for Reducing Health Disparities
 - Equality California Institute
 - Native American Health Center, Inc.
 - California Pan-Ethnic Health Network
 - Mental Health Association in California
 - California Center for Research on Women and Families

F. Committee Participation: OHE staff have active and ongoing participation on the following committees:

1. Mental Health Services and Oversight and Accountability Commission (MHSOAC) Cultural and Linguistic Competence Committee (CLCC)
2. Mental Health Services and Oversight and Accountability Commission (MHSOAC) Services Committee
3. MHSA Partners Forum
4. California Mental Health Directors Association (CMHDA) Cultural Competence, Equity and Social Justice Committee
5. California Mental Health Planning Council
6. California Institute for Mental Health (CiMH)
7. Superior Region Ethnic Service Managers
8. Central Region Ethnic Service Managers
9. Southern Region Ethnic Service Managers
10. California Committee on Employment of People with Disabilities
11. Director’s Disability Advisory Council

G. Cultural Competence Regional Trainings: OHE is developing an RFP to provide California Brief Multicultural Competence Scale (CBMCS) regional trainings to county mental health providers. This RFP will allow counties to receive cultural competence training utilizing the CBMCS training curriculum at low or no cost, and will assist county

staff in becoming resident trainers in their respective geographic area. OHE plans to develop this program and release an RFP by June, 2013.

Health Research and Statistics Unit (HRSU)

HRSU will be the technical backbone of OHE researching and producing data to fulfill statutory mandated reports and to provide baseline information for programs in their work to eliminate health and mental health inequities in California.

A. Clearinghouse

HRSU will inventory and organize the already abundant information collected by CDPH programs, State agencies, research organizations, and community-based organizations on the demographics and geography of vulnerable populations and inequities in health and mental health outcomes, health services, and social determinants of health. HRSU will also collect existing information on interventions to reduce health and mental health inequities. This will allow numerous stakeholders to rapidly access information on health and mental health inequities and potential solutions.

B. Synthesis and Gap Analysis

HRSU will synthesize existing data and conduct additional analyses to provide a periodic statistical profile (in line with its biennial legislative mandate) of health and mental health inequity in California that can serve as a baseline against which progress can be measured. This information builds on the expertise of multisectoral CDPH programs that have compiled standardized rubrics of indicators such as the Let's Get Healthy California Task Force and the Health in All Policies Task Force's Healthy Community Data and Indicators Project, and the Strategic Growth Council's Regional Progress Report. Complemented with additional analyses, these projects provide a foundation to fulfill the legislative mandate to analyze key factors as they relate to health and mental health disparities and inequities. In particular, the Healthy Community Data and Indicators Project aims to fill a void in information at the community and neighborhood level through leveraging of geospatial analysis. An analysis of data gaps impacting specific vulnerable populations, geographies, social determinants, and mental health and physical health outcomes will also help target additional investments in data collection, policy, or infrastructure and reveal opportunities that other agencies might consider by adding an equity component to their data analyses. More broadly, HRSU will provide a framework to help evaluate the impact of interventions to reduce health and mental health inequities.

C. Coordination of Strategic Programs and Initiatives and Data Sharing

HRSU will be a focal point for many existing CDPH programs and other state agencies that are developing or updating strategic plans with a focus on vulnerable populations and/or health equity. These include the federal Healthy People 2020, CDPH's Statewide Plan for Chronic Disease Prevention and recommendations by the Let's Get Healthy California task Force and the Health in All Policies Task Force. HRSU will also play a role in facilitating data sharing by CDPH, other State agencies, and academic researchers who are conducting analyses of health and mental health equity, environmental justice, and vulnerability to environmental pollutants and climate change.

D. Technical Assistance

HRSU will provide technical assistance to other CDPH programs, state agencies, local health departments and stakeholders who are working to collect and report information on health inequities. Measurement of health and mental health inequities is becoming a prevalent practice in county health departments' health status reports and opportunities exist for a bi-directional flow of information and technical assistance.

E. Interagency Collaboration with Department of Health Care Services

CDPH and DHCS are tasked with working closely to reduce health and mental disparities in the health care delivery system, particularly for the Medi-Cal population. The previous areas (clearinghouse, data synthesis and gap analysis, coordination of strategic planning, and technical assistance) are inclusive of DHCS. CDPH and DHCS will meet on a regular basis during 2013 to further refine and define the collaborative roles of each department and meetings are planned to explore this interagency collaboration.

F. Comprehensive, Cross-sectoral Strategic Plan

HRSU will take the leadership of developing a comprehensive, cross-sectoral strategic plan to eliminate health and mental health disparities and inequities with collaboration of CDEU, PU, external and internal stakeholders. The strategies and recommendations developed will take into account the needs of vulnerable communities to ensure strategies are developed throughout the state to eliminate health and mental health disparities and inequities. This plan will establish goals and benchmarks for specific strategies in order to measure and track disparities and the effectiveness of these strategies. This plan will be updated periodically, but not less than every two years, to keep abreast of data trends, best practices, promising practices, and to more effectively focus and direct necessary resources to mitigate and eliminate disparities and inequities. OHE will seek input from the public on the plan through an inclusive public stakeholder process. The first report is due by July 01, 2013 and the following work is in support of developing this report.

- Begin working and analyzing relevant databases to identify health and mental health disparities among the vulnerable population groups defined in the Assembly Bill 1467.
- Prepare data agenda for OHE (Appendix D).
- Begin a federal, state and local level² literature review.

G. Women's Health Gynecologic Cancer Information Program (GCIP) -Translation Contract

DHCS recently executed a contract with the California Family Health Council (CFHC) to provide for the Women's Health GCIP translation. OHE works collaboratively with DHCS and CFHC by providing consultancy to the CFHC to create the first drafts (English) of the following GCIP materials to translate into 25 languages:

² Centers for Disease Control and Prevention (CDC) and Agency for Health Research and Quality (AHRQ)

- What Women Need to Know About Cancer of the Ovaries
- What Women Need to Know About Cancer of the Uterus
- What Women Need to Know About Cancer of the Cervix

H. California Women's Health Survey (CWHS)

CWHS was established to provide information about women's health and to serve as a catalyst for innovative solutions that impact the health of California's women. CWHS is an annual telephone survey that collects information from a sample of approximately 4,000 randomly selected adult women aged 18 years or older on a wide variety of health indicators and health-related knowledge, behaviors, attitudes, and some demographic information such as age, race/ethnicity, employment status, and education. CWHS is a unique collaborative interdepartmental and private industry effort between the California Departments of Public Health, Health Care Services, Mental Health, Alcohol and Drug Programs, and Social Services, and private partners such as the California Medical Review, Inc. and the Public Health Institute (PHI).

CWHS provides information on a wide variety of behaviors related to past and present involvement in healthcare systems, food security status, participation in government nutrition programs, prenatal care, vitamin consumption, alcohol consumption, breastfeeding, sexually transmitted diseases, intimate partner violence, utilization of cancer screening procedures, and other preventative measures. HRSU will use CWHS information and data to address health and mental health disparities and socioeconomic determinants of health among California women who are identified as one of the vulnerable communities defined in the bill.

I. Healthy People 2010 (HP 2010) Review

HP 2010 is a set of health goals and objectives to achieve over a decade of the century. California has monitored HP goals and objectives since the early 1980's, and continues to monitor the state's progress in meeting the challenges of increasing the quality and years of healthy life and of eliminating health disparities for its residents. It contained 467 objectives that identified specific measures to monitor health in 28 focus areas³, each representing an important part of public health. The HRSU will continue to analyze and track HP targets in order to monitor the state's progress in eliminating health disparities and achieving health equities for California residents. Appendix E provides the HP 2010 analysis that was completed by HRSU using the most current data available.

J. Update on OHE implementation to the Senate Budget Committee: July - December 2012.

K. Prepare interagency agreement between CDPH and DHCS.

L. Meetings attended:

³ Healthy People 2010 Goals and Objective, California Department of Public Health.

- Data Policy Advisory Committee (DPAC) meetings.
- Working with Dr. Vickie M. Mays, University of California, Los Angeles (UCLA) to collect mental health data.

Policy Unit

I. Health in All Policies (HiAP)

HiAP Task Force: The HiAP Task Force is working to carry out collaborative actions listed in eight implementation plans that address issues such as access to healthy food, physical activity, transportation, and safer communities. Through a partnership with the Public Health Institute (PHI), CDPH staffs the HiAP Task Force. The HiAP Task Force continues to build partnerships across policy sectors. HiAP Task Force staff are partnering with the American Public Health Association to produce a guide for local and state health departments to help them use a Health in All Policies approach. Anticipated release of the guide will be early 2013. HiAP Task Force staff also provides limited technical assistance to local governments. Significant accomplishments of the Task Force are listed below.

- A. Farm to Fork Office established: Via interagency agreement, CDE, CDPH, and CDFA established a new Farm to Fork Office in July 2012 to encourage and expand the availability of affordable and locally grown produce through ‘farm-to-fork’ policies and programs, including supporting school gardens. October and November, 2012 activities include meetings with interagency partners and external stakeholders to prioritize strategies and develop reporting mechanisms.
Partner agencies: CAL FIRE, California Farm to School (F2S) Taskforce, CDE, CDFA, CDPH, OPR.
- B. Developing guidance on Community Safety through Environmental Design: The HiAP Task Force has received funding from The California Endowment and the California Obesity Prevention Program to create and disseminate guidance on techniques for using environmental design to reduce crime and increase perceived safety as a way to promote physical activity, infill development, and community cohesiveness. October and November, 2012 activities include researching best practices and developing case studies of communities that already employ these methods.
Partners agencies: AG, CAL FIRE, Caltrans, CDE, CDPH, CSD, HCD, OPR
- C. Health and Health Equity Criteria in State Grant processes: The HiAP Task Force will assess the impact of health and health equity criteria in State grant Request For Applications (RFAs), with a goal of developing recommendations to improve or apply this approach in other RFAs.
Partner agencies: CAL FIRE, CDPH, HCD, Parks and Recreation, Resources, SGC
- D. Promoting Active Transportation and Sustainability through School Facilities: The HiAP Task Force and Strategic Growth Council (SCG) are partnering with CDE and the University of California Berkeley Center for Cities & Schools to facilitate a series of meetings to discuss the links between Safe Routes to School, sustainable communities, complete streets, and school facilities decision-making to begin in December, 2012.

October and November, 2012 activities include meetings with interagency partners and external stakeholders in preparation for a multi-agency convening on December 6, 2012. Partner agencies: CDE, Caltrans, CDPH, HCD, OPR, OTS, SGC

- E. Housing Siting and Air Quality: The Housing Siting and Air Quality Workgroup, which grew out of the HiAP Task Force is working with agencies to foster an understanding of the interrelation between and implications of public policy issues regarding housing proximity to major roadways. The task force has held three stakeholder workshops in Sacramento and Los Angeles, and is participating in follow-up efforts with Los Angeles County. October and November 2012 activities include developing recommended processes for balancing public policy objectives affecting air quality and siting of transit-oriented development; and identifying research needs and demonstration efforts to mitigate adverse environmental and public health impacts in residential areas proximate to major urban roadways and transportation corridors.

Partner agencies: HCD, CDPH, CAL FIRE, Caltrans, ARB, OPR

- F. Promoting Urban and Community Greening: Multiple agencies are working together to develop common messages to promote urban and community greening. October and November, 2012 activities include meetings with interagency partners and external stakeholders to identify strategies and next steps.

Partner agencies: CAL FIRE, OPR, SGC, Parks and Recreation, ARB, EPA, and HCD

- G. Incorporating Health and Health Equity in State Documents: The HiAP Task Force has committed to incorporating a health and health equity perspective into state guidance, surveys, and technical assistance documents where feasible and appropriate. In July and August 2012, OPR solicited input from CDPH on the draft 2011 and 2012 Annual Planning Surveys to ensure that health considerations were included. OPR has also opened the review period for the General Plan Guidelines, and is currently working with multiple agencies to incorporate a health perspective, including recommendations for supporting healthy transportation, food policies, and community safety. November and December, 2012 activities include meetings with multiple state agencies and external stakeholders, and to establish a process for gathering health and equity information and providing it to the relevant State partners.

Partner agencies: The HiAP Task Force and CDPH

- H. Promoting State Approaches to Healthy and Sustainable Food Procurement: The HiAP Task Force, CDPH and PHI have secured funding from The Kaiser Permanente Community Benefit Program to promote healthy and sustainable food procurement at a State level. Currently, HiAP Task Force staff is completing a report outlining State food procurement policies and identifying opportunities to support healthy food procurement. November and December, 2012 activities include partnering with Registered Dietitians from CDPH and CDCR to develop nutrition standards for State purchasing, and working with other state agencies to explore implementation options for healthy and sustainable food procurements.

Partner agencies: Parks and Recreation, CAL FIRE, CDE, CDCR, DGS, CDPH, DOR, PIA, and the State Controller's Office.

Note: For Agency and Department Acronyms see Appendix F.

II. Climate Change and Public Health

A. Collaboration with state and local public health efforts

The team provides technical support, training, and planning assistance to local health departments through CCLHO and collaborates with numerous local and regional health organizations on a range of climate and health related initiatives. Furthermore, the team leads efforts within CDPH to incorporate important climate change developments and planning processes into ongoing public health program efforts.

B. Climate Action Team

The Climate Change and Public Health team represents CDPH on the state Climate Action Team (CAT), co-chairs the CAT Public Health Workgroup and, working with other agencies, coordinates the public health components of the state's mitigation and adaptation efforts.

C. Climate Adaptation Strategy (CAS): CDPH climate and health staff drafted and solicited review on the draft public health sector chapter of the Climate Adaptation Strategy which is being updated by the Adaptation Sector Lead Workgroup under the leadership of the Natural Resources Agency. One of the priority projects of the public health chapter is to expand climate vulnerability assessments working with local public health departments at the county level. CDPH has received a grant from CDC which will permit us to conduct up to ten county-level vulnerability assessments that will be an important part of county and regional level climate and health adaptation planning processes.

D. Extreme Heat Adaptation Interim Guidance: Working with Cal EPA and a multi-agency Extreme Heat Workgroup, staff finalized the draft Guidance and prepared it for release on August 31, 2012, for a 4-month public review and comment period. The Guidance presents recommendations for consideration by state agencies related to heat preparedness and response, for cooling buildings, roadways and other covered surfaces and community wide heat resilience in the face of climate change driven temperature increase.

E. Public Health Workgroup: Staff coordinated two statewide public workgroup meetings (July 9 and Sept 10) to review and collect input on the 2012 update to the state's Climate Adaptation Strategy and the Extreme Heat Adaptation Interim Guidance Document from state partners and a variety of public health, health equity, and environmental health stakeholder groups.

F. Grant awards: The office developed, submitted and was awarded a 4-year federal cooperative agreement from CDC for development of a detailed state climate and health adaptation plan which will allow a more robust assessment of the projected climate impacts on the health of the state's population, including an expanded assessment of the risk and needs of vulnerable populations. CDPH will use CDC's model program, Building Resilience Against Climate Effects (Cal BRACE), to assess and forecast health

impacts. CDPH will work with up to 10 local areas to implement the Cal BRACE planning and early implementation program for addressing climate and health impacts with the goal of enhancing resilience and preparedness

- G. On November 7, 2012, the SAC Branch, in partnership with University of California at Davis (UCD) Health Systems Trauma Prevention Program, will kick off a seven-week evidence-based fall prevention program, “Stepping On,” on the UCD Health Systems campus. Fourteen older adults will initiate their participation in this pilot program, which will be led by a UCD-affiliated physical therapist. Guest lecturers will include an ophthalmologist, a pharmacist and a personal safety expert. It is anticipated that this pilot will lead to replication of the “Stepping On” program throughout the state.

III. Healthy Places Team

- A. Healthy Community Indicators: CDPH received funding to develop a standardized set of statistical measures that describe healthy community environments that meet the basic needs of all, has adequate levels of economic development, a sustainable and quality environment, health and social equity, and respectful social relationships. The indicators are a means to measure the progress towards achieving the goals set forth in healthy community framework of the HiAP Task Force. The initiative launched a project in collaboration with the nine Bay Area health departments (Bay Area Regional Health Inequity Initiative), regional planners, and local elected officials to pilot six indicators. The project has started an analysis of data availability and reliability from the American Community Survey by race/ethnicity for census places and census tracts. This addresses neighborhood conditions that impact health outcomes and health equity.
- B. Mitigation: Health co-benefits and transportation-related reductions in greenhouse gas emissions: CDPH has developed the Integrated Transport and Health Impacts Model (ITHIM), which predicts the health co-benefits of active transport-walking, bicycling alone and in conjunction with transit-as a strategy to reduce greenhouse gas emissions. CDPH is providing technical assistance to county health departments on calibrating the model to their jurisdictions and how to estimate the health co-benefits in different transportation and land use planning scenarios. CDPH is also exploring the feasibility of integrating this health co-benefits model into other statewide travel and land use planning models.

Next Steps

- A. Hire the OHE Deputy Director.
- B. Establish and convene the Advisory Committee for OHE.
- C. Prepare an interagency agreement between CDPH and DHCS.

This Agreement is entered into by and between CDPH and DHCS to fulfill the requirement of AB 1467 requires that an interagency agreement be established between the CDPH and the DHCS to outline the process by which the departments will jointly work to advance the mission of OHE. OHE is currently assessing and outlining activities

where cross collaboration and partnering with DHCS is needed. An initial meeting with DHCS is scheduled in January, 2013.

- D. Establish a comprehensive, cross-sectoral strategic plan to eliminate health and mental health disparities and inequities.

OHE will develop a comprehensive, cross-sectoral strategic plan to eliminate health and mental health disparities and inequities with collaboration of CDEU, PU, external and internal stakeholders. The strategies and recommendations developed will take into account the needs of vulnerable communities to ensure strategies are developed throughout the state to eliminate health and mental health disparities and inequities. This plan will establish goals and benchmarks for specific strategies to measure and track disparities and the effectiveness of these strategies. This plan will be updated periodically, but not less than every two years, to keep abreast of data trends, best practices, promising practices, and to more effectively focus and direct necessary resources to mitigate and eliminate disparities and inequities. The first report is due by July 01, 2013.

- E. Continue to convene Health in All Policies Task Force, provide staffing and technical assistance as needed for Strategic Growth Council implementation plans and exploring additional windows of opportunities for cross-sectoral approach to address social determinants of health, equity and sustainability needs for a healthy population using a Health in All Policies approach.
- F. Complete *Health in All Policies: A Guide for Local and State Governments* and disseminate; provide support to Community Transformation Grant coordinating team as they work with California local health departments to use a HiAP approach in their work.
- G. Continue to provide technical expertise to the Climate Action Team (CAT) and to lead the CAT Public Health Work Group to support public health adaptation and mitigation strategies related to climate change with a focus on developing effective climate and health communications.
- H. Begin implementation of the Building Resiliency Against Climate Effects (BRACE) federally funded project.
- I. Begin implementation of Healthy Community Indicator data base development.
- J. Begin development and implementation of the CRDP Phase II.
- K. Continue outreach and engagement efforts with various community stakeholders from vulnerable communities as defined in AB1467.

- L. Continue in a technical assistance and advisory capacity to multiple community organizations and government partners.

Appendix A: The Omnibus Health Trailer bill for 2012-13 [AB 1467 (Committee on Budget)]

The State Department of Public Health shall establish an Office of Health Equity for the purposes of aligning state resources, Decision making, and programs to accomplish all of the following:

(1) 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, including, but not limited to, vulnerable communities and culturally, linguistically, and geographically isolated communities.

(2) 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.

(3) 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.

(4) Improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and inequities.

(c) The duties of the Office of Health Equity shall include all of the following:

(1) Conducting policy analysis and developing strategic policies and plans regarding specific issues affecting vulnerable communities and vulnerable places to increase positive health and mental health outcomes for vulnerable communities and decrease health and mental health disparities and inequities. The policies and plans shall also include strategies to address social and environmental inequities and improve health and mental health. The office shall assist other departments in their missions to increase access to services and supports and improve quality of care for vulnerable communities.

(2) Establishing a comprehensive, cross-sectoral strategic plan to eliminate health and mental health disparities and inequities. The strategies and recommendations developed shall take into account the needs of vulnerable communities to ensure strategies are developed throughout the state to eliminate health and mental health disparities and inequities. This plan shall be developed in collaboration with the Health in All Policies Task Force. This plan shall establish goals and benchmarks for specific strategies in order to measure and track disparities and the effectiveness of these strategies. This plan shall be updated periodically, but not less than every two years, to keep abreast of data trends, best practices, promising practices, and to more effectively focus and direct necessary resources to mitigate and eliminate disparities and inequities. This plan shall be included in the report required under paragraph (1) of subdivision

(d) The Office of Health Equity shall seek input from the public on the plan through an inclusive public stakeholder process.

(3) Building upon and informing the work of the Health in All Policies Task Force in working with state agencies and departments to consider health in appropriate and relevant aspects of public policy development to ensure the implementation of goals and objectives that close the gap in health status. The Office of Health Equity shall work collaboratively with the Health in All Policies Task Force to assist state agencies and departments in developing policies, systems, programs, and environmental change strategies that have population health impacts in all of the following ways, within the resources made available:

(A) Develop intervention programs with targeted approaches to address health and mental health inequities and disparities. (B) Prioritize building cross-sectoral partnerships within and across departments and agencies to change policies and practices to advance health equity.

(C) Work with the advisory committee established pursuant to subdivision (f) and through stakeholder meetings to provide a forum to identify and address the complexities of health and mental health inequities and disparities and the need for multiple, interrelated, and multisectoral strategies.

(D) Provide technical assistance to state and local agencies and departments with regard to building organizational capacity, staff training, and facilitating communication to facilitate strategies to reduce health and mental health disparities.

(E) Highlight and share evidence-based, evidence-informed, and community-based practices for reducing health and mental health disparities and inequities.

(F) Work with local public health departments, county mental health or behavioral health departments, local social services, and 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. The Office of Health Equity shall seek to link local efforts with statewide efforts.

(4) Consult with community-based organizations and local governmental agencies to ensure that community perspectives and input are included in policies and any strategic plans, recommendations, and implementation activities.

(5) Assist in coordinating projects funded by the state that pertain to increasing the health and mental health status of vulnerable communities.

(6) Provide consultation and technical assistance to state departments and other state and local agencies charged with providing or purchasing state-funded health and mental health care, in their respective missions to identify, analyze, and report disparities and to identify strategies to address health and mental health disparities.

(7) Provide information and assistance to state and local departments in coordinating projects within and across state departments that improve the effectiveness of public health and mental health services to vulnerable communities and that address community environments to promote health. This information shall identify unnecessary duplication of services.

(8) Communicate and disseminate information within the department and with other state departments to assist in developing strategies to improve the health and mental health status of persons in vulnerable communities and to share strategies that address the social and environmental determinants of health.

(9) Provide consultation and assistance to public and private entities that are attempting to create innovative responses to improve the health and mental health status of vulnerable communities.

(10) Seek additional resources, including in-kind assistance, federal funding, and foundation support.

(d) In identifying and developing recommendations for strategic plans, the Office of Health Equity shall, at a minimum, do all of the following:

(1) 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.

(2) 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:

(A) Income security such as living wage, earned income tax credit, and paid leave.

(B) Food security and nutrition such as food stamp eligibility and enrollment, assessments of food access, and rates of access to unhealthy food and beverages.

(C) Child development, education, and literacy rates, including opportunities for early childhood development and parenting support, rates of graduation compared to dropout rates, college attainment, and adult literacy.

(D) Housing, including access to affordable, safe, and healthy housing, housing near parks and with access to healthy foods, and housing that incorporates universal design and visitability features.

(E) Environmental quality, including exposure to toxins in the air, water, and soil.

(F) Accessible built environments that promote health and safety, including mixed-used land, active transportation such as improved pedestrian, bicycle, and automobile safety, parks and green space, and healthy school siting.

(G) Health care, including accessible disease management programs, access to affordable, quality health and behavioral health care, assessment of the health care workforce, and workforce diversity.

(H) Prevention efforts, including community-based education and availability of preventive services.

(I) Assessing ongoing discrimination and minority stressors against individuals and groups in vulnerable communities based upon race, gender, gender identity, gender expression, ethnicity, marital status, language, sexual orientation, disability, and other factors, such as discrimination that is based upon bias and negative attitudes of health professionals and providers.

(J) Neighborhood safety and collective efficacy, including rates of violence, increases or decreases in community cohesion, and collaborative efforts to improve the health and well-being of the community.

(K) The efforts of the Health in All Policies Task Force, including monitoring and identifying efforts to include health and equity in all sectors.

(L) Culturally appropriate and competent services and training in all sectors, including training to eliminate bias, discrimination, and mistreatment of persons in vulnerable communities.

(M) Linguistically appropriate and competent services and training in all sectors, including the availability of information in alternative formats such as large font, braille, and American Sign Language.

(N) Accessible, affordable, and appropriate mental health services.

(3) Consult regularly with representatives of vulnerable communities, including diverse racial, ethnic, cultural, and LGBTQ communities, women's health advocates, mental health advocates, health and mental health providers, community-based organizations and advocates, academic institutions, local public health departments, local government entities, and low-income and vulnerable consumers.

(4) Consult regularly with the advisory committee established by subdivision (f) for input and updates on the policy recommendations, strategic plans, and status of cross-sectoral work.

(e) The Office of Health Equity shall be organized as follows:

(1) A Deputy Director shall be appointed by the Governor or the State Public Health Officer, and is subject to confirmation by the Senate. The salary for the Deputy Director shall be fixed in accordance with state law.

(2) The Deputy Director of the Office of Health Equity shall report to the State Public Health Officer and shall work closely with the Director of Health Care Services to ensure compliance with the requirements of the office's strategic plans, policies, and implementation activities.

(f) The Office of Health Equity shall establish an advisory committee to advance the goals of the office and to actively participate in decision making. The advisory committee shall be composed of representatives from applicable state agencies and departments, local health departments,

community-based organizations working to advance health and mental health equity, vulnerable communities, and stakeholder communities that represent the diverse demographics of the state. The chair of the advisory committee shall be a representative from a nonstate entity. The advisory committee shall be established by no later than October 1, 2013, and shall meet, at a minimum, on a quarterly basis. Subcommittees of this advisory committee may be formed as determined by the chair.

(g) An interagency agreement shall be established between the State Department of Public Health and the State Department of Health Care Services to outline the process by which the departments will jointly work to advance the mission of the Office of Health Equity, including responsibilities, scope of work, and necessary resources.

AB 1467, Section 131019.5, includes the following definitions of terminology used in the statutes that establish OHE:

(1) "Determinants of equity" means social, economic, geographic, political, and physical environmental conditions that lead to the creation of a fair and just society.

(2) "Health equity" means efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

(3) "Health and mental health disparities" means 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.

(4) "Health and mental health inequities" means disparities in health or mental health, or the factors that shape health, that are systemic and avoidable and, therefore, considered unjust or unfair.

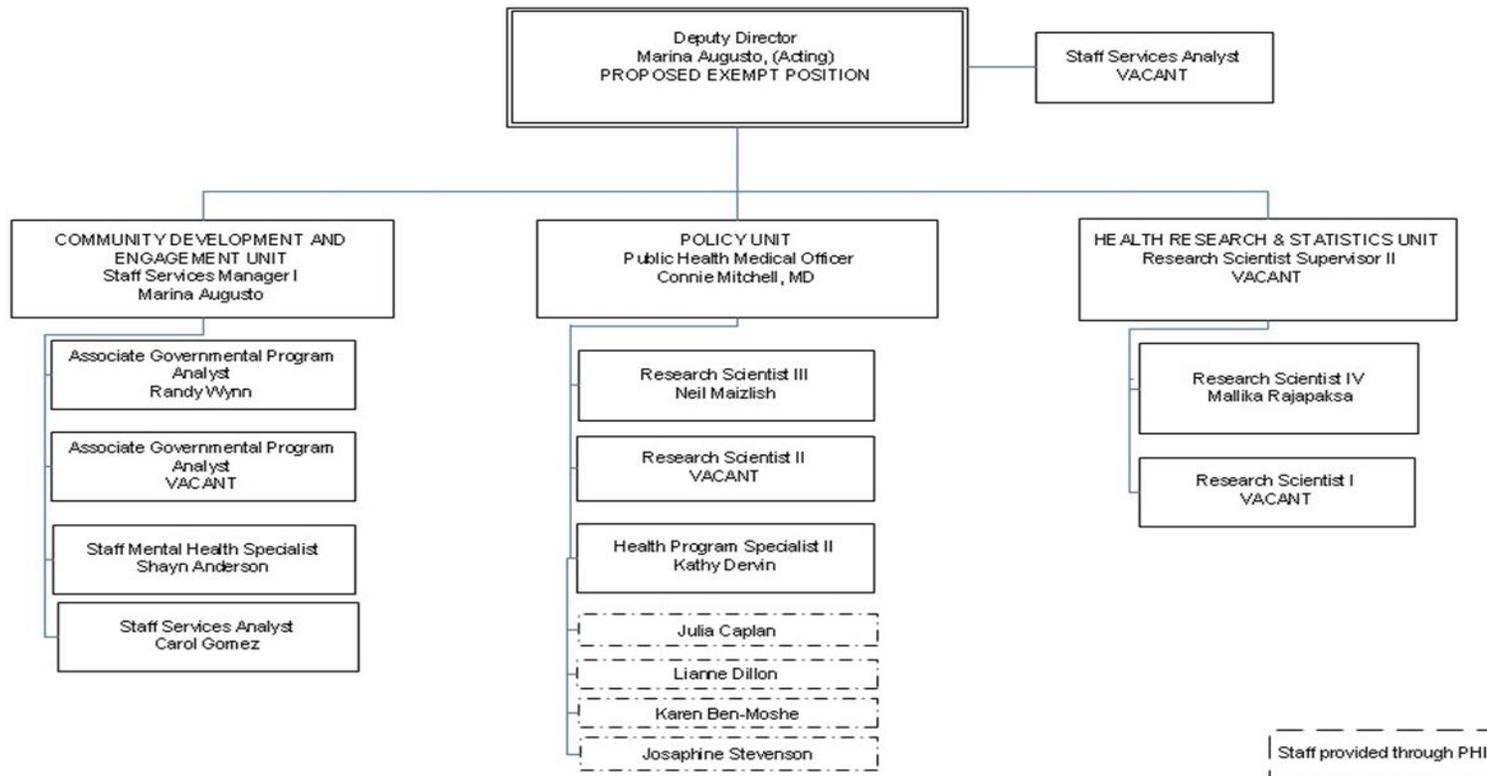
(5) "Vulnerable communities" include, but are not limited to, women, racial or ethnic groups, low-income individuals and families, individuals who are incarcerated and those who have been incarcerated, individuals with disabilities, individuals with mental health conditions, children, youth and young adults, seniors, immigrants and refugees, individuals who are limited-English proficient (LEP), and lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) communities, or combinations of these populations.

(6) "Vulnerable places" means 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.

Appendix B: Office of Health Equity – Organization Chart



California Department of Public Health Office of Health Equity



Updated: October 2012

Appendix C: California Demographics

In 2010⁴, the total California population was 37,253,956. Approximately 59.8 percent, or more than 22.3 million persons, identified as belonging to a racial or ethnic minority population. 40.1 percent were White, 37.6 percent Hispanic or Latino, 12.8 percent Asian, 0.3 percent Native Hawaiian and other Pacific Islander, 5.8 percent Black or African American, 0.4 percent American Indian and Alaska Native, and 2.8 percent some other or two or more races. During the 10 year period between 2000⁵ and 2010, the Asian, Hispanic, Native Hawaiian and other Pacific Islander and two or more races population groups increased by 30.9 percent, 27.8 percent, 23.9 percent and 7.3 percent respectively while American Indian and Alaska Native, White, Black or African American population groups decreased by 9.3 percent, 5.4 percent, and 0.8 percent, respectively.

Among Californian population, 6.8 percent were under 5 years old, 25.0 percent under 18 years old, 70.4 percent age 21 and above, 22.2 percent age 55 and above, 16.3 percent age 60 and above, and 11.4 percent age 65 and older. The Hispanic or Latino population is relatively young and exhibits the highest percentage of children, ages under 5 years and under 18 years, at 9.6 percent and 33.9 percent respectively and the lowest percentage of elderly (age 60 and above and 65 and above) at 8.0 percent and 5.3 percent respectively compared with other racial and ethnic groups. In comparison, Whites constitute an aging population, with the highest percentage of elderly (age 60 and above and age 65 and above) at 24.7 percent and 17.6 percent respectively and the lowest percentage of children (under 5 years and under 18 years) at 4.3 percent and 17.0 percent respectively.

During the period between year 2000 and 2010, Hispanic or Latino had the highest percentage increased among children under 5 years old and under 18 years old (13.6 percent and 17.4 percent respectively) while Black or African American had the highest percentage decreased under 5 years old (18.9 percent) and American Indian and Alaska Native had the highest percentage decreased under 18 years old (24.2 percent). The highest percentage of elderly population increased was among Native Hawaiian and other Pacific Islander (age 55 and above: 80.6 percent and age 60 and above: 78.7 percent).

Of the total population, 50.3 percent or 18.7 million was female. Among the female racial and ethnic groups: 50.2 percent were White, 49.5 percent Hispanic or Latino, 52.7 percent Asian, 50.4 percent Native Hawaiian and other Pacific Islander, 50.6 percent Black or African American, 50.5 percent American Indian and Alaska Native, and 50.9 percent some other or two or more races. Overall female population increased by 10.2 percent between the years 2000-2010. Female population among Asian, Hispanic or Latino, Native Hawaiian and other Pacific Islander, and two or more races increased by 32.8 percent, 29.6 percent, 25.4 percent and 8.8 percent respectively. American Indian and Alaska Native, White and Black or African American female population decreased by 9.7 percent, 6.2 percent and 1.5 percent respectively.

In 2010⁶ the estimated foreign born population in California was 9.9 million (27.0 percent). Of this total, 58.3 percent were Hispanic or Latino followed by Asians (25.4 percent). Among these population groups, Hispanic or Latino had the highest percentage of foreign born, citizen by naturalization, (40.1 percent) followed by Asians (36.6 percent). The highest percentage of

⁴ California Department of Finance, Demographic Research Unit, 2010 Census data, State Census Data Center.

⁵ California Department of Finance, Demographic Research Unit, 2000 Census data, State Census Data Center.

⁶ Current Population Survey Data: March 2010, Department of Census.

foreign born, not a citizen of the United States, was Hispanic or Latino (72.5 percent) followed by Asians (16.6 percent). According to the CDPH Refugee Health Program, CDPH, there were 10,299 refugee arrivals from different countries in federal fiscal year 2010. Of this total, most of the refugees who arrived to California were Arabic (21.6 percent) followed by Armenian (17.4 percent).

In California, Whites reported the highest “excellent” health (37.0 percent), followed by Hispanics (34.5 percent), Blacks (28.3 percent), Asians (27.8 percent), Hawaiian/ Pacific Islanders (27.6 percent), and American Indians (24.5 percent). At the other extreme, American Indians reported the highest “poor” health (11.13 percent), followed by Asians (3.6 percent), Blacks (3.6 percent), White (3.4 percent), and Hispanics (2.7 percent). Concurrently, Hispanics reported the highest percentage of persons “not covered” by health insurance (30.8 percent), followed by Blacks (17.8 percent), Asians (16.7 percent), and Whites (11.5 percent).⁷

In 2010⁸, the percentage of owner-occupied housing units was highest for Whites (64.3 percent) and the highest percentage of renter-occupied housing units was highest for Black or African American (62.6 percent). In households, the percentage of children (own child) under 18 years was highest among Hispanic or Latino population group (48.9 percent) and lowest for Native Hawaiian and Other Pacific Islander (0.3 percent) compared with other racial and ethnic groups. The percentage of other relatives living in the household was highest (55.9 percent) for Hispanic or Latino compared with other racial and ethnic groups.

To better understand the context of disparities *in vulnerable communities* defined as racial and ethnic communities, women, persons with disabilities, and the LGBTQ communities in California, it is important to understand more about California’s population.

In 2009⁹:

- In California, racial and ethnic communities were more likely to be uninsured. 37.4 percent of Californian adults who did not speak English well or not at all were uninsured, compared to 18.3 percent of those who spoke English very well. 23.1 percent of American-Indian/Alaska Natives, 22 percent of Latinos, 16.9 percent of Native Hawaiian/Pacific Islanders, 14.8 percent of African Americans, and 11.4 percent of Asians were uninsured.
- Of the California population about 6.5 percent or 1.8 million had serious psychological distress. The higher percentages of persons who had serious psychological distress (23.4 percent) were in the lowest income level (0-99 percent FPL¹⁰) and in grade 12 at 26.3 percent compared with other education levels. About 14.3 percent of the population needed help for emotional or mental health problems or use of alcohol and/or drug. This percentage was higher among African Americans (16.6 percent) and Whites (16.0 percent). About 8.7 percent of the population seriously thought about committing suicide with the higher percentages among American-Indian/Alaska Natives (13.0 percent) and African Americans (11.4 percent).

⁷ Current Population Survey Data: March 2010, Department of Census.

⁸ California Department of Finance, Demographic Research Unit, 2010 Census data, State Census Data Center.

⁹ California Health Interview Survey (CHIS): web page: <http://www.chis.ucla.edu/main/default.asp>

¹⁰ The set of minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. In the United States, this level is determined by the Department of Health and Human Services. FPL varies according to family size. The number is adjusted for inflation and reported annually in the form of poverty guidelines. Public assistance programs, such as Medicaid in the U.S., define eligibility income limits as some percentage of FPL.

- Approximately 27.4 percent or 7.6 million persons in California had a disability¹¹. American-Indian/Alaska Natives had the highest percentage at 47.2 percent followed by African Americans at 30.1 percent. Among the persons with disabilities 55.5 percent had serious psychological distress and 45.8 percent thought about committing suicide, 43.2 percent needed help for emotional and mental health problems or use of alcohol and/or drug. About 43.0 percent were in 0-199 percent federal poverty level (FPL).
- An estimated 3.2 percent or 0.8 million persons of California's population identified themselves as gay, lesbian, bisexual, or homosexual. Of these population groups, the bisexual group had the highest percentage of serious psychological distress at 4.7 percent followed by gay, lesbian or homosexual (2.5 percent). The bisexual group had the highest percentage (41.7 percent) needing help for emotional or mental health problems or use of alcohol and drug followed by gay, lesbian, or homosexual at 33 percent. The bisexual population group had the highest percentage (4.5 percent) who seriously thought about committing suicide followed by gay, lesbian, or homosexual at 3.2 percent. Among the gay, lesbian, or homosexual population groups, about 71.9 percent fall within the highest income level of 300 percent and above FPL. About 26.1 percent of these population groups completed a BA/BS degree and the bisexual group completed the highest percentage of some college education (26.9 percent).
- About 65.6 percent of Californian women had 2 or fewer annual mammogram screening tests. Latino women (56.9 percent) had received 2 or fewer mammograms, with 33.4 percent reporting they never had a mammogram. Asian women are the largest group failing to receive Pap tests (21.0 percent). Among women 52.3 percent were at 0-99 percent FPL, and about 50.5 percent of women had received no formal education.

¹¹ Disability status due to physical, mental or emotional condition.

Appendix D: Data Agenda for the Office of Health Equity

HRSU begins working and analyzing relevant databases to identify health and mental health disparities among the vulnerable population groups defined in the Assembly Bill 1467 - Section 131019.5.

- (1) "Determinants of equity" mean social, economic, geographic, political, and physical environmental conditions that lead to the creation of a fair and just society.
 - Social and Economic: Education and Income
Educational attainment and family or household income are two indicators used commonly to assess the influence of socio economic circumstances on health.

Data sources: US Census, Current Population Survey (CPS), California Health Information Survey (CHIS)
 - Geographic and physical environmental conditions
Healthy homes are essential to a healthy community and population. They contribute to meeting physical needs (e.g., air, water, food, and shelter) and to the occupants' psychological and social health. Housing is typically the greatest single expenditure for a family. Safe housing protects family members from exposure to environmental hazards, such as chemicals and allergens, and helps prevent unintentional injuries.

Data sources: US Census, American Housing Survey (AHS), California Department of Housing (CDH), California Department of Finance (CDOF)
- (2) "Health equity" - All people have full and equal access to opportunities that enable them to lead healthy lives.
Data sources: All data sets that can be analyzed access to care including Medi-Cal (MC) data
- (3) "Health and mental health disparities" - Differences in health and mental health status among distinct segments of the population defined as "Vulnerable communities" include:
 - Racial or ethnic groups
Data sources: Demographic information from CDOF, US Census, CHIS, and other data sources which provide demographic information in California.
 - Women
Data sources: California Women's Health Survey (CWHS), Office of Statewide Health Planning and Development (OSHPD) Patient Discharge data (disparities in hospitalization among women), US Census, CHIS, and CPS.
 - Low-income individuals
Data sources: CDOF, US Census, CPS, and CHIS.

Maponic's data purchased from Easy Analytic Software Inc. (EASI) to create a Socio-economic status (SES) indicator to identify income levels of California's population. The

indicator will be developed based on three demographic characteristics of the ZIP code: median household income, median home value, and percent of homes occupied by owner.

- Families individuals who are incarcerated and those who have been incarcerated
Data sources: HRSU is researching the data sources for this population group.
- Individuals with disabilities
Data sources: CHIS, OSHPD
- Individuals with mental health conditions, children, youth and young adults, and seniors
Data sources: CHIS
- Immigrants
Data sources: CPS, CDOF, US Census
- Refugees
Data sources: California Refugee Program, CDPH
- Individuals who are limited-English proficient (LEP)
Data sources: Languages Spoken at Home, U.S. Census data, 2010 American Community Survey, Public Use Microdata Sample, Data provided by the Department of Finance, Demographic Research Unit; Office of Health Planning and Development, Patients Discharge Data; California Refugee Program, CDPH; DHCS Medi-Cal Eligibility Data
- Lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) communities
Data sources: CHIS

- (4) "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.
Data sources: from HiAP

Appendix E: Healthy People 2010 (HP 2010) Review

HP 2010: *Understanding and Improving Health* focused on achieving two overarching goals: (1) to increase quality and years of healthy life and (2) to eliminate health disparities. It contained 467 objectives that identified specific measures to monitor health in 28 focus areas, each representing an important part of public health. OHE will continue to analyze and track efforts to achieve HP 2010 targets by working collaboratively with state partners and community stakeholders to increase access to quality of culturally and linguistically competent health care and services. Below is the latest data available^{12,13,14} on HP 2010 targets by race and ethnicity, under the following 10 of 28 focus areas:

- 1) Cancer (HP 2010 Target = 158.6 per 100,000 population)**

African Americans continue to experience significantly higher cancer death rates than any other racial or ethnic population in the state at 221.8 per 100,000 in 2009. African American males had a higher mortality rate at 271.7, compared to African American females at 190.2. Cancer death rates for Whites were 168.8 in 2009. The *HP 2010* target for both Hispanics and Asians is being achieved as of 2009 at 114.9 and 112 respectively.
- 2) Diabetes Mellitus (HP 2010 Target = 46.0 per 100,000 population)**

Across race and ethnic groups in 2009, African Americans had the highest diabetes-related death rate. However, all groups were below the *HP 2010* target rate in 2009 with African Americans at 41.7, Hispanics at 26.9, Asians at 15.9, and Whites at 15.6.
- 3) Heart Disease (HP 2010 Target = 162 per 100,000 population)**

African Americans had a significantly higher heart disease (HD) death rate in 2009 compared to all other racial or ethnic groups at 251. African American males had a higher mortality rate at 302.5 compared to African American females at 209. The HD death rate for Whites was 177.1 in 2009, with males having the highest mortality rate at 224.4 compared to females at 139.9. Asians reported the lowest rate in 2009 at 98.6, followed by Hispanics at 121, with both of these groups meeting and exceeding the *HP 2010* objective for Heart Disease.
- 4) Cerebrovascular Diseases (HP 2010 Target = 48 per 100,000 population)**

African Americans had the highest death rate at 57.3 for cerebrovascular disease (stroke) across racial and ethnic groups in California and did not meet the *HP 2010* target in 2009. All other groups met and exceeded the Cerebrovascular Disease death rate with Whites at 37.1 followed by Asians at 34.1, and Hispanics at 31.8.
- 5) Chronic Lower Respiratory Diseases (HP 2010 Target = 62.3 per 100,000 population)**

California's White population had the highest mortality rate for chronic lower respiratory diseases (CLRD) in 2009 at 45.8, followed by African Americans at 41.8 that is more than double that of Hispanics at 17.8 and Asians at 16.4. However, the *HP 2010* target for CLRD as of 2009 is being met by all groups.

¹² All death rates showed in this section are age-adjusted death rates.

¹³ Data for Native Americans and Pacific Islanders are not available in death statistical data tables posted on the CDPH website: <http://www.cdph.ca.gov/data/statistics/Pages/DeathStatisticalDataTables.aspx>.

¹⁴ California Health Interview Survey data, 2009. Due to data limitations, Native Hawaiian and Other Pacific Islander data cannot be extracted for this category.

- 6) **Homicides (*HP 2010* Target = 2.8 per 100,000 population)**
The homicide mortality rate for African Americans in 2009 was nearly eight times more than the *HP 2010* target at 21.9, followed by Hispanics at 6.5.¹⁵
- 7) **Adults aged 20 years and older who are obese (BMI equal to or greater than 30.0 percent) (*HP 2010* Target = 15.0 percent)**
The Asian population is the only group that met and significantly exceeded the *HP 2010* target for obesity in 2009 at 6.8 percent. American Indians/Alaska Natives had nearly tripled the *HP 2010* target rate in 2009 at 43.7 percent, followed by Hispanics at 30.3 percent, African Americans at 28.4 percent, and Whites at 21.2 percent.
- 8) **Adults aged 18 years and older who engage in no leisure-time physical activity (*HP 2010* Target = 20.0 percent)**
American Indian/Alaska Natives is the only group that did not meet the *HP 2010* target for adults aged 18 years and older who engage in no leisure-time physical activity in 2009 at 20.4 percent. Asians met the objective at 17.3 percent, followed by African Americans at 16.3 percent, Hispanics at 15.2 percent, and Whites at 12.1 percent.
- 9) **Cigarette smoking by adults (*HP 2010* Target = 12.0 percent of persons aged 18 years and older)**
The Asian population is the only group that met and exceeded the *HP 2010* target for cigarette smoking by adults in 2009 at 10.2 percent. American Indian/Alaska Natives had double the *HP 2010* target rate at 24.2 percent, followed by African Americans at 16.6 percent, Whites at 14.2 percent, and Hispanics at 12.7 percent.
- 10) **Persons age under 65 with health insurance (*HP 2010* Target=100 percent)**
The *HP 2010* target was not achieved for any race or ethnic population under age 65 in California by 2009. In 2009, American Indians/Alaska Natives had the highest rate of those uninsured at 27.7 percent, followed by Hispanics at 23 percent, African Americans at 16.6 percent, Asians at 12.5 percent, and Whites at 10.5 percent.

¹⁵ For Whites and Asians, the data are not available in top 10 causes of death frequency tables posted on the CDPH website: <http://www.cdph.ca.gov/data/statistics/Pages/DeathStatisticalDataTables.aspx>.

Appendix F: Agency and Department Acronyms

AG	Office of the Attorney General
ARB	Air Resources Board
BTH	Business, Transportation and Housing Agency
CAL FIRE	Department of Forestry and Fire Protection
Cal/EPA	Environmental Protection Agency
Caltrans	Department of Transportation
CDCR	Department of Corrections and Rehabilitation
CDE	Department of Education
CDFA	Department of Food and Agriculture
CDPH	Department of Public Health
CSD	Department of Community Services and Development
DGS	Department of General Services
DOF	Department of Finance
DOR	Department of Rehabilitation
DOC	Department of Conservation
DSS	Department of Social Services
EPA	Environmental Protection Agency
F2S	Taskforce Farm to School Taskforce
HCD	Department of Housing and Community Development
OPR	Governor's Office of Planning and Research
OTS	Office of Traffic Safety
Parks	Department of Parks and Recreation
PIA	Prison Industry Authority
SCO	State Controller's Office
SGC	Strategic Growth Council