Demographic Report on Health and Mental Health in California

Reporting Data through July 31, 2024 to the Legislature and the People of California by the Office of Health Equity, California Department of Public Health

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Executive Summary

The Office of Health Equity (OHE) was established within the California Department of Public Health (CDPH) in 2012, as outlined in Sections 131019.5 and 152 of the California Health and Safety Code. A key duty of the OHE is creating a biennial legislative report on health and mental health inequities. Health and mental health disparities are differences in health status among different groups. These differences can occur by age, race, ethnicity, sexual orientation, gender identity, income level, educational attainment, disability, geographic location, or combinations of these and other factors. Health and mental health inequities are differences among groups created by underlying social, economic, geographic, political, and environmental factors that are systemic, avoidable—and therefore unjust and unfair. We call these underlying factors social determinants of health (SDOH). This report includes data updates from the 2023 report on key SDOH and mental health measures across the state and among marginalized groups through July 31, 2024. These data can be used to inform areas of action needed to improve the health and mental health disparities among Californians.

Highlights of findings include:

- *Income security:* Poverty in California when (defined as 200% of the federal poverty level), varies substantially by race and ethnicity. Asian American and White people have the lowest poverty rates, 21.7% and 19.5%, respectively, compared to other racial and ethnic groups (e.g., 41.5% of Latino people). When disaggregating data further according to Asian ethnicity, Hmong (47.5%), Cambodian (40.7%) and Tibetan (40.5%) people are more likely to live in poverty compared to Filipino (14.2%) and Indian (10.6%) Californians.

- *Food security:* One in nine adults in California are unable to afford enough food, and one in six California children do not always have enough to eat. People with low-incomes and who are racially-marginalized, as well as those who identify as bisexual, disproportionally experience food insecurity. Among Californians with lower incomes, food insecurity rates are higher among adults who are Native Hawaiian or Pacific Islander (59.9%), American Indian or Alaska Native (51.2%), and Black or African American (48.5%) adults have higher rates of food insecurity compared to Californians with low-income overall. Further, adults with lower incomes who identify as bisexual experienced high food insecurity rates in recent years: 51.8% in 2020, 49.1% in 2021, and 60.0% in 2022.

- *Childhood development and education:* Racial inequities in educational achievement and attainment persist across the life course. Higher proportions of children who are Black or African American (36.1%), American Indian or Alaska Native (33.1%), Latino (31.0%), and Native Hawaiian and Pacific islander (28.8%) are below third-grade reading standards, compared to California overall (24.8%). There are also lower proportions of adults who are Latino (15.5%), American Indian or Alaska Native (16.6%) and Native Hawaiian or Pacific Islander (21.2%) with a four-year college degree, compared to California overall (35.9%). However, within race and ethnic categories there are substantial differences in educational attainment. For example, within the Asian American category, 82.3% of Taiwanese Americans have a four-year college degree compared to 19.4% of Laotian Americans.

- *Housing:* Black or African American and Latino households experience a disproportionately high burden of housing costs: 57.9% of Black or African American renters and 53.2% of Latino renters spend more than 30% of their income on housing in comparison to 50.5% of California renters overall. These findings, using the most recent data available (2016 to 2020), are similar to those using 2015 to 2019 data.

- *Air pollution and climate change:* Black or African American and Latino people are exposed to ultrafine particles, nitric oxide and nitrogen dioxide at median concentration levels 8.0% to 30.0% higher than the overall population average. White, multiracial, and American Indian or Alaska Native groups report the highest self-reported experiences of extreme weather-related events in the past two years, 54.8%, 54.5% and 52.3%, respectively, compared to the Californian population overall (42.2%).

- *Built environment:* Barriers to the creation of more active transportation infrastructure, which enhances bicycling and walking, and safety

concerns. Certain communities report safety concerns disproportionately, with Black or African American children three times more likely to report feeling less safe in nearby parks and playgrounds compared to White children.

- *Access to health care:* Despite overall improvements in health insurance coverage, racial inequities persist. From 2014 to 2022, the proportion of Latinos who were uninsured was higher than other racial and ethnic groups. Immigration status also plays a role: in 2022, non-naturalized immigrants under 65 were nearly five times more likely to be uninsured than U.S. born citizens of the same age, at 19.4% and 4.2%, respectively.

- *Prevention efforts:* Colorectal cancer screenings are effective in detecting and treating cancer early. The U.S. Preventive Services Task Force (USPSTF) recommends that all adults be screened for colorectal cancer starting at age 45 up until age 75, with careful consideration of pros and cons among those 76 to 85. In 2022, Latino people were less likely to obtain recommended tests for colorectal cancer screening.

- *Experiences of discrimination:* According to 2021-2022 data, 25.0% of Black or African American and 13.0% of Latino adults in California reported experiencing unfair treatment in the health care setting due to their race and ethnicity, compared to 8.0% of adults overall. This is an increase from 2016-2017, when 14.0% of Black or African American and 6.7% of Latino adults reported experiencing unfair treatment in medical care, compared to 5.1% of Californians overall.

- *Neighborhood safety:* Safe neighborhoods are essential to community mental and physical health and health equity, as neighborhood safety influences residents' ability to be physically active, maintain social connections, and experience positive health outcomes. In 2022, 33.2% of adults perceived their neighborhood to be safe all of the time, compared to 50.5% in 2018. Perceptions of neighborhood safety differed by racial and ethnic groups in 2018 to 2022: Asian (31.6%), Black (33.7%), Latino (35.6%), and multiracial (34.3%) groups were less likely than California-adults overall (38.3%) to report feeling safe in their neighborhood all the time.

- *Linguistic competency and access to health care:* Compared to adults who speak English very well, adults with Limited English Proficiency (LEP) are more likely to report fair or poor health (40.9% versus 15.4%), and to lack current health insurance (17.4% versus 9.6%). Persons with LEP may

experience more barriers to accessing health care, health care coverage, and have more difficulty communicating with their providers.

- *Culturally competent health care:* The demographic composition of the health care workforce is not representative of the racial and ethnic diversity of the California population, a key aspect to providing culturally competent care: Latino people represent 39.5% of California's population but are underrepresented in every category within the health care workforce (e.g., medicine, nursing, oral, behavioral, mental, and allied health). Black or African American people, 5.4% of the state's population, account for 3.6% of physicians according to US Census Bureau 2021 data.

- *Mental health:* According to 2021 to 2022 data, individuals who identify as transgender or gender non-conforming reported the highest percentage of ever having suicidal thoughts (55.5%), compared to all race, ethnic, sexual orientation and gender identity groups. When analyzed by sexual orientation for the same years, individuals who identify as bisexual are more likely to experience suicidal thoughts (48.5%), followed by those who identify as gay or lesbian (35.4%). When analyzed by citizenship status for the same time period, naturalized- (10.4%) and non-naturalized citizens (12.5%) experienced the lowest rates of suicide ideation, compared to U.S. born citizens (22.5%) living in California.

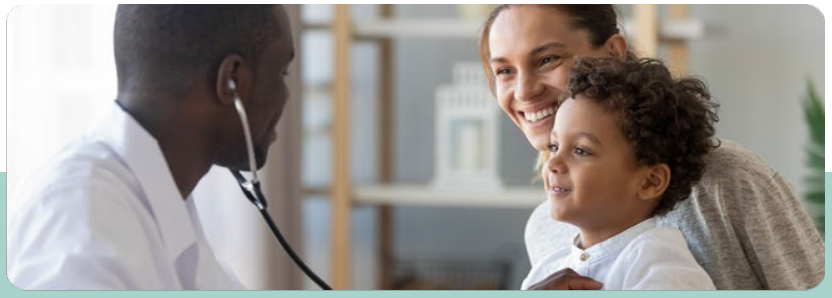
The patterns shown across multiple indicators underscore the structural barriers many of California's groups that have been marginalized, particularly those who are racially marginalized, face to achieving optimal health. They also show that more work is needed to identify underlying drivers of these inequities to strengthen California's commitment to achieving health equity through data-informed action.

Introduction

CDPH is committed to improving physical and mental wellbeing and achieving health equity throughout California, particularly in underserved communities. One way to promote health equity is to ensure that published data more accurately reflects the diversity of demographic characteristics in California. The Office of Health Equity (OHE) was established within the California Department of Public Health (CDPH) in 2012, as outlined in Sections 131019.5 and 152 of the California Health and Safety Code. A key duty of the OHE is creating a biennial legislative report on health and mental health inequities. Where data are available and show meaningful results, we present data in this updated report by various characteristics such as race, sexual orientation, gender identity, citizenship status and disaggregated Asian and Black or African American ancestry. To ensure we could report on the most nuanced data available, we used high-quality data sources available as of July 2024, such as the U.S. Census Bureau American Community Survey and the California Health Interview Survey. Additional information on data sources and statistics in this report are available in a separate Technical Report.

We acknowledge that self-identified race and ethnicity are social constructs that reflect both individual identity and the complex relationships between different groups of people; they are proxy measures of sociocultural factors that influence health and mental health. We use varied definitions of racial and ethnic categories, depending on the data source. Thus, while this report presents data by demographic characteristics like race, ethnicity, and income level, the characteristics themselves are not the cause of health inequities. Rather, they are markers that help identify inequities and what groups are most impacted. The true drivers of health inequities are systemic factors, including historical and ongoing structural racism, residential segregation, income inequality, unequal access to quality education and healthcare, and discriminatory policies and practices that compound over time. Simply documenting health disparities by demographic groups without examining the underlying structural drivers, risks reinforcing negative stereotypes and stigma. This report aims to illuminate the markers that help measure inequities to inform the development of effective solutions.

By providing data-driven understanding of the magnitude and distribution of SDOH, this report aims to help mobilize the understanding of and sustain the commitment to improvements in health equity in California. Working with the OHE Advisory Committee and other partners within and external to CDPH, OHE will continue to strive for its vision of everyone in California having full and equal access to opportunities for optimal health, and its mission of promoting equitable social, economic, and environmental conditions to achieve optimal health and mental health for all.




Income Security

Key Points to Consider:

- **Income and Health:** How much money people make dramatically impacts their health. People with higher incomes usually have better health and live longer lives.
- **Income Gap:** The difference between what the rich and the poor make has become more prominent over time. In California, the wealthiest people have seen their income increase by 59.0% since 1980, while the poorest have only seen a 13.0% increase.
- **Income Disparities:** In California, income differences are still a big issue, especially for families led by single women. About one in five (20.5%) of these families live below the poverty line, while only 5.1% of married couples with children do. These income differences are even worse for some racial and ethnic groups, showing how income and race can combine to create more significant challenges.

Income security is defined as adequate income to support a standard of living now and in the foreseeable future. The consequences of income insecurity include higher rates of mortality, chronic and acute diseases and mental health disorders, compared to those who are income secure. [1-3]

California Income Disparities

The income gap in California ranks eighth highest in the nation. In 2022, families at the 90th percentile of income earned 10 times more than those at the 10th percentile ($305,000 versus $29,000), before accounting for taxes and safety net programs. Since 1980 the income gap has widened as incomes in the 90th percentile have increased by 59.0%, while those in the 10th percentile only grew by 13.0%. While the income inequality gap narrowed slightly between 2021and 2022 during the COVID-19 pandemic, by 2022 the gap was wider than it had been in 2019.[4]

Income security differs, depending on the measure used. The official poverty measure is calculated using pretax income to a poverty threshold determined by family composition. Using this measure, the percentage of people in poverty in California has remained about the same in recent years from 11.0% (2019-2021) to 11.4% (2020-2022) and is comparable to the national poverty rate in 2022 (11.5%).[5, 6] When using the supplemental poverty measure (SPM), California's poverty rate (13.2%) is greater than the national poverty rate of 9.8%.[6] The SPM provides a more complete picture as it incorporates the cost of housing, taxes, non-cash benefits, and day-to-day costs such as childcare, work-related expenses, utilities, clothing, and medical costs.

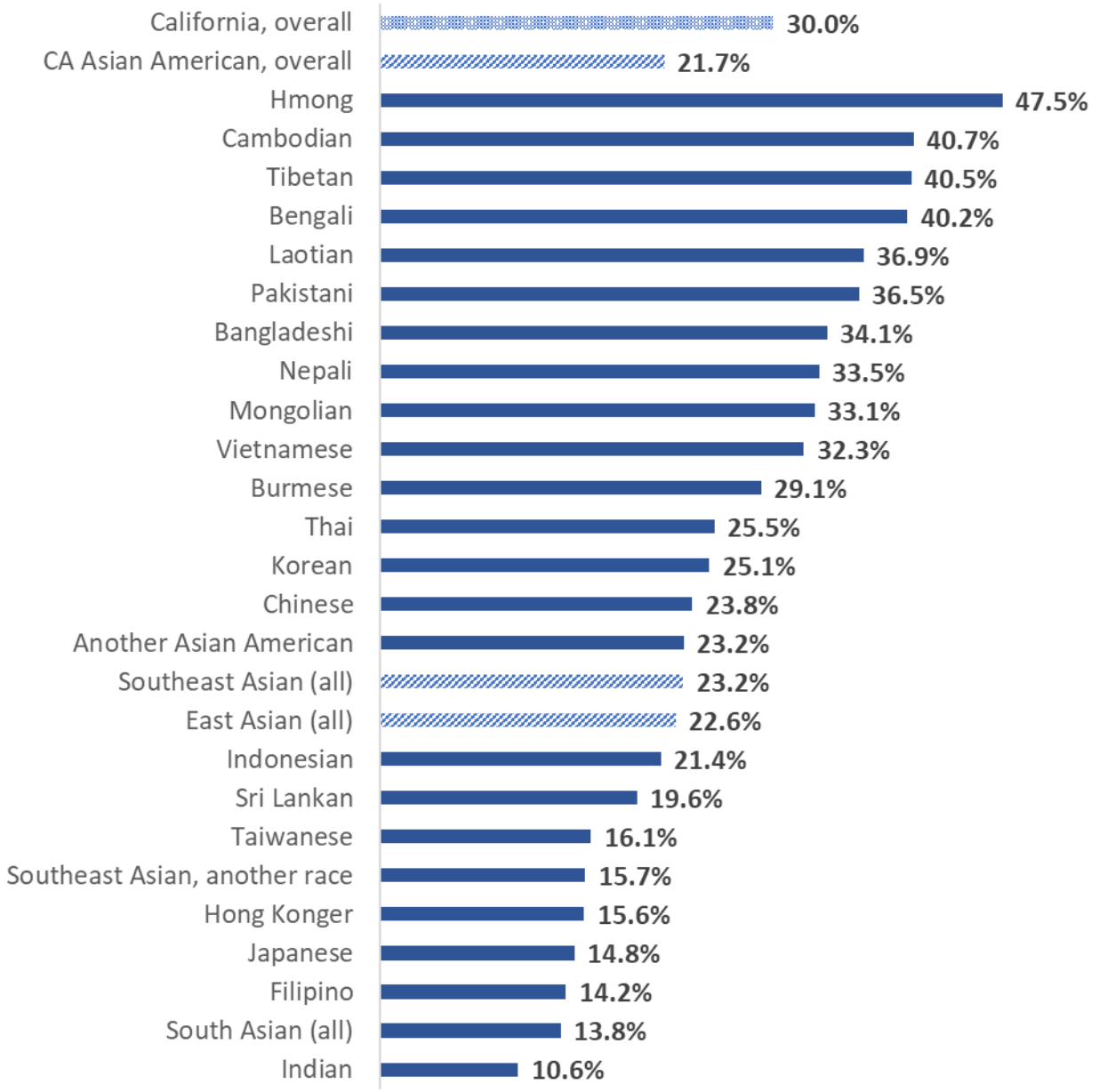
California poverty, when defined as 200% of the federal poverty level (FPL), varies substantially by race and ethnicity. Asian American and White people have the lowest poverty rates, 21.7% and 19.5%, respectively, compared to other racial and ethnic groups (e.g., 41.5% of Latino people).[7] When disaggregating data further according to Asian ancestry (**Figure 1**), Hmong (47.5%), Cambodian (40.7%) and Tibetan (40.5%) Californians are more likely to live in poverty compared to Filipino (14.2%) and Indian (10.6%) Californians.

The Gender Wage Gap

In addition to race and ethnicity there are also disparities in income by gender in California. In 2021, women earned 81.0% of men's earnings. Furthermore, women earn less than men in every industry. The gender-wage gap is greater for women experiencing societal, systemic and historical oppression, such as Latina and Black women who earn 44.0% and 58.0%, respectively, of what White men earn.[8]

Inequities in income are evident among family households in California headed by single women — approximately one in five (20.5%) are below the FPL compared to 5.1% of married couples with children (**Figure 2**). Although the overall proportion of single-female households has remained relatively stable since 2010, [9] higher proportions of American Indian or Alaska Native (22.7%), Black or African American (23.5%), and Latina (25.3%) female-headed households are in poverty, whereas 18.0% of White and 14.0% of Asian American female-headed households live below the FPL (**Figure 2**).

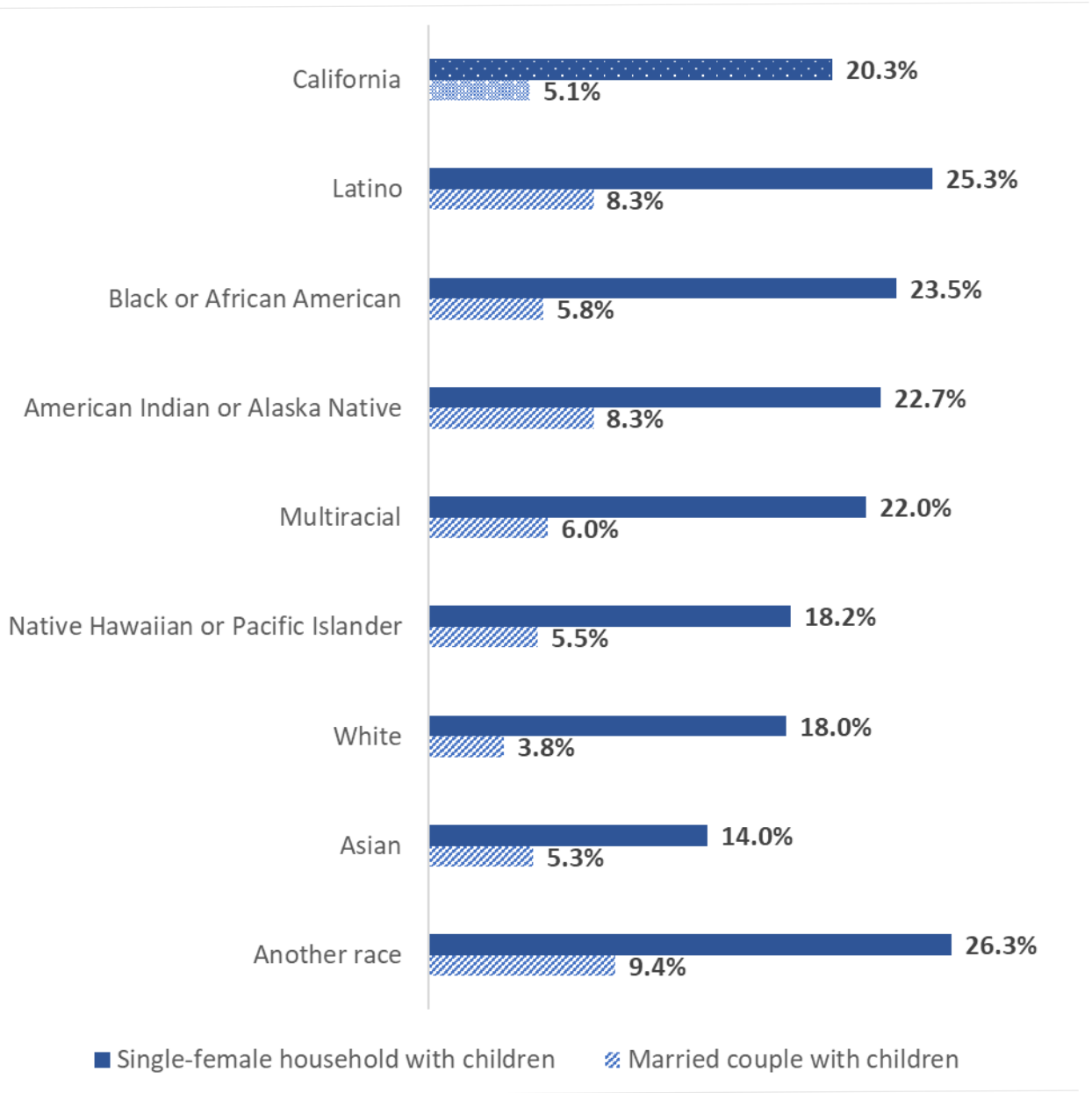
Figure 1: Percentage of Californians in poverty, by Asian ancestry, 2016-2020. Among Asian Californians, those with Hmong, Cambodian, Tibetan, and Bengali ancestry have the highest percentage of individuals living in poverty (below $52,500 a year for a family of 4).



Source: National Equity Atlas analysis of U.S. Census Bureau, American Community Survey Data

Note: Poverty is defined as income below 200% of the federal poverty level. In 2020, the 100% federal poverty level for a family of four including two children was $26,250, doubled to $52,500 for this analysis.

Figure 2: Percentage of families whose income in the past 12 months was below the federal poverty level, by race, ethnicity and household status, California, 2018-2022. Single-female households with children, particularly those of Latino, Black or African American, and American Indian or Alaska Native backgrounds, experience disproportionate rates of poverty compared to other demographic groups.



Source: U.S. Census Bureau, American Community Survey, 5-year estimate (2018-2022); Table S1702, Poverty Status in the Past 12 Months of Families.

Food Security and Nutrition

Food security, defined as stable access to affordable, sufficient, and nutritious food for an active, healthy life, is a basic human right.[1] Yet in California, too many people cannot afford to put enough food on the table. Recent data shows, 11.2% of California adults faced difficulty having enough to eat, similar to the national rate of 11.4%.[2] Children also experience high rates of food insecurity. In this regard, California fares slightly better than the national average, with 16.9% of the state's children experiencing food insecurity compared to 18.5% of children nationwide.[3]

Food Insecurity and Health

Individuals experience food insecurity across different age groups, with significant impacts on both adults and children. In adults up to age 65, it is associated with reduced nutrient intake, increased mental health issues including depression, and a higher prevalence of chronic conditions.[4, 5] The effects extend to psychological well-being in adults [6] and college students [7] with low-incomes, as they experience elevated levels of psychological distress.
Children face equally serious consequences, as food-insecurity puts them at a greater risk for various health issues. These include anemia, unhealthy diet quality, cognitive difficulties, aggression, anxiety, hospitalization, poor general health, asthma and poor oral health.[4]

Key Points to Consider:

- **Food Insecurity and Health:** Not having enough food affects many Californians, leading to serious health problems. About 1 in 9 adults (11.4%) and 1 in 6 children (16.9%) don't always have enough to eat, resulting in less nutritious diets, mental health issues, and long-term illnesses.

- **Lower-Income Food Struggles:** Money plays a big role in who has enough food. For Californians with lower incomes, about 4 in 10 (40.0%) struggle to get enough food. This problem hits certain groups harder, like Native Hawaiian or Pacific Islander communities and adults who identify as bisexual.

- **Food Deserts and Swamps:** Where people live affect what they eat. About 2.7 million Californians live in areas called "food deserts" where it's hard to find healthy food. Many areas also have too many unhealthy food choices, called "food swamps." These neighborhood food problems can lead to more obesity and diabetes.

Food Insecurity Disparities

A large proportion (40.0%) of adults with lower-incomes experience food insecurity in California, but its impacts vary across

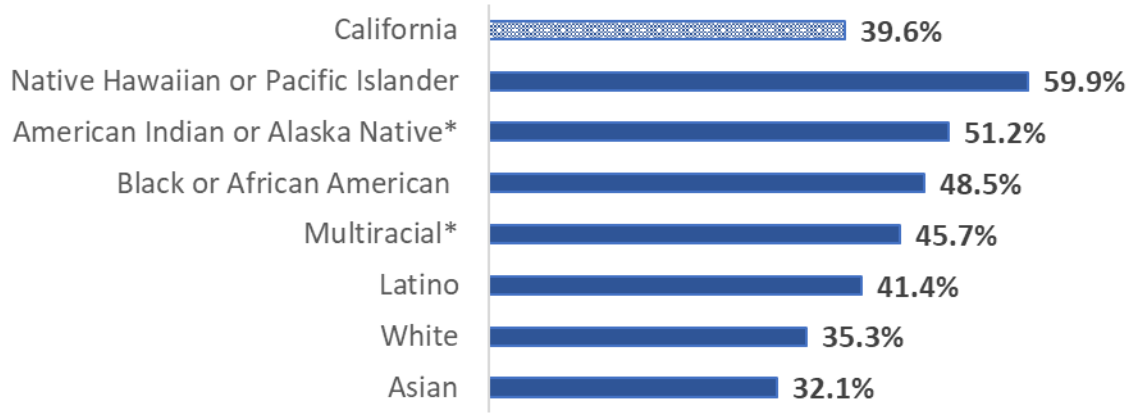
demographic groups. Among populations with lower incomes, Native Hawaiian or Pacific Islander, and Black or African American adults experience disproportionately higher rates of food insecurity compared to Californians overall (**Figure 3**).

There is growing research in sexual minority groups documenting greater food insecurity compared to their peers who identified as straight.[8, 9] Utilizing California Health Interview Survey data, lower income adults who identify as bisexual adults had higher food insecurity rates in recent years: 51.8% in 2020, 49.1% in 2021, and 60.0% in 2022. These percentages were above those of other sexual orientation groups (**Figure 4**). These results mirror other studies that found that people who identified as bisexual had higher rates of food insecurity compared to other sexual orientation groups.[10] Bisexuals may experience higher rates of poverty, discrimination, violence and stigma compared to other sexual minority groups.[10]

Food insecurity in California is prevalent in rural and urban areas, with an estimated 2.7 million Californians residing in geographic areas that are both low-income and with limited access to healthy foods.[11] These "food deserts" defined by the U.S. Department of Agriculture as areas "with limited access to affordable and nutritious food, and composed of predominantly lower-income communities" may impact diet and chronic disease.[12] The relationship between food store availability and diet and health outcomes were mixed.[13] More research is needed on the impacts of opening food stores in food deserts on health, economics and quality of life.

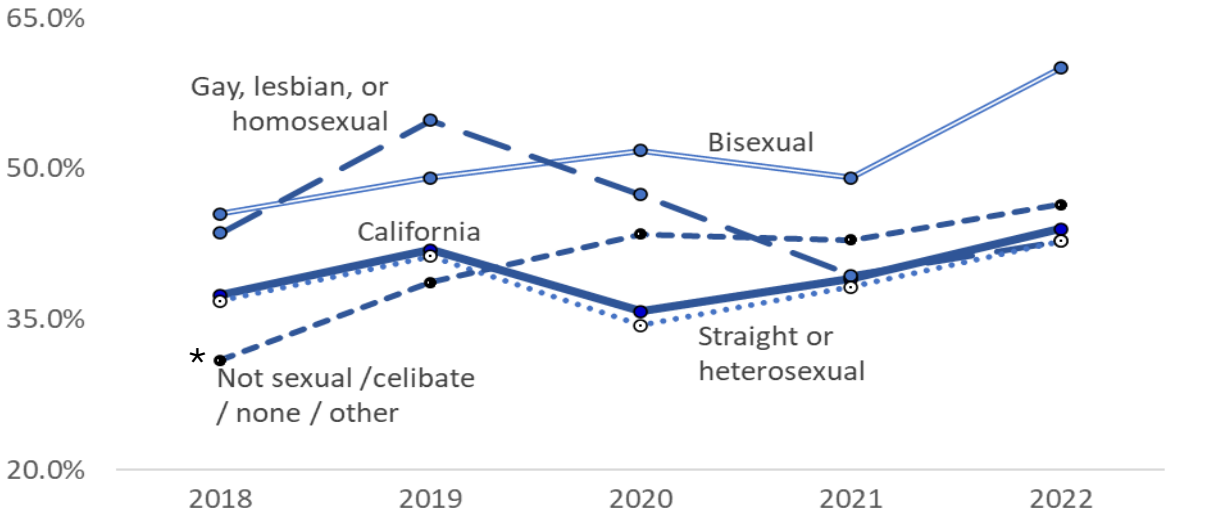
Simultaneiously, many communities face an overabundance of fast-food restaurants and convenience stores relative to supermarkets and produce vendors, creating "food swamps" associated with higher rates of obesity and diabetes-related hospitalizations.[14-16]

Figure 3: Percentage of Californian adults with low-income who are unable to afford enough food, by race or ethnicity, 2018-2022. Native Hawaiian or Pacific Islander adults in California experience the highest rate of food insecurity at 59.9%, significantly above the state average of 39.6% and nearly double the rate for Asian adults at 32.1%.



Source: University of California Los Angeles, California Health Interview Survey
*Values overlap with the California average and therefore may not be statistically different

Figure 4. Percentage of Californian adults with low-income that were unable to afford enough food, by sexual orientation, 2018-2022. Adults who identify as bisexual adults in California experience higher rates of food insecurity in 2020 to 2022 compared to other sexual orientation groups reaching 60.0% by 2022.



Source: University of California Los Angeles, California Health Interview Survey
* Statistically unstable

Child Development and Education

Key Points to Consider:

- **Childhood Shapes Our Future:** The first years of life are critical. They set the stage for our health, success, and happiness as adults. Quality early education programs have great impact, especially for kids from underserved communities.

- **Education Gaps Start Early:** In California, not every child gets a fair shot at success. We see this in reading levels as early as third grade, where students with lower incomes struggle more than their peers. These gaps widen through high school and college, affecting entire communities for generations.

- **Tough Childhoods Don't Hit Everyone Equally:** Some of our kids face more adversity than others. American Indian, Black, Latino youth, and children who identify as LGBTQ+ are more likely to experience multiple Adverse Childhood Experiences (ACEs). These early hardships can lead to lifelong health and social challenges. California has set an ambitious goal: to cut ACEs in half within one generation. This isn't just about helping kids—it's about breaking cycles of disadvantage and building a resilient, thriving state for all.

This section examines the connection between early childhood experiences, educational outcomes and long-term health and well-being in California. It highlights disparities across various demographic groups in areas such as early education, reading proficiency, high school graduation rates, and college degree attainment, while also discussing the impact of Adverse Childhood Experiences (ACEs) on lifelong health and success.

The foundations for lifelong health, prosperity, and well-being are formed from birth to age 12. Early childhood experiences significantly influence education and health disparities.[1, 2] Early development shapes skills directly affecting physical and mental health, including health literacy, self-discipline, decision-making, eating habits, and conflict negotiation.[3, 4]

Educational Pathways

Providing high-quality educational and developmental care for infants and toddlers during their critical early years is one of the most effective ways to support healthy childhood development. Early childhood education programs and centers play a crucial role in fostering the cognitive and social growth, particularly in communities that are underserved, with helping to advance health equity from the earliest stages of life.[5] These programs, such as licensed daycares, Head Start or

transitional kindergartens, can help bridge educational gaps, leading to improvements in adult health later on.[6] When children lack these opportunities, the effects begin to show in later childhood educational performance metrics like reading proficiency. In California, despite overall improvement in third-grade reading standards (24.8% below reading standard in 2022-23 versus 29.5% in 2018-19), significant gaps persist.[7, 8] For instance, 31.9% of economically disadvantaged third-graders were reading below standard in 2022 to 2023 when data were last available, compared with 12.9% of higher-income peers.[7] Similar reading-level gaps exist between boys and girls, and among racial and ethnic groups (**Figure 5**).

High School Graduation Disparities

These early educational disparities are further reflected in high school graduation rates, illustrating the persistent educational inequities in California. While the state's overall graduation rate has remained the same (85.8% in 2019 to 86.4% in 2023)[9, 10] significant variations persist across racial, ethnic and social groups. African American, American Indian or Alaska Native, and Pacific Islander students, as well as English learners, students experiencing homelessness, those with disabilities, and youth in foster care all have markedly lower graduation rates.[10] These

disparities have far-reaching consequences, as research indicates that individuals who do not complete high school face higher risks of unemployment, poverty, reliance on public assistance, poor health outcomes, increased mortality, and lower civic participation compared to high school graduates.[11]

Four-Year College Degree Disparities

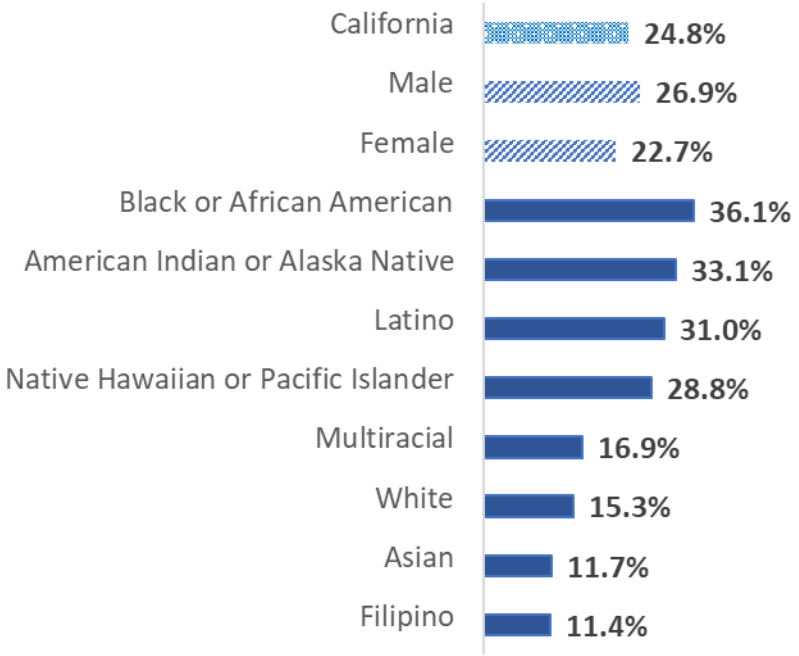
As seen in the side-by-side comparison of **Figures 5 and 6**, early educational disparities may have long-lasting impacts on later educational outcomes. Lower proportions of Black or African American, American Indian or Alaska Native and Latino groups attained a four-year college degree compared to California overall (**Figure 6**). Notably, even within the Asian American category, there is substantial variation in educational attainment, ranging from 82.3% attaining a four-year college degree for Taiwanese Americans compared to 19.4% for Laotian Americans. This wide disparity underscores the diverse experiences and outcomes within the broader Asian American community in California (**Figure 7**).

Adverse Childhood Experiences

The California Office of the Surgeon General was established in 2019, with ACEs and toxic stress among its key priorities, and the goal of reducing them by half in one generation.[12] ACEs encompass a set of categories of child abuse, neglect, and household challenges.[12] An accumulation of ACEs increases the likelihood of developing long-term health problems.[13-16] Individuals with four or more ACEs are more likely to report frequent mental distress, engage in risky behaviors and suffer from chronic diseases.[15, 16]

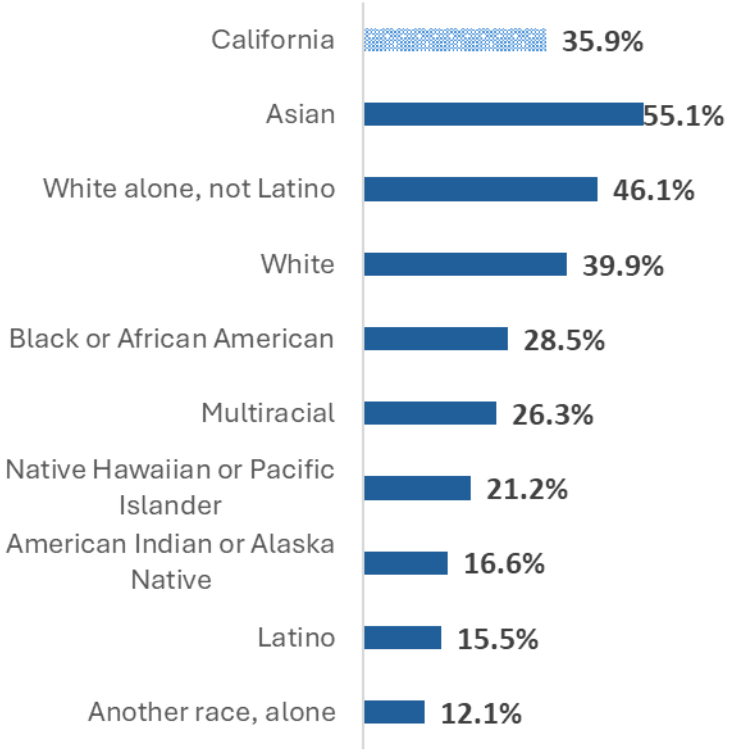
The prevalence of ACEs as accounted in adults differs by race, ethnicity, and sexual orientation.[17] In California. American Indian or Alaska Native, Black or African American, and Latino persons, were more likely to have four or more ACEs (32.1%, 24.9% and 23.0%, respectively) than Asian, Native Hawaiian or Pacific Islander and White persons (8.6%, 17.5% and 18.4%, respectively). Sexual minorities, such as bisexual (37.4%) and gay or lesbian (29.0%) individuals, had a higher prevalence of four or more ACEs.

Figure 5: Percentage of 3rd graders who are below standard in reading by race, ethnicity and gender, California, 2022-2023. Reading proficiency gaps persist among California 3rd graders, with males and Black or African American students showing the highest proportion below standard.



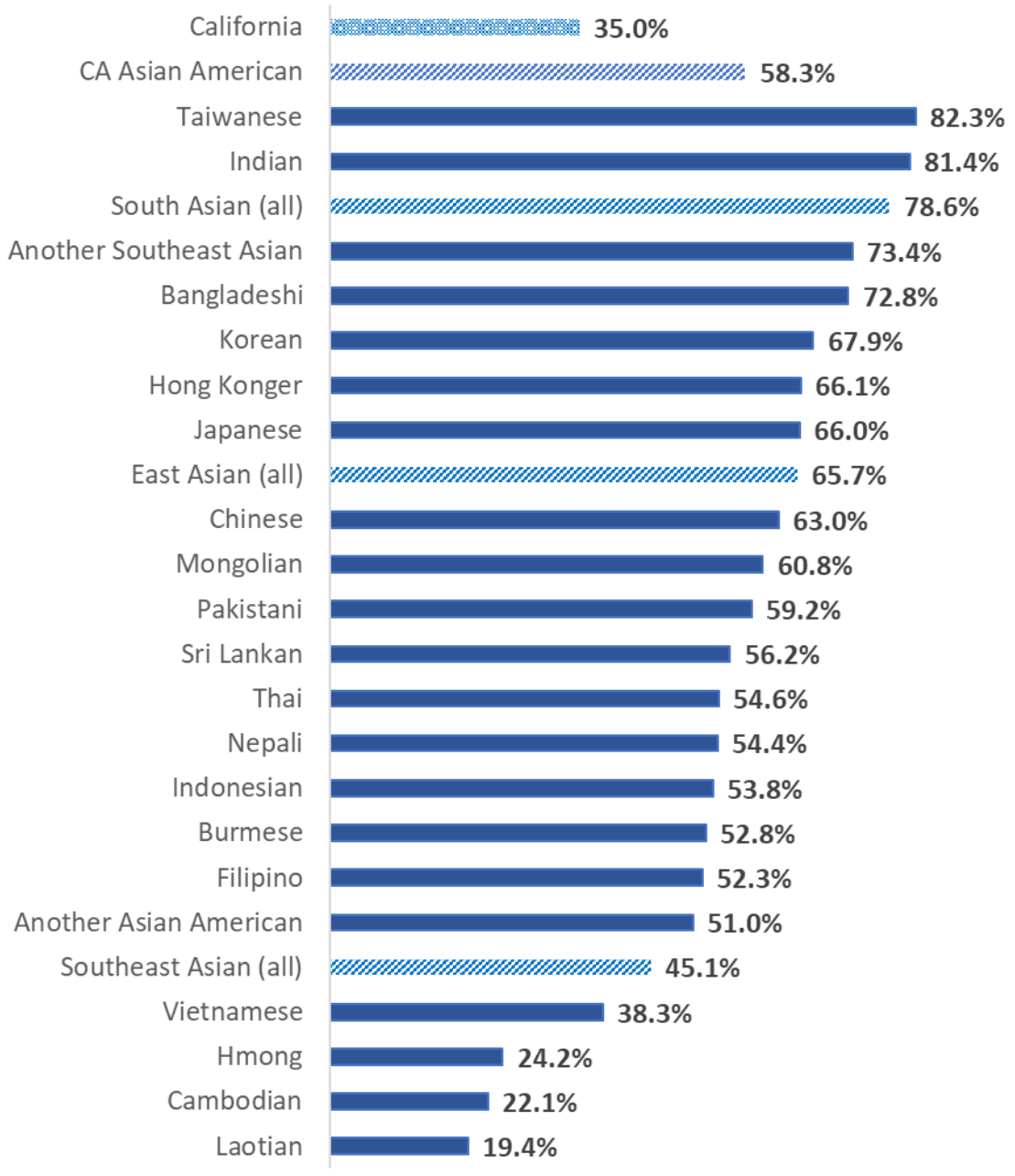
Source: California Department of Education, California Assessment of Student Performance and Progress. Reading standards portion of the English language arts/Literacy, Smarter Balanced Summative Assessments.

Figure 6: Percentage of Californians aged 25 and older attaining a bachelor's degree or higher, by race and ethnicity, 2018-2022. Asian and non-Hispanic White Californians have higher proportion of bachelor's degree completion compared to other groups.



Source: U.S. Census Bureau, American Community Survey, 5-year estimate (2018-2022) Table S1501 Educational Attainment.

Figure 7. Percentage of Californians aged 25 - 64 attaining a bachelor's degree or higher, by Asian ancestry, 2020. Attainment rates of a bachelor's degree or higher among groups of Asian ancestry in California range from 82% for Taiwanese Americans to 19% for Laotian Americans, representing a 63-percentage point difference within the broader Asian Californian category.



Source: National Equity Atlas analysis of U.S. Census Bureau, American Community Survey Data, 2016-2020.

Housing and Health

Key Points to Consider:

- **Housing Costs Hit Some Harder:** The price of having a place to live isn't the same for everyone. In California, families of Black and Latino backgrounds often spend a bigger portion of their money on rent or mortgages than California overall.
- **Housing Stability Patterns:** Long-standing structural barriers in California's housing system affect who can maintain stable, affordable housing. While 16.0% of citizens struggle to keep their housing, this rate rises to 30.0% for non-naturalized immigrants. Similar systemic inequities result in adults with American Indian or Alaska Native, Black, and Latino backgrounds having higher rates of housing instability.
- **Home Conditions and Health:** Where you live affects your health. People who don't have much money, and certain racial groups like American Indian or Alaska Native and Black people, are more likely to live in homes with structural issues (like bad plumbing) or overcrowding (too many people squeezed into a small space).

Housing as a social determinant of health encompasses a range of experiences, such as housing instability, unaffordable housing and poor housing quality. Housing instability includes being behind on rent/mortgage, and unaffordable housing is when families are cost-burdened. [1, 2] Households are considered to be cost burdened if they spend more than 30.0% of their income on housing, and severely cost burdened if they spend more than 50.0% of their income on housing. [3] Individuals experiencing housing instability, unaffordable housing or poor quality housing are more likely to have poorer physical and mental health. [2, 4, 5]

Housing Instability

Housing instability is driven by several factors, including affordability, unhealthy housing, evictions, and/or living in overcrowded situations. [1,2] In California, approximately 1 in 5 adults (18.0%) over the age of 18 felt that their housing situation was unstable. American Indian or Alaska Native, Black or African American and Latino adults had the highest housing instability rates in the state (29.0%, 26.0% and 24.0%, respectively), more than twice reported by White (11.0%) adults. Housing instability also varies by citizenship status with 30.0% of non-naturalized immigrants reported experiencing housing instability, compared to 16.0% of citizens. [5]

Unaffordable Housing

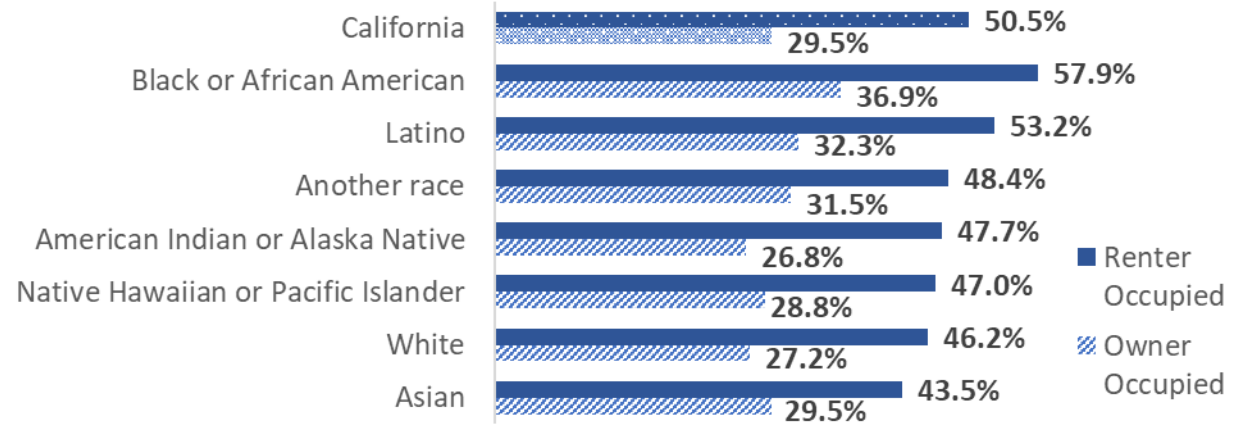
Affordable housing and homeownership are key to reducing intergenerational poverty and increasing economic mobility.

Research suggests that increasing access to affordable housing is the most cost-effective strategy for reducing childhood poverty and increasing economic mobility in the United States. [6] However, for most households, the cost of housing is the single largest expense, and is less affordable over the years: while median rent increased 37.0% since 2000, median household income for renters has only increased 7.0%. [7] When costs become unmanageable, households can fall behind on rent or mortgage payments and may face eviction.

Approximately 78.0% of renters with extremely low-income are spending more than half of their income on housing costs, compared to just 6.0% of renters with moderate-incomes. [7] Households with high housing cost burdens are considered "shelter poor," as they have less to spend on other essentials, such as food, clothing, and health care, and report lower levels of life satisfaction. [8, 9]

In California, Black or African American and Latino households experience a disproportionately high burden of housing costs: 57.9% of Black or African American renters and 53.2% of Latino renters are housing cost-burdened in comparison to 50.5% of California renters overall (**Figure 8**). These findings, using the most recent data available (2016 to 2020), are similar to those using 2015 to 2019 data where 58.2% of Black or African American renters and 54.6% of Latino renters were cost-burdened. Similar trends are observed for severely cost-burdened households. In 2016 to 2020, 33.0% of Black or African American and 27.9% of American Indian or Alaska Native renters were severely cost-burdened, compared to the state's average of 26.0%.

Figure 8: Percentage of Californians who are housing cost burdened, by homeowner status, race, and ethnicity, 2016-2020. Black or African American and Latino Americans experience a larger proportion of housing cost burden overall, especially among those who rent.



Source: U.S. Department of Housing and Urban Development, OHE analysis of Comprehensive Housing Affordability Strategy (CHAS) data, Table 9

The impact of housing cost burden is reflected in the rates of reported 'worry about struggling with rent or mortgage.' In 2022, the highest rates of such worry were observed in adults with Native Hawaiian or Pacific Islander and Latino backgrounds (62.3% and 50.7%, respectively), compared to California overall (40.5%). [5] Although 40.2% of adults with Asian ancestry worried about struggling with rent or mortgages, which was comparable to the state rate, higher rates were observed in some subgroup populations of Asian background or descent (**Figure 9**).

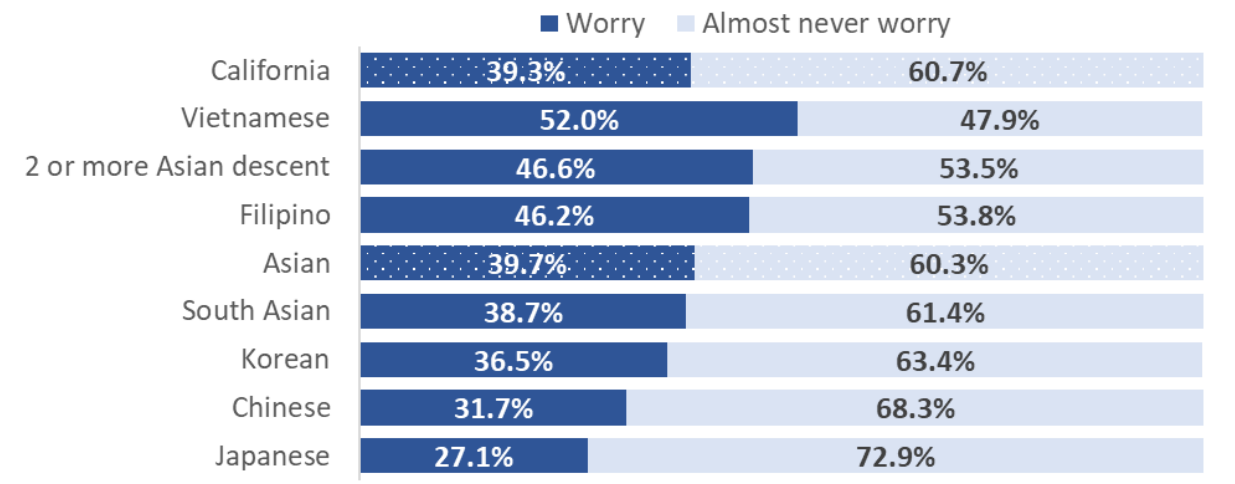
Unhealthy Housing

According to national data, homeowners with lower incomes are more likely to live in substandard housing, with plumbing, heating, cooling and/or electrical problems. Unhealthy housing also differs by race and ethnicity, as American Indian or Alaska Native (9.6%) and Black or African American (5.7%) homeowners are more likely to live in substandard housing. [8]

In California, 43.5% of households have at least one of the following housing problems: incomplete kitchen or plumbing facilities, more than one person per room, and cost burden greater than 30.0%. More than a quarter (25.7%) have at least one of four severe housing problems: incomplete kitchen or plumbing facilities, more than one person per room, and cost burden greater than 50.0%.

Disparities in housing stability, affordability, and quality across racial, ethnic, and socioeconomic groups in California highlight the close connection between housing, health, and health equity, reflecting the need for broader systemic changes to ensure stable, affordable, and safe housing for all Californians.

Figure 9: Percentage of Californians who worried about struggling with rent or mortgage, by Asian ethnicity, 2021-2022. Vietnamese Americans are almost twice as likely as Japanese Americans to worry about housing payments.



Source: University of California Los Angeles, California Health Interview Survey

Air Pollution and Climate Change

Key Points to Consider:

- **Air Pollution in California**: Six cities rank among the nation's top ten most polluted due to air quality. Climate change is worsening air quality through rising temperatures and wildfires, affecting everyone but impacting lower income communities and people of color the hardest.
- **Unequal Air Pollution Burden and Climate Impacts:** Communities of color and lower-income neighborhoods face higher pollution levels. People with Black and Latino backgrounds are exposed to 8-30% higher levels of certain air pollutants than average. Climate change is expected to worsen these existing health and economic inequities.
- **Varied Climate-Related Impacts:** The impact of climate-change related exposures and extreme weather events varies across ethnic and racial groups. White and multiracial people report the highest rates of these events (54.8% and 54.5%). Mental health impacts also differ with multiracial (15.8%) and White (13.4%) people reporting higher rates of mental health effects from extreme weather compared to the state average (8.9%).

The environment – the air we breathe; the water we drink; the soil that nourishes the food we eat; and all the natural and human-made conditions of the places we live, work, learn, and play – and the consequences of climate change have profound impacts on the health of all. [1] Climate change is defined as the long-term change in the average temperatures and weather patterns. [2] People with lower socioeconomic status, children, older adults, communities of color, Indigenous people, and those with preexisting or chronic health conditions are more vulnerable to the impacts of climate change. [3]

Polluted Air

Many California communities suffer from poor air quality. Climate change is leading to hotter and drier conditions, which can increase ozone pollution and contribute to wildfires that increase particle pollution. [4] Ozone and particle pollution are both independently hazardous to health. [5] There is also evidence that short-term co-exposure to extreme heat and air pollution are more strongly associated with risk of mortality than their individual effects, [6] which makes Californians particularly vulnerable.

Six Californian cities are among the top ten most polluted cities in the nation by ozone, six by year-round particle pollution and seven by short-term particle pollution in years 2020 to 2022. [5] In years 2019 to 2021, the same six California cities were in the top ten by ozone, and year-round air

pollution. [7] For short-term particle pollution, Los Angeles-Long Beach was no longer in the top ten most polluted cities as they were ranked #10 in 2019 to 2021 but #11 2020 to 2022. [5, 7]

Disparities in Air Pollution Burden

Pollution burdens tend to be higher in communities that are racially and ethnically minoritized and among lower-income populations. [8] The state's smoggiest cities are also the cities with the highest densities of people of color. [9] The disproportionate exposure is further concentrated in particular neighborhoods. People with Black or African American and Latino backgrounds are exposed to ultrafine particles, nitric oxide and nitrogen dioxide, at median concentrations levels 8.0% to 30.0% higher than the overall population average. [10] Communities with lower incomes are also at higher risk to air pollution. [11] Lower-income communities may lack political power and influence to inhibit factories and roads being built in their communities. [11]

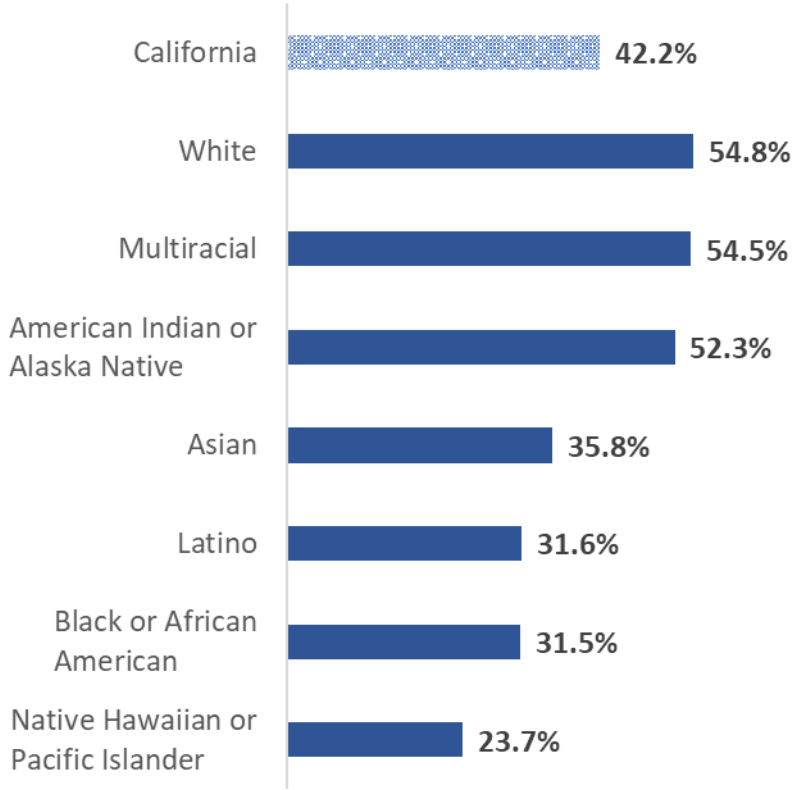
Climate Change Threatens Widening Inequities

Climate change poses significant risks to the health and mental and physical well-being of all Californians today and for generations to come, [12] although African American, American Indian and Alaska Native, Latino, and Native Hawaiian or Pacific Islander people are more vulnerable and have less capacity to adapt to climate change due to differential access to resources (e.g., afford air conditioning to reduce heat risk). [13] Extreme weather and climate-related events, such as wildfires, are predicted to damage infrastructure, ecosystems, and social systems, and exacerbate economic inequality. [12]

The percentage of Californians experiencing extreme weather events (e.g., heat, wildfire, floods) varies substantially when broken down by race and ethnicity (**Figure 10**). People with white and multiracial backgrounds report the highest extreme weather-related event experiences, 54.8% and 54.5%, respectively, compared to the population overall (42.2%). When surveyed about how mental health was affected by extreme weather-related events (**Figure 11**), multiracial (15.8%), and White (13.4%) people were more likely to report being impacted, compared to all Californians (8.9%). There are few studies examining the impact of extreme weather in diverse communities. However, research, especially longitudinal studies, on race, mental health and weather extremes is needed.

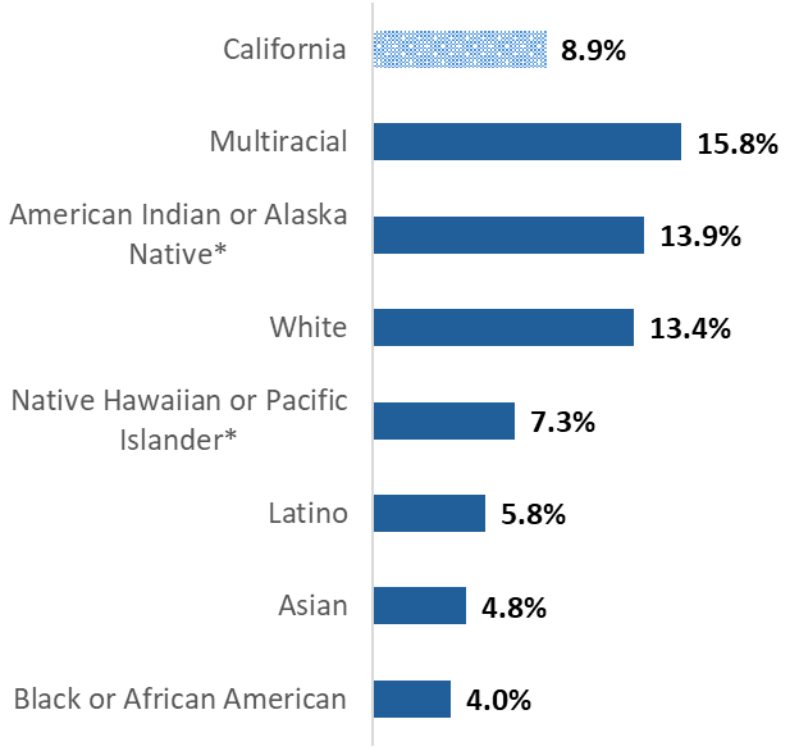
Responding to climate change through public health prevention and preparedness measures across sectors (e.g., housing, transportation, energy) can help reduce existing health inequities, improve living conditions, increase communities' ability to adapt and lead to better health and equity outcomes. [14]

Figure 10. Californians reporting extreme weather events in last two years by race and ethnicity, 2021-2022. Californians who have White, multiracial or American Indian or Alaska Native backgrounds reported the highest rates of experiencing extreme weather events compared to the overall state population.



Source: University of California Los Angeles, California Health Interview Survey

Figure 11. Impact of extreme weather events on mental health, by race and ethnicity, 2021-2022. Multiracial and White Californians reported the highest percentage of mental health impacts.



Source: University of California Los Angeles, California Health Interview Survey
*Statistically unstable
Note: American Indian or Alaska Native percentage estimates overlap with California overall and therefore may not be statistically different.

Built Environment: Healthy Neighborhoods, Healthy People

The built environment consists of human-designed or modified surroundings that provide people with living, working, learning and recreational spaces. [1] How the built environment is prioritized and designed impacts quality of life, physical, mental and social health. [2, 3]

Active Transportation

Active transportation refers to mobility that involves human-powered movement, but most commonly refers to walking and bicycling. [4] This form of transportation promotes physical activity, healthier body weights, and population-level health benefits. [2, 3] The built environment influences whether people walk or cycle for transportation and thereby increases physical activity levels. [3] The built environment also influences levels of recreation. [3] Studies found that the shorter the distance to a destination, the more likely people will walk or cycle. [5] Barriers to the creation of more active transportation infrastructure include lack of political will and funding, and safety concerns. [6] Safety perceptions particularly impact community behavior. When areas are viewed as unsafe, residents are less likely to engage in physical activity, experience a decline in fitness levels, and face increasing social isolation. [5]

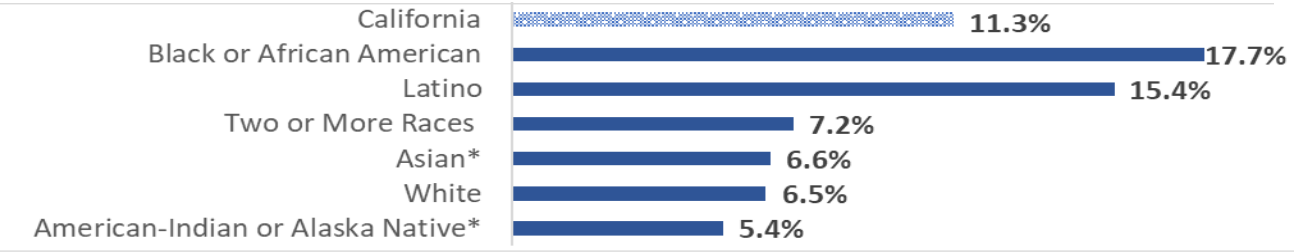
Key Points to Consider:

- **Built Environment Impact:** Neighborhood design directly affects health and quality of life. Some Californians face more barriers to health and opportunity than others because they often lack safe parks, walkable streets, and reliable transportation that can connect them to essential resources like jobs, schools, healthcare, and fresh food.

- **Active Transit, Healthy Communities:** Limited access to vehicles, particularly among Californians with Black and Latino backgrounds, creates barriers to reaching jobs and essential services. Safe, accessible walking and biking infrastructure can help connect these communities while improving health outcomes and reducing emissions - though many neighborhoods still lack these vital improvements.

- **Parks and Greenspace Progress:** Parks and greenspaces are linked to life expectancy and community health, but their effectiveness depends on factors like safety and cultural considerations rather than mere presence alone, highlighting the need for community-informed approaches and research to park development.

Figure 12: Percentage of Californian children who reported not feeling safe at nearby parks or playgrounds, by race and ethnicity, 2018 – 2022. Black or African American children are three times more likely to feel unsafe in parks than White children.



Source: University of California Los Angeles, California Health Interview Survey
* Statistically unstable
Note: Native Hawaiian and Pacific Islander children suppressed due to small sample size.

These safety concerns disproportionately affect certain communities, with Black or African American and Latino children feeling less safe in nearby parks and playgrounds compared to other groups (**Figure 12**).

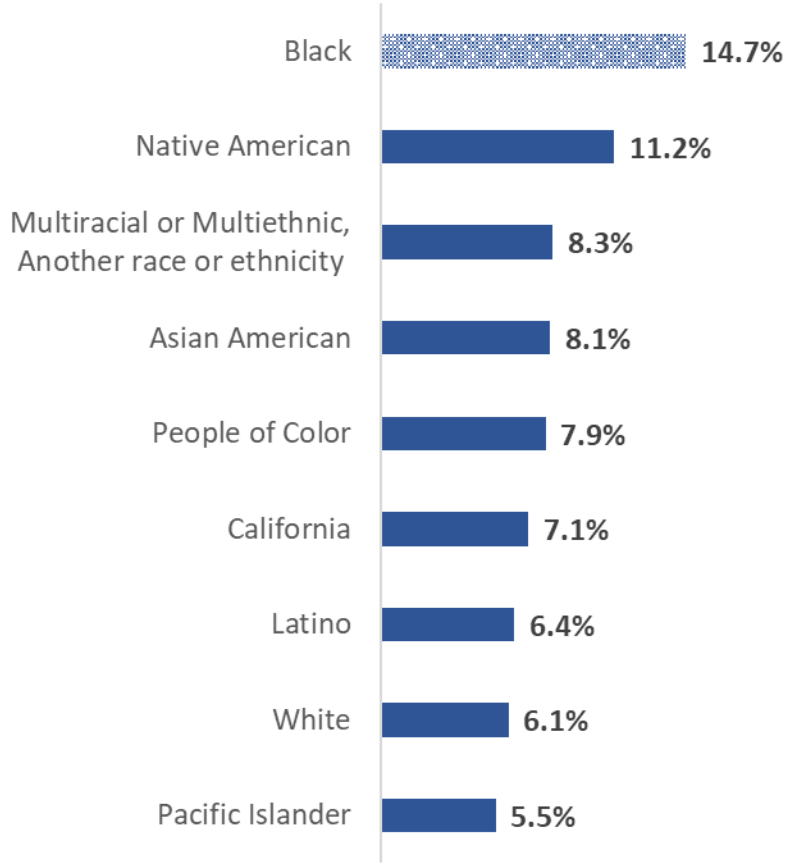
Vehicle Inequities

By promoting active transportation, California can connect society's marginalized groups to jobs, education, and training opportunities, which is particularly important given the disparities in vehicle availability across different racial and ethnic groups. For example, Black Californians have significantly lower rates of vehicle access, potentially limiting economic and educational oportunities (**Figure 13**). [7] Within California's Black communities, vehicle access varies substantially by ancestry group – Jamaican residents are five times more likely than Nigerian residents to lack access to a vehicle, at 20.0% and 5.0%, respectively. (**Figure 14**).

Parks and Greenspace

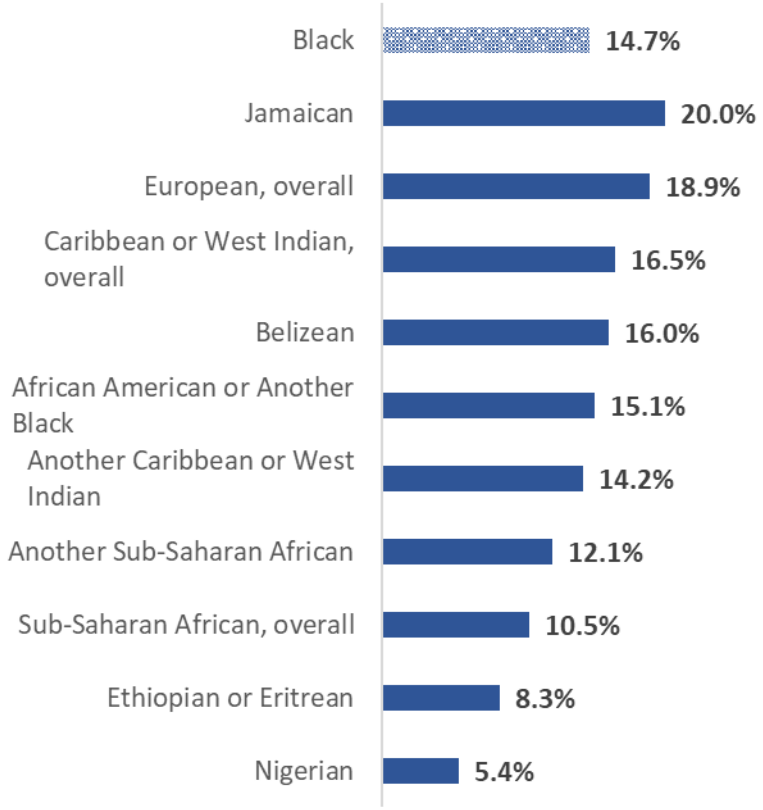
Parks and greenspace are vital to community health and are positively associated with life expectancy. [8, 9] It is believed that communities with larger amounts of low-income and high-minority groups often have less access and usage of parks. However, recent research presents mixed findings on this assumption. [10] Presence of parks alone in lower-income neighborhoods may not be enough to improve park use, as park features impact whether parks are utilized. [11] In fact, Spanish-speaking Latino, Asian and Native Hawaiian or Pacific Islander people are more likely to use parks for social interactions, compared to non-Latino White people. [12] Incorporating community-based research to understand cultural factors and park features that increase usage among society's historically marginalized communities can offer an avenue to promote health equity in California [14].

Figure 13: Percentage of Californians without access to a vehicle, by race and ethnicity, 2016-2020. Black Californians reported the highest rate of vehicle unavailability at 14.7%, more than twice the state average of 7.0%.



Source: National Equity Atlas analysis of U.S. Census Bureau, American Community Survey Data, 2016-2020.

Figure 14: Percentage of Black Californians without access to a vehicle, by ancestry, 2016-2020. Access to vehicles varies widely among Black Californian communities, spanning from 5.4% without access (Nigerian background) to 20.0% (Jamaican background).



Source: National Equity Atlas analysis of U.S. Census Bureau, American Community Survey Data, 2016-2020.

Access to Health Care

Key Points to Consider:

- **Insurance Coverage**: In California, about 1 in 16 people under 65 don't have health insurance. While this is better than the national average, some groups are less likely to have insurance, especially Latino communities, and non-naturalized immigrants.
- **Finding Care**: More than half of uninsured Californians don't have a regular doctor or clinic to go to when they're sick.
- **Paying for Care**: Even with insurance, medical bills burden many Californians, with more than 1 in 4 residents (28.0%) struggling to pay their healthcare expenses in 2023. This hits lower-income families and people with differing racial and ethnic backgrounds the hardest, with Black and Latino Californians more likely to report struggling with medical bills (40.0% and 36.0% respectively) compared to the state average of 28.0%. As a result, many Californians may skip doctor visits because they can't afford them.

Health Insurance Coverage

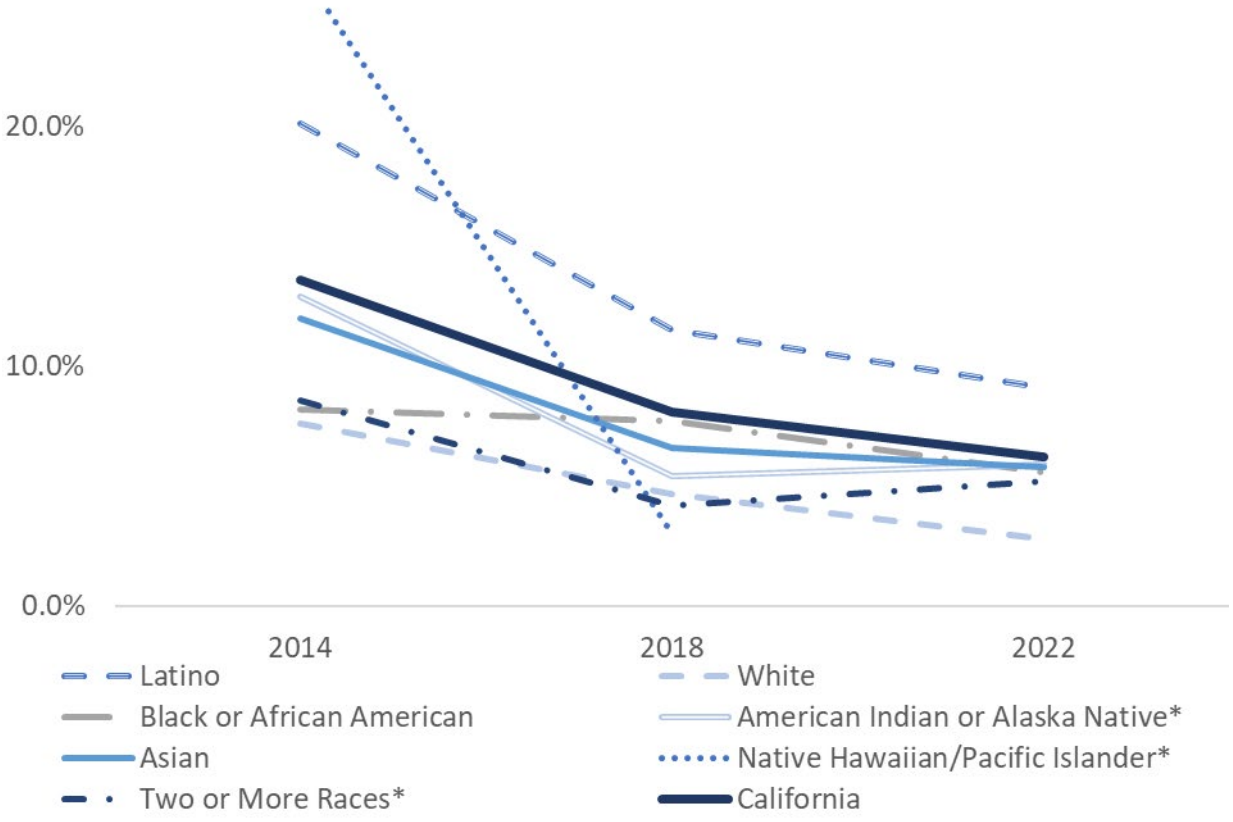
Health insurance coverage serves as a leading health indicator of community well-being. Leading health indicators are a subset of high-priority Healthy People 2030 objectives. According to this objective the aim is to achieve 92.4% health insurance coverage for Americans under the age of 65. [1, 2] However, disparities continue to persist among different demographic groups nationally. While the uninsured rate for Americans under 65 improved from 10.9% to 9.6% in 2022, Latino and American Indian or Alaska Native people under 65 had the highest uninsured rates at 18.0% and 19.1%, respectively. [3]

California performs better than the national average, with 6.1% of residents under 65 lacking health insurance. However, consistent racial and ethnic disparities persist within the state as well (**Figure 15**). From 2014 to 2022, the proportion of uninsured Latinos was higher than other racial and ethnic groups in California. Immigration status also plays a role: in 2022, for those under age 65, non-naturalized immigrants were more likely to be uninsured than U.S. born citizens, as the uninsured rate for non-naturalized immigrants was 19.4% - nearly five times higher than the 4.2% among U.S. born citizens (**Figure 16**).

Sexual orientation can also influence insurance coverage differences. Historically, adults that identify as lesbian, gay, bisexual, transgender, queer or another sexual orientation (LGBTQ+) were less likely than non-LGBTQ+ adults to be insured. According to national data, insurance coverage gaps began to

narrow in 2019 due to the Affordable Care Act. [4]

Figure 15. Percentage of Californians under 65 years without health insurance, by race and ethnicity, 2014-2022. From 2014-2022, uninsured rates fell across all racial and ethnic groups in California. While Latinos saw the largest drop (20.1% to 9.0%), they remained the most likely to be uninsured.



Source: University of California Los Angeles, California Health Interview Survey
*Statistically unstable

In California, while most sexual orientation groups show insurance coverage rates similar to the state average, those who identified as not sexual/celibate/none/other have higher uninsured rates at 19.7% in 2022.

The expansion of health insurance is encouraging, as national data demonstrates that insurance coverage increases access to regular healthcare and preventive services, along with disease management programs. [3] This impact is particularly evident in California, where 54.9% of uninsured residents reported having no usual place to go to when sick or in need of health advice.

A Usual Source of Care

In 2021 to 2022, 15.8% of Californians did not have a usual place to go when they were sick or

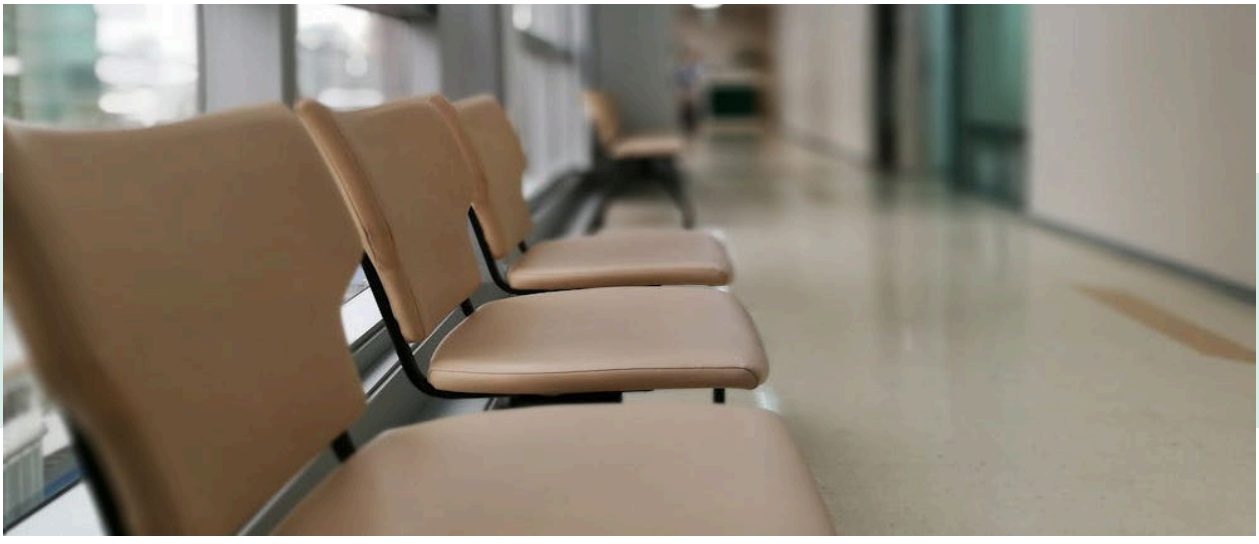
needed preventive care or advice; this is an increase from 13.7% observed in 2019 to 2020. Furthermore, having a usual source of care varied substantially by ethnicity and citizenship (**Figure 17**). In 2021 and 2022, 20.0% of Latino residents lacked a usual source of care. The disparity is even more pronounced when additionally considering citizenship status: 29.4% of Latino non-naturalized immigrants reported no regular source of healthcare.

The lack of regular healthcare access may force individuals to delay necessary medical treatment, which can lead to worsening health outcomes. [5] In California, half the population reported skipping health care due to cost concerns. Among those who delayed care, nearly half indicated their health condition worsened as a result. [6]

Unaffordable Health Care and Impacts

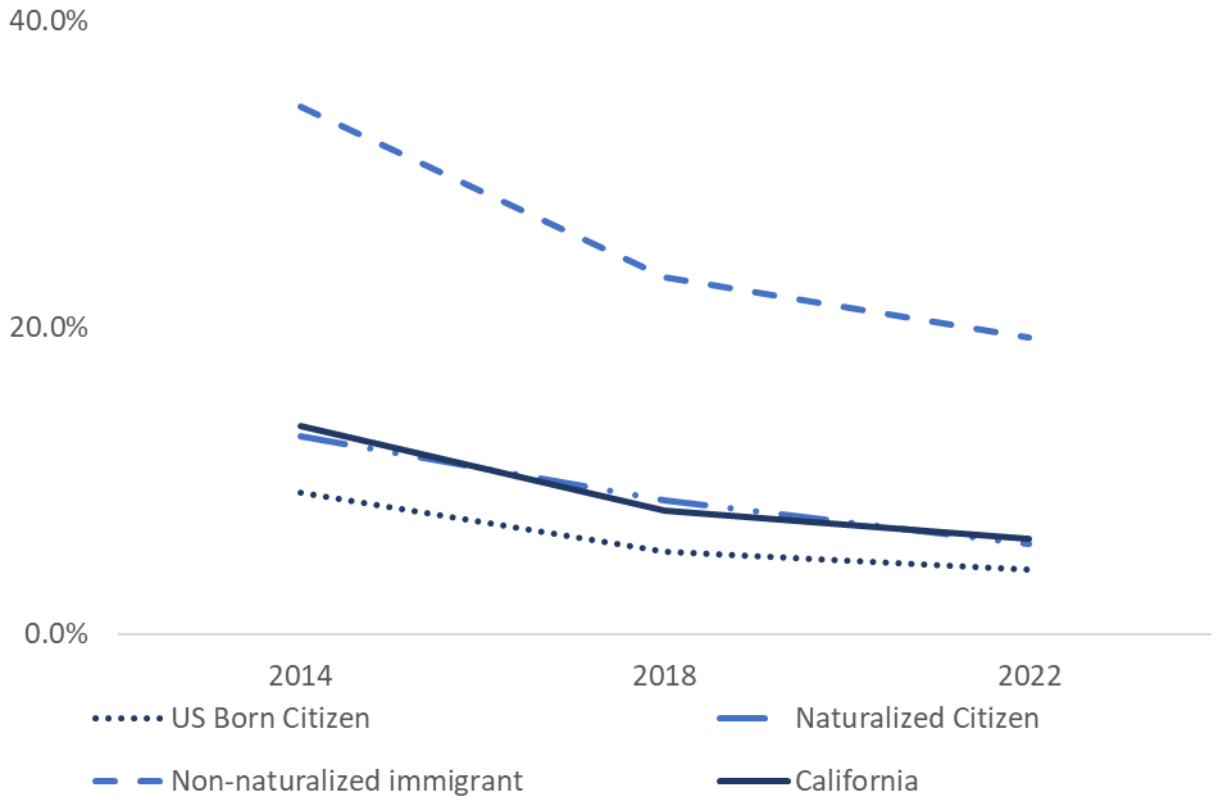
While families contribute to healthcare through wages and taxes, [5] even those with health insurance can struggle with affordability. [5] In California, the prevalence of high deductibles (over $2,000) among workers has more than doubled, rising from 31.0% in 2012 to 70.0% in 2020. [6] The burden of medical costs continues to grow, with 28.0% of Californians reporting difficulties paying medical bills in 2023. [6] These financial challenges disproportionately affect some groups in California: 46.0% of individuals with lower income (below 200% FPL), 40.0% of Black people, 36.0% of Latino people, and 40.0% of people with Spanish as their primary language report having trouble paying medical expenses. [6] These financial barriers to care can lead to increased use of emergency services and preventable hospitalizations. [3]

One quality of health care indicator is length-of-stay in an emergency department. Length-of-stay reflects the time from patient arrival to discharge and longer length-of-stays represent less efficiency of patient flow and less



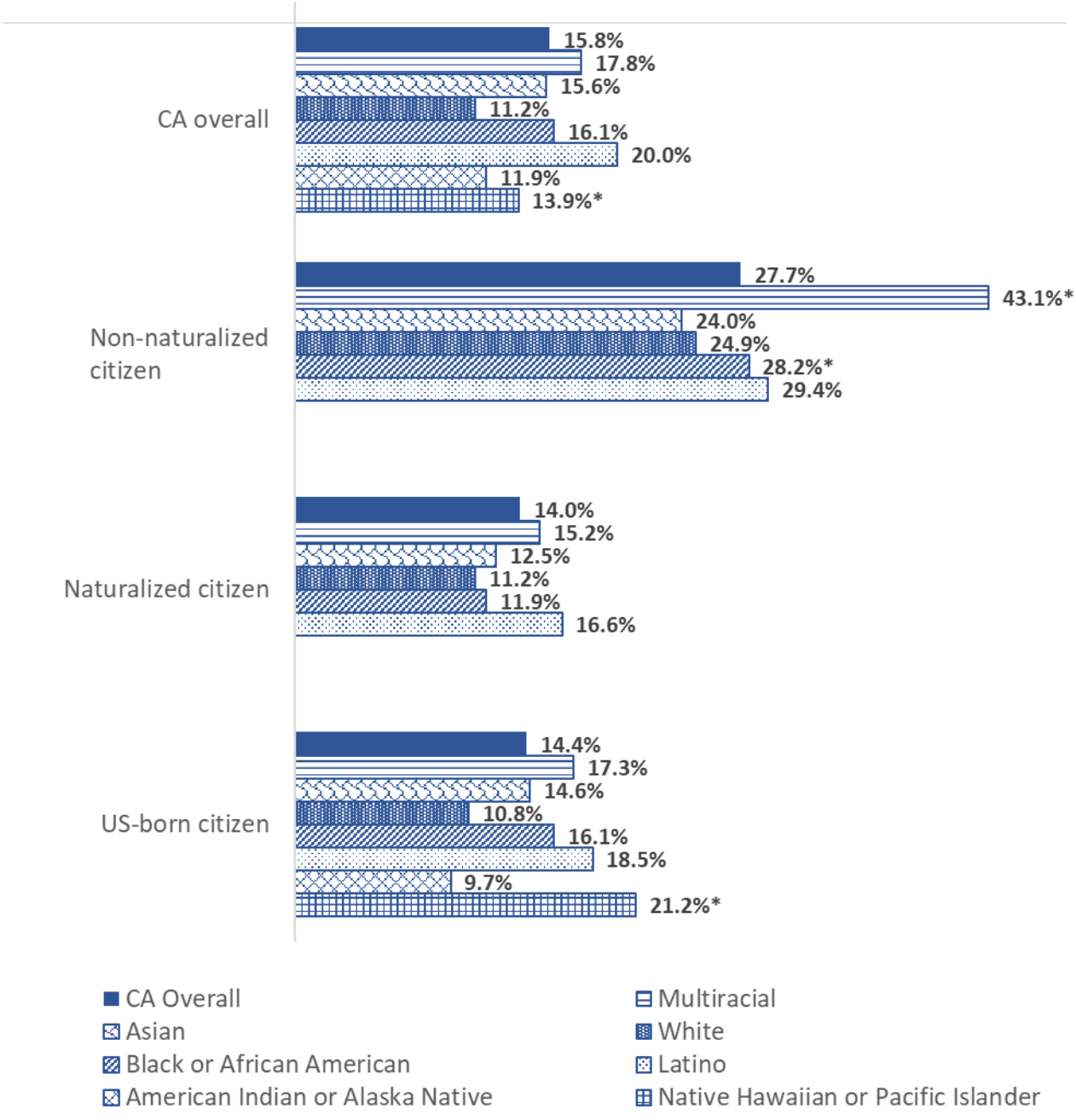
timely receipt of care. According to 2021 data, California's emergency departments fared worse than the national average for length-of-stay for discharged patients. Mental health patients spent, on average, 4.5 hours in the emergency department before being sent home, compared to the national average of less than 3 hours. [7] Another health care quality indicator, unplanned hospital readmissions within 30 days, varied substantially by race and ethnicity, with Black or African American people having higher readmission rates (18.0%) than Californians overall (14.5%). [7] These disparities extend to in-hospital deaths as well: While 34.5% of deaths in California in 2021 occurred in hospitals, the rates were 44.7% for Latino and 42.7% for Native Hawaiian or Pacific Islander people. [7]

Figure 16. Percentage of Californians under 65 years without health insurance, by citizenship and immigration status, 2014-2022. Non-naturalized immigrants in California consistently had the highest uninsured rates from 2014-2022, though these rates declined over time.



Source: University of California Los Angeles, California Health Interview Survey

Figure 17. Percentage of Californians without a usual source of care, by immigration status, race and ethnicity, 2021-2022. Non-naturalized immigrants across all racial and ethnic groups were more likely to lack a usual source of care, compared to naturalized citizens and U.S.-born residents.



Source: University of California Los Angeles, California Health Interview Survey
Note: Native Hawaiian or Pacific Islander and American Indian or Alaska Native are suppressed in naturalized and non-naturalized categories due to small sample size
*Statistically unstable

Prevention Efforts

Key Points to Consider:

- **Prevention Takes Many Forms:** Communities and doctors work together to spot health problems early and teach people how to stay healthy. This approach helps make sure everyone has a fair chance at good health.

- **Drinking Too Much:** One in five California adults report drinking too much alcohol at one time (binge drinking). Recent 2022 data shows young adults aged 25-39 reporting even higher proportions of binge drinking. It's recommended by health experts for communities to work together to help address this issue.

- **Cancer Differences:** Colorectal cancer, the third most common cancer, affects groups of people differently. American Indian and Alaska Native people have the highest rates (49 per 100,000), followed by Black people (42 per 100,000), while Asian American and Pacific Islander people have the lowest rate (29 per 100,000). Prevention efforts focus on screenings through patient navigation programs and mailed screening kits.

Healthy People 2030

Clinical and community prevention strategies are essential components of public health improvement. Prevention encompasses multiple approaches, from public health campaigns and early disease detection to managing existing conditions and community outreach about health behaviors. Through these comprehensive strategies, healthcare providers and communities can address Healthy People 2030's leading health indicators, which include reducing binge drinking and increasing colorectal cancer screenings to improve overall health. [1]

Preventing Excessive Alcohol Use

In the U.S. excessive alcohol use is responsible for 1 in 5 deaths among adults ages 20 to 49 years. [2] In California, average annual number of alcohol-attributable deaths increased 38.5% from 2012 to 2022. [3] Excessive alcohol use, such as binge drinking, is a leading preventable cause of death among adults and has been recognized as a public health problem. [4] Harmful alcohol use is ranked seven as a risk factor for death and disability globally, and has been associated with injury, suicide, certain cancers, liver disease, mental disorders and communicable disease. [5]

The Healthy People 2030 goal is to have 25.4% or less of adults 21 years and older to report binge drinking of alcohol in the past 30 days. Binge drinking is defined as 5 or more drinks for men and 4 or more drinks for women within about 2 hours. About 19.1% of people ages 21 and older in California reported binge drinking in

the past 30 days. This proportion varies by age and race. For example, from 2021 to 2022, 28.3% of Californians ages 25 to 39 years reported binge drinking. Further, 22.2% of Latino people 21 and older reported binge drinking the past month. Percentages differ within Latino ethnicity, as people ages 21 and older from South America were more likely to binge drink in the past 30 days (33.6%) compared to similar aged people from Central America (19.5%).

There are promising policies in the environment to reduce harmful alcohol use in adults. [2] Abstention from alcohol has been recommended as the healthiest option. [5] Whereas other studies and the U.S. Dietary Guidelines for Americans recommend light to moderate levels of alcohol consumption, such as less than or equal to 7 drinks per week for females and less than or equal to 14 drinks per week in males, and avoidance of binge drinking entirely as acceptable. [5] To reduce binge drinking, the U.S. Community Prevention Services Task Force recommends community interventions involving coalitions and partnerships to prevent substance use in adolescents and young adults. [6]

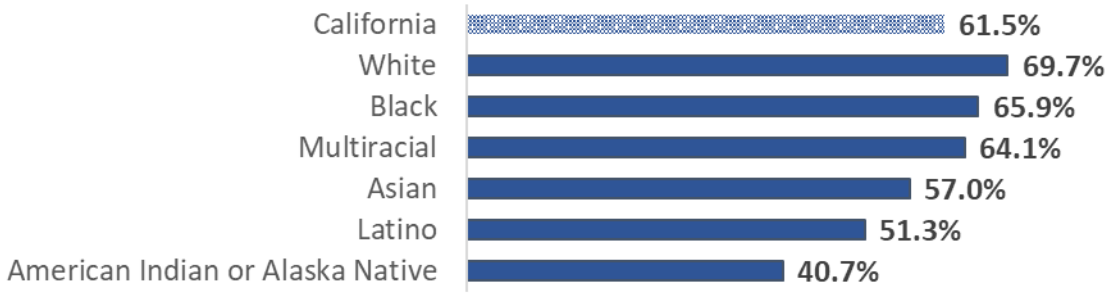
Cancer Prevention and Colorectal Cancer Screenings

Colorectal cancer is the third most diagnosed cancer, the third most common cause of cancer-

related death in the U.S. and is the leading cause of cancer in men ages 50 and younger. [7] More than half of colorectal cancer is attributable to modifiable risk factors such as high alcohol consumption, smoking, an unhealthy diet, physical inactivity and excess body weight. [7] In the U.S., American Indian or Alaska Native (48.6 per 100,000) and non-Hispanic Black people (41.7) experience higher incidence of colorectal cancer compared to Asian American or Pacific Islander people (28.6). [7] In California, the age-adjusted mortality rate for colorectal cancer was 11.9 per 100,000, in 2019. [8] The mortality rate would likely be significantly higher without clinical preventive care such as screenings and treatments.

Colorectal cancer screenings are effective in detecting and treating cancer early. [7] The U.S. Preventive Services Task Force (USPSTF) recommends that all adults be screened for colorectal cancer

Figure 18: Percentage of respondents aged 45-75 years who received one or more of the recommended tests for colorectal cancer screening within the recommended time interval, by race and ethnicity, California, 2022. Colorectal cancer screening rates varied across racial and ethnic groups, ranging from 69.7% among White residents to 40.7% among American Indian or Alaska Native residents, with the overall state average at 61.5%.



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (BRFSS), 2022. Note: Estimates for Native Hawaiian or Pacific Islander and Another Race are not available.

starting at age 45 and up until age 75, with careful consideration of pros and cons among those 76 to 85. [9] People with Latino background are less likely to obtain recommended tests for colorectal cancer screening (**Figure 18**).

Although American Indian and Alaska Native people are also less likely to meet screening tests (40.7%) compared to other race and ethnic groups, due to small numbers and wide confidence intervals, this difference is not statistically significant. Colorectal cancer screening percentages cannot be compared to 2020 data, as the USPSTF recommendation was for those ages 50 to 75. Data do not allow for disaggregation of race and ethnic groups, however literature has found that communities of South Indian American people have lower rates of cancer screening compliance than other race and ethnic groups. [10]

In addition to clinical preventive services, there are community-based prevention interventions which focus on improving population health. Patient navigators can provide guidance through colorectal cancer screening processes, the complexities of the health system, and discuss educational, cultural and logistical barriers that impact screening completion and follow-up. [11] Patient navigators have been shown to improve screening uptake by 100%. [11] Mailing of fecal immunochemical test (i.e., FIT) kits to patients has also been shown to be an effective approach to increase colorectal cancer screening in population-based studies. [11] Intentional outreach efforts from health systems to improve colorectal cancer screening rates in the community may ameliorate existing racial and ethnic colorectal cancer screening disparities.

Experiences of Discrimination

Discrimination—the unequal treatment of individuals or groups - is complex and rooted in historical social policies. When communities face ongoing discrimination, it intensifies the physical and mental health challenges that society's historically marginalized groups experience at higher rates than others. [1] Numerous studies have documented the role of discrimination in health disparities. [1]

Health Care

Discrimination across institutional, structural, and interpersonal dimensions and settings. According to 2021-2022 data, for example, 25.0% of Black or African American and 13.0% of Latino adults in California reported experiencing unfair treatment in the health care setting due to their race and ethnicity, compared to 8.0% of adults overall (**Figure 19**). This is an increase from 2016-2017, when 14.0% of Black or African American and 6.7% of Latino adults reported experiencing unfair treatment in medical care, compared to 5.1% of Californians overall.

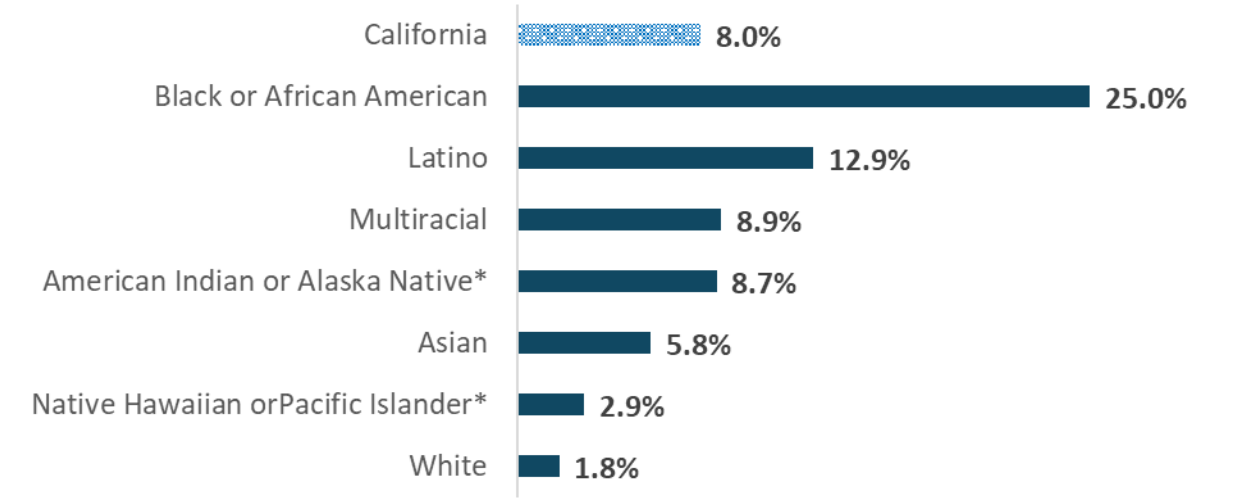
Reported Hate Crimes

Numerous professional associations along with state, county, and city governments have acknowledged the scope of the negative psychological and physical health impacts of discrimination by declaring racism and discrimination public health issues and crises. [2]

Key Points to Consider:

- **Unequal Treatment in Health Care:** In California, 25.0% of Black or African American and 13.0% of Latino adults report unfair treatment in health care settings – up from 14.0% and 6.7% in 2016-2017. More research is needed to understand why, including how the COVID-19 pandemic impacted healthcare delivery.
- **Hate Crimes and Violence**: While overall hate crimes went down by about 9% from 2022 to 2023, some types of hate crimes increased: religious hate crimes went up by 30.0%, and crimes targeting people because of their sexual orientation went up slightly.
- **Enforcing the Law Differently:** Police used serious force against 658 people in 2023, with Latino and Black people facing force at higher rates than their share of the state's population. For example, while Black people are only 5.0% of California residents, they were involved in 18.7% of these incidents.
- **Indigenous Violence:** Native American and Alaska Native people face higher rates of discrimination - they are killed by police three times more often than White people. In 2022, over 5,000 Native women were reported missing or murdered in the U.S.

Figure 19: Percentage of Californians who ever experienced unfair treatment getting medical care due to race and ethnicity, 2021-2022. Black or African American Californians experience unfair treatment in getting medical care more than three times the state average of 8.0%.



Source: University of California Los Angeles, California Health Interview Survey
* Statistically unstable

One sobering measure of interpersonal discrimination is the occurrence of hate crimes. Black or African American people were more likely to report hate crimes or hate incidents in 2022 compared to California overall (**Figure 20**). While in California, the number of reported hate crime offenses decreased 8.9%, from 2,589 in 2022 to 2,359 in 2023, these numbers may be incomplete, as not all agencies submitted full data for 2023. [3] In 2023, hate crime events involving religious bias increased 30% from 303 in 2022 to 394. Hate crime events motivated by sexual orientation also saw an increase from 2022 to 2023, from 391 to 405. [3]

Police Violence

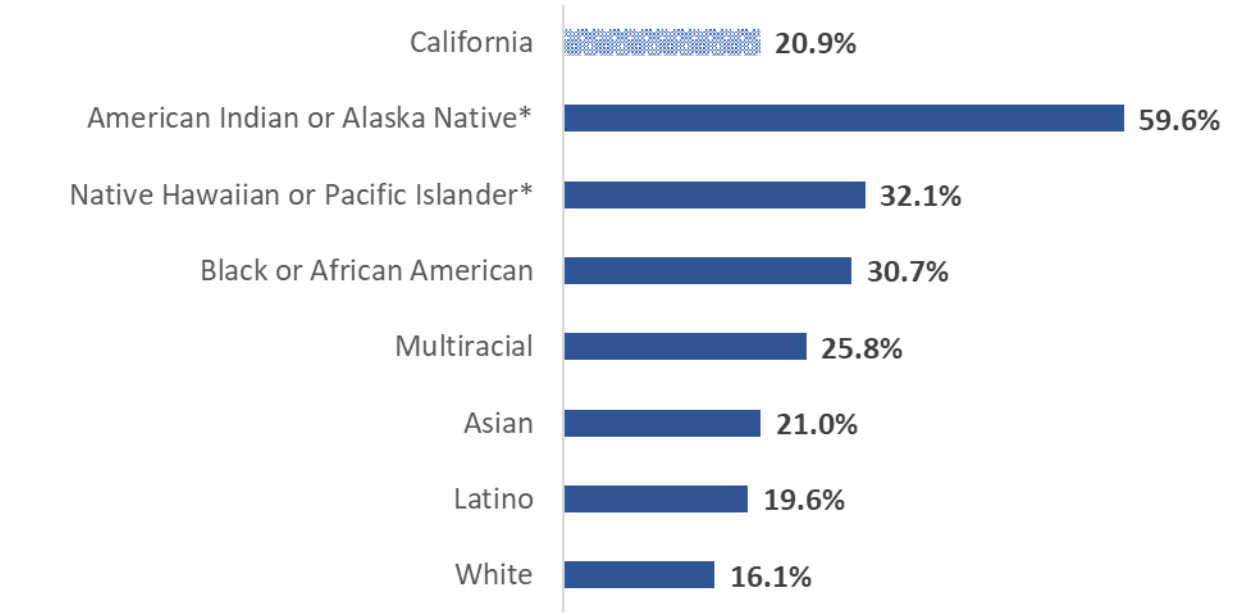
Use of force is defined as incidents where use of force by an officer or a civilian resulted in either serious bodily injury or death of an officer or civilian. [4] In 2023, there were a total of 658 civilians involved in incidents in California that involved the discharge of a firearm or use of force by police: 48.5% were Latino, 18.7% were Black or African American, and 26.0% were White people. [4] These proportions exceed California population shares, where Latino residents comprise 40.0%, and Black or African American residents are 5.0%. The White population in California is 35%. [5]

Indigenous Persons

Historical injustices among indigenous persons include land dispossession, language and cultural losses, boarding schools, and forced migration, with the impacts of racism against American Indians or Alaska Native people continuing to this day. [6] American Indian and Alaska Native people die by police use of force at three times the rate of White people and 2.6 times higher than Black or African American people. [6] Furthermore, American Indians or Alaska Natives are incarcerated at a rate 38% higher than the national average. [6]

The impact extends beyond policing: in 2021, homicide was the eighth leading cause of death in American Indian or Alaska Native persons between the age of 1 and 54. [7] In 2022, there were 5,491 cases of missing indigenous women and girls in the U.S., and murder was the third leading cause of death in American Indian girls and women ages 10 to 24. [7] In urban areas, most perpetrators were of non-American Indian or Alaska Native background, while in rural areas, the perpetrators were more likely to be American Indian or Alaska Native. [7] With American Indian or Alaska Native people facing high levels of violence, more can be done to strengthen crime data collection, and ensure that crimes are adequately tracked, investigated, and perpetrators are held accountable.

Figure 20: Percentage of Californians who reported experiencing a hate crime or hate incident in 2022 by race and ethnicity. Black people experience hate crimes and incidents at larger proportions compared to Californian overall.



Source: University of California Los Angeles, California Health Interview Survey
* Statistically unstable

Neighborhood Safety, Social Cohesion and Collective Efficacy

Violent Crime in California

Exposure to violence and crime is associated with chronic health conditions. [1, 2] Inter-related individual and community risk factors for crime and violence include poverty, discrimination, racism, inadequate housing, a history of trauma, substance use, and mental health problems. [2]

The violent crime rate in California increased 1.7% from 495 per 100,000 residents in 2022 to 503 in 2023. [3] Compared to 2022, there were modest increases in robberies (3.8%) and aggravated assaults (1.7%), and decreases in homicides (13.7%) and rapes (3.0%). [3] Homicides and violent crime are declining after a surge during the COVID-19 pandemic. [3] Where homicide victim race and ethnicity were reported, 47.5% were Hispanic, 26.8% were Black, 17.1% were White and 8.6% were other race and ethnic groups. [4] Proportions for homicide victims were larger than population proportions for Latino (40%), and Black (5%) persons in California. [5] Firearms were used the most in homicides, accounting for 72.8%. [4]

Key Points to Consider:

- **Community Impact:** Communities with higher concentrations of poverty and unemployment are more likely to experience violence. While California's overall violent crime increased 1.7% from 2022 to 2023, these impacts vary across communities.
- **Crime Affects Some Groups More**: Not all communities face the same levels of violence. Among California murder victims in 2023, almost half (47.5%) were Hispanic, about one-fourth (26.8%) were Black, 17.1% were White, and 8.6%were from other racial and ethnic groups.
- **Feeling Safe in Neighborhoods:** Perceived neighborhood safety has significantly declined. In 2018, about half of adults felt safe all the time. By 2022, only about one-third felt this way. Latino, multiracial, Black or African American, and Asian residents were less likely than other Californians to feel completely safe where they live.

Healthy Neighborhoods and Social Cohesion

Safe neighborhoods are essential to community mental and physical health and health equity. [6] A healthy neighborhood provides resources needed to live a healthy life, such as access to green space, healthy foods, health care and safety. [6] Neighborhood social cohesion is defined as close social relationships in the neighborhood and oriented toward the common good of the members of that community. [7]

Social cohesion may reduce stress which is linked with systemic inflammation and can induce immune dysregulation. [7] Close social relationships protect from loneliness and increase positive health behaviors. [7] Positive behaviors include participation in healthier activities and collective activities to promote social order and safety. [7]

Healthy Neighborhoods and Collective Efficacy

Collective efficacy, an aspect of social cohesion, is defined as trusting relationships with neighbors and their perceived ability to make positive changes in the community using informal social control. [7] The collective health of neighborhoods is associated with the social relationships among residents, including the degree of mutual trust, and sense of connectedness among neighbors. [8] Residents of close-knit neighborhoods can work together to provide support when problems arise. [8] Further, research has shown that higher neighborhood collective efficacy has been associated with better self-reported physical and mental health. [8]

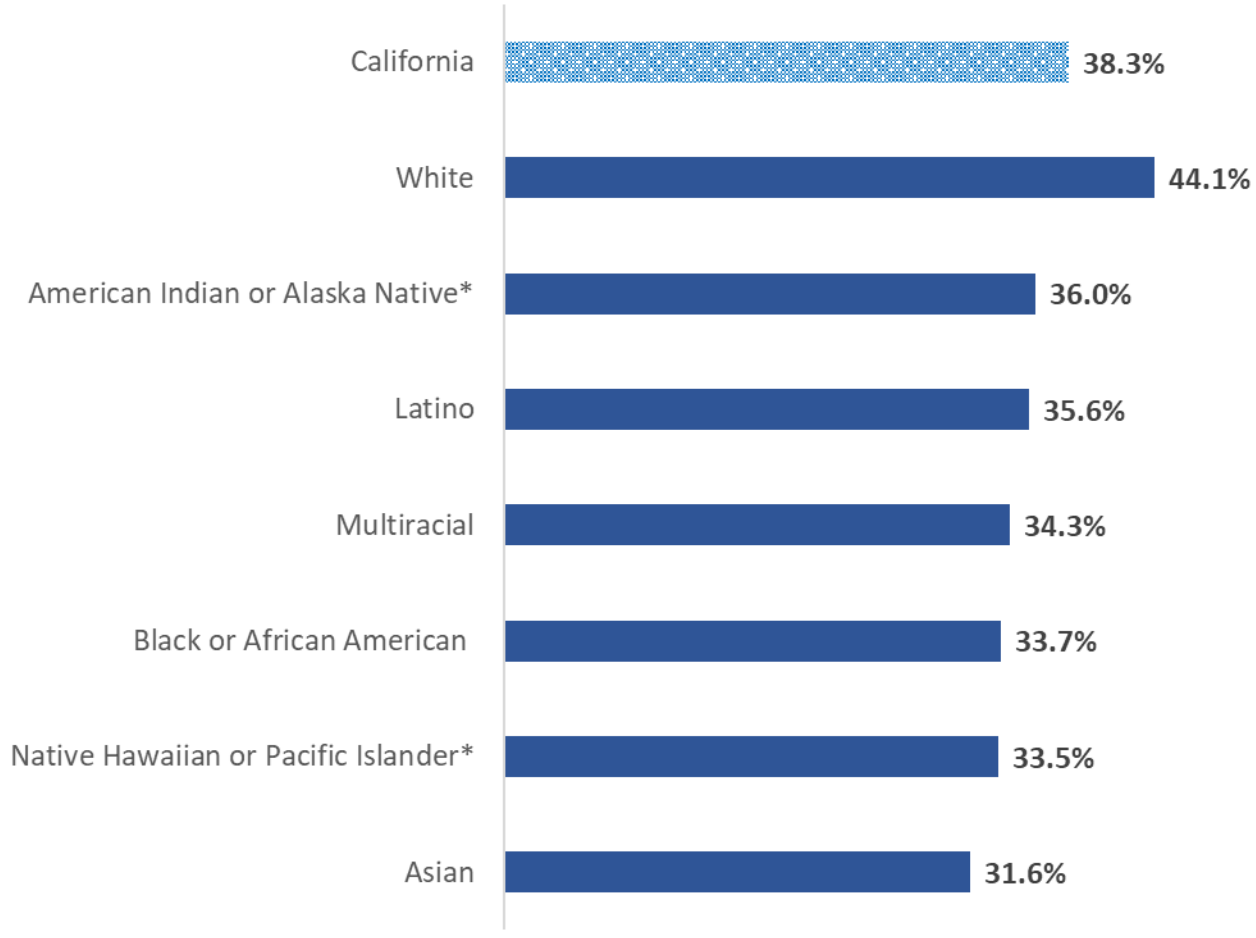
Trend and Disparities in Perceived Neighborhood Safety

In 2018 to 2022, 38.3% of Californians felt safe in their neighborhoods all the time, compared to 49.8% in 2013 to 2017. Perceptions of neighborhood safety

differed by racial and ethnic groups in 2018 to 2022: Asian (31.6%), Black (33.7%), multiracial (34.3%) and Latino (35.6%) people were less likely than California-adults overall (38.3%) to feel safe in their neighborhood all the time (**Figure 21**).

Almost two out of five Californians feel safe in their neighborhood all the time. However more research is needed to understand factors driving the decreasing trend in perceived neighborhood safety from 2013-2017 to 2018-2022; neighborhood safety defined as feeling safe in their neighborhood all the time.

Figure 21: Percentage of Californians who feel safe in their neighborhood all the time by race and ethnicity, 2018-2022. Approximately one-third of Latino, multiracial, Black or African American, and Asian residents feel safe in their neighborhood all the time, falling below the state average of 38.3%.



Source: University of California Los Angeles, California Health Interview Survey
*Confidence intervals overlap, and values may not be statistically different

Cultural and Linguistic Competence

Cultural and linguistic competency is the ability of health care providers and organizations to communicate with clients and communities, to understand and respond to their cultural beliefs and practices regarding health, wellness and illness, and to tailor delivery of care to patients with diverse values, beliefs, and linguistic needs. [1] California's growing population diversity represents an opportunity for health care delivery systems to provide culturally and linguistically appropriate care. Nearly half of Californians (44.4%) five years and older speak languages other than English at home and 17.4%, or 6.4 million, have Limited English Proficiency (LEP). [2]

Nationally, Healthy People 2030 is developing an objective to increase the proportion of adults with LEP who report that their health care provider explains things in a way that is easy to understand. [4] LEP status is associated with communication barriers, being more likely to be admitted into the hospital, and elevated health care costs. [5]

Persons with LEP are more likely to be people of color. [3] People in racially and ethnically minoritized groups and lower-income households are more likely than White and higher-income groups to experience racism, discrimination, culturally insensitive care and dissatisfaction with care. [3] In California, the majority of adults with LEP, self-identify as Latino (73.0%) or report Asian ancestry (24.0%). [3] When evaluating California as a whole, 21.9% of Latino people and 22.0% of

Key Points to Consider:

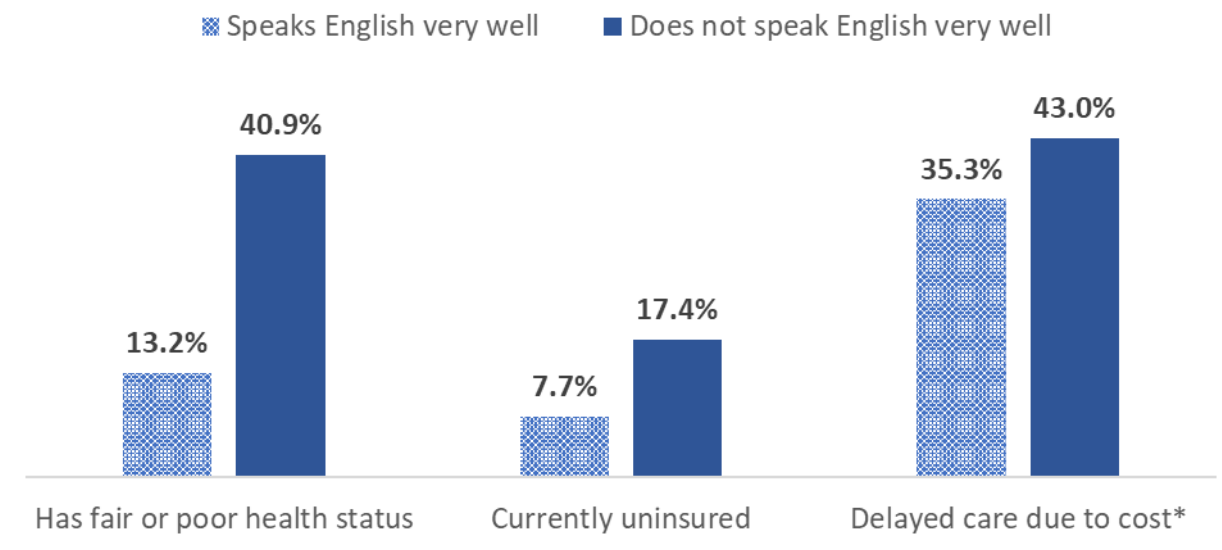
- **Growing Language Needs:** California's healthcare system serves a linguistically diverse population, with over 40% speaking languages other than English at home. People with limited English proficiency face barriers when seeking medical care, which often results in more frequent hospitalizations and increased healthcare expenses.
- **Health Disparities**: Compared to English-proficient adults, those with Limited English Proficiency report poorer health status and are less likely to have health insurance. This particularly affects Latino (73.0%) and Asian (24.0%) communities, who make up the majority of California's LEP population.
- **Workforce Representation Gap:** While California's healthcare workforce is becoming more representative of California's diversity, gaps remain. For example, Latino residents make up 39.5% of the population but are underrepresented across healthcare sectors. The nursing workforce shows promising progress, with non-White individuals comprising 54.0% of registered nurses in 2022.

Asian people are LEP, compared to 19.9% of Californians. Adults with LEP are more likely to report fair or poor health, and to lack current health insurance, compared to adults who speak English very well. (**Figure 22**).

Health Care Workforce

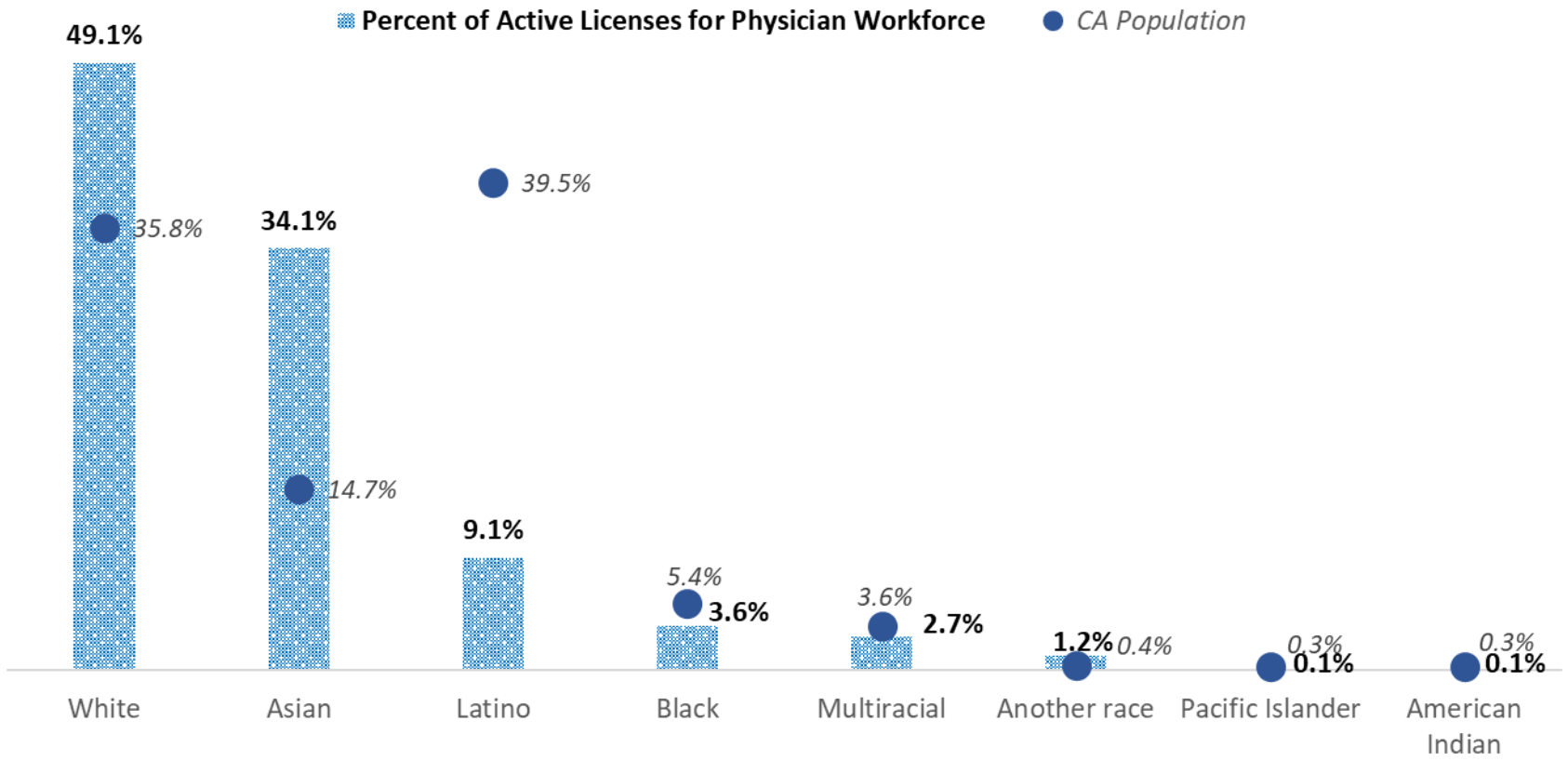
The demographic composition of the health care workforce is not representative of the racial and ethnic diversity of the California population: Latino people represent 39.5% of California's population but are underrepresented in every category within the health care workforce (e.g., medicine, nursing, oral, behavioral, mental, and allied health). [6] Black or African American people, 5.4% of the state's population, account for 3.6% of physicians (**Figure 23**). In comparison to the physician workforce, the state's nursing workforce is more racially and ethnically diverse. In 2022, people of diverse racial and ethnic identities comprised more than half, or 54.0%, of California's registered nurses. [7]

Figure 22: Percentage of Californians speaking languages other than English at home with poor or fair health, who delayed health care due to costs or lack of insurance, and lack health insurance coverage, by English proficiency status, 2021-2022. Californians with limited English proficiency are more likely to have poor health and lack health insurance coverage.



Source: University of California Los Angeles, California Health Interview Survey
*Confidence intervals overlap, and values may not be statistically different

Figure 23: Race and ethnicity of Californian physicians compared to population shares, 2023. California's physician workforce shows significant underrepresentation of healthcare providers with Latino and Black or African American backgrounds compared to the state's population demographics.



Source: California Department of Health Care Access and Information's Race & Ethnicity of California's Health Workforce, 2023.

Note: 'Physician' includes naturopathic doctor, osteopathic physician and surgeon, physician and surgeon, physician assistant.

Mental Health Access and Impact

Key Points to Consider:

- **Mental Health Impact:** As recently as 2022, one in six adults and one in three teens reported having experienced serious psychological distress, making mental health conditions among the most common health conditions that Californians experience.
- **Community Impact:** Some groups of people have higher rates of mental health challenges. Native Hawaiian and Pacific Islander (28.5%) and Latino (18.7%) residents experience higher rates of serious distress than the state average. Individuals who identify as transgender or gender non-conforming (55.5%) and bisexual (48.5%) have high rates of suicidal ideation.
- **Treatment Access Barriers:** Mental health care and access to treatment remains uneven across populations. Among those with serious psychological distress, people with Latino background and non-naturalized citizens are more likely to lack regular care sources and health insurance than Californians overall.

Mental health includes emotional, psychological and social wellbeing and allows an individual to relate to others, cope with the stresses of life, and make healthy choices. [1] Caring for one's mental health is just as important as caring for one's physical health as both contribute to overall well-being and the ability to thrive. [1] For example, depression can increase the chances of developing diabetes, heart disease and stroke. [1] Likewise, having chronic physical conditions can also increase the likelihood of developing depression. [1] Two-thirds of adults and adolescents with major depressive episodes do not receive treatment. [2]

People who experience mental health symptoms that are serious, persistent, and interfere with daily living, may be experiencing a mental health condition. [1] Common mental health conditions include major depressive disorder, attention deficit hyperactivity disorder and panic disorder. [1] Protective factors for mental well-being include positive social relationships, access to employment, housing and educational opportunities, and learned coping skills for managing life situations. [1] Living in safe neighborhood environments can also be protective of mental health. [1]

Mental health conditions are among the most common health conditions that Californians experience. [1] About one in six adults and one in three teens ages 12 to 17 reported having experienced serious psychological distress during the past year in 2022.

Prevalence of Mental Illness by Race, Ethnicity, Sexual Orientation and Gender Identity

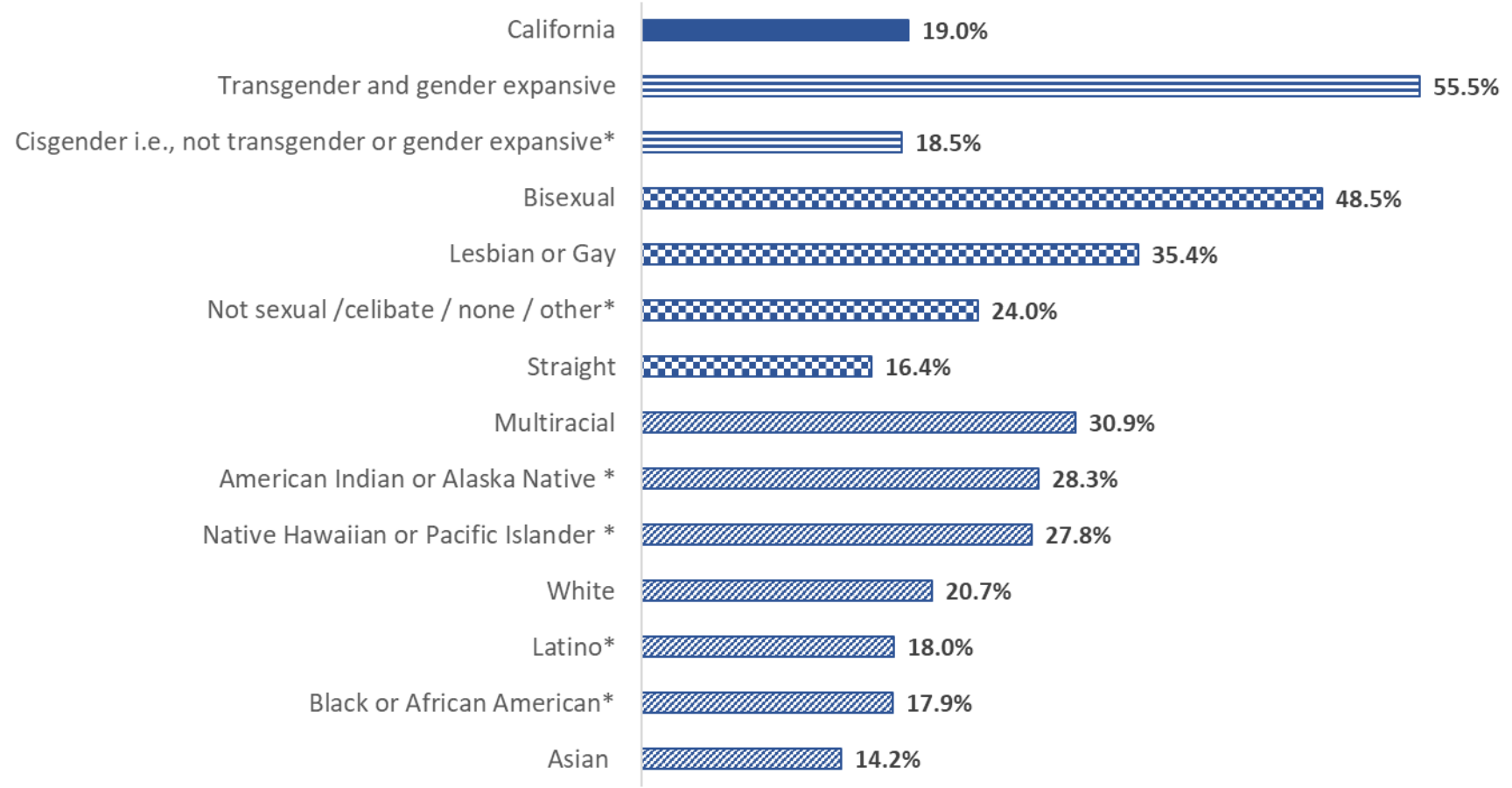
The prevalence of mental distress differs by race and ethnicity. Multiracial (23.7%) and Latino (18.7%) people were more likely than California-overall (16.7%) to experience serious psychological distress the past year. A notable difference in the pattern of disparities of serious psychological distress by race and ethnicity is the rate of suicidal ideation, which is higher among multiracial (30.9%), and White (20.7%) people, compared to California-overall (19.0%). (**Figure 24**).

Suicidal ideation also differs by gender identity, sexual orientation and citizenship status. According to 2021 to 2022 data, persons identifying as transgender or gender non-conforming reported the highest percentage of ever having suicidal thoughts (55.5%), compared to all groups (**Figure 24**). When analyzed by sexual orientation for the same years, suicidal thoughts are most common among individuals who are bisexual (48.5%), followed by those who identify as gay or lesbian (35.4%). The lowest rates of suicidal ideation for the same time period were seen in naturalized- (10.4%) and non-naturalized citizens (12.5%), compared to U.S. born citizens (22.5%) living in California.

Access to Mental Health Services by Race, and Citizenship

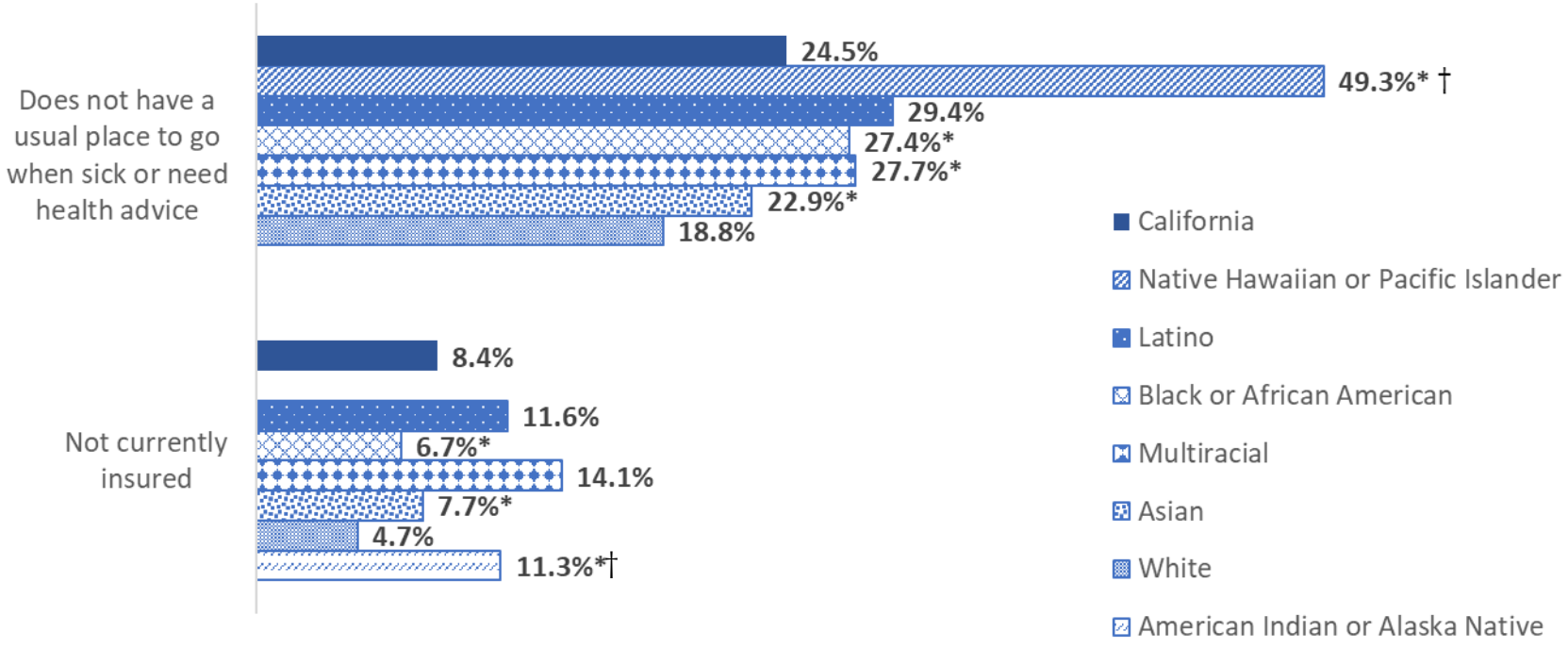
Based on 2021 to 2022 data, there is unequal access to mental health treatment and preventive services in adults by race, ethnicity, and citizenship. Affordability of care and low rates of health insurance coverage in populations that are underserved have been major barriers to mental health care. Among adults with serious psychological distress in the past year, Latino people were more likely to have no usual source of care (29.4%), and no health insurance (11.6%) compared to Californians overall (**Figure 25**). Non-naturalized citizens with serious psychological distress faced barriers to care, as they were more likely than U.S. born- and naturalized citizens, and California overall, to lack health insurance (21.0%) (**Figure 26**).

Figure 24: Percentage of Californians who seriously thought about committing suicide; by gender identity, sexual orientation, race and ethnicity, 2021-2022. Over half of Californians who identify as transgender/gender non-conforming report having suicidal thoughts, significantly higher than other demographic groups.



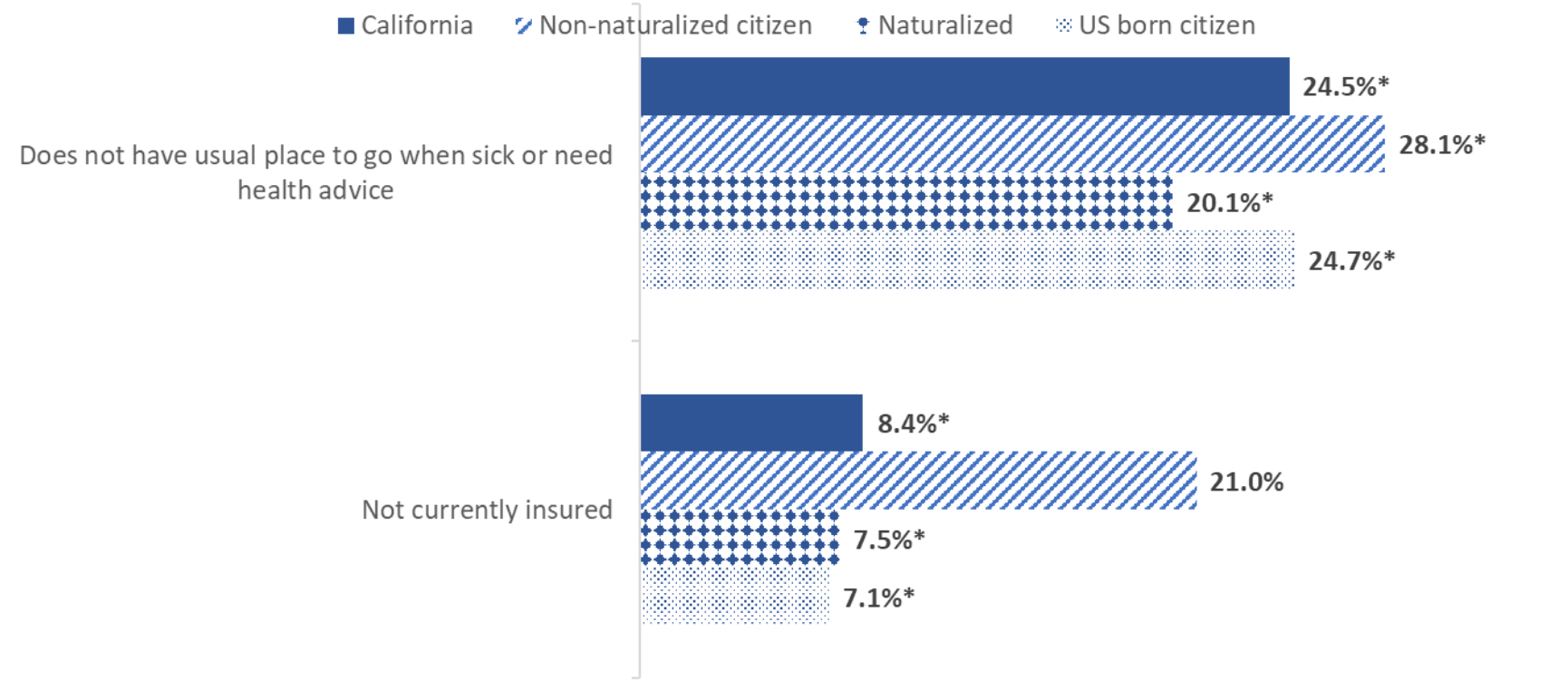
Source: University of California Los Angeles, California Health Interview Survey
*Confidence intervals overlap, and values may not be statistically different

Figure 25: Percentage of Californians with serious psychological distress in the past year who reported not having a usual place to go when sick or need health advice, or not currently having health insurance, by race and ethnicity, 2021-2022. Among those with serious psychological distress, greater proportions of Latino people lack access to a usual place to go when sick or need health advice, and multiracial people lack health insurance.



Source: University of California Los Angeles, California Health Interview Survey
*Confidence intervals overlap, and values may not be statistically different within each grouping
†Statistically unstable
Note: due to small sample sizes, the proportion for American Indian or Alaska Native people is suppressed in "Does not have a usual place to go when sick or need health advice" category and Native Hawaiian or Pacific Islander people in "not currently insured" category.

Figure 26: Percentage of Californians with serious psychological distress in the past year who reported not having a usual place to go when sick or need health advice, or not currently having health insurance, by citizenship, 2021-2022. Non-naturalized citizens experiencing serious psychological distress are more likely to lack health insurance compared to U.S.-born citizens.



Source: University of California Los Angeles, California Health Interview Survey
*Confidence intervals overlap, and values may not be statistically different within each grouping

California Department of Public Health, Office of Health Equity

Biennial Reporting of Activities Required by Chapter 1.5, Multicultural Health

California Health and Safety Code § 152

Between July 1, 2022, and June 30, 2024, the Office of Health Equity (OHE) conducted efforts within each of the nine required activities outlined in HSC §152. A high-level summary of those efforts is outlined below.

Activity (1) Perform strategic planning.

- Convened the Office of Health Equity Advisory Committee (OHE AC) with diverse experts and representatives to advance health and mental health equity, especially for underserved communities. The OHE AC advises on policies, enhances access to quality health services, and works to eliminate health disparities. The Committee meets quarterly to provide strategic guidance and ensure progress toward equity goals.
- Partnered with the Office of Policy and Planning (OPP) in the ongoing development and implementation of the Statewide Health Equity Plan (SHEP). This collaboration with local health jurisdictions, community organizations, and other partners, identifies strategies and priorities for collectively advancing health equity and improving community health.
- Participated in planning for the Department's California Syndromic Surveillance Program aimed to help protect the health and safety of California's diverse people and communities by supporting rapid detection and response to emerging health and safety threats.
- Developed and released the California Reducing Disparities Project Sustainability, Scalability and Systems Transformation Framework to respond to emerging opportunities and challenges, recognizing the intrinsic value of the historical and cultural expertise of people of color and LGBTQ+ communities.
- Convened the Children and Youth Behavioral Health Initiative Advisory Council to inform strategic direction and design of a statewide campaign to improve youth mental health.
- Served on the Health in All Policies Task Force to plan and collaborate across State agencies to advance racial equity in processes, policies, and distribution of resources.

- Served on various working groups and advisory committees, including, the Department of Managed Health Care's Transgender, Gender Diverse, or Intersex (TGI) Health Care Quality Standards and Training Curriculum Working Group; the UC Davis Community Advisory Committee for the Environmental Health Sciences Center; the Strategic Growth Council; the Public Health Alliance of Southern California Technical Advisory Committee; the Tracking California Advisory Committee; the Integrated Climate Adaptation and Resilience Program Technical Advisory Committee for the Office of Land Use and Climate Innovation (previously called the Office of Planning and Research); California Department of Education's LGBTQ+ Statewide Advisory Task Force; CDPH's Rape Prevention and Education (RPE) Program.

Activity (2) Conduct departmental policy analysis.

- Deputy Director served as chair of the Multicultural Technical Advisory Committee to plan for the 2025-2026 cycle of the California Health Interview Survey (CHIS), the nation's largest state-level health survey.
- Analyzed 17 state legislative bills for their potential impacts on CDPH, OHE, and the health of Californians facing inequities.
- Led CDPH's internal efforts to standardize the collection and display of sexual orientation and gender identity (SOGI) demographic data, worked with the Center for Health Statistics and Informatics and the Director's Office in response to the Joint Legislative Audit of compliance with SOGI demographic data collection mandates and co-authored a report outlining methods for determining population data on SOGI to support the calculation of population rates.
- Established the Tribal Health Equity Advisory Group (THEAG) and the Black Health Equity Advisory Group (BHEAG) to center community wisdom and expertise that inform CDPH policies and programs.

Activity (3) Coordinate projects funded by the state.

- Administered the California Reducing Disparities Project (CRDP), a first of its kind initiative designed to reduce mental health disparities experienced by historically unserved, underserved, and inappropriately served communities by increasing access to culturally and linguistically responsive services, through funding provided to 32-35 local community partners and five community specific technical assistance providers.
- Administered the Children and Youth Behavioral Health Initiative (CYBHI). Through CYBHI, OHE developed the statewide media campaign Take Space to Pause (TSTP). TSTP is a mental health stigma reduction effort that motivates

California teens to take help-seeking actions before mental health challenges become more serious. The campaign is running concurrently with local level efforts supported by 28 grantees across the state.
- Administered the Transgender, Gender Non-Conforming and Intersex (TGI) Wellness and Equity Fund – a first-of-its-kind investment addressing health inequities experienced by TGI communities, granting $10 million to 17 community-based organizations.
- Administered the Reproductive Justice Fund, which supports nonprofit organizations across the state to increase access to abortion services through education and outreach to people who have experienced systemic barriers to accessing abortion care. OHE provided 17 community-based organizations with $8.9 million in funding.
- Designed, launched and maintained California's online abortion information portal, abortion.ca.gov. The purpose of this website is to ensure that Californians have access to accurate information about access to abortion services as the federal landscape changes. From the launch date of 9/6/2022 through 6/30/2024, the website was viewed over 600,000 times, by more than 258,000 visitors.
- Administered the Lesbian, Bisexual, Transgender and Queer (LBTQ) Health Equity Initiative, funding $11.7 million in services. The LBTQ Initiative funds 31 community-based projects and 6 research studies in 55 counties throughout California. The projects include healthcare access, community outreach, and programs that build the capacity of medical providers to better serve LBTQ Californians.

Activity (4) Identify the unnecessary duplication of services and future service needs.

- Convened and coordinated with California Environmental Protection Agency offices on shared environmental health priorities.
- Convened the Cross-CDPH Climate Change and Health Equity Workgroup to coordinate departmental work on health impacts of climate change. Convened the Cross-CDPH Housing and Homelessness Workgroup to expand collaboration and implement a housing and homelessness collective impact model across CDPH.
- Convened, in partnership with Office of Policy and Planning, a Data Disaggregation Workgroup with community and academic partners and local health department and CDPH staff to support bi-directional communication and learning around disaggregating race and ethnicity data.

Activity (5) Communicate and disseminate information and perform liaison functions.

- The Deputy Director served as Departmental Tribal Liaison and Equity Officer.
- Hosted several meetings and trainings to promote engagement, connection, and best practices for improving social and structural determinants of health with local health jurisdictions, grantees, and community partners. Meetings occurred in areas of climate and health, behavioral health, LGBTQI+ health, data disaggregation, tribal health, culture and health, health equity, and community engagement.
- Hosted an annual convening for CRDP grantees to celebrate successes and prepare for the next year of the grant program.
- Initiated "The Effect of Climate Change on Californians' Health Storytelling" project to communicate the effects of climate change on health.
- Maintained public websites providing data, guidance, and information on behavioral health, health equity, climate and health, community engagement, and OHE programmatic efforts.
- Published and disseminated updated guidance for staying safe in the face of extreme heat: CDPH Extreme Heat Guidance for Local Health Jurisdictions; CDPH Extreme Heat Guidance for Schools; and the CDPH Interim Guide to Health Equity-Centered Local Heat Planning.
- Published a report on the 2022 California heat wave excess mortality, including results by race/ethnicity (CDPH Report - Excess Mortality During September 2022 Heat Wave in California).

Activity (6) Perform internal staff training and assessment for cultural competency

- Identified actionable steps to embed equitable measures within CDPH policies, procedures and workplace culture by 1) Increasing psychological safety among CDPH employees; 2) Integrating equity principles in operational plans, policies and procedures; and 3) Integrating equity tools in policy that influence program and budget decisions.
- Assessed competencies and experiences of over 2,000 CDPH staff related to anti-racism, equity, and psychological safety, while assessing the staff perception of organizational competencies regarding equity and becoming a healing organization.
- Assessed CDPH staff readiness to engage in equity work, community engagement, cultural humility, data collection and analysis, and program outcomes through an all-staff survey and key informant interviews of staff that work with Black and rural populations.
- Administered the 2022 and 2023 annual Organizational Assessment for Equity Infrastructure to Local Health Jurisdictions to assess and understand local

public health capacity for equity, identify technical assistance needs and inform the State Health Equity Plan (SHEP).
- Provided training and technical assistance to over 1,200 CDPH staff on LGBTQ+ culturally competent program development, the use of inclusive language, transgender health, sexual orientation and gender identity demographic data collection and gender-inclusive hiring practices.

Activity (7) Serve as a resource for ensuring that programs collect and keep data and information, strategies, and programs related to multicultural health issues

- Released a report on *Asian and Pacific Islander Data Disaggregation Highlights* in response to Assembly Bill 1726 (2015-2016), in collaboration with departmental partners.
- Published the legislatively mandated *Demographic Report on Health and Mental Health Equity in California* in October 2023.
  Maintained and updated data dashboards and tools including Healthy Communities Indicators project and the Climate Change and Health Vulnerability Indicators.
- Released *The California Reducing Disparities Project Phase 2 Statewide Evaluation Report* on the effectiveness and return on investment of community-defined evidence practices. Results showed an economic return on investment (ROI) of $4.32 to $5.67 for every dollar invested.
- Trained over 650 local health jurisdiction staff on sexual orientation and gender identity and gender-inclusive language guidance.

Activity (8) Encourage innovative responses by public and private entities that are attempting to address multicultural health issues.

- Implemented the Centers for Disease Control and Prevention (CDC)-funded California Building Resilience and Climate Equity (CalBRACE) Project. These funds support three California-based Tribes to conduct climate adaptation and mitigation projects, the Community Health Workers, Healthy Homes, and Healthy Families weatherization pilot project, and provide technical assistance to local health jurisdictions and tribes.
- Contributed to California's Fifth Climate Change Assessment, that will highlight the current and future impacts and inequities of climate change on health in California populations.
- Supported the Hoopa Valley Tribe in Humboldt County with designing and implementing a rapid needs assessment, with the aim of understanding tribal members' experiences during and after severe winter storms, to better protect health in the future.

- Designed and implemented a grant-funding structure to support small community-based organizations in successfully applying for and receiving state funding. This equitable approach to funding levels the playing field, supports the long-term sustainability of these organizations and builds lasting partnerships for future collaborations.
- Funded research studies focused on identifying gaps and needs in reproductive health and abortion coverage throughout California, gender affirming care, and the intersection of racism and homophobia experienced by queer Black or African American parents in family support systems.
- Conducted 21 virtual town hall meetings for with local community partners in LGBTQ+ communities focused on program design for health equity initiatives.

Activity (9) Provide technical assistance related to funding for multicultural health.

- Funded efforts through the CRDP to support sustainability of local community implementation of community-based evidence practices using a 3S - sustainability, scalability, and systems- approach in partnership with the CRDP Cross-Population Scaling and Sustainability Committee.
- Provided funding, programmatic and administrative oversight for five ongoing, priority population-specific technical assistance providers to support local CRDP implementation.
- Funded the Community Health Workers, Healthy Families, and Healthy Homes project to train and support community health workers to connect farmworker families with low-income with energy efficiency and weatherization services to improve their housing conditions and health outcomes.
- Provided technical assistance to local health jurisdiction health equity leads to reduce health inequities and improve the wellbeing of California's communities.
- Provided training and technical assistance to 21 TGI Fund grantees, including specialized technical assistance for capacity building.
- Provided training and technical assistance to 28 community grantees to support development and implementation of CYBHI Local-Level campaigns, including a monthly Test, Share and Learn (TSL) Lab for co-learning across campaigns.
- Built infrastructure to facilitate meaningful engagement with local health jurisdiction, tribal, and community-based partners though health equity specialists with experience serving marginalized and underserved communities including Black, Tribal, Latino/x, Asian American/Native Hawaiian/Pacific Islander, rural, people with disabilities, and people experiencing homelessness.

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