

Place & Health: Is Your Zip Code More Important Than Your Genetic Code?

CDPH Health Equity Speakers Series
February 10, 2016
Sacramento, CA

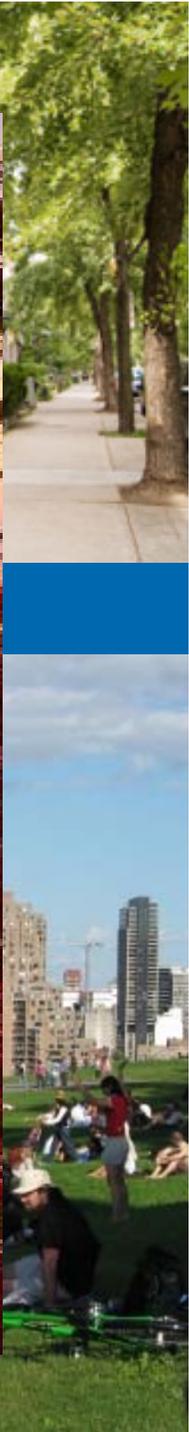
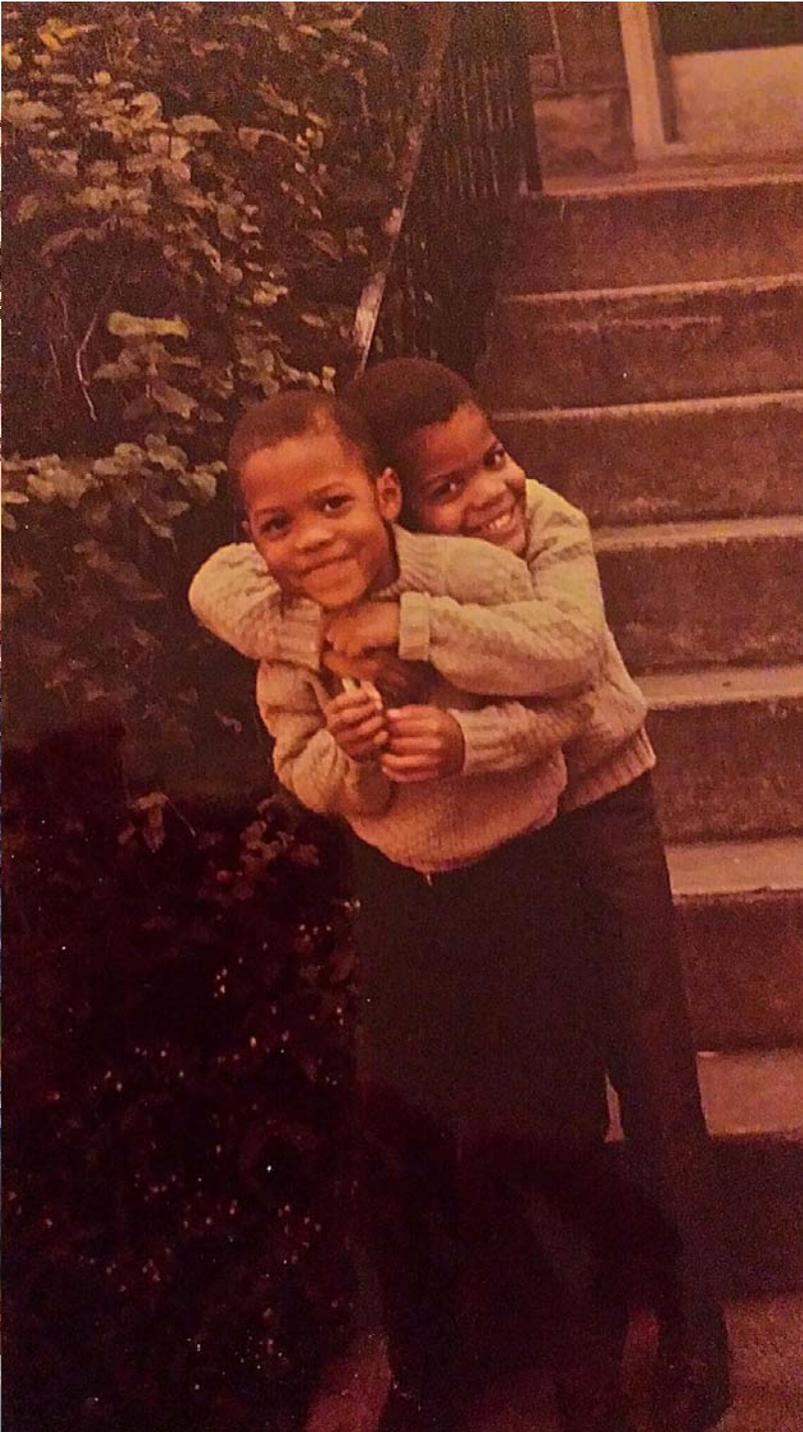
Tony Iton, M.D., J.D., MPH
The California Endowment

➤ *I will say then that I am not, nor ever have been, in favor of bringing about in any way the social and political equality of the white and black races — that I am not, nor ever have been, in favor of making voters or jurors of negroes, nor of qualifying them to hold office, nor to intermarry with white people; and I will say in addition to this that there is a physical difference between the white and black races which I believe will forever forbid the two races living together on terms of social and political equality. And inasmuch as they cannot so live, while they do remain together there must be the position of superior and inferior, and I as much as any other man am in favor of having the superior position assigned to the white race.*

- Abraham Lincoln 1858

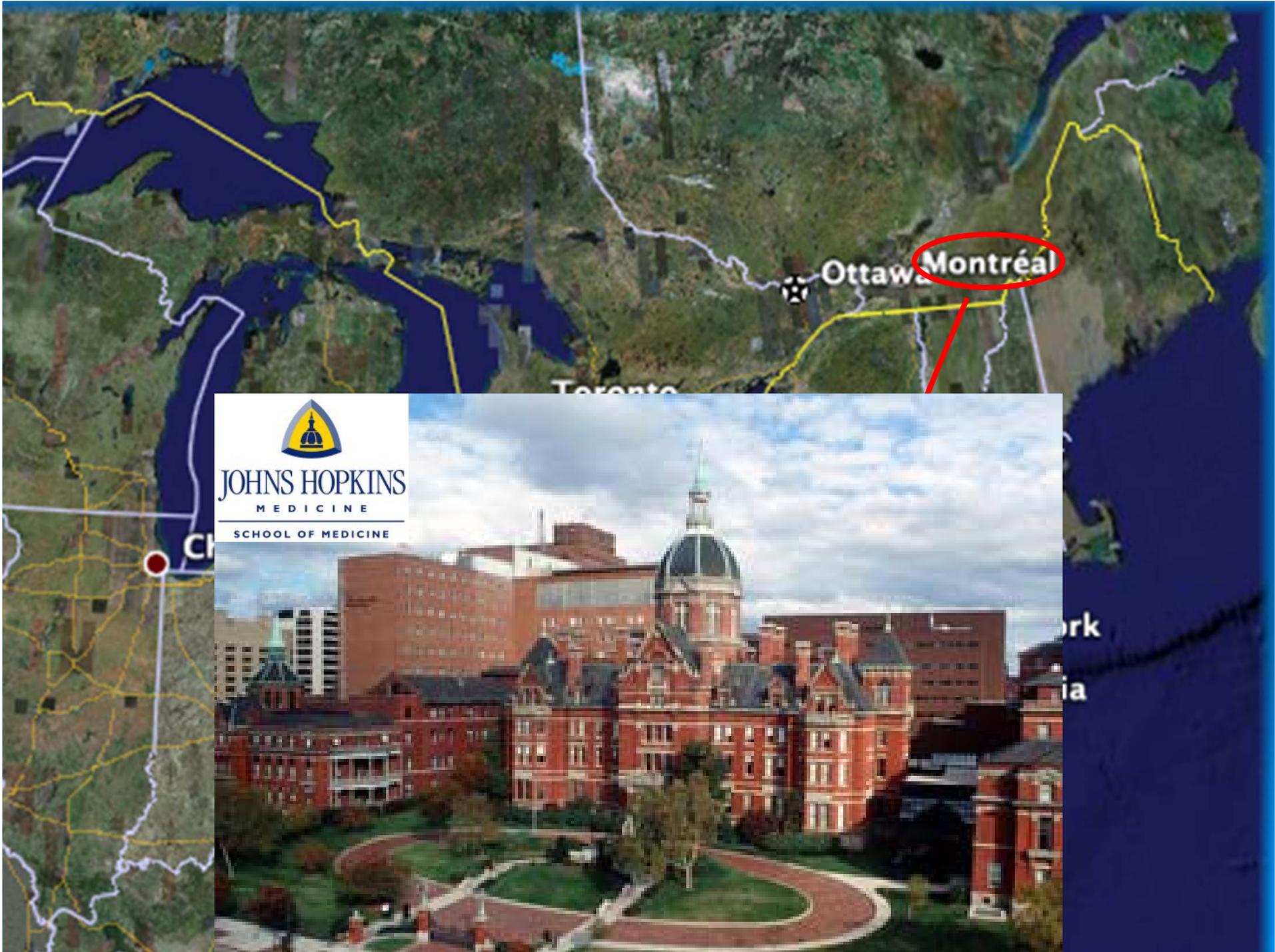
Why Place Matters





Canadian Social Contract

- Universal health insurance-Canada Health Act
- Universal dental care to age 10
- Universal child care benefit
- Highly subsidized post secondary education
- High quality community resources-parks, sports leagues, libraries, community centers





LIFE

**Does Your *Zip Code*
Matter More Than
Your *Genetic Code* ?**

CERTIFICATE OF DEATH

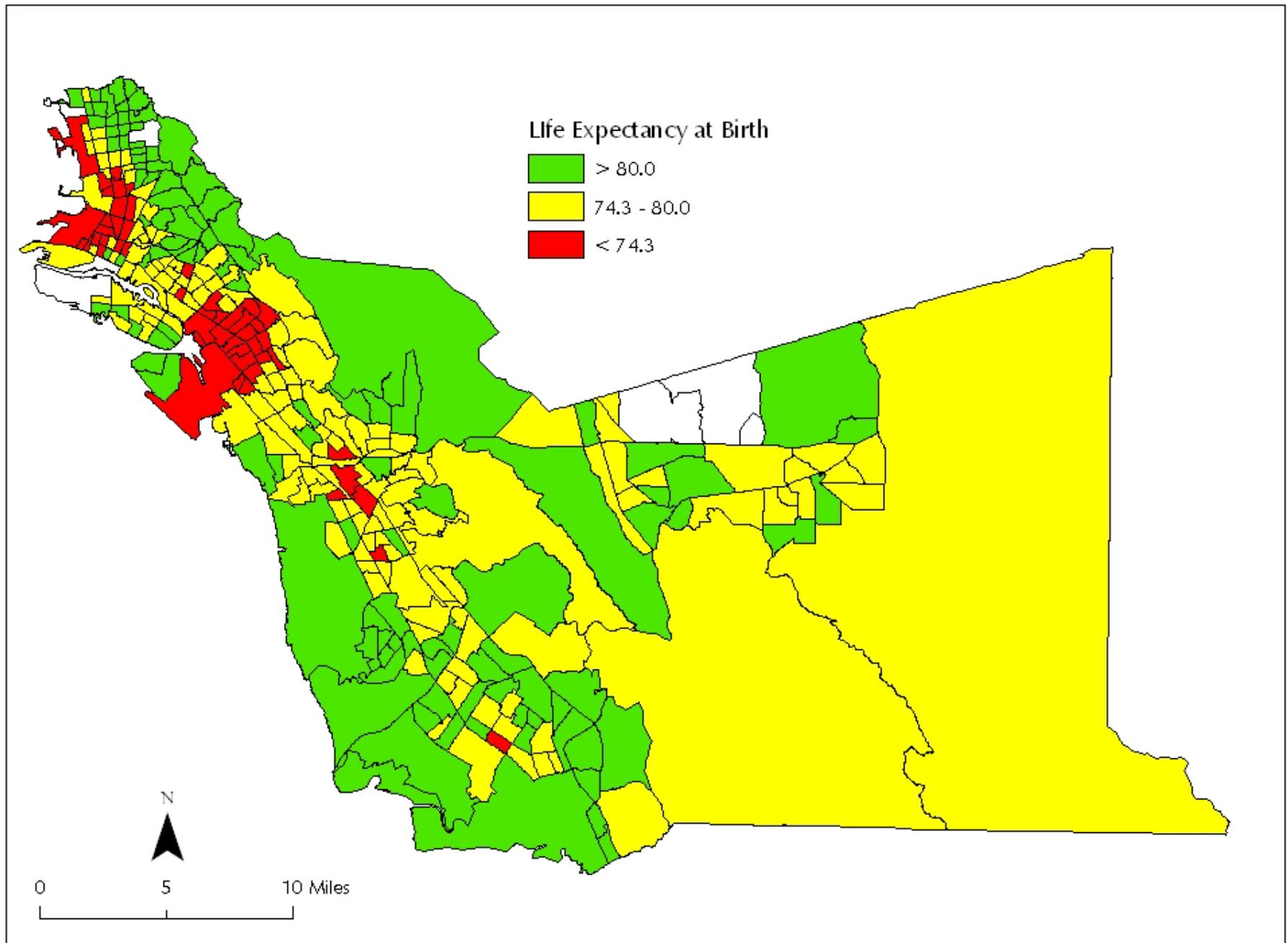
STATE OF CALIFORNIA
USE BLACK INK ONLY / NO ERASURES, WHITEOUTS OR ALTERATIONS
VS-1 (REV 1/04)

3200701000029

STATE FILE NUMBER		LOCAL REGISTRATION NUMBER	
1. NAME OF DECEDENT -- FIRST (Given) DONALD		3. LAST (Family) DUCK	
2. MIDDLE H.		4. DATE OF BIRTH mm/dd/yyyy 02/14/1937	
5. AGE Yrs. 69		6. SEX M	
9. BIRTH STATE/FOREIGN COUNTRY FINLAND		10. SOCIAL SECURITY NUMBER 243-65-9974	
11. EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNK		12. MARITAL STATUS (at time of Death) NEVER MARRIED	
13. EDUCATION -- Highest Level/Degree (see worksheet on back) 06		14/15. WAS DECEDENT HISPANIC/LATINO(A)/SPANISH? (if yes, see worksheet on back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
17. USUAL OCCUPATION -- Type of work for most of life. DO NOT USE RETIRED TEACHER		18. KIND OF BUSINESS OR INDUSTRY (e.g., grocery store, road construction, employment agency, etc.) EDUCATION	
19. YEARS IN OCCUPATION 4		20. DECEDENT'S RESIDENCE (Street and number or location) 348 8TH AVE	
21. CITY ALAMEDA		22. COUNTY/PROVINCE ALAMEDA	
23. ZIP CODE 94501		24. YEARS IN COUNTY 3	
25. STATE/FOREIGN COUNTRY CA		27. INFORMANT'S MAILING ADDRESS (Street and number or rural route number, city or town, state, ZIP) 345 HIGH ST, OAKLAND, CA 94601	
26. INFORMANT'S RELATIONSHIP SUE -, MOUSE		28. NAME OF SURVIVING SPOUSE -- FIRST -	
29. MIDDLE -		30. LAST (Maiden Name) -	
31. NAME OF FATHER -- FIRST THOMAS		32. MIDDLE -	
33. LAST DUCK		34. BIRTH STATE CA	
35. NAME OF MOTHER -- FIRST MINNIE		36. MIDDLE -	
37. LAST (Maiden) UNKNOWN		38. BIRTH STATE UNKNOWN	
39. DISPOSITION DATE mm/dd/yyyy 01/22/2007		40. PLACE OF FINAL DISPOSITION RES 345 HIGH ST, OAKLAND, CA 94601	
41. TYPE OF DISPOSITION(S) CR/RES		42. SIGNATURE OF EMBALMER MANUEL FLORES	
43. LICENSE NUMBER EMB6370		44. NAME OF FUNERAL ESTABLISHMENT CLARENCE N COOPER MORTUARY INC	
45. LICENSE NUMBER FD381		46. SIGNATURE OF LOCAL REGISTRAR ANTHONY ITON, M.D.	
47. DATE mm/dd/yyyy 01/18/2007		101. PLACE OF DEATH EDEN MEDICAL CENTER	
102. IF HOSPITAL, SPECIFY ONE <input checked="" type="checkbox"/> IP <input type="checkbox"/> ER/OP <input type="checkbox"/> DOA		103. IF OTHER THAN HOSPITAL, SPECIFY ONE <input type="checkbox"/> Hospice <input type="checkbox"/> Nursing Home/ LTC <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Other	
104. COUNTY ALAMEDA		105. FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number or location) 20103 LAKE CHABOT RD	
106. CITY CASTRO VALLEY		107. CAUSE OF DEATH as chain of events -- diseases, injuries, or complications -- that directly caused death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. IMMEDIATE CAUSE (A) PNEUMONIA	
108. DEATH REPORTED TO CORONER? Time Interval Between Cause and Death (A) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO REFERRAL NUMBER 0		109. BIOPSY PERFORMED? (B) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
110. AUTOPSY PERFORMED? (C) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		111. USED IN DETERMINING CAUSE? (D) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
112. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107 DEMENTIA			
113. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 107 OR 112? (if yes, list type of operation and date.) NO			
113A. IF FEMALE, PREGNANT IN LAST YEAR? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK			
114. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED. Decedent Attended Since mm/dd/yyyy Decedent Last Seen Alive mm/dd/yyyy		115. SIGNATURE AND TITLE OF CERTIFIER GARY WINSETT BROWN M.D.	
116. LICENSE NUMBER A38965		117. DATE mm/dd/yyyy 02/03/2006	
118. TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE MICHAEL ANDREW HOGARTH M.D. 2315 STOCKTON BLVD, SACRAMENTO, CA 95817		119. I CERTIFY THAT IN MY OPINION DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED.	
120. INJURED AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK		121. INJURY DATE mm/dd/yyyy	
122. HOUR (24 Hours) 0034		123. PLACE OF INJURY (e.g., home, construction site, wooded area, etc.)	
124. DESCRIBE HOW INJURY OCCURRED (Events which resulted in injury)			
125. LOCATION OF INJURY (Street and number, or location, and city, and ZIP)			
126. SIGNATURE OF CORONER / DEPUTY CORONER		127. DATE mm/dd/yyyy	
128. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER		129. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER	
STATE REGISTRAR	A	B	C
	D	E	
FAX AUTH. #		CENSUS TRACT	

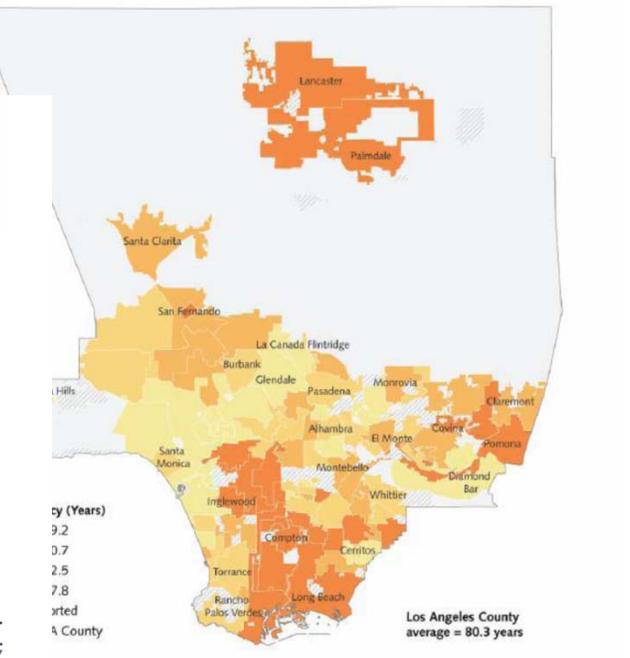
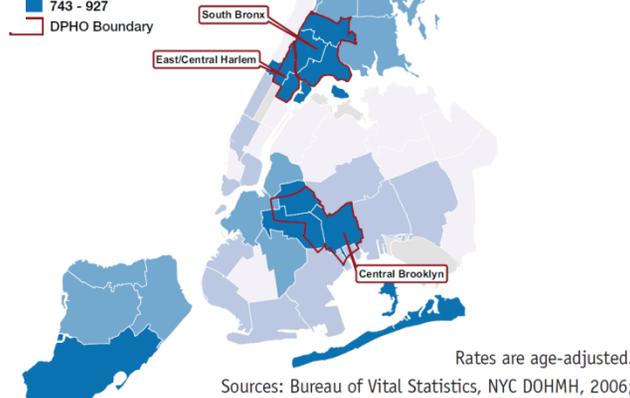
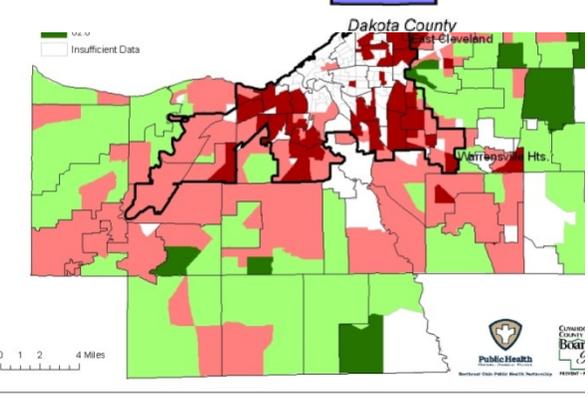
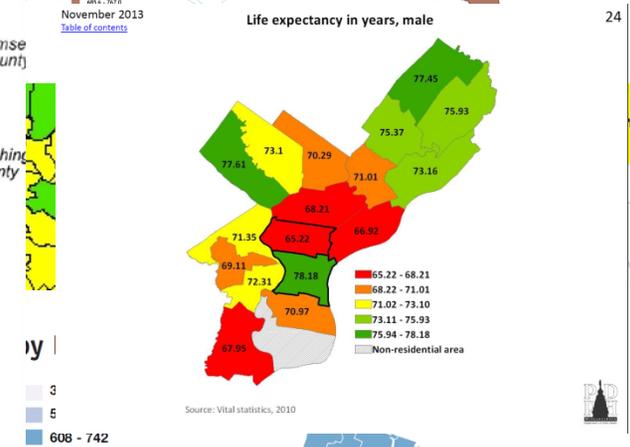
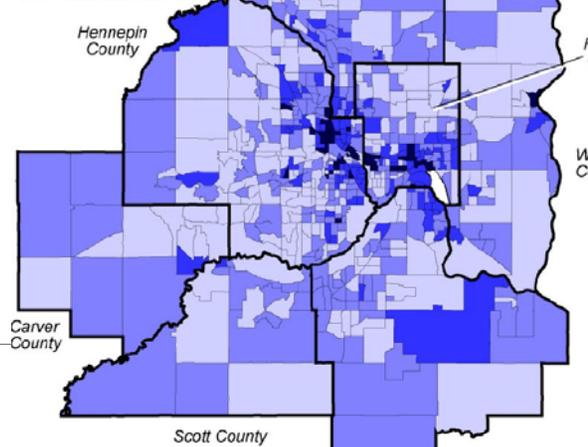
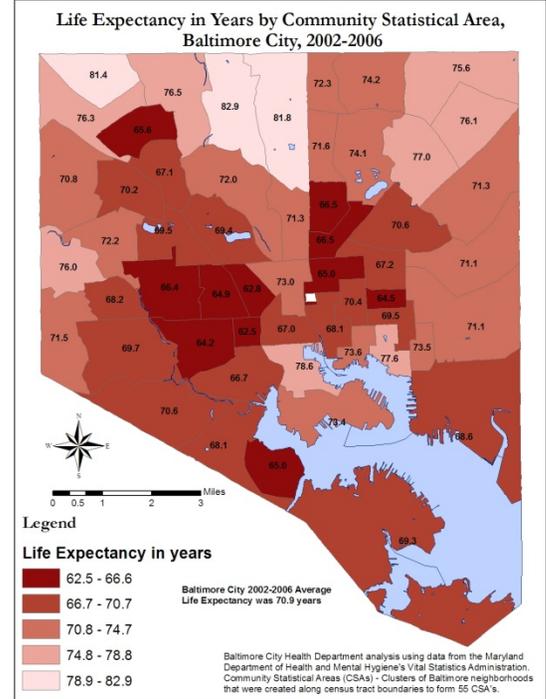
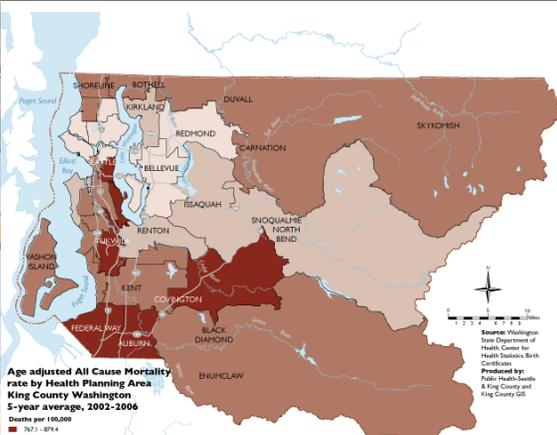
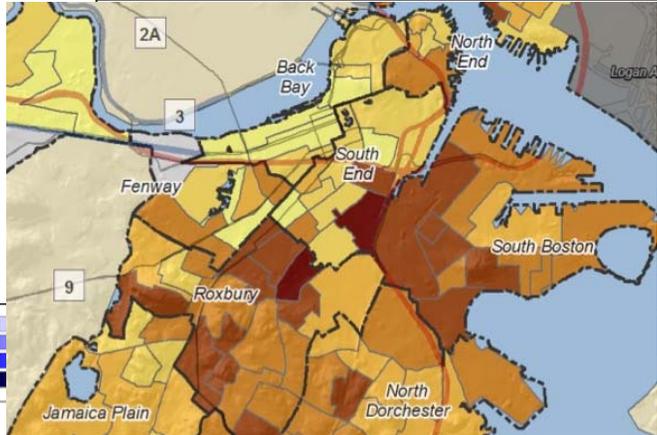


Life Expectancy by Tract

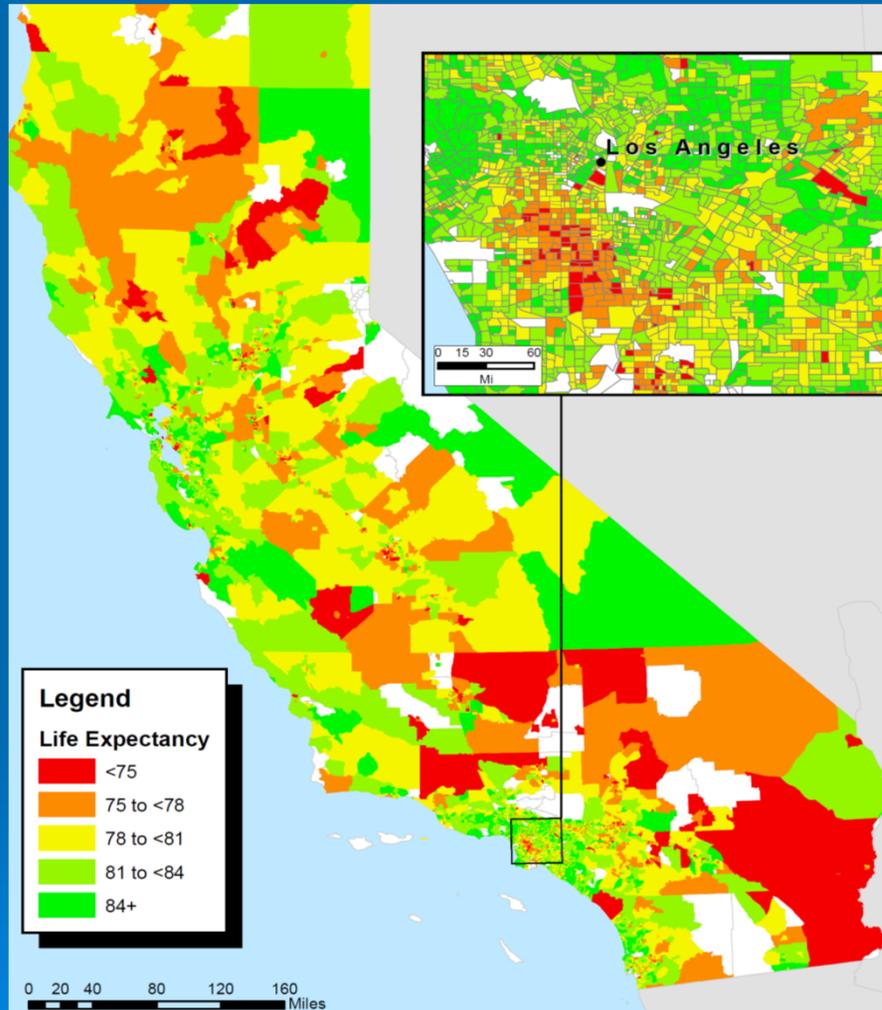


Source: CAPE, with data from vital statistics 1999-2001.

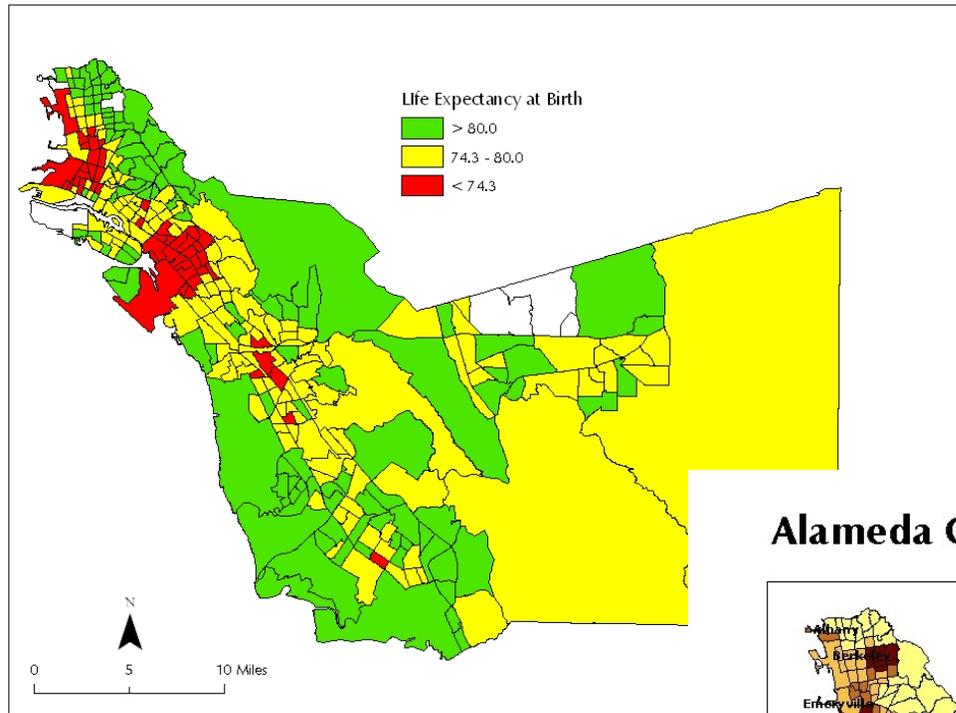
Life Expectancy by Tract



Life expectancy by census tract

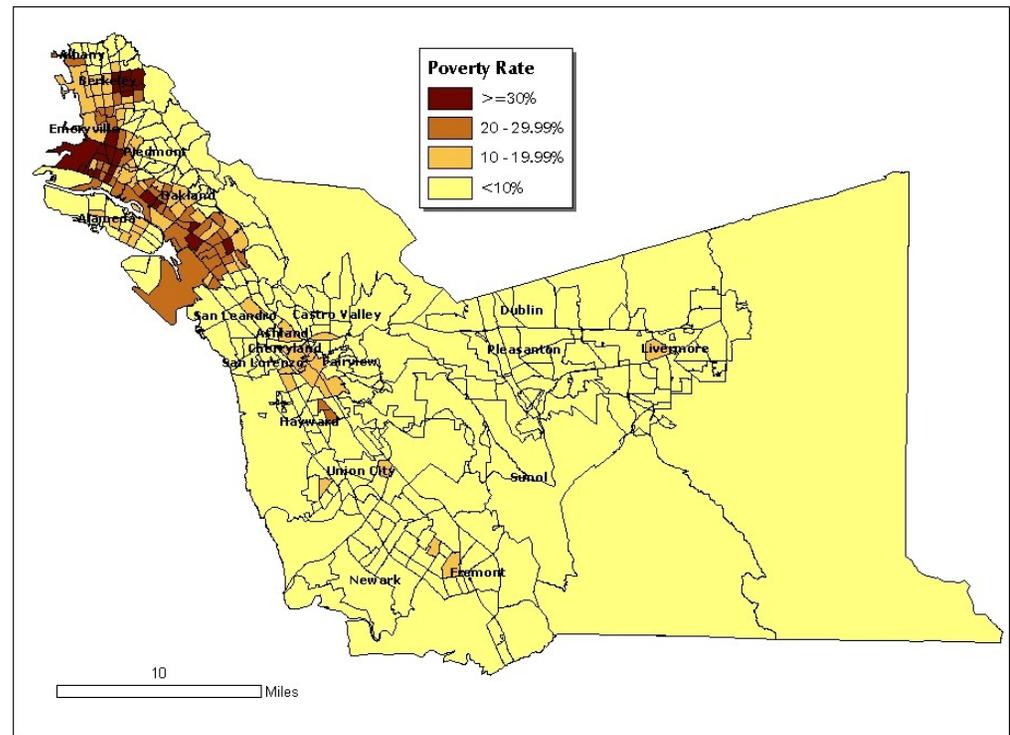


Life Expectancy by Tract



Source:

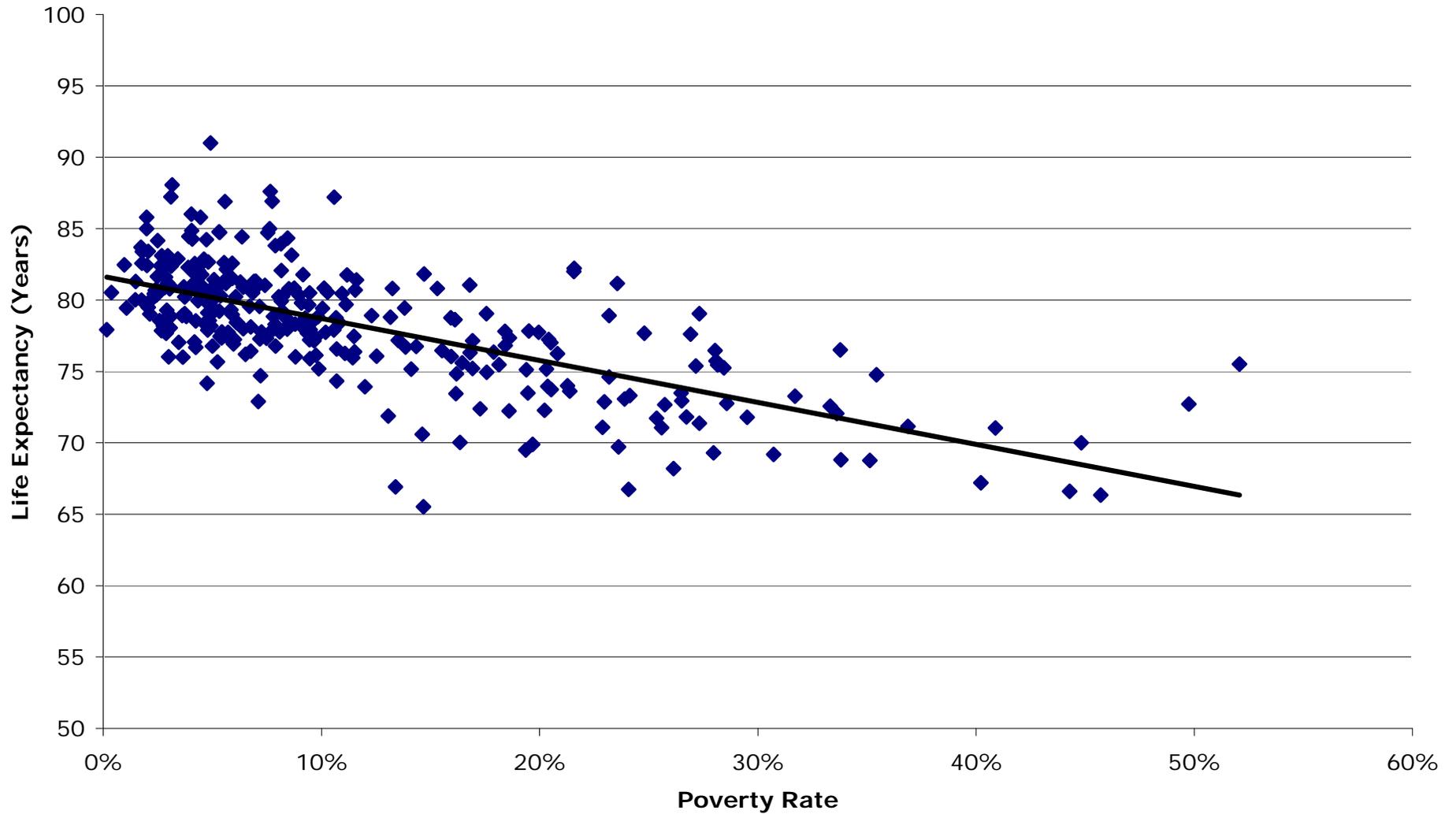
Alameda County Poverty



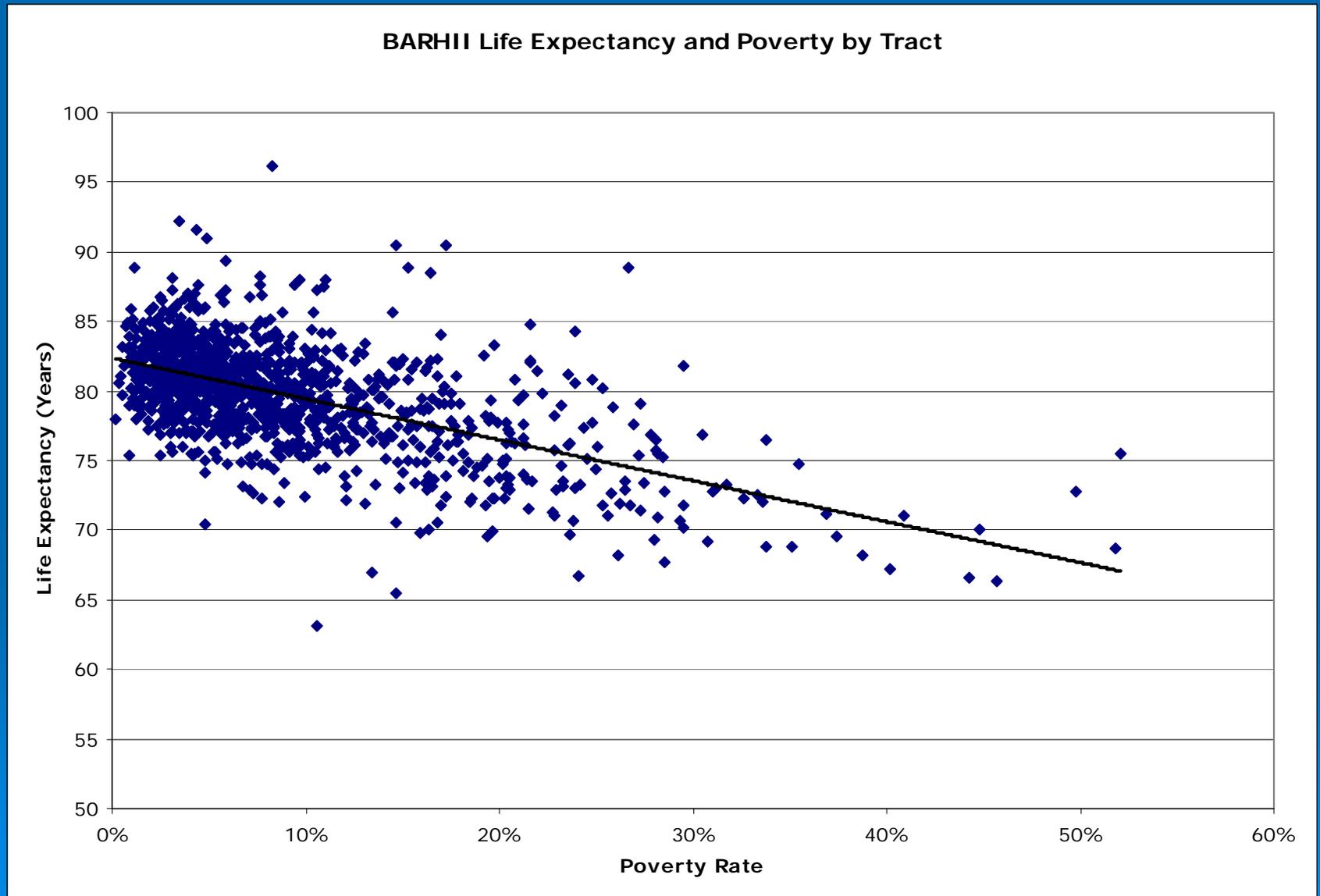
Source: CAPE; Census 2000.

Life Expectancy by Poverty Group 2000-2003

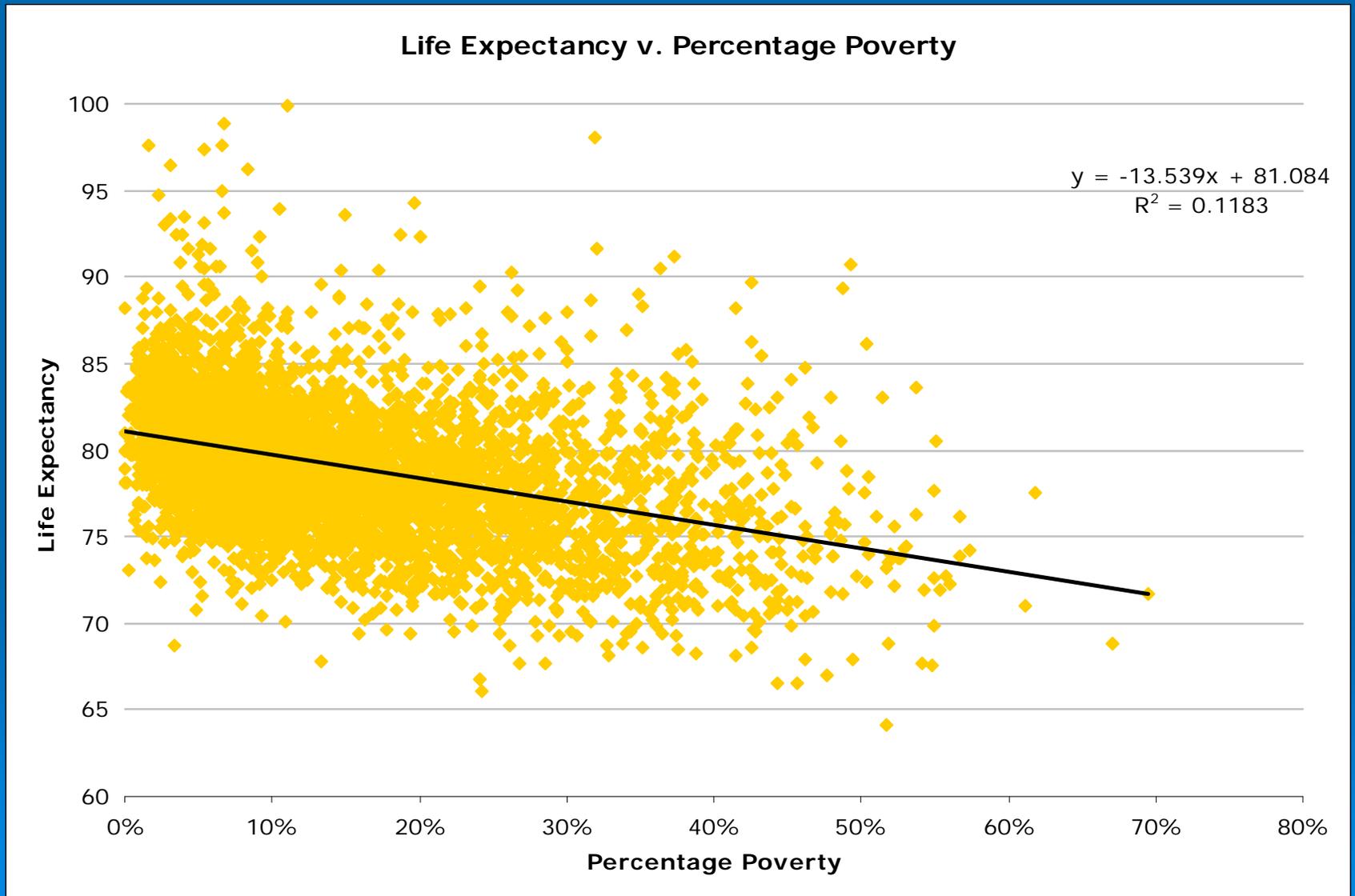
Alameda County



Bay Area Poverty vs. Life Expectancy



California Poverty vs. Life Expectancy



Cost of Poverty in San Francisco Bay Area

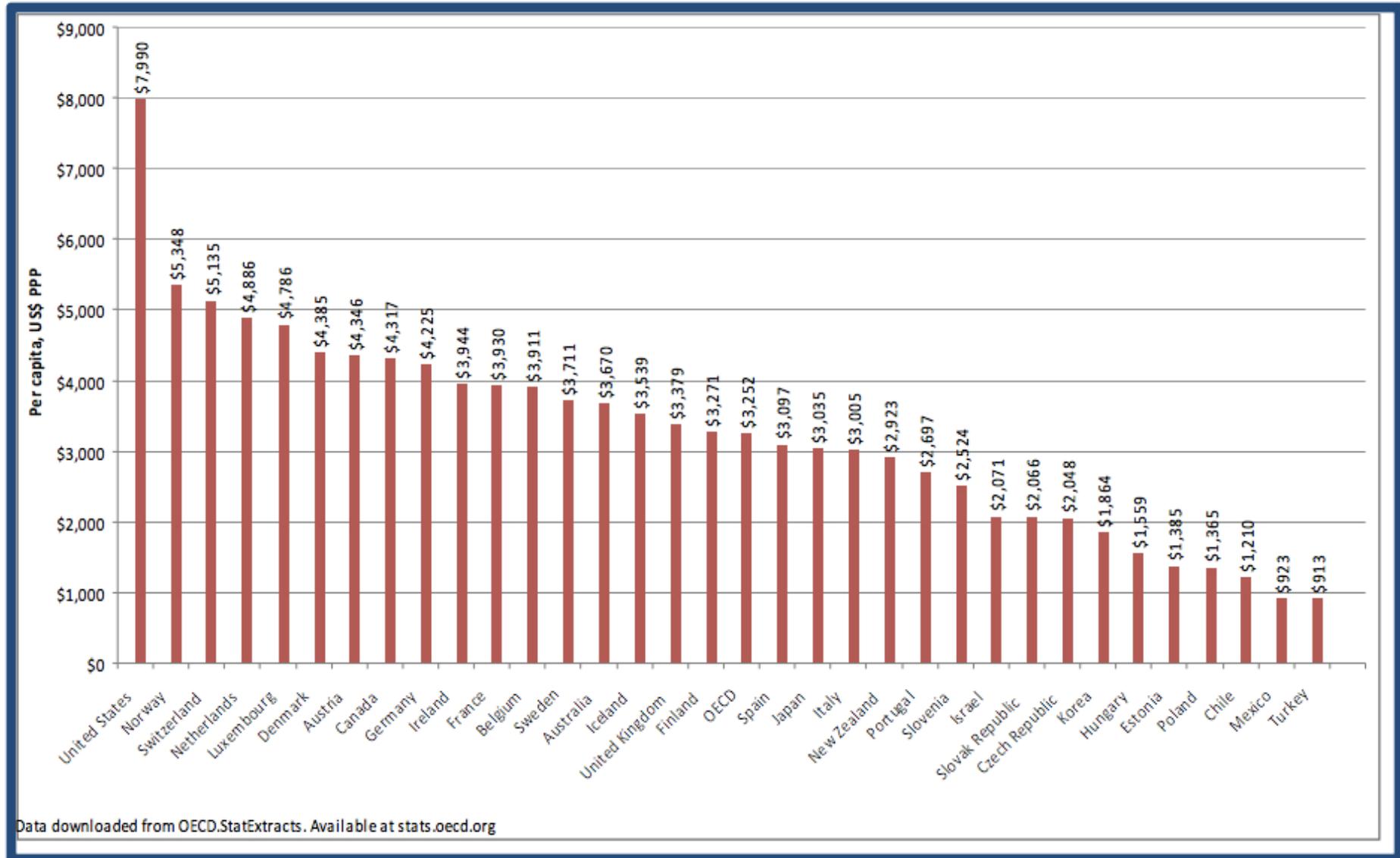
- *Every additional \$12,500 in household income buys one year of life expectancy*
- *(Benefit appears to plateau at household incomes above \$150,000)*
- *Similar gradients in Baltimore, NYC, Philadelphia, Hennepin County (Minneapolis-St. Paul), Colorado, California, AND Cuyahoga County (\$6304/year of life)*

The shape of health to come: prospective study of the determinants of 30-year health trajectories in the Alameda County Study

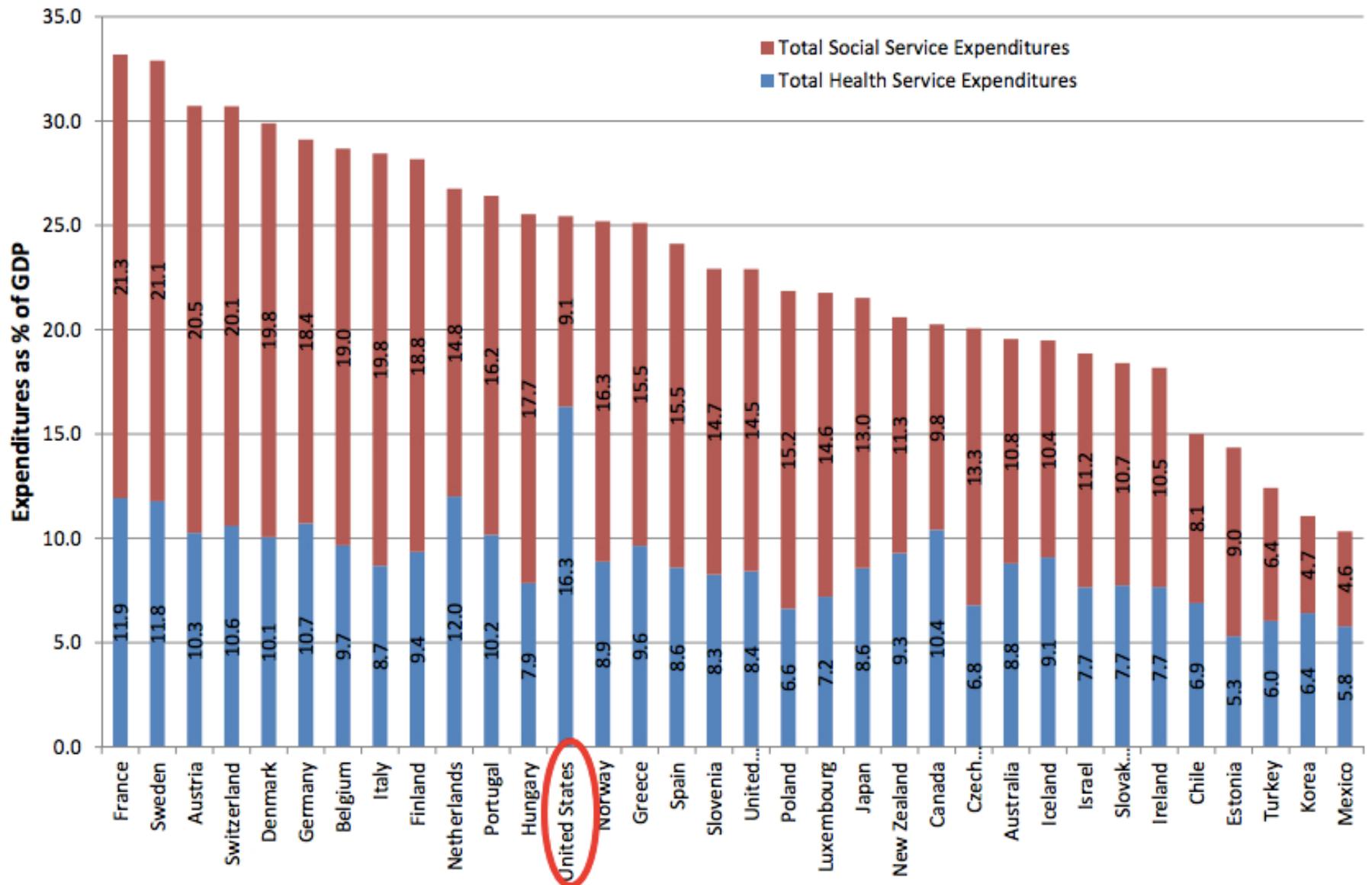
George A Kaplan,^{1*} Peter T Baltrus² and Trivellore E Raghunathan³

A 30 year longitudinal study of nearly 7000 Alameda County residents from 1965 forward. Those residents with household income 1 SD above mean were 25% less likely to die prematurely, 1 SD below mean were 35% more likely to die early.

Spending on health care



Total health care investment in US is *less*



In OECD, for every \$1 spent on health care, about \$2 is spent on social services
In the US, for \$1 spent on health care, about 55 cents is spent on social services

Findings

The ratio of social to health spending was significantly associated with better health outcomes:

- Less infant mortality, low birth weight, premature death; longer life expectancy
- Non-significant for maternal mortality

This remained true even when the US was excluded from the analysis

Life Expectancy of White Americans



US Whites

	Life Expectancy
US White	79 years*
Qatar	79 years
Costa Rica	79 years
Nauru	79 years

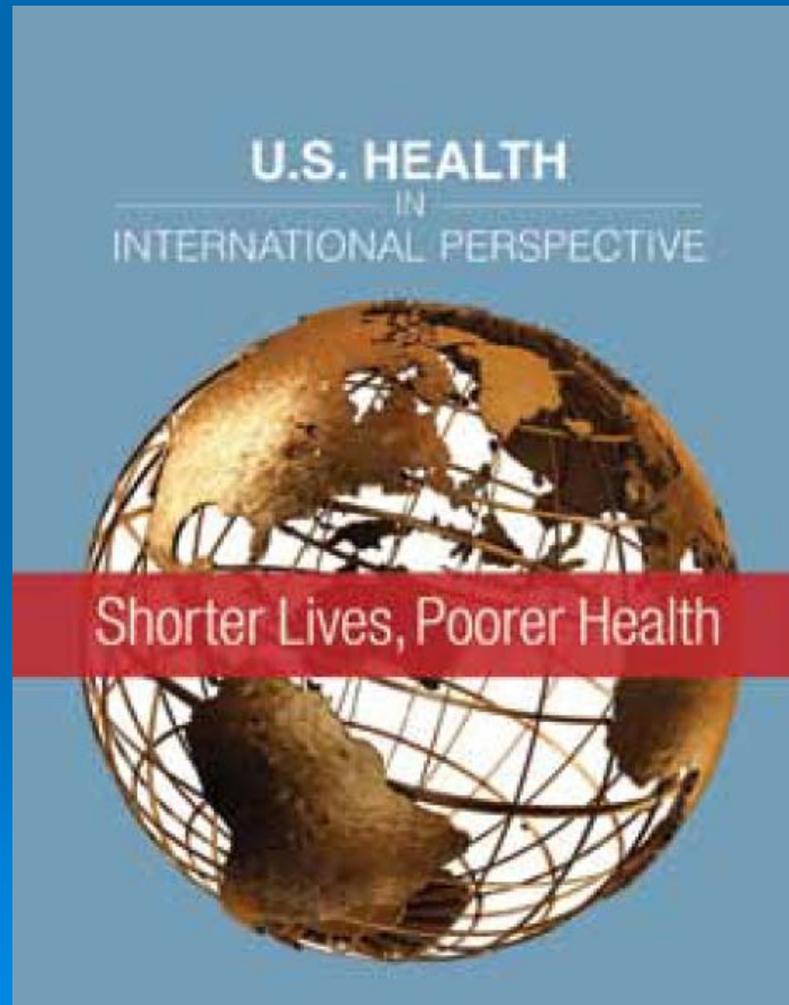
US Whites Living Shorter Lives Than:

- 80 years: Belgium, Chile, Denmark, Lebanon, Slovenia
- 81 years: Austria, Finland, Germany, Greece, Ireland, Malta, Netherlands, Portugal, UK
- 82 years: Canada, Cyprus, France, Iceland, Israel, S. Korea, Luxembourg, Monaco, New Zealand, Norway, Sweden
- 83 years: Andorra, Australia, Italy, San Marino, Singapore, Spain, Switzerland
- 84 years: Japan

- 33 countries (only 17 in 1990)

“Shorter Lives, Poorer Health”

-January 2013 IOM Report on US Health Compared to 17 peer countries



“Shorter Lives, Poorer Health”

-January 2013 IOM Report on US Health Compared to 17 peer countries

- “ *The panel was struck by the gravity of its findings.* For many years, Americans have been dying at younger ages than people in almost all other high-income countries. This disadvantage has been getting worse for three decades, especially among women.

“Shorter Lives, Poorer Health”

-January 2013 IOM Report on US Health Compared to 17 peer countries

- “The US health disadvantage cannot be fully explained by the health disparities that exist among people who are uninsured or poor, as important as these issues are. Several studies are now suggesting that even advantaged Americans—those who are white, insured, college-educated, or upper income—are in worse health than similar individuals in other countries.”

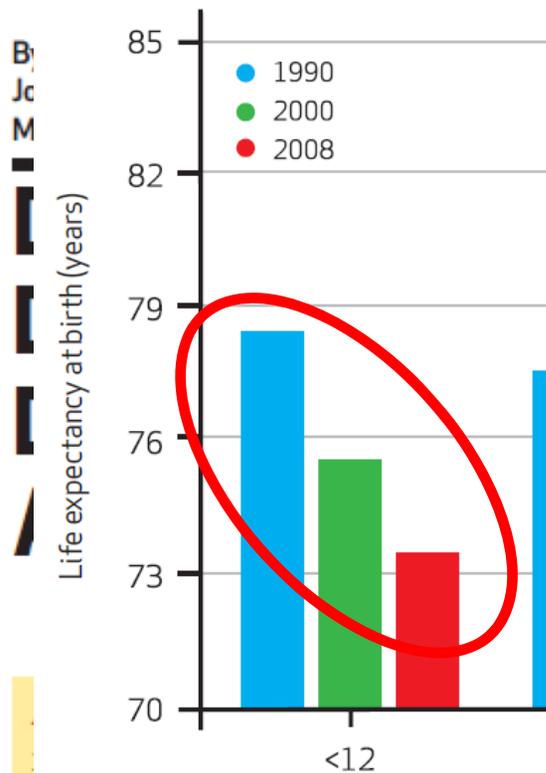
Life span of
women not
uneducated

Health Affairs Blog

HOME TOPICS ARCHIVE SUBMIT

ASSOCIATED TOPICS: EQUITY AND DISPARITIES, POPULATION HEALTH, PUBLIC HEALTH

Life Expectancy At Birth, By Years



To Understand Climbing Death Rates Among Whites, Look To Women Of Childbearing Age

Laudan Aron, Lisa Dubay, Elaine Waxman, and Steven Martin

November 10, 2015

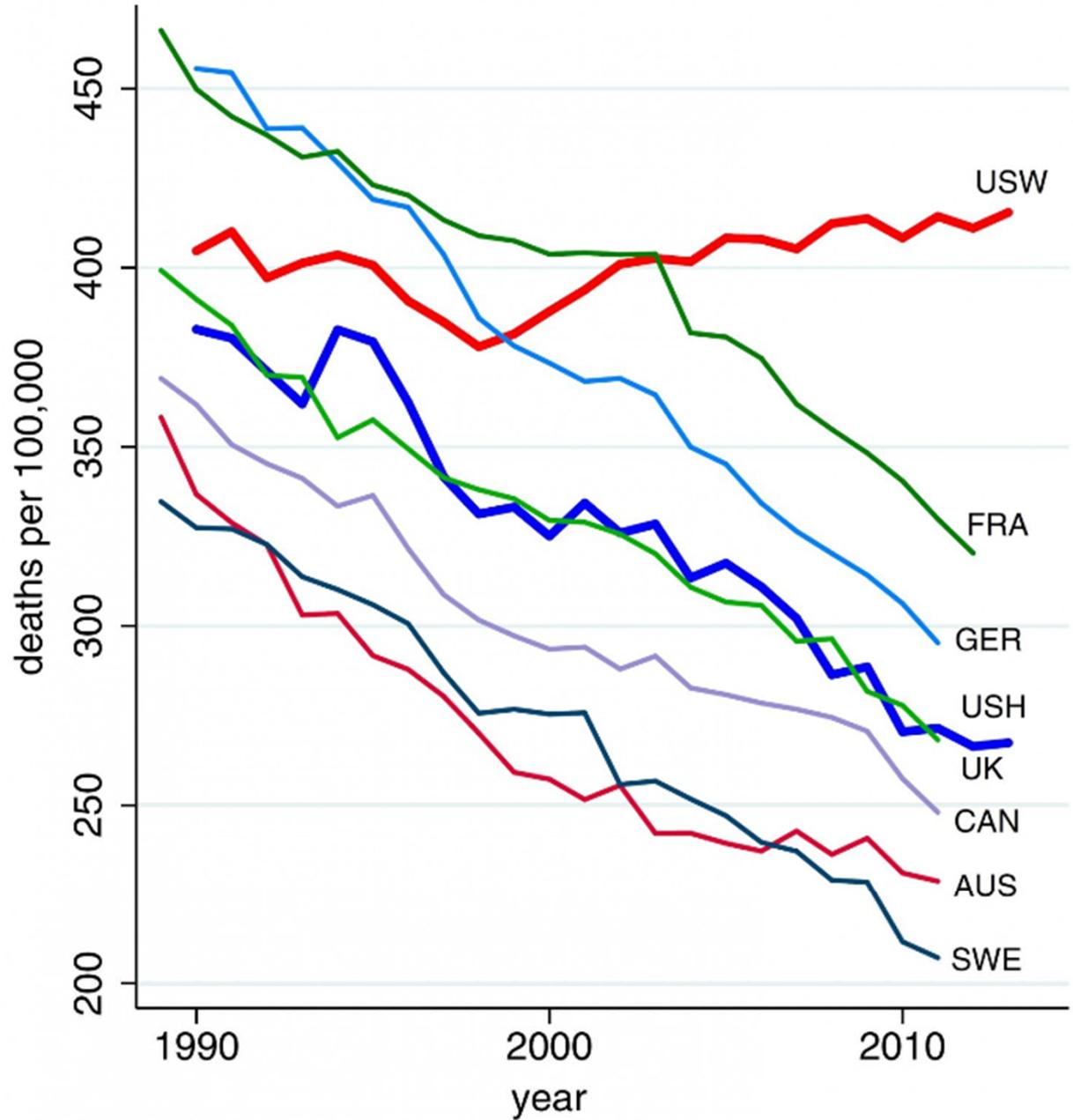




HEALTH

Death Rates Rising for

By GINA KOLATA NOV. 2, 2015



Death rate for U.S. non-Hispanic whites (USW), U.S. Hispanics and six comparison countries, aged 45-54. (Source: Proceedings of the National Academy of Sciences.)

6'0"
5'10"
5'8"
5'6"
5'4"
5'2"
5'0"
4'10"

PRISON
\$62,300

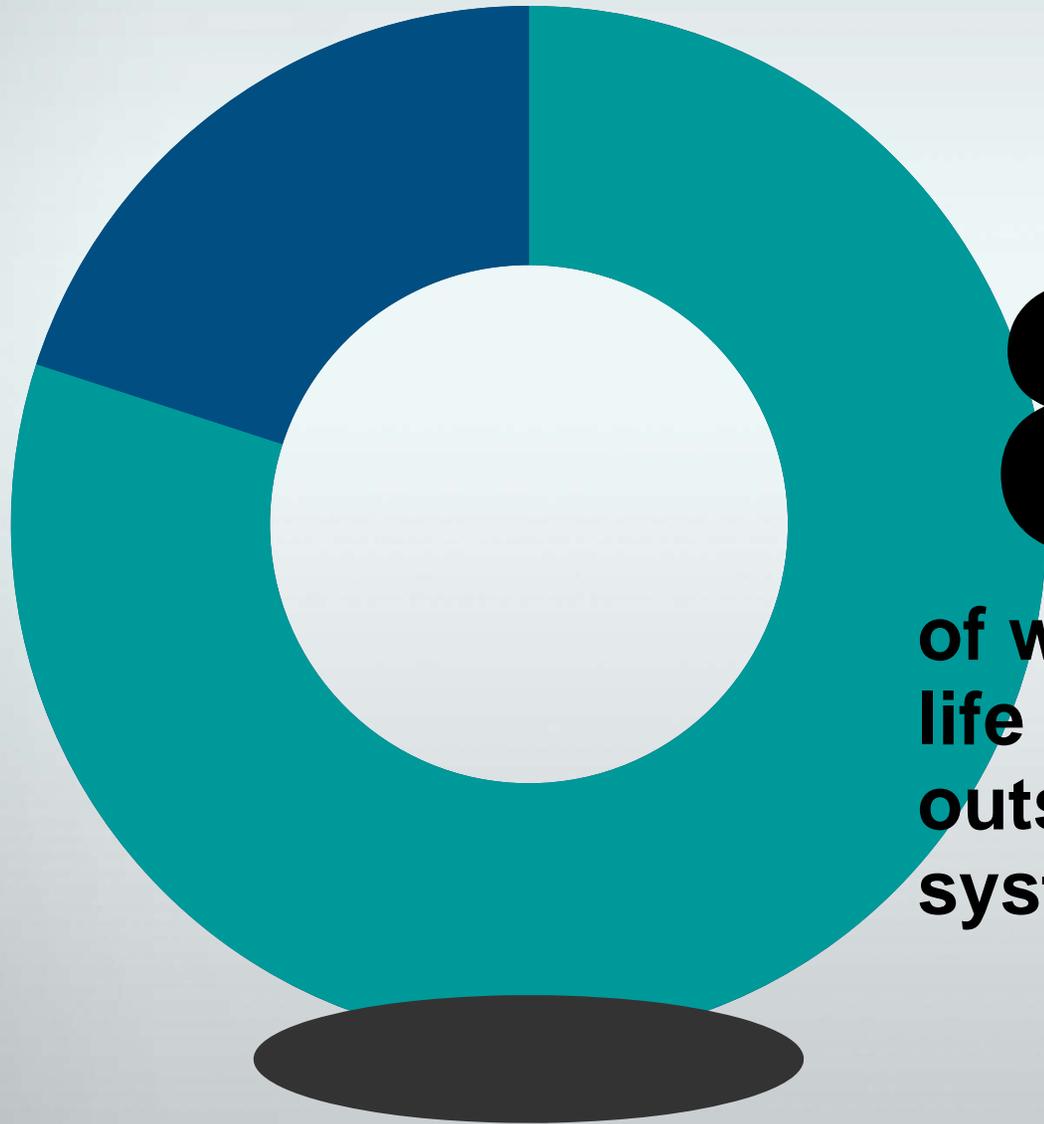
health happens here

SCHOOL
\$9,100

Do the math.

CSWA

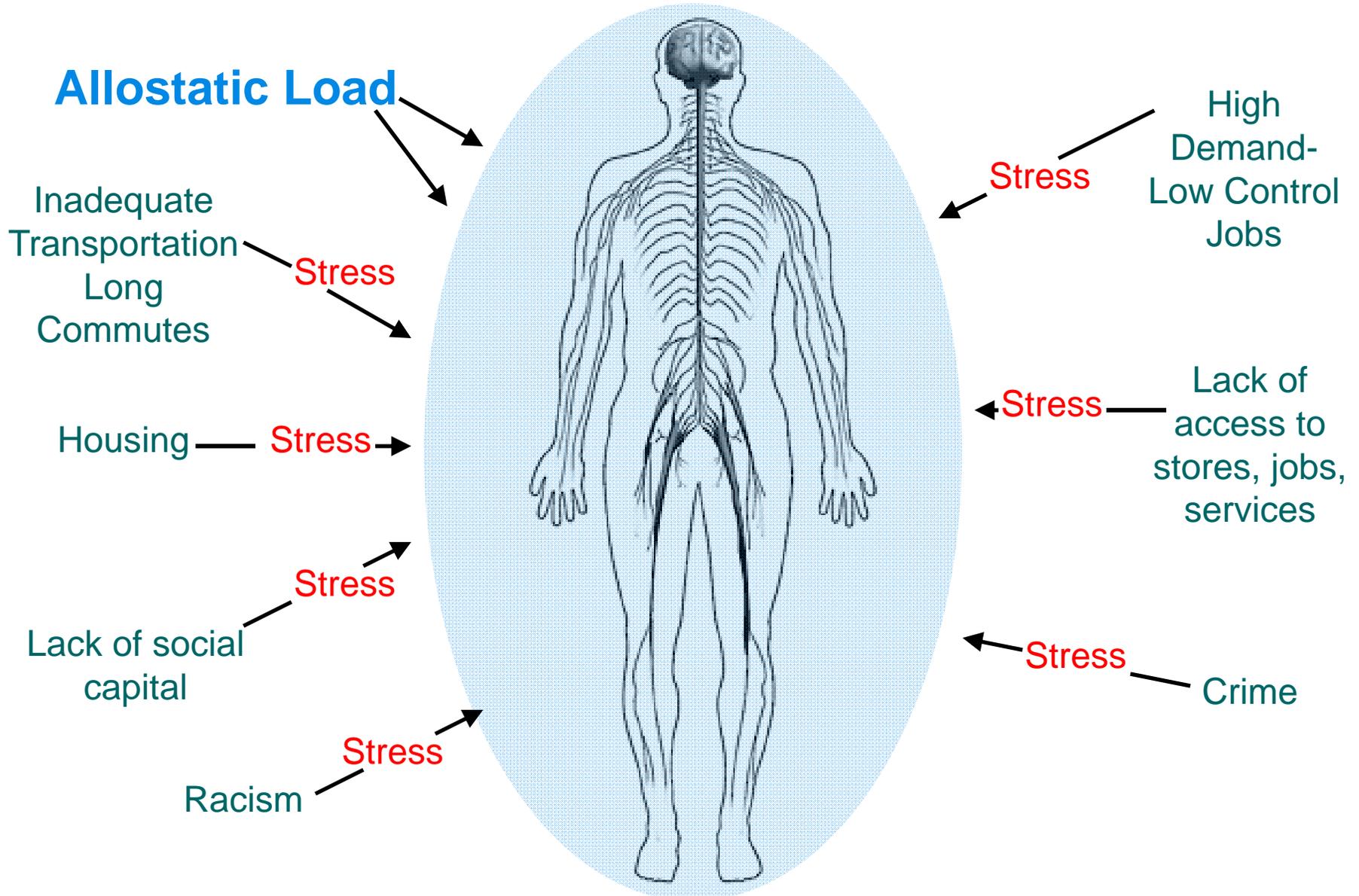




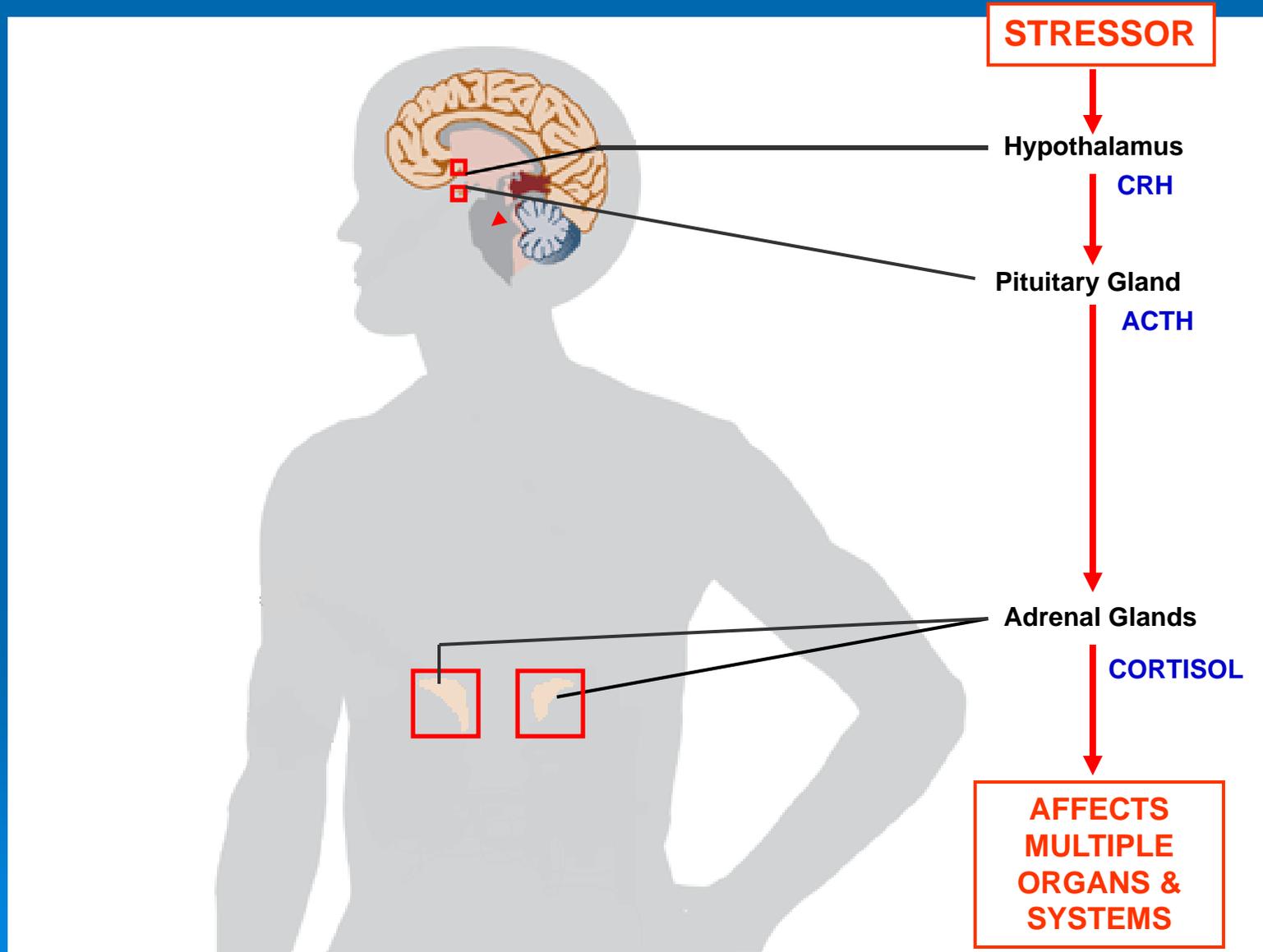
80%

**of what influences your
life expectancy happens
outside of the healthcare
system**

When the external becomes internal: How we internalize our environment



Stress pathway from brain to body



Stressed vs. Stressed Out

➤ Stressed

- Increased cardiac output
- Increased available glucose
- Enhanced immune functions
- Growth of neurons in hippocampus & prefrontal cortex

➤ Stressed Out

- Hypertension & cardiovascular diseases
- Glucose intolerance & insulin resistance
- Infection & inflammation
- Atrophy & death of neurons in hippocampus & prefrontal cortex

Telomeres



T
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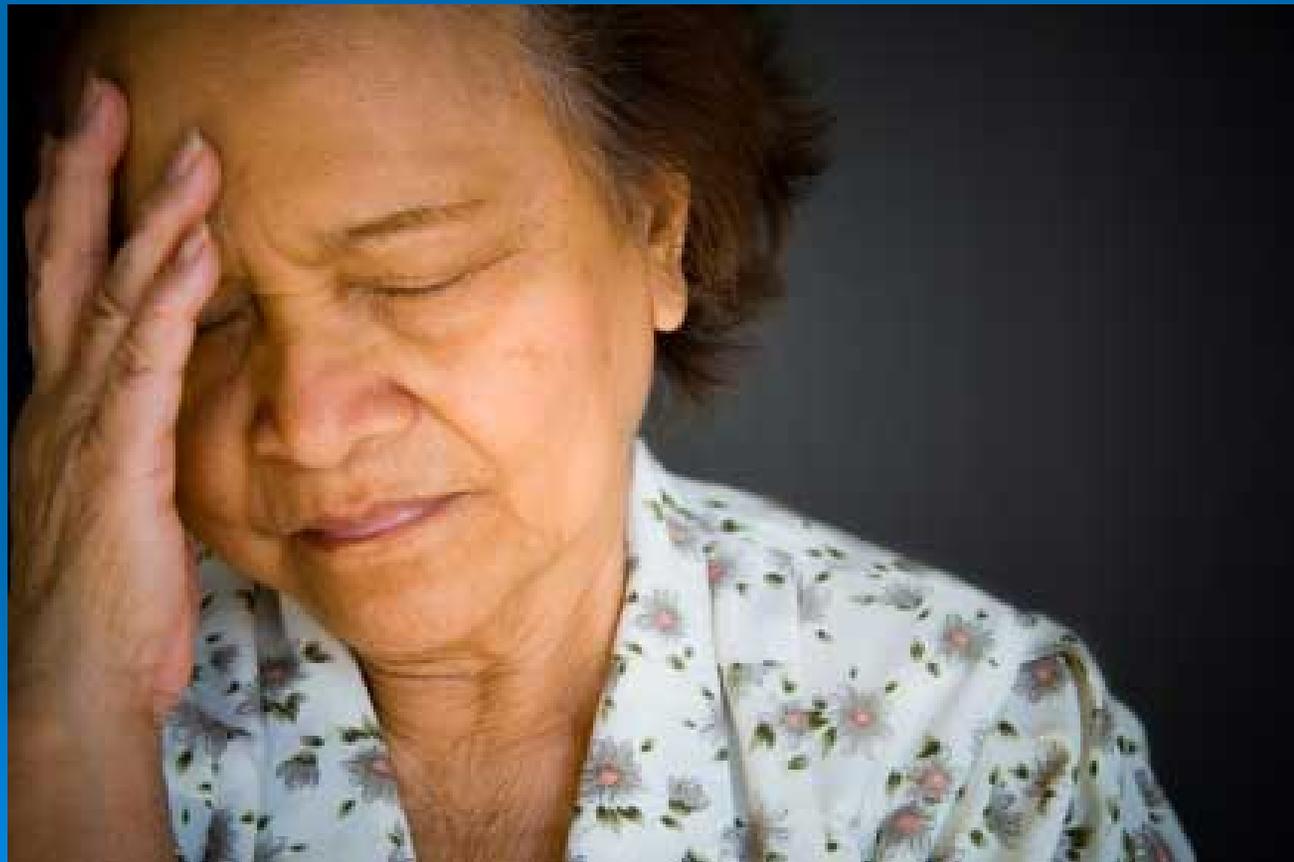
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Telomeres

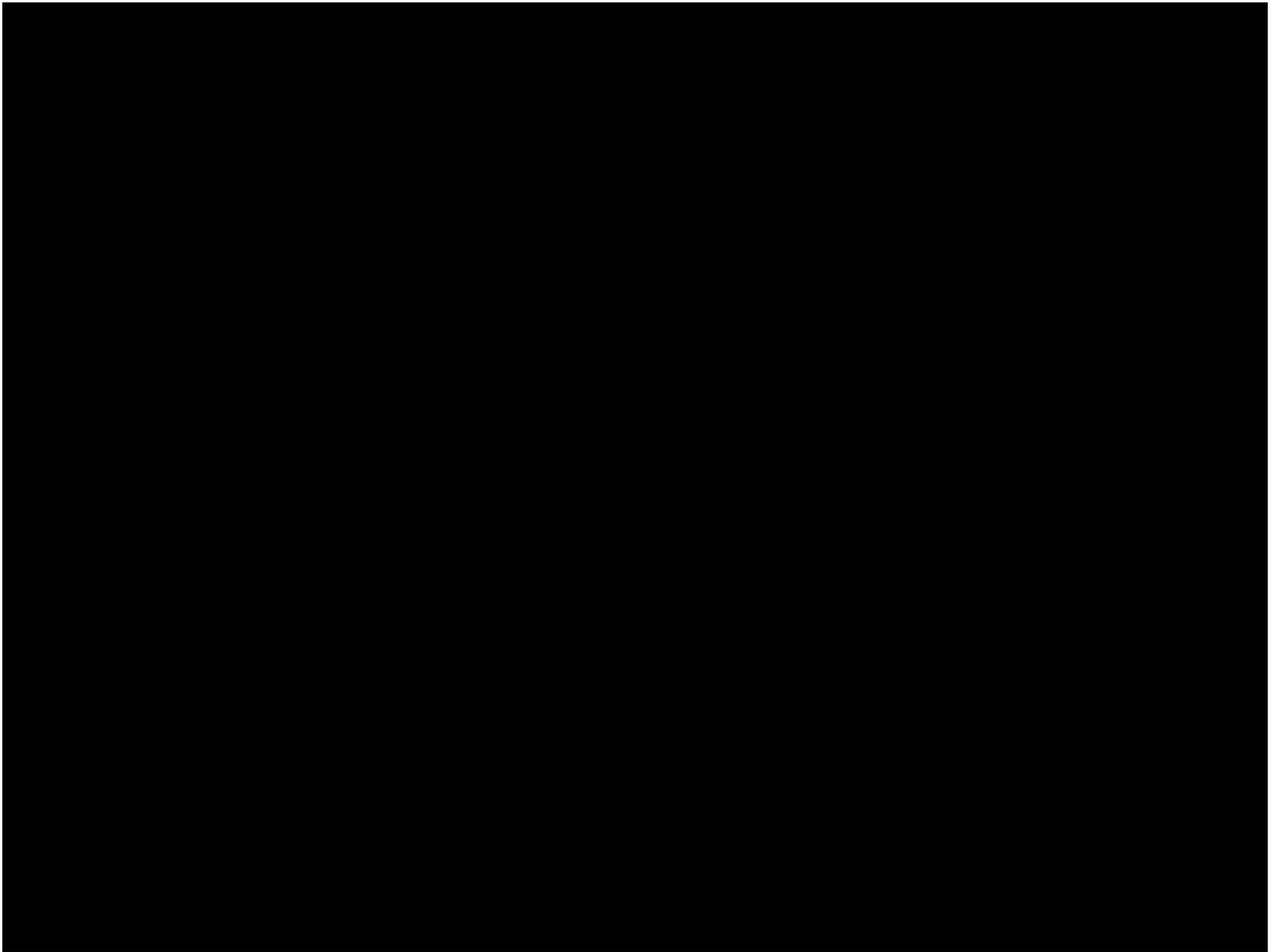
- Changes in diet, exercise, stress management and social support may result in longer telomeres.
- Telomere length reduced by poverty, education, safety stress, negative social interactions, low neighborhood satisfaction, hopelessness, and obesity.

Loss of Control



Disparities are the tip of the iceberg...



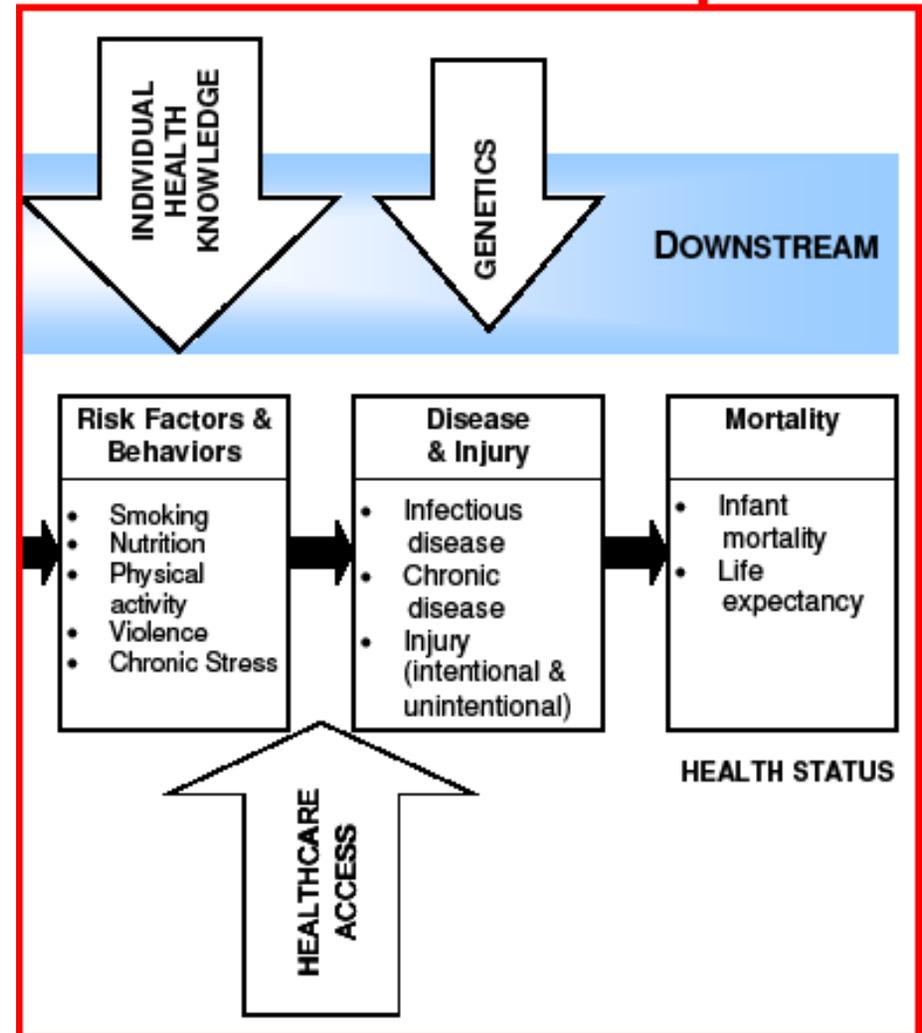


A Practitioner's Framework



A Framework for Health Equity

Medical Model

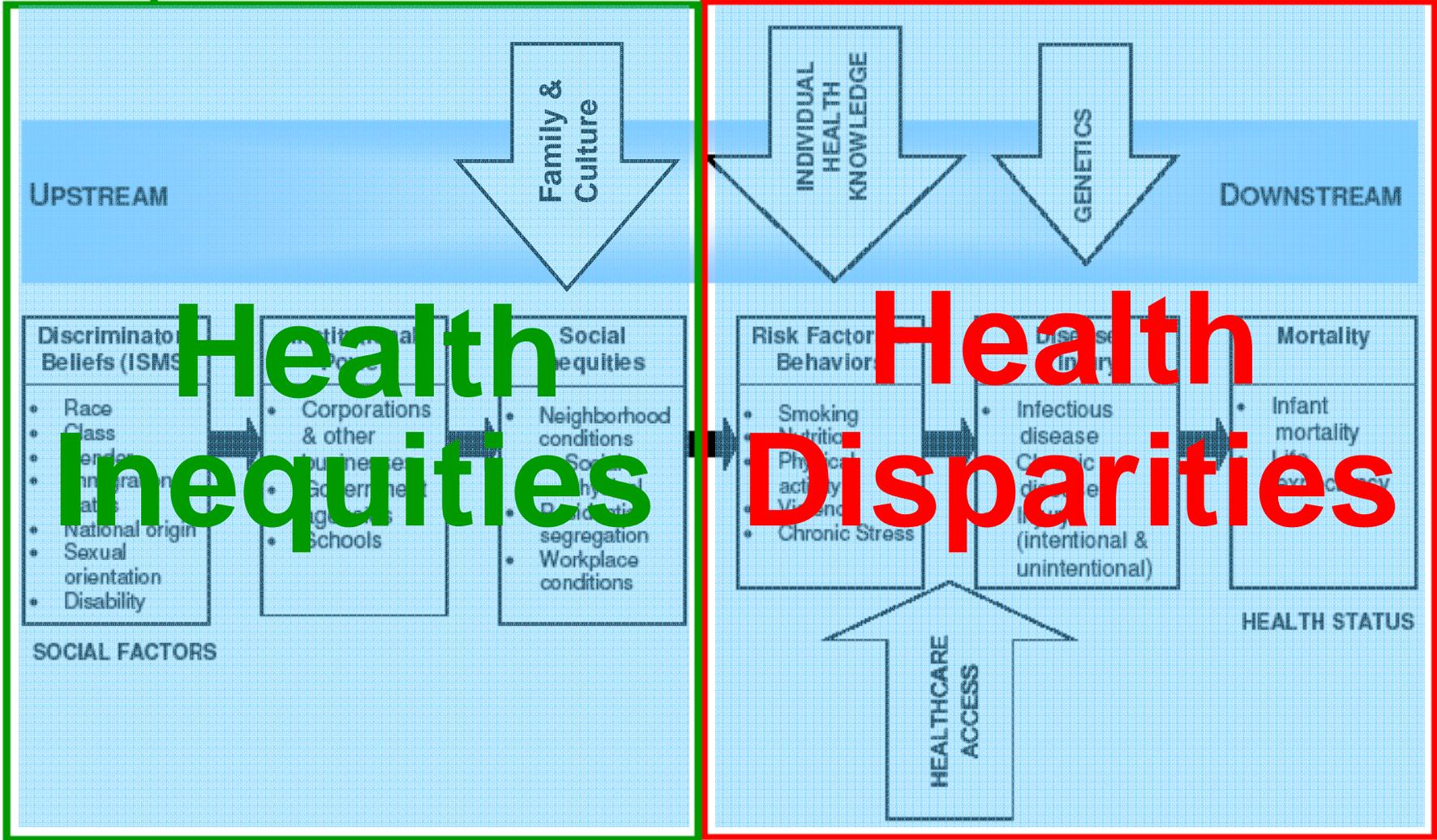


- Adapted by ACPHD from the Bay Area Regional Health Inequities Initiative, Summer 2008

A Framework for Health Equity

Socio-Ecological

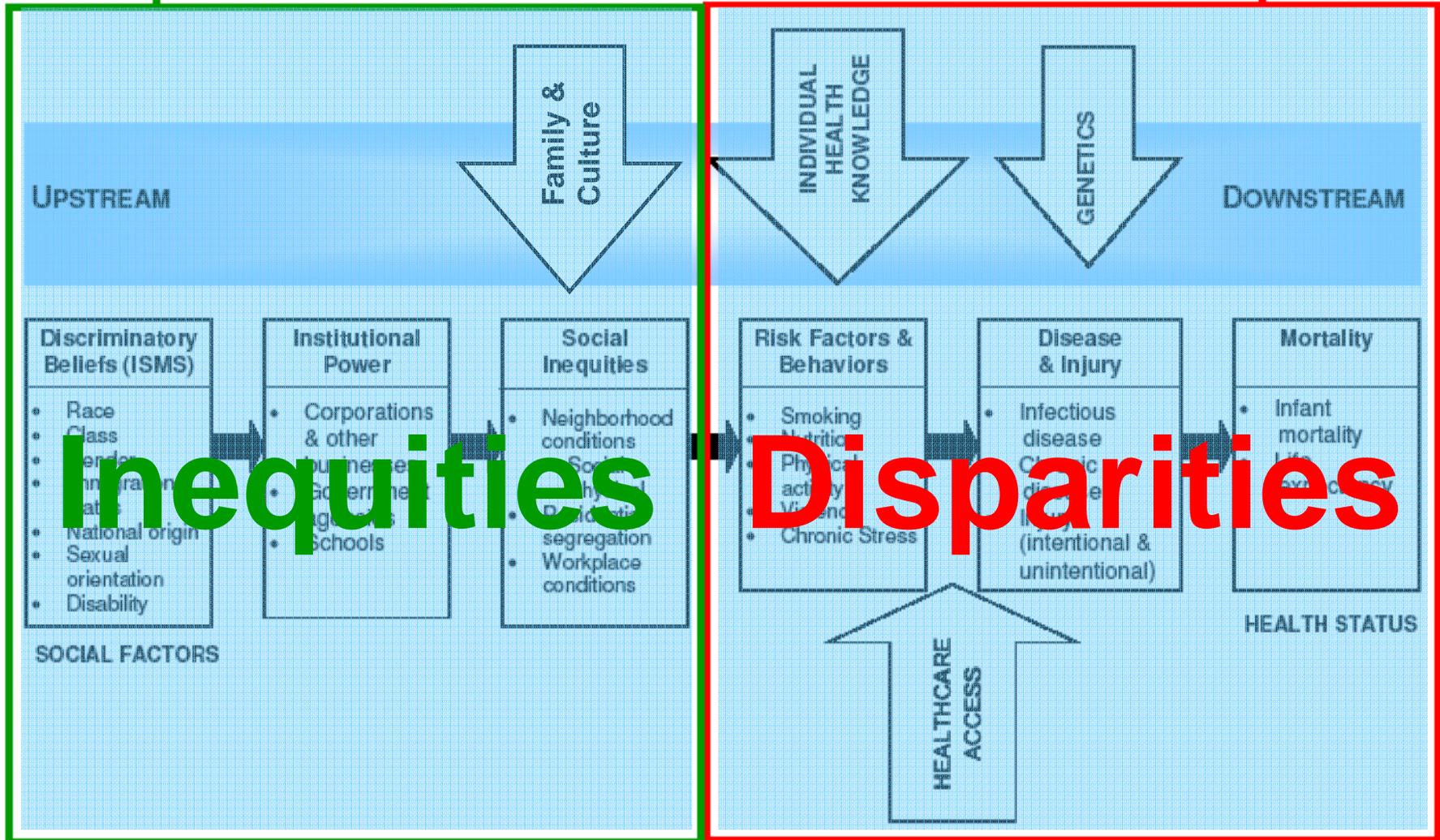
Medical Model



A Framework for Health Equity

Socio-Ecological

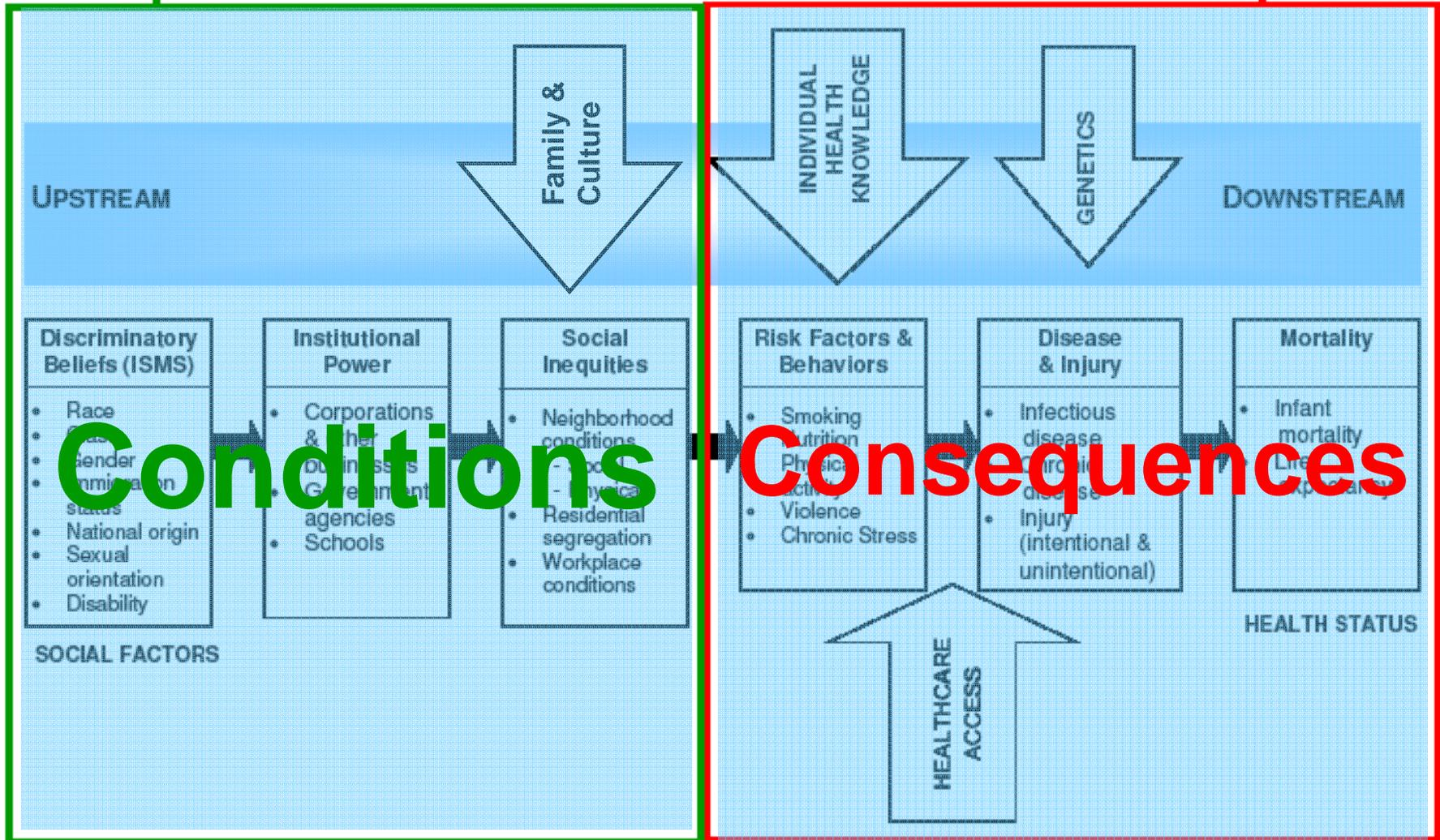
Medical Model



A Framework for Health Equity

Socio-Ecological

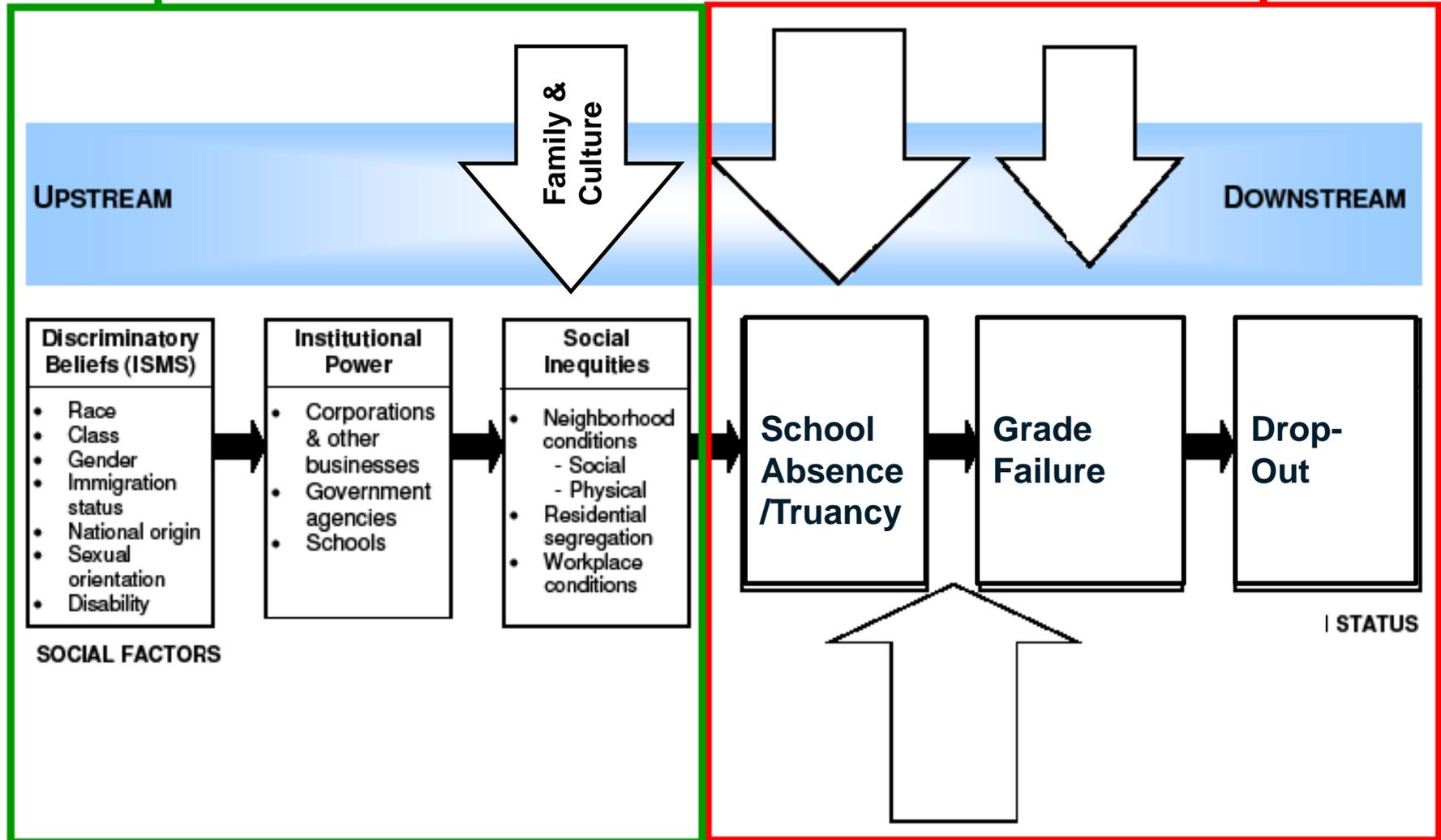
Medical Model



A Framework for Health Equity

Socio-Ecological

Medical Model

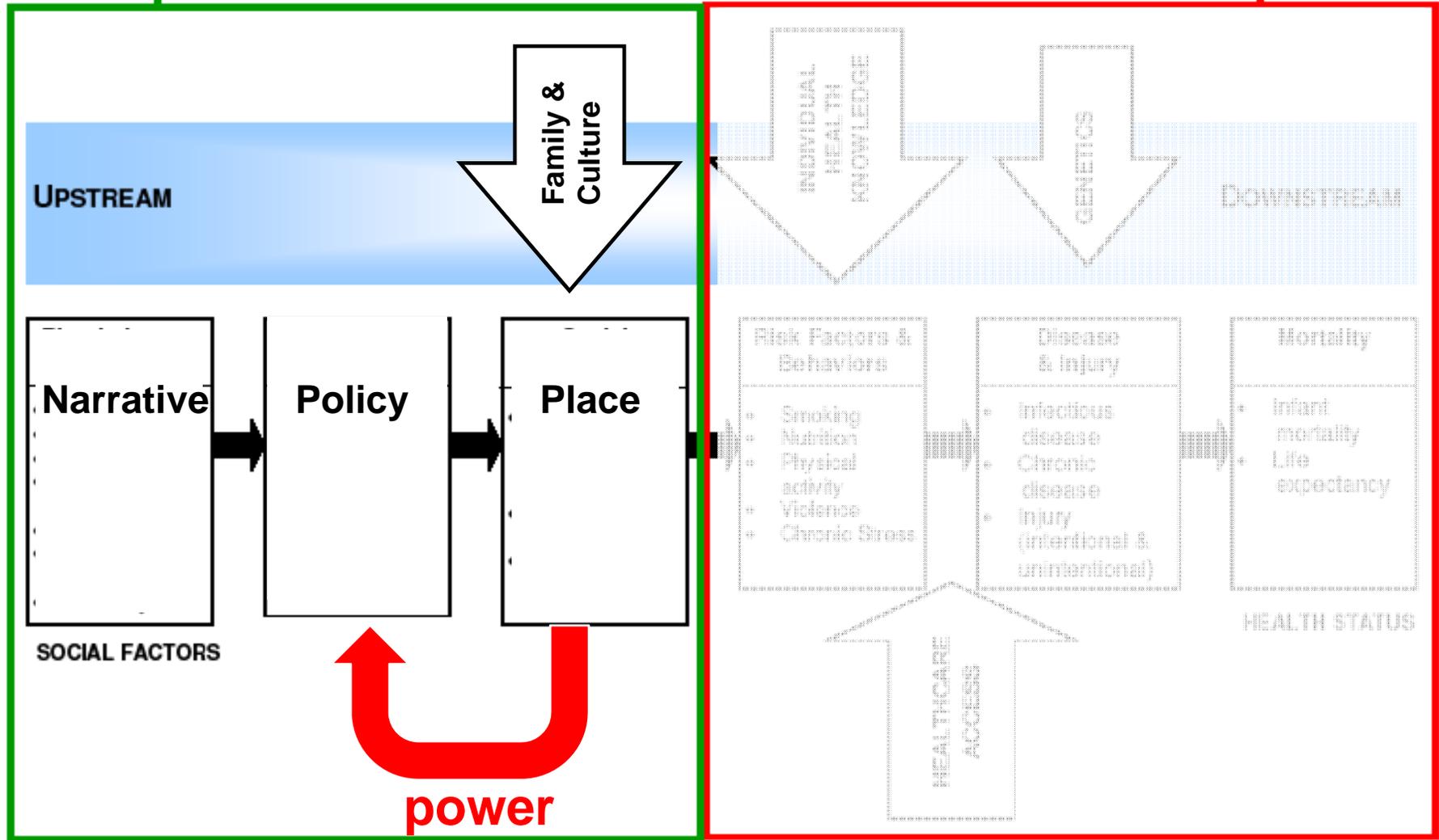


- Adapted by ACPHD from the Bay Area Regional Health Inequities Initiative, Summer 2008

A Framework for Health Equity

Socio-Ecological

Medical Model



- Adapted by ACPHD from the Bay Area Regional Health Inequities Initiative, Summer 2008

Socio-Ecological (society)

Medical Model (individuals)

Biased Beliefs (Isms)



Policies & Practices



Neglected Communities



Behavior



Disease



Death

Drivers of Change

Health Education

Clinics

Emergency Rooms

Building Healthy Communities

*An Ecological Approach to
Improving Population Health*



health
happens
here



Building Healthy Communities

health
happens
here

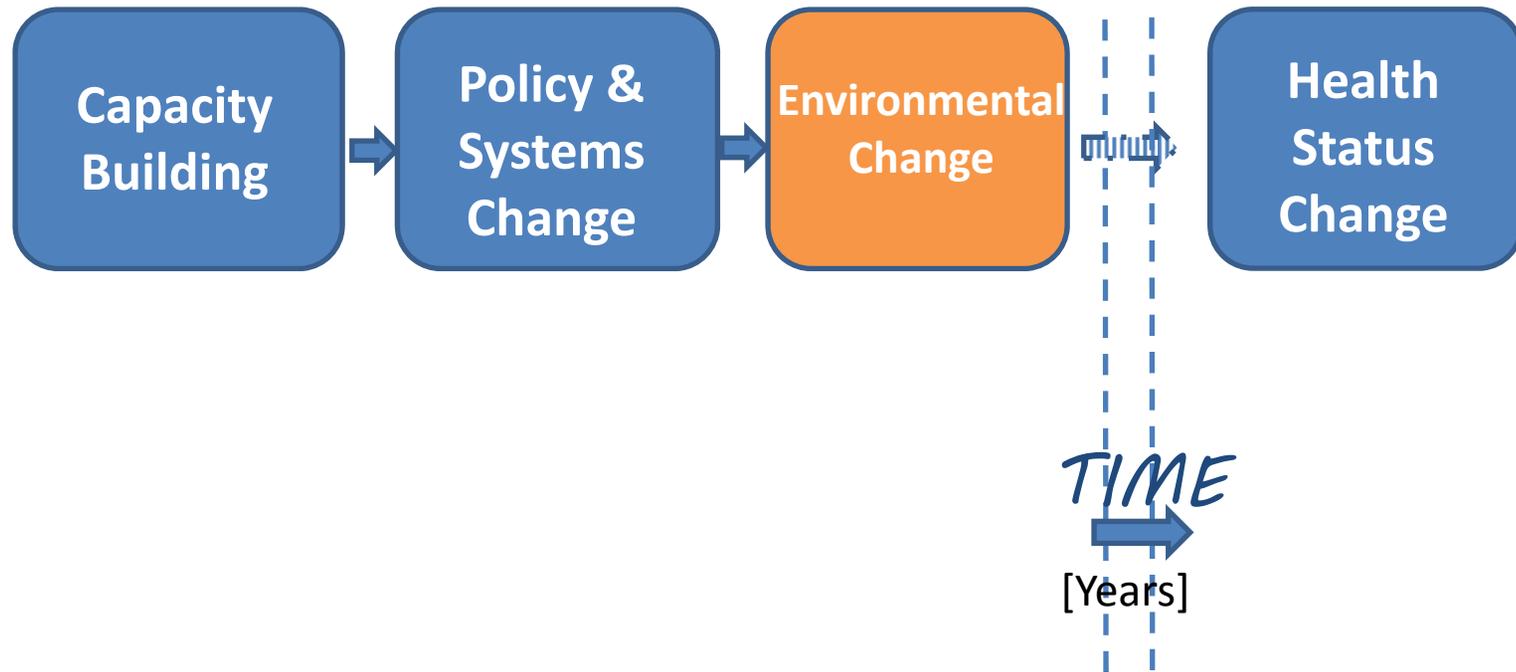




- Physical
- Social
- Economic
- Services
- POLITICAL

LIFE

BHC Theory of Change



BUILDING HEALTHY COMMUNITIES Theory of Change



Our Community Partners



Human Capital: Our Greatest Resource





Zip code

Life expectancy

The “What”

The Core Content of Our Work



BHC Planning Process



PREVENTION

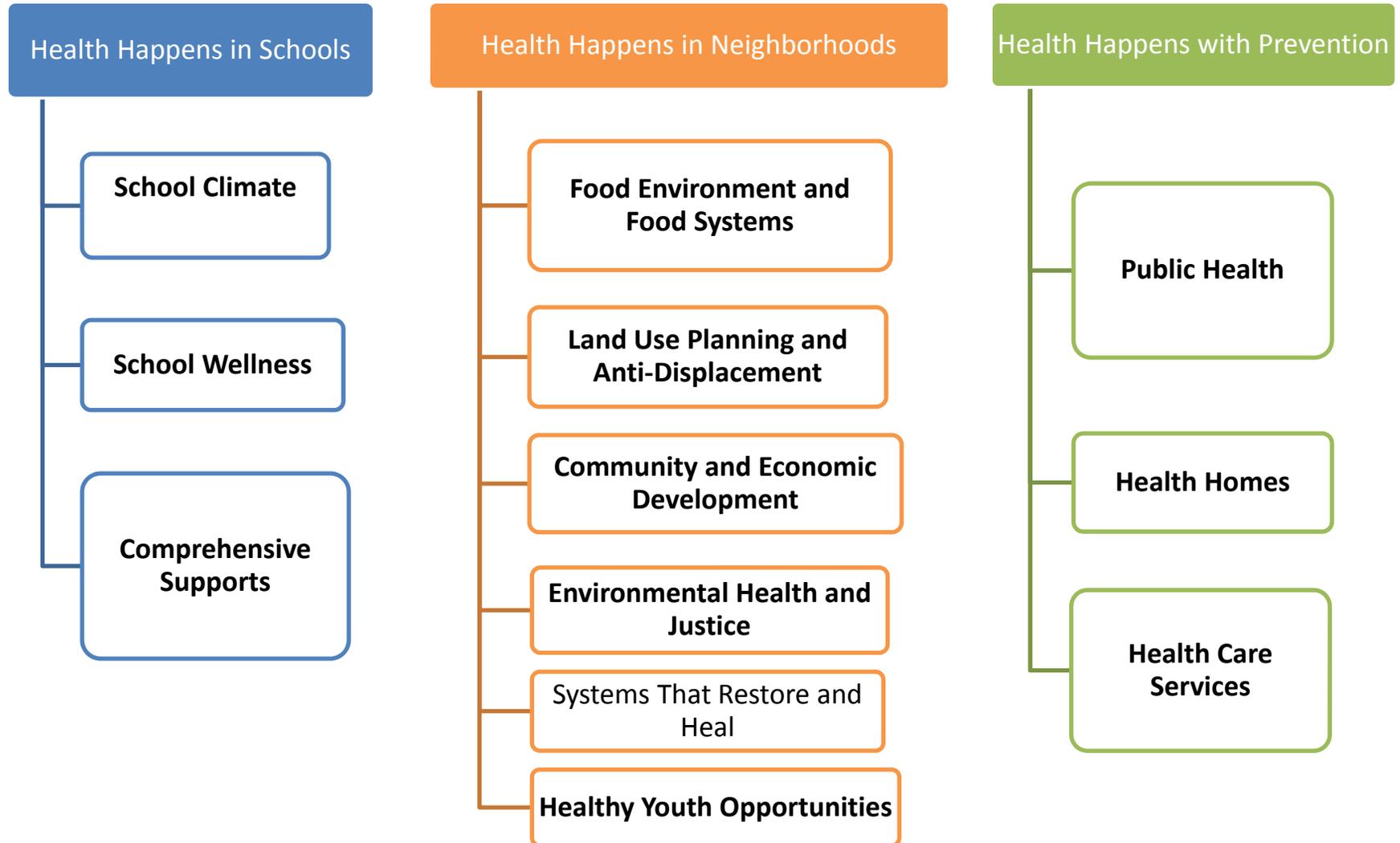
SCHOOLS



NEIGHBORHOODS



“Transformative Twelve” Policy Domains



The “How”

Our Approach in Broad Strokes



4 Systems/Institutional Targets

Health systems are family-centered and prioritize prevention opportunities for children, young adults, and families

Human services systems are family centered, prioritize prevention, and promote healthy opportunities for children, young adults, and families

**BHC
HUB**

Schools promote healthy behaviors and are a gateway for resources and services for families

Physical, social, & economic environments in local communities support health



Healthy
Communities

Leveraging
Partnerships

Collaborative
Efficacy

Resident
Power

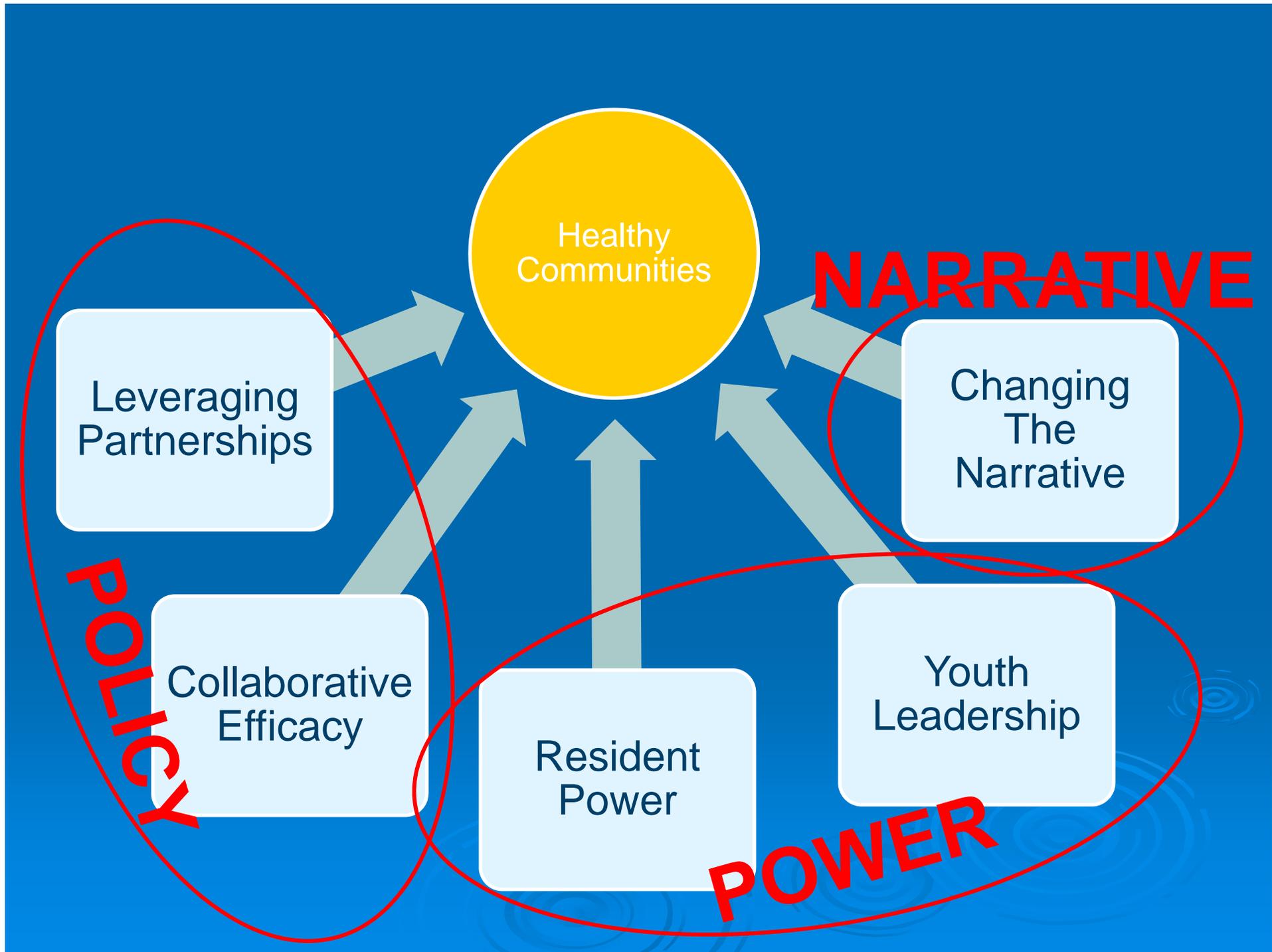
Youth
Leadership

Changing
The
Narrative

NARRATIVE

POLICY

POWER



Early Results

- Contribution vs. Attribution
- But for.....



Early Results

- 3 million+ new Medi-Cal beneficiaries
 - 1 million eligible for sentencing reduction
 - 150,000 fewer school suspensions
 - 250,000 undocumented children covered by health insurance
 - 100+ new health promoting local policies
 - 14 new grocery stores
- 

“Physicians are the natural attorneys of the poor, and social problems fall to a large extent within their jurisdiction” -Rudolph Virchow 1821-1902



health happens **here**



Contact Information

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Senior Vice President
The California Endowment

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(510) 271-4310





Building Healthy Communities

Drivers of Change

People
Power

Youth
Leadership,
Development
and Organizing

Enhanced
Collaboration
& Policy
Innovation

Leveraging
Partnerships
& Resources

Changing
the
Narrative



People Power

GOALS: Resident organizing and training activities support resident engagement and leadership in local decision-making forums and policy and systems change campaigns. Local systems and institutions promote full and active participation by residents in policy development and implementation. Residents value and have the tools to engage in multi-racial alliances for change.



People Power

As part of the *People Power* vision, we aim to help BHC communities develop the following capacities by 2020:

- Adult residents from traditionally marginalized communities occupy positions of influence and authority in their communities, across public, community-based and private institutions.
- Traditionally marginalized and excluded residents have voice and power in local government agencies and nonprofit decision-making processes.
- Pathways and structures are in place within organizations and community-wide to support resident healing, leadership development and organizing, with residents leading organizing efforts for local, regional and statewide impact.
- Local structures—formal and informal—are in place to support mobilizing resident voice and power.
- Multi-racial and inclusionary alliances build people power and deepen impact.



Youth Leadership, Development and Organizing

GOALS: Youth leadership training and a continuum of other youth development activities support a network of motivated, activated youth leaders in reaching their full potential, serving as leaders in the movement to create healthy and just communities. Youth are organizing within and across all Building Health Community (BHC) sites and beyond. BHC supports leadership development as well as youth academic, economic, and socio-emotional development, employing a trauma- and healing-informed approach. Additionally, BHC supports pushes for norms change within public and private institutions to promote active participation by youth in decision making at the local, regional and statewide levels.



Youth Leadership, Development and Organizing

As part of the *Youth Leadership* vision, we aim to help BHC communities develop the following capacities by 2020:

- Local youth increasingly occupy positions of influence in their communities.
- Pathways and structures to support local youth healing, leadership development and organizing are in place.
- Youth voice and leadership are incorporated in decision making by public agencies and community based organizations.
- Public and private institutions prioritize and increase funding to promote healthy youth development, resiliency, and power.

Enhanced Collaboration & Policy Innovation

GOALS: Improve the way key systems collaborate by enhancing the quality and quantity of interactions between systems players, community-based organizations, and residents to promote constructive and innovative system redesign and performance optimization. Enhance the quality of cross-sector collaboration, resident/stakeholder engagement, and data-sharing/analysis. Tools and mechanisms are made available to facilitate root cause analysis, stakeholder engagement, collaboration (such as the Hub, the convening and coordinating table for all BHC stakeholders), data sharing, and improved local policy analysis and development.

Enhanced Collaboration & Policy Innovation

As part of the *Collaboration and Policy* vision, we aim to help BHC communities develop the following capacities by 2020:

- Local government agencies, community based organizations, residents and other stakeholders work collaboratively across issue areas to establish and pursue shared outcomes and power.
- Local structures and practices grounded in the meaningful participation of marginalized populations are in place to promote and sustain ongoing, inclusive and collective efforts to advance health equity.
- Coalitions, collaborations, and other structures that promote working across issues and sectors are in place to support innovative advocacy approaches to advance policy, systems and social norms change.
- Local policies, practices and structures promote equity and inclusion of historically marginalized populations.
- Community stakeholders, including nonprofit organizations, systems leaders, and policy makers integrate an equity lens in policy development and practice.



Building
Healthy Communities

Five Drivers of Change

Leveraging Partnerships and Resources

GOAL: Strategic partnerships among the many sectors connected to BHC priorities leverage new dollars or other discrete resources so that transformative community strategies thrive and are sustained.

Leveraging Partnerships and Resources

As part of the *Partnerships and Resources* vision, we aim to help BHC communities develop the following capacities by 2020:

- Community stakeholders in divested neighborhoods mobilize and secure new forms of private capital by building community development skills and fostering new relationships.
- Community stakeholders mobilize and secure increased investment of public dollars across sectors (e.g. public health, education, human services, transportation, public works, public safety, public housing, etc.) to address the social determinants of health, such as housing, jobs, food, transportation, and all the opportunities, resources, and services people and communities need to be healthy in disinvested neighborhoods.
- Local residents are directly engaged in the implementation and governance of partnership agreements, such as community benefit agreements, both to reinforce their power and to maximize the potential for sustainability.



Changing the Narrative

GOAL: Engage the local media and local messengers influential with elected officials and other leaders in weaving a compelling and new narrative about community health and prevention, and the historical and structural context for low income communities.

Changing the Narrative

As part of the *Changing the Narrative* vision, we aim to help BHC communities develop the following capacities by 2020:

- People value health equity and inclusion. They understand that the social and physical environment influence health and contextualize current inequities and community problems within a historical and structural context.
- The dominant narrative recognizes historically marginalized communities (Boys and Men of Color, Undocumented, LGBTQ, Women, Formerly Incarcerated) as valuable members of the community and they are supported by policies, practices and structures that ensure their inclusion.
- Local structures—formal and informal—are in place to facilitate adult and youth residents to tell their own stories.

Case Study

Parks Disparity in Fresno







#OneHealthyFresno



with better parks!

FresnoBHC.org



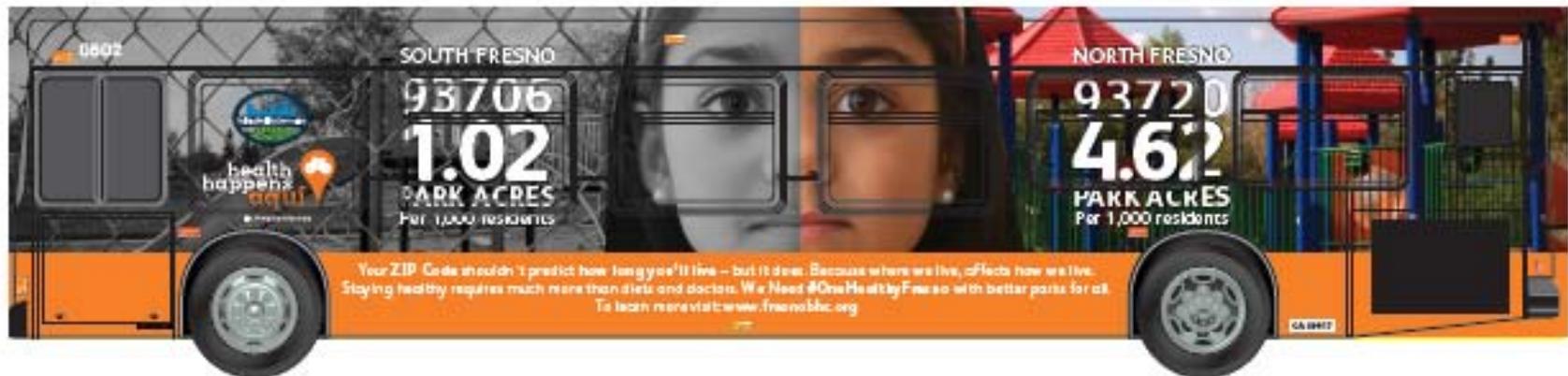
HERE ARE THE FACTS

According to the Adopted 2035 City of Fresno General Plan¹:

-  The provision of **parkland is uneven across the City of Fresno.**
-  Many of the **central neighborhoods in Fresno lack convenient access to parkland** and **fall well below the 3.0 acre per 1,000 residents standard** established by the State of California.
-  Established **neighborhoods south of Shaw** and the south industrial area have a **deficit of 984 acres in City park space**

Area	Population ²	City Park Space ¹		Pocket/Neighborhood/Community Parks	
		Total Acres	Acres per 1,000 Residents ²	Total Acres	Acres per 1,000 Residents ²
Downtown Planning Area	65,509	235.84	3.60	72.91	1.11
Established Neighborhoods South of Shaw	238,116	242.73	1.02	231.78	0.97
Established Neighborhoods North of Shaw	165,534	764.43	4.62	194.96	1.18
Combined Development Areas NW ³	47,122	43.56	0.92	42.30	0.90
DA-1 South	15,056	296.55	19.70	48.92	3.25
Combined Development Areas East ⁴	15,385	21.25	1.38	21.25	1.38
South Industrial Area	11,316	20.23	1.79	20.23	1.79
Total	558,038	1,625	2.91	632	1.13
Using 2010 City Population	495,000	1,625	3.28	632	1.28

1. City Park Space includes parks owned and/or maintained by the City or parks where there is little likelihood that the use or access will change. City Park Space does not include lands controlled by other jurisdictions where policy changes could limit or eliminate those lands from use as parkland, such as school district properties. Parks under the jurisdiction of the San Joaquin River Conservancy currently open directly to city residents.







COMMUNITY MATTERS
PARKS CONTROVERSY
FRESNO

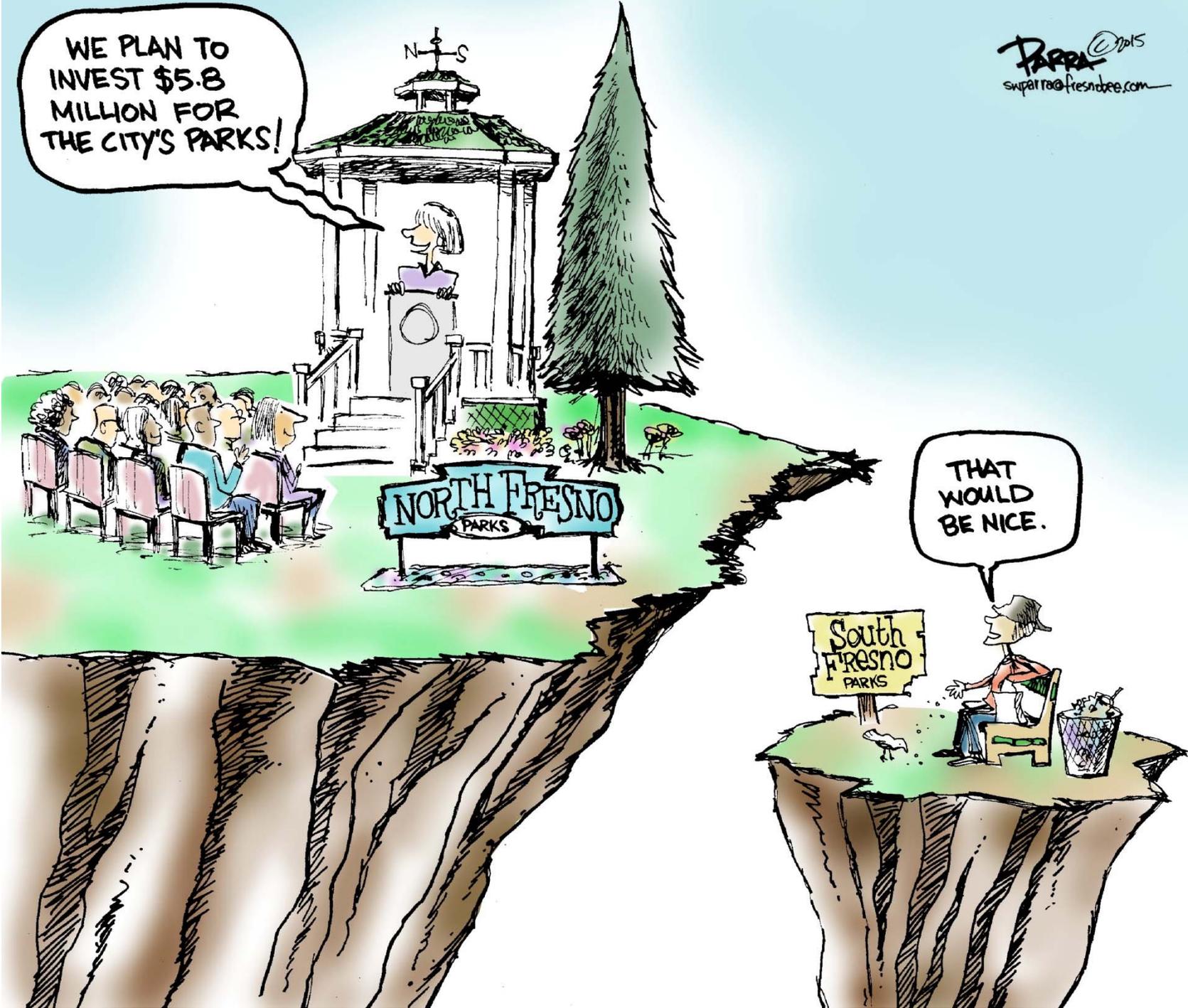
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COMMUNITY MATTERS
KATHRYN HERR
LOCAL NEWS THAT MATTERS

WE PLAN TO INVEST \$5.8 MILLION FOR THE CITY'S PARKS!

DARRA © 2015
suparra@fresnobee.com



BREAKING NEWS Fresno Fire Captain Pete Dern walks out and addresses the media

FRESNO

CITY LEADERS OUTLINE PLANS TO REVITALIZE FRESNO PARKS, ADD TWO NEW ONES



Fresno Mayor Ashley Swearingin says park improvements will be paid with cash.

Share +1 Tweet EMBED

FRESNO



Fresno Fire Captain Pete Dern walks out and addresses the media
Updated 1 hr 9 mins ago



Fresno Fire Captain Pete Dern talks after months of burn injury recovery
Updated 1 hr 11 mins ago



Fresno Fire Captain Pete Dern - Full Press Conference
Updated 1 hr 40 mins ago



Your Weekend



Woman beat with pipe, 2 kids rescued in Fresno carjacking, police say

MORE FRESNO ▶

POLITICS