Demographic Analysis on Health and Mental Health Disparities and Inequities

SAMPLE DATA w/ NARRATIVES

California Health and Safety Code, Section 131019.5 requires the Office of Health Equity (OHE) to conduct a demographic analysis periodically to identify and develop recommendations for the strategic plan not less than every two years. The first strategic plan and demographic report are due on July 1, 2014.

Currently, OHE is in the process of developing the first demographic report, which will include key factors related to health and mental health disparities and inequities identified by Assembly Bill 1467. These key factors include:

A. Income security; B. Food security and nutrition; C. Child development, education and literacy; D. Housing; E. Environmental quality; F. Accessible built environments; G. Health care; H. Prevention efforts; I. On-going discrimination and minorities stressors against individuals and groups in vulnerable communities; J. Neighborhood safety and collective efficacy; K. Efforts of the Health in All Policies Task Force; L. Culturally appropriate and competent services and training; M. Linguistically appropriate and competent services and training; and N. Accessible, affordable and appropriate mental health services.

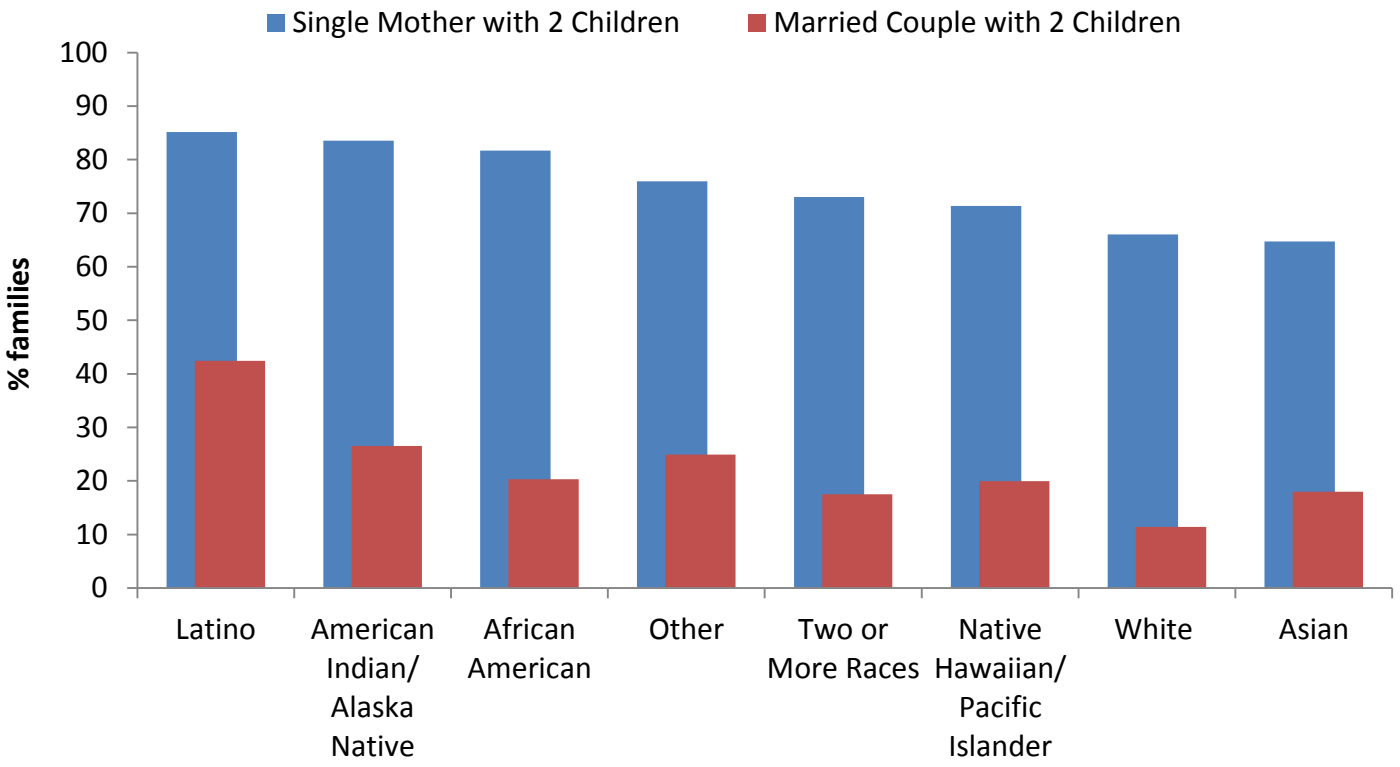
OHE is working collaboratively with the Department of Health Care Services (DHCS) to develop data points for all key factors described above and to complete the demographic report--the first step of the strategic plan--in a timely manner.

Samples of data points developed for key factor categories of A, B, C, D, E, F, H, I, and J and a related narrative for each of the categories, including a short description of the category and data sources, are included in this packet. DHCS is currently working on data points and related narratives for key factor categories G, L, M, and N.

OHE invites your input, expertise and decision-making help as an Advisory Committee member to complete this report; however, OHE holds the final decision making authority. Please contact the following OHE staff members to provide your feedback:

1. Mallika Rajapaksa, PHD
   Email: Mallika.Rajapaksa@cdph.ca.gov
   Telephone: 916-552-9856
2. Thi Mai, MPH
   Email: Thi.Mai@cdph.ca.gov
   Telephone: (916) 324-0070

Figure 1. Percentage of Families With Children (Single Mother and Married Couple) Earning Less Than the Living Wage by Race/Ethnicity, California, 2010



Source: Living Wage Calculator (www.livingwage.mit.edu) and American Community Survey, 2006-2010. Analysis by CDPH-Office of Health Equity and UCSF, Healthy Community Indicators Project.

A. Income Security – Figure 1

Description of significance:

Income is critical for maintaining basic life necessities as well as achieving "quality of life" expectations and aspirations[2]. Living wage generates a sufficient income to meet subsistence needs such as food, shelter, clothing, transportation, and child care[4]. Families experience poverty when they are unable to achieve a minimum standard of living[1]. During a period of economic downturn in 2009 to 2010, the rates of poverty and low-income status increased across families in the United States, particularly among those headed by women[3]. Wider disparities between the rich and the poor are associated with lower overall life expectancy, higher mortality, and increased risk of social isolation, stress, and poor health outcomes[5].

Data Source:

Living Wage Calculator (www.livingwage.mit.edu) and American Community Survey, 2006-2010. Analysis by CDPH-Office of Health Equity and UCSF, Healthy Community Indicators Project.

Brief description of Healthy Community Indicators Project (HCI):

Project funded by Strategic Growth Council (SGC) provides statistical data that can be used to plan healthy communities and evaluate the impact of plans, projects, policy, and environment changes on community health. The HCI is a collaboration between CDPH and the University of California San Francisco (UCSF) to create and disseminate indicators linked to the Health in All Policies Healthy Communities Framework. This framework identifies key attributes (i.e. housing, transportation, health care, nutrition, environmental quality, and social and economic development) of a healthy community through all stages of life. For more information, visit HCI at: http://www.cdph.ca.gov/programs/Pages/HealthyCommunityIndicators.aspx

Methodology:

- Data on living were extracted from the Living Wage Calculator website and re-formatted without changes.
- Income data were tabulated from 2006-2010 American Community Survey and stratified by race/ethnicity.
- Prevailing (median) wages for selected occupations in 2010 were downloaded from the Employment Development Department based on the first quarter of the Occupational and Employment Statistics Survey 2009.
- The living wage for two family types (an adult with 2 children and 2 adults with 2 children) was applied against the income distribution of single women with children and married couple with children, respectively.
- The percent of families living below the living wage is the number of families that fell below the living wage divided by the total number of families of that type.

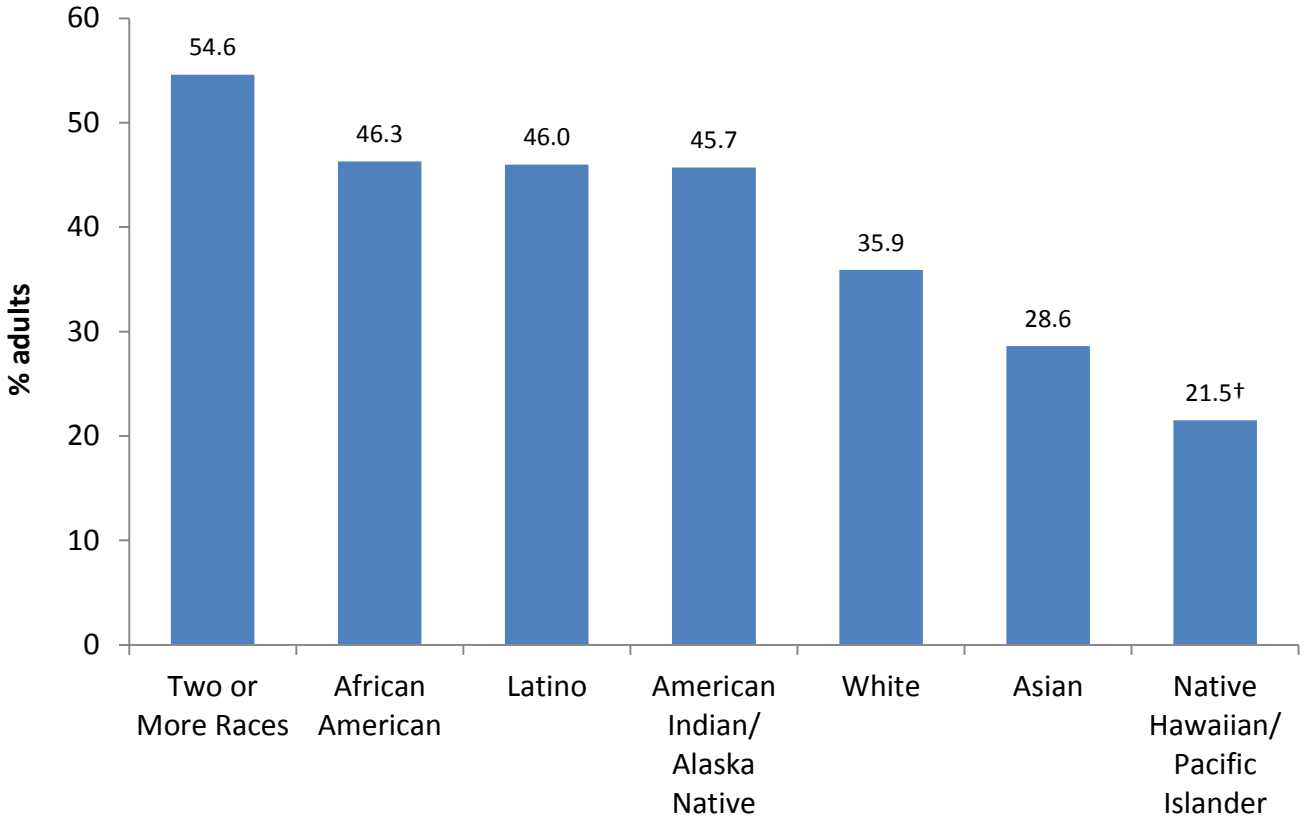
Definition:

Living wage - hourly wage rate or annual income that a sole provider working full-time (2080 hours/year) must earn to provide his/her family a minimum standard of living, covering costs of food, child care, health insurance, housing, and other necessities.

Reference:

1. Cauthen NK, Fass S. 10 important questions about child poverty and family economic hardship. Columbia University Mailman School of Public Health: National Center for Children in Poverty. 2009;1-8.
2. Halverson JA, Bischak G. Underlying socioeconomic factors influencing health disparities in the Appalachian region: Section I introduction, data and methods. West Virginia University, Department of Community Medicine: Mary Babb Randolph Cancer Center/ Office for Social Environment and Health Research. March 2008. Available at: http://www.arc.gov/research/researchreportdetails.asp?REPORT_ID=9
3. Redd Z, Karver TS, Murphey D, Moore KA, Knewstub D. Two generations in poverty: Status and trends among parents and children in the United States, 2000-2010. Child Trends Research Brief. November 2011;1-17.
4. Bhati R, Katz M. Estimation of health benefits from a local living wage ordinance. American Journal of Public Health. 2001; 91(9):1398-1402.
5. Kahn RS, Wise PH, Kennedy BP, Kawachi I. State income inequality, household income, and maternal mental and physical health: cross sectional national survey. British Medical Journal. 2000; 321:1311-1315.

Figure 2a. Percentage of Adults Whose Income is Less Than 200% of the Federal Poverty Level That Reported Having Food Insecurity by Race/Ethnicity, California, 2011-2012



Source: UCLA, California Health Interview Survey, 2011-2012
† Statistically unstable

B. Food Security and Nutrition – Figure 2a

Description of significance:

Food insecurity has been defined as the inability to afford enough food for an active healthy life in socially acceptable ways[3]. A recent United States Department of Agriculture (USDA) report found that in California, 15.6% of households were food insecure during 2010-2012, which is a higher rate than the national average[1]. In many low-income communities, healthy food options can be costly or hard to find[5]. When food access becomes severely limited, adults and children in food-insecure households may experience hunger, and hunger has a disproportionate impact on particular communities and racial ethnic groups[3,4]. Numerous studies have found that adults who are food insecure have poorer health and are at risk of major depression as well as chronic diseases such as heart disease, obesity, diabetes, and hypertension[2].

Data Source:

UCLA, California Health Interview Survey, 2011-2012

Brief description of California Health Interview Survey (CHIS):

CHIS is the largest random-dial telephone survey in California that asks questions on a wide range of health topics. CHIS is conducted by UCLA Center for Health Policy Research in collaboration with the California Department of Public Health (CDPH) and California Department of Health Care Services (DHCS) on a continuous basis that takes two years to complete a full data cycle, with over 50,000 Californians surveyed. From each participating household, an adult, teen, and child are randomly selected to interview. The selected adult respondent must be the parent or legal guardian of children and/or adolescents living in the household in order for children and/or adolescents to be selected. The interviews are conducted in multi-languages including English, Spanish, Chinese (Mandarin and Cantonese dialects), Tagalog, Vietnamese, and Korean. The large CHIS sample includes people from many racial and ethnic groups across the 58 counties of California. The survey provides high quality data that accurately represents California's diverse populations and geographic areas. For more information, please visit CHIS: http://healthpolicy.ucla.edu/chis/Pages/default.aspx

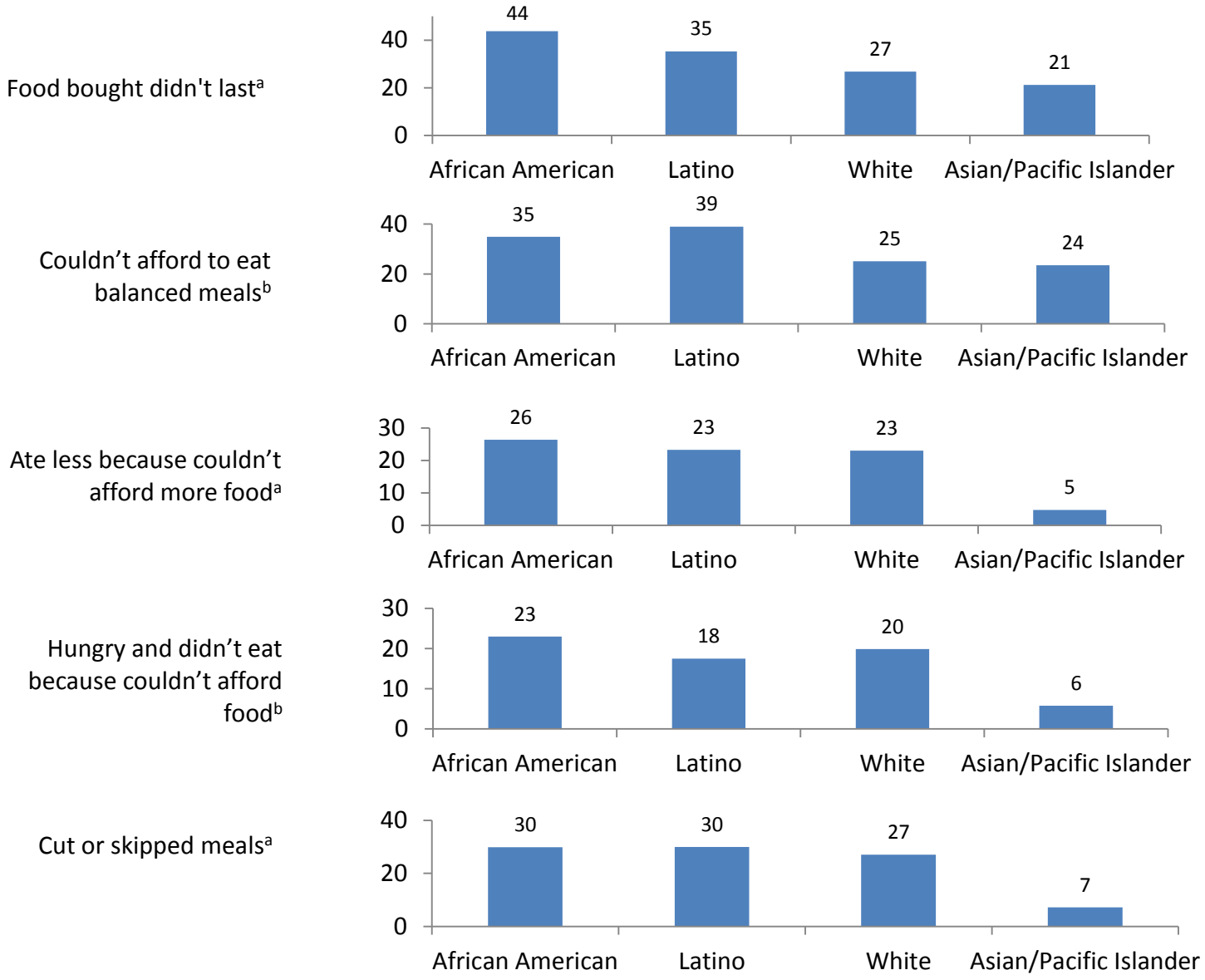
Methodology:

- The variable (food security status level) provides a categorical measure of food security status for adults (18 years and older) whose income is less than 200% of the federal poverty level.
- This variable is derived from questionnaire items AM1-AM5 (http://healthpolicy.ucla.edu/chis/design/Documents/CHIS2011adultquestionnaire.pdf). (Note: Construction of this variable requires complex procedure that includes scoring system)
- Cases with fewer than 3 missing values in questionnaire AM1-AM5 were imputed.
- Cases with more than 3 missing values are computed.

Reference:

1. Jensen-Coleman A, Nord M, Singh A. Household food security in the United States in 2012. United States Department of Agriculture, Economic Research Service. 2003;1-33.
2. Karpilow KA, Reed DF, Chamberlain PT, Shimada T. Understanding nutrition: A primer on programs and policies in California. California Center for Research on Women and Families, Public Health Institute. 2011; 2:1-8.
3. Kaiser L, Baumrind N, Dumbauld S. Who is food-insecure in California? Findings from the California Women's Health Survey, 2004. Public Health Nutrition. 2007; 10(6):574-581.
4. Kaiser LL, Martin AC, Metz DL, Nicholson Y, Fujii ML, Lamp CL, Townsend MS, Crawford PB, Melgar-Quinonez H. Food insecurity prominent among low-income Latinos. California Agriculture. 2004; 58(1):18-23.
5. Solving the problem of childhood obesity within a generation. White House Task Force on Childhood Obesity Report to the President. May 2010; 1-120.

Figure 2b. Percentage of Adults Living in CalFresh Households That Reported Behaviors Indicating Food Insecurity, California, 2011



Source: California Dietary Practices Survey (CDPS), 2011. Analysis by the Network for a Healthy California , California Department of Public Health.
[a]p-value<.001, [b]p-value<.01. (The p-value for each group signifies that the differences observed within that group are statistically significant.)

B. Food Security and Nutrition – Figure 2b

Description of significance:

(please see the description for figure 2a)

Data source:

California Dietary Practices Survey, 2011. Analysis by the Network for a Healthy California (Network), California Department of Public Health.

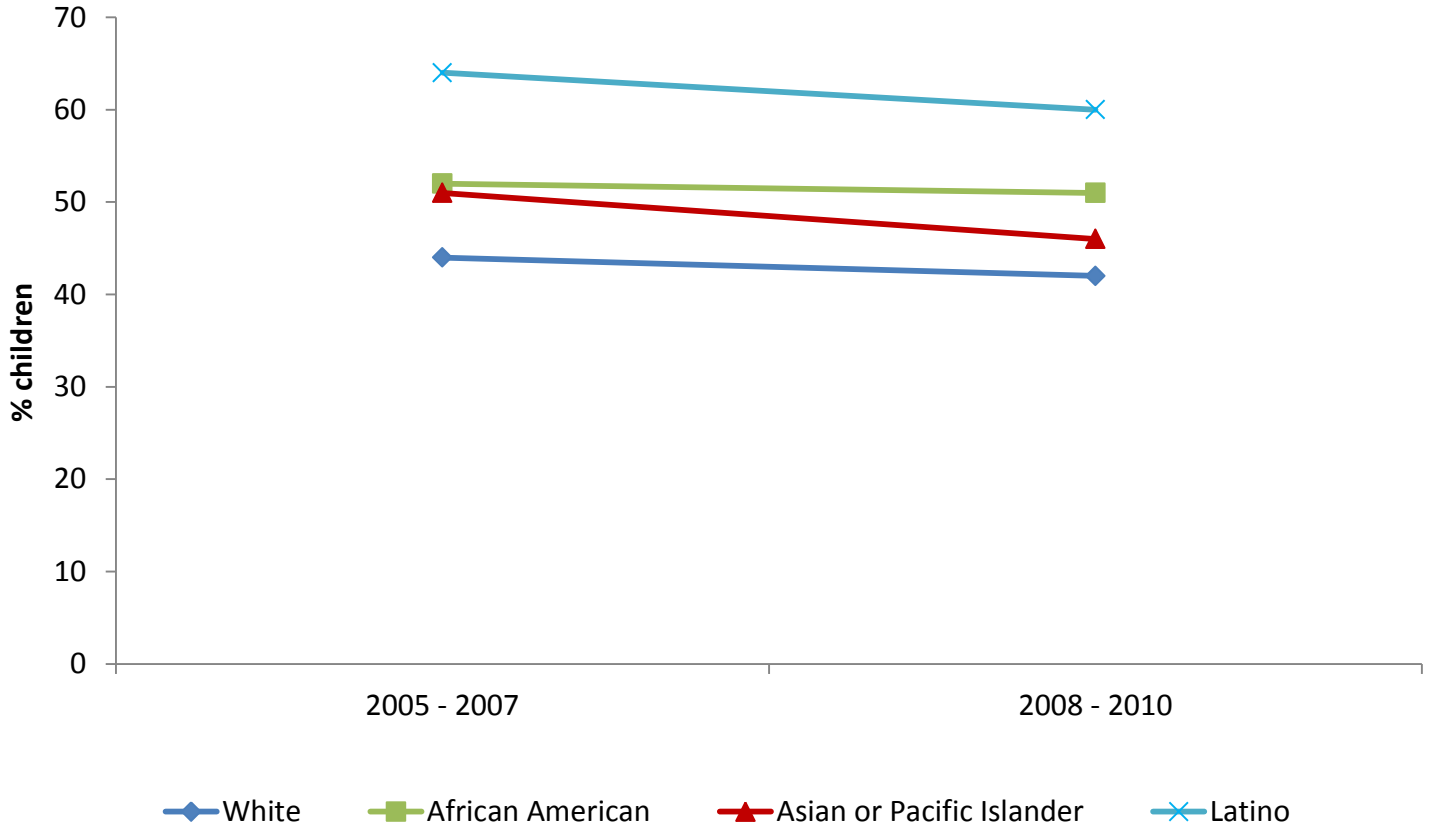
Brief description of California Dietary Practices Survey (CDPS):

CDPS is the most extensive dietary and physical activity assessment of adults 18 years and older in the state of California. It is an important tool for gauging Californians' progress towards meeting the 2010 Dietary Guidelines for Americans and the Healthy People 2020 objectives. CDPS began in 1989 and is administered biennially in odd years. This survey was created and is analyzed by CDPH's Network for a Health California. CDPS is conducted between the months of June and October. It uses a list of participating CalFresh households and randomly phone dials about 1,400-1,500 adults for interview. Food, beverage, and fruit and vegetable consumptions are collected using a simplified 24-hour recall which queried about each meal on the previous day. The consumption questions are followed by questions that assessed motivations, barriers, knowledge, attitudes, and behavior related to healthy eating and health practices. The survey also collects data on food security, CalFresh and WIC participation, worksite and neighborhood environments, food shopping, and policy. Data are weighted to the 2000 United States Census in order to provide representative data for the state as a whole. For more information, visit CDPS at:
http://www.cdph.ca.gov/programs/neop/Pages/CaliforniaStatewideSurveys.aspx

Methodology:

- Adults reporting behaviors indicating food insecurity based on the following questions:
    1) The food that I bought just didn't last, and I didn't have money to get more. Was that often, sometimes, rarely, or never true for you or your household in the last 12 months? Note: Percent reporting "often" or "sometimes" is categorized as food bought didn't last
    2) I couldn't afford to eat balanced meals. Was that often, sometimes, rarely, or never true for you or your household in the last 12 months?
    3) In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money to buy food?
    4) In the last 12 months, were you ever hungry but didn't eat because you couldn't afford enough food?
    5) In the last 12 months, did you or other adults in your household ever cut the size of your meals or skip meals because there wasn't enough money for food?
- P-value was calculated from Chi Square test. The differences observed within each group are statistically significant.

Figure 3a. Percentage of California Children Ages 3 to 4 Who Are Not Attending Preschool by Race/Ethnicity, 2005-07 and 2008-10



Source: KIDS COUNT Data Center, Annie E. Casey Foundation, 2011
Data Source: Population Reference Bureau, analysis of data from the U.S. Census Bureau, Three-year American Community Survey, 2005-07 to 2009-11.
Preschool includes any group or class of institution providing educational experiences for children during the years preceding kindergarten.

C. Child Development – Figure 3a

Description of significance:

There is increasing recognition in policy, research, and clinical practice communities that early childhood provides the physical, cognitive, and social-emotional foundation for lifelong health, learning, and well-being[1]. A number of adult health and medical conditions have their origins in early childhood[2]. Evidence shows that experiences in the first years of life are extremely important for a child's healthy development and lifelong learning. How a child develops during this time affects future cognitive, social, emotional, and physical development, which influences school readiness and later success in life[2]. More than any other developmental period, early childhood sets the stage for health literacy, self-discipline, the ability to make good decisions about risky situations, eating habits, conflict negotiation[1]. Research on a number of adult health and medical conditions points to pre-disease pathways that have their beginnings in early childhood[3]. Although early childhood is typically healthy ages, it is during this time that children are at risk for conditions such as asthma, obesity, dental caries, child maltreatment, and developmental and behavioral disorders. While typically nonfatal, these conditions affect children, their education, and the health and well-being of the adolescents and adults they will become[1].

As mothers with young children have entered the labor force, families have shifted a greater portion of early child care from parents to non-parental babysitters, family day care providers, and early education centers. These care arrangements differ by income and other socio-economic characteristics in the type and quality of care children receive. Children in less advantaged families receive less formal or lower quality care. The quality of these arrangements influences child development and health, as well as inequalities in children's early care[4].

Data Source:

KIDS COUNT Data Center, Annie E. Casey Foundation, 2011. KIDS COUNT is a project of the Annie E. Casey Foundation to track the well-being of children in the United States

Methodology:

KIDS COUNT data center used Population Reference Bureau, analysis of data from the U.S. Census Bureau, 2005-07 to 2009-11 three-year American Community Survey. Due to small sample size, the 3-year American Community Survey was used to increase accuracy of the estimates.

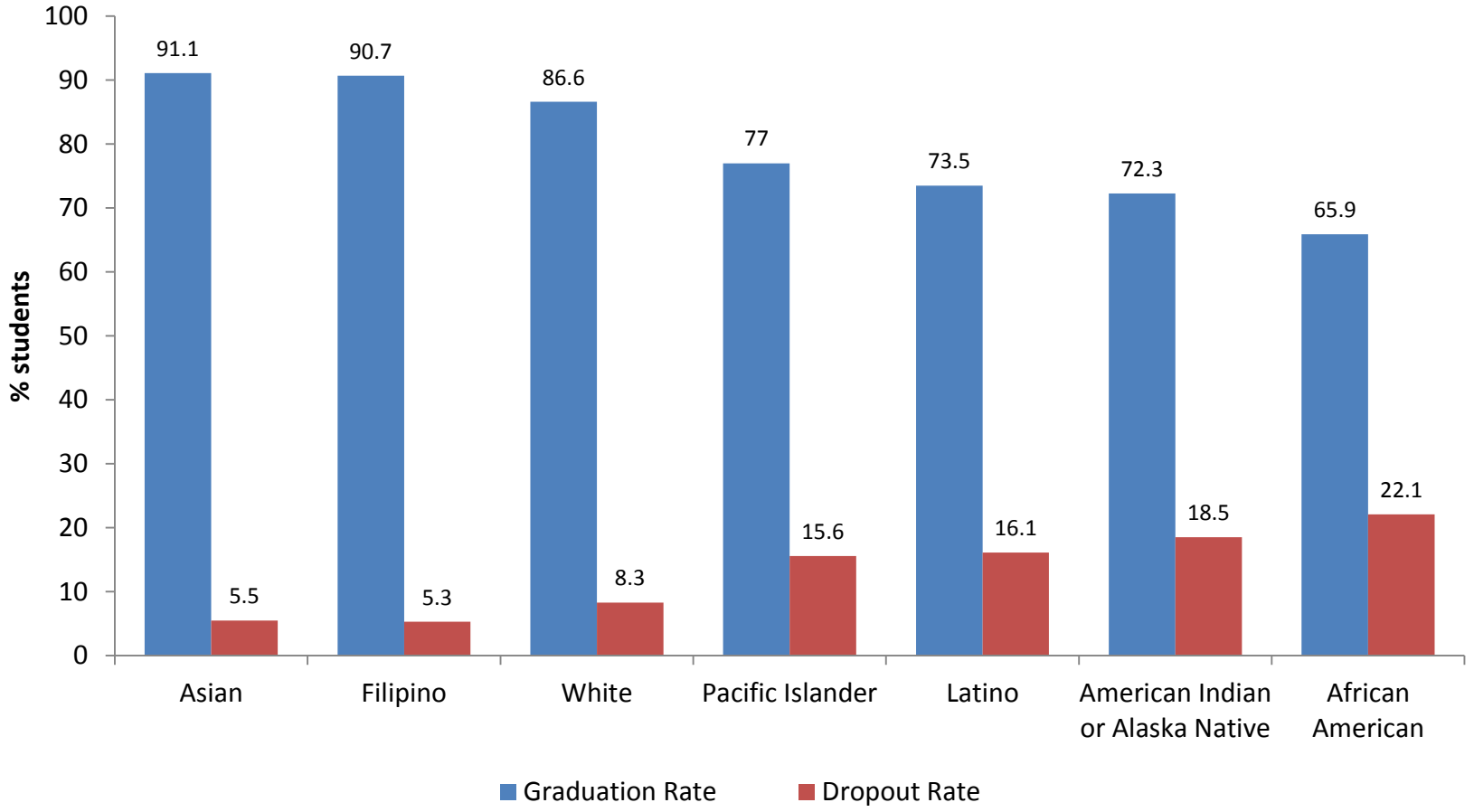
Definition:

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

Reference:

1. Healthy People 2020. Early and middle childhood. Available at: http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=10
2. Let's Get Healthy California Task Force Final Report. December 19, 2012. Available at: http://healthyriversidecounty.org/home/images/DOWNLOADS/PUBLICATIONS/Lets_Get_Healthy_California.pdf
3. Schore AN. Affect regulation and the origin of the self: The neurobiology of emotional development. Florence KY: Psychology Press; 1999.
4. Rosenbaum D, Ruhm C, Waldfogel J. Inequality in Early Childhood Education and Care: What Do We Know?, May 1, 2003, http://www.russellsage.org/sites/all/files/u4/Meyers%20et%20al.pdf

Figure 3b. Graduation and Dropout Rates for California High School Students by Race/Ethnicity, Class of 2011-2012



Source: California Department of Education, Data Reporting Office.
Dropout definition: Either 1) was enrolled in grades 7, 8, 9, 10, 11 or 12 at some time during the previous school year AND left school prior to completing the school year and has not returned to school as of Information Day or 2) Did not begin attending the next grade (7, 8, 9, 10, 11 or 12) in the school to which they were assigned or in which they had pre-registered or were expected to attend by Information Day.
Note: Each race and ethnic group excludes percentages of "Still Enrolled high school student Rates" and may not add up to 100%.

C. Child Development – Figure 3b

Description of significance:

Adolescence (ages 10 to 19) is a critical transitional period that includes the biological changes of puberty and a time when behavioral patterns established. The behavioral patterns established during this developmental period help determine young people's current health status and their risk for developing chronic diseases in adulthood[1]. Although adolescence are generally healthy times of life, several important public health and social problems either peak or start during these years. Examples include homicide, suicide, motor vehicle crashes including those caused by drinking and driving, substance use and abuse, smoking, sexually transmitted infections including human immunodeficiency virus (HIV), teen and unplanned pregnancies, and homelessness[2]. The leading causes of illness and death among adolescents are largely preventable and the financial burdens of preventable health problems in adolescence are large[3] . Health outcomes for adolescents are grounded in their social environments and are frequently mediated by their behaviors influenced at the individual, peer, family, school, community, and societal levels. Also adolescents growing up in distressed neighborhoods characterized by concentrated poverty are at risk for a variety of negative outcomes, including poor physical and mental health, crime, and risky sexual behavior[4].

Data Source:

California Department of Education, Data Reporting Office.

Brief description of California Department of Education (CDE) Data:

The California Department of Education uses California Basic Educational Data System (CBEDS) and California Longitudinal Pupil Achievement Data System (CALPADS) to collect and share demographic data about students, schools, school districts, and classified staff in the California public school systems from K-12. The CBEDS are collected once a year in October using two different forms, and each form is completed separately by each county/district and public school. Student aggregate counts (graduates, dropouts, and various enrollment counts) previously collected through CBEDS are now collected at the individual student level using CALPADS Statewide Student Identifiers (SSIDs). These data aggregated up to the school level and then combined with data collected through CBEDS for reporting purposes. CBEDS data files are available to schools, districts, parents, government groups, control agencies, CDE staff, the media, and the general public.

Reference:

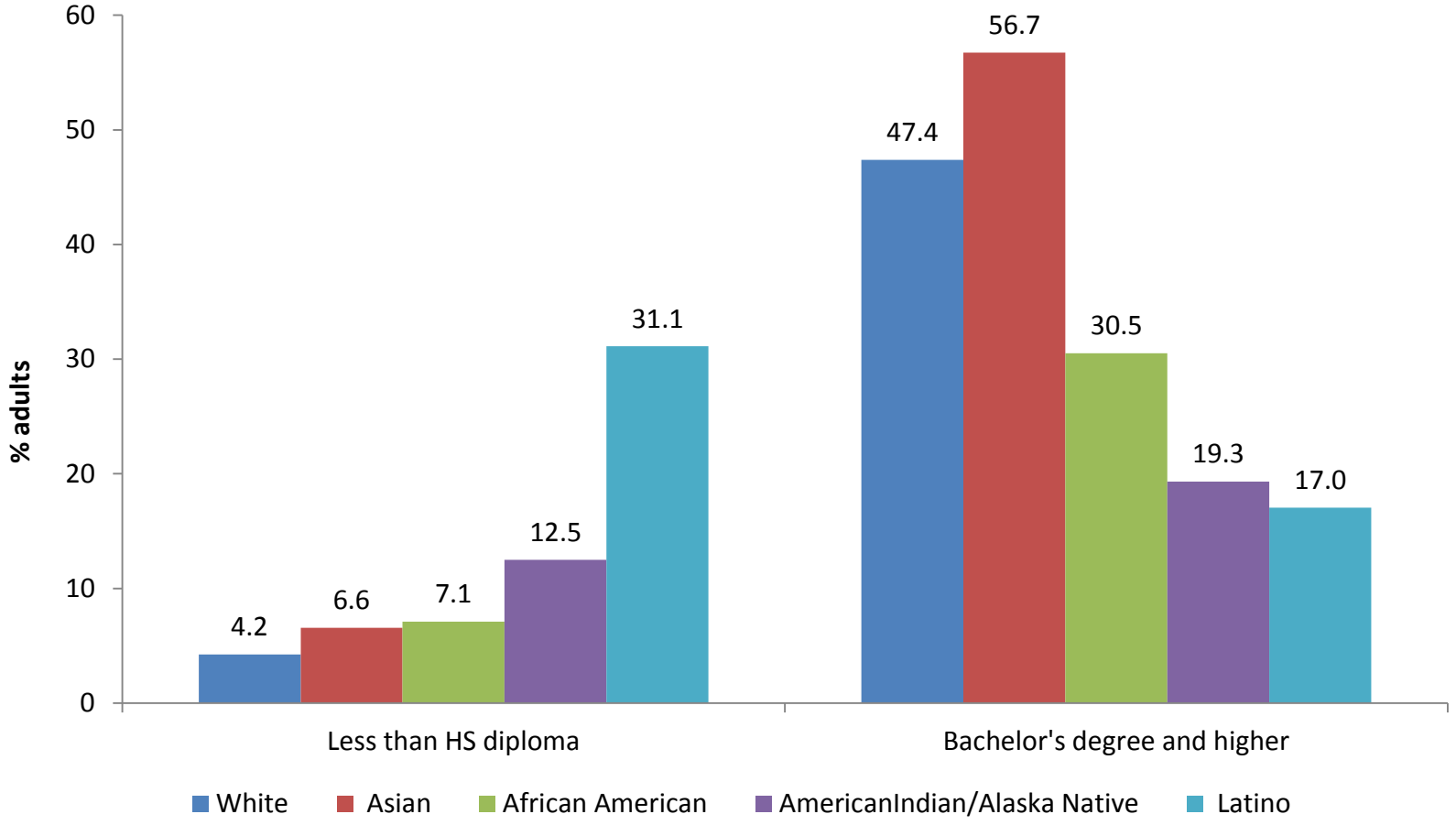
1. Lawrence RS, Gootman JA, Sim LJ. Adolescent health services: Missing opportunities, National Research Council and Institute of Medicine, Committee on Adolescent Health Care Services and Models of Care for Treatment, Prevention, and Healthy Development, Washington: National Academies Press, 2009. Available at: http://books.nap.edu/openbook.php?record_id=12063&page=1

2. Healthy People 2020. Adolescent health. Available at: http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=2#Ref_03

3. Mulye TP, Park MJ, Nelson CD, et al. Trends in adolescent and young adult health in the United States. J Adolescent Health. 2009;45(1):8-24. Available at: http://download.journals.elsevierhealth.com/pdfs/journals/1054-139X/PIIS1054139X09001244.pdf [PDF - 474 KB]

4. Lerner RM, Steinberg L, Leventhal T, Brooks-Gunn J. *Diversity in developmental trajectories across adolescence: Neighborhood influences*. Chapter 15 in Handbook of Adolescent Psychology; 26 JUL 2013:451-86. Available at: http://onlinelibrary.wiley.com/doi/10.1002/9780471726746.ch15/summary

Figure 3c. Educational Attainment of Adults Aged 18 to 64 Years By Race/Ethnicity, California, 2011-2012



Source: UCLA, California Health Interview Survey, 2011-2012
Definition: Adults are in ages 18-64 years excluding seniors age 65 and above.
Note: Each race and ethnic group excludes percentages of HS graduate, no college and some college or associate's degree and may not add up to 100%.

C: Child Development – Figure 3c

Brief description of significance:

The 2003 National Assessment of Adult Literacy (NAAL) measures the English literacy of America's adults (people age 16 and older living in households or prisons). The average quantitative literacy scores of adults increased between 1992 and 2003, though average prose and document literacy did not differ significantly from 1992. Among Blacks, average prose literacy scores increased and average document literacy scores rose between 1992 and 2003. The average prose scores of Asians/Pacific Islanders increased as well between 1992 and 2003.The average prose literacy scores of Hispanics fell from 1992 to 2003, while average document literacy scores decreased. Average prose and document literacy scores among Whites did not change during this period[1]. The socioeconomic factors were related indirectly to children's academic achievement through parents' beliefs and behaviors but that the process of these relations was different by racial group. Parents' years of schooling was found to be an important socioeconomic factor[2].

Data Source:

UCLA, California Health Interview Survey, 2011-2012

Brief description of California Health Interview Survey (CHIS)

CHIS is the largest random-dial telephone survey in California that asks questions on a wide range of health topics. CHIS is conducted by UCLA Center for Health Policy Research in collaboration with the California Department of Public Health (CDPH) and California Department of Health Care Services (DHCS) on a continuous basis that takes two years to complete a full data cycle, with over 50,000 Californians surveyed. From each participating household, an adult, teen, and child are randomly selected to interview. The selected adult respondent must be the parent or legal guardian of children and/or adolescents living in the household in order for children and/or adolescents to be selected. The interviews are conducted in multi-languages including English, Spanish, Chinese (Mandarin and Cantonese dialects), Tagalog, Vietnamese, and Korean. The large CHIS sample includes people from many racial and ethnic groups across the 58 counties of California. The survey provides high quality data that accurately represents California's diverse populations and geographic areas. For more information, please visit CHIS: http://healthpolicy.ucla.edu/chis/Pages/default.aspx

Methodology:

Only adults were included. Results are displayed for grades 1-8, grade 9-11, grade 12 (high school), some college, vocational school, AA/AS degree, BA/BS degree, some graduate school, MA/MS degree, PhD or equivalent, or no formal education. For the analysis, two education groups were selected: less than HS diploma and Bachelor's degree and higher.

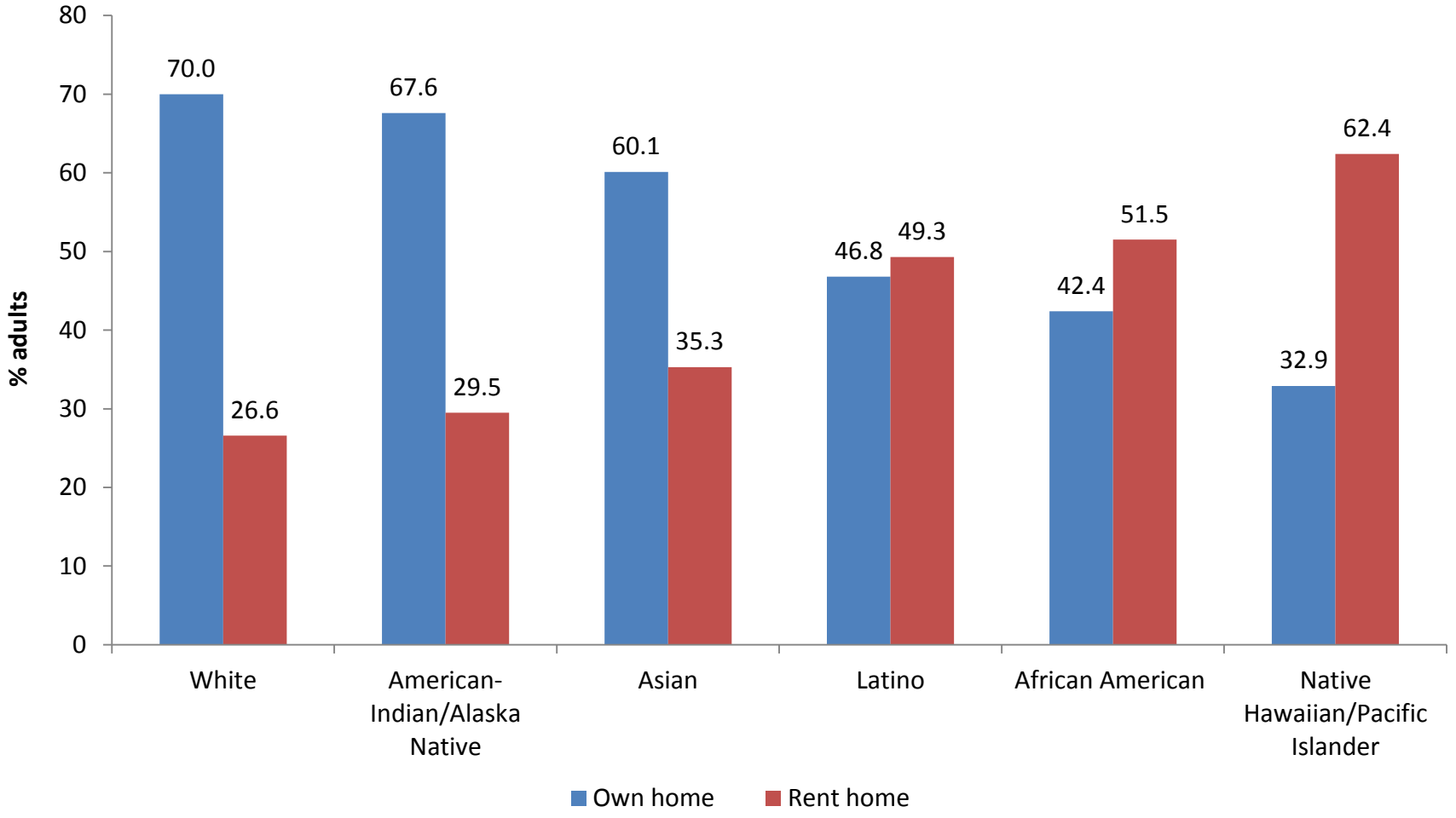
Definition:

Adults are in ages 18-64 years excluding seniors age 65 and above.

Reference:

1. U.S. Department of Education, Institute of Education Sciences, National Assessment of Adult Literacy (NAAL): A First Look at the Literacy of America's Adults in the 21st Century. Available at: http://nces.ed.gov/naal/pdf/2006470.pdf
2. Davis-Kean PE. The Influence of Parent Education and Family Income on Child Achievement: The Indirect Role of Parental Expectations and the Home Environment. Journal of Family Psychology. 2005;19(2):294-304.

Figure 4. Percentage of Adults Who Own or Rent Their Home by Race/Ethnicity, California, 2011-2012



Source: UCLA, California Health Interview Survey, 2011 – 2012
Note: Each race and ethnic group excludes percentages of "Have other arrangement" and may not add to 100%.

D. Housing – Figure 4

Brief description of significance:

The Department of Health and Human Services has defined housing insecurity as high housing costs in proportion to income, poor housing quality, unstable neighborhoods, overcrowding, or homelessness[1]. Healthy and safe housing protects family members throughout their life stages from exposure to environmental hazards, such as chemicals and allergens, unintentional injuries, and supports mental and emotional health. In contrast, inadequate housing or housing insecurity is associated with a wide range of health conditions, including infectious and chronic diseases, injuries, respiratory infections, asthma, lead poisoning, mental health and can adversely affect child development[2]. California housing is among the most costly in the nation, so finding affordable housing is a significant challenge for many middle- and low-income families. Housing typically is considered affordable if it comprises 30% or less of a family's income[3]. According to 2011 estimates, only 34% of low-income children in the U.S. and 24% of low-income children in California lived in affordable housing[4]. Families that spend more than half of their income on housing tend to spend much less than other families on essential items, such as food, health care, and clothing[3]. Low-income parents with high housing cost burdens are more likely to report that their children have fair or poor health than low-income parents in more affordable housing situations[1]. Research has also shown that unaffordable or unstable housing can diminish a child's opportunities for educational success by increasing the chance that he or she will have to move, change schools, and disrupt instruction[5]. In some cases, a lack of affordable housing can result in families living in crowded households, and studies have shown a link between residential crowding and the prevalence of certain infectious diseases, poor educational attainment, and psychological distress[6].

Data Source:

UCLA, California Health Interview Survey, 2011-2012

Brief description of California Health Interview Survey (CHIS):

(Please see category C: Child Development, Figure 3c, for detailed information)

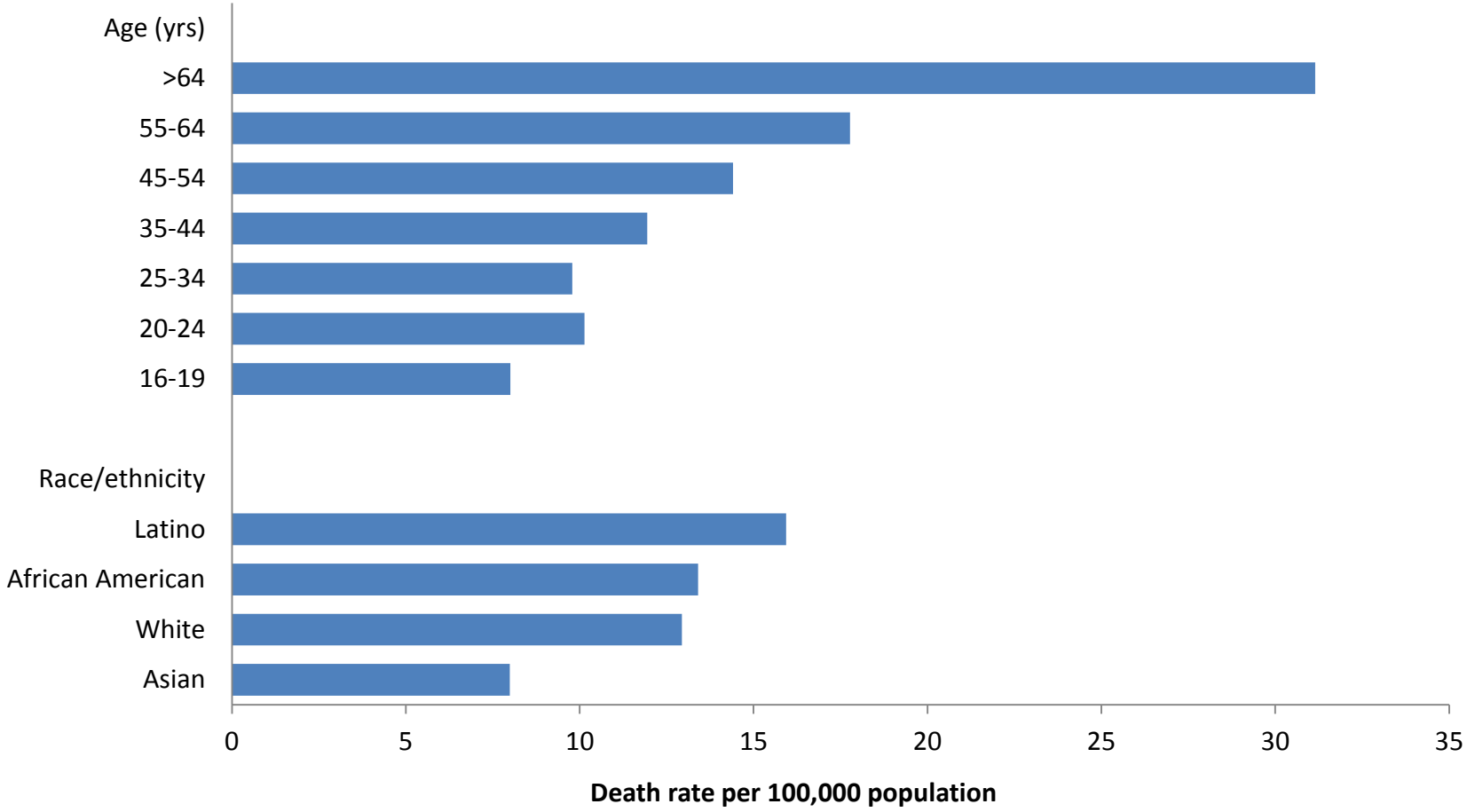
Methodology:

The question asked from adult respondents was: "Do you own or rent your home?" and results were displayed in three levels: own home, rent home, or have other arrangement. Each race and ethnic group excludes percentages of "Have other arrangement" in the figure and may not add to total percentage of 100.

Reference:

1. Johnson A, Meckstroth A. Ancillary services to support welfare to work. Washington, DC: US Department of Health and Human Services; June 22, 1998:20-23. Available at: http://aspe.hhs.gov/hsp/isp/ancillary/front.htm.
2. Krieger J, Higgins DL. Housing and health: time again for public health action. Am J Public Health. 2002;92:758–68.
3. The Center for Housing Policy. The well-being of low income children: Does affordable housing matter? Insights from Housing Policy Research. Washington, DC: National Housing Conference. Available at: http://www.nhc.org/insights.html
4. The Annie E. Casey Foundation. (2012). *Kids Count Data Center: Children in low-income households where housing costs exceed 30 percent of income*. Available at: http://datacenter.kidscount.org/data/tables/71-children-in-low-income-households-where-housing-costs-exceed-30-percent-of-income?loc=1&loct=2#detailed/2/6/false/867,133,38,35,18/any/376,377
5. The Center for Housing Policy. *The impacts of affordable housing on education: A research summary.* Insights from Housing Policy Research. Washington, DC: National Housing Conference, 2011. Available at: http://www.nhc.org/vital_links.html
6. Evans GW, Kantrowitz E. Socioeconomic status and health: The potential role of environmental risk exposure. Annual Review of Public Health. *2002; 23*:303-331. Available: http://www.annualreviews.org/doi/full/10.1146/annurev.publhealth.23.112001.112349

Figure 5a. Work-Related Fatal Injury Rates by Age and Race/Ethnicity, California, 2006-2010



Source: California Department of Industrial Relations. U.S. Department of Labor, Bureau of Labor Statistics, in cooperation with State and Federal agencies, Census of Fatal Occupational Injuries, American Community Survey, 2006-2010

E. Environmental Quality – Figure 5a

Description of significance:

On average, 12-13 workers die each day in the United States from work-related injuries[1]. Workplace deaths are estimated to cost the U.S. economy approximately $6 billion annually. Workers need more workplace safety and health protections[1]. Therefore, identifying disparities in work-related fatalities rates can help public health authorities to focus on prevention efforts and improving health equity[1].

Data source:

California Department of Industrial Relations. U.S. Department of Labor, Bureau of Labor Statistics, in cooperation with State and Federal agencies, Census of Fatal Occupational Injuries, American Community Survey, 2006-2010.

Brief Description of Bureau of Labor Statistics of the U.S. Department of Labor (BLS):

BLS is responsible for measuring labor market activity, working conditions, and price changes in the economy. It collects, analyzes, and disseminates essential economic information to the public. BLS Census of Fatal Occupational Injuries (CFOI) produces counts of fatal work injuries. Information about each work place fatal injury is obtained by cross-referencing the source of records, such as death certificates, workers' compensation reports, and Federal and Administrative reports. To ensure that fatal injuries are work-related, cases are substantiated with two or more independent source documents, or a source document and a follow-up questionnaire.
CFOI collects data annually for the preceding calendar year. For more information, please visit BLS at http://www.bls.gov/iif/oshcfoi1.htm

Methodology:

- Fatalities due to event or exposure (including transportation incidents, assaults and violent acts, contact with objects and equipment, falls, exposure to harmful substances or environments, fires and explosions, and other that was not shown) are based on the Bureau of Labor Statistics Occupational Injury and Illness Classification Manual.
- Fatal injury counts exclude illness-related deaths unless precipitated by an injury event.
- Death rate is calculated as the total number of occupational fatalities over the total population (civilian employed individuals aged 16 years and over) and multiply by 100,000.
- Aggregated population data was tabulated from American Community Survey 2006-2010.
- American Indian/ Alaska Native and Native Hawaiian or Pacific Islander are not included due to insufficient numbers of fatalities reported.

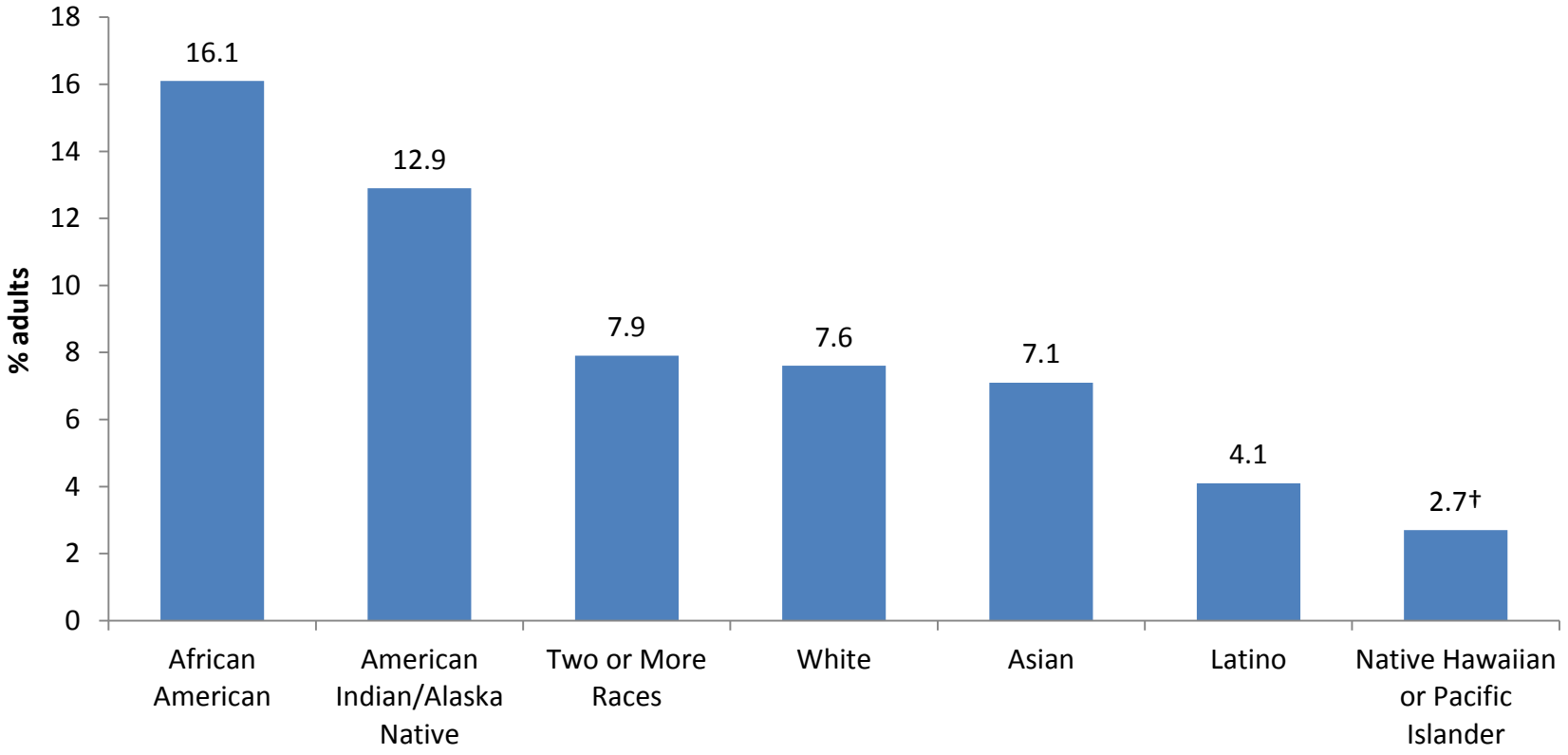
Definition:

An injury or illness is considered by the Occupational Safety and Healthy Administration (OSHA) to be work-related if an event or exposure in the work environment either caused or contributed to the resulting condition or significantly aggravated a pre-existing condition.

Reference:

1. Marsh SM, Menendez CC, Baron SL, Steege AL, Myers JR. CDC health disparities and inequalities report: Fatal work-related injuries – United States, 2005-2009. Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report. 2013; 62 (3):41-45.

Figure 5b. Percentage of Adults That Reported the Presence of Smoking Inside Their Home, California, 2011-2012



Source: UCLA, California Health Interview Survey, 2011-2012
†Statistically unstable

E. Environmental Quality – Figure 5b

Description of significance:

Secondhand smoke can be harmful to health regardless of the duration of the exposure[1]. For nonsmokers, breathing secondhand smoke has harmful effects on the lung, cardiovascular and respiratory system. Exposure to secondhand smoke is not evenly shared[1]. In the United States, more children (18.2%) lived with someone who smoked inside their home compared to adult nonsmokers (5.4%)[1]. Secondhand smoke exposure tends to be higher for African Americans, and for persons with low-income[1].

Data source:

UCLA, California Health Interview Survey, 2011-2012

Brief description of California Health Interview Survey (CHIS):

CHIS is the largest random-dial telephone survey in California that asks questions on a wide range of health topics. CHIS is conducted by UCLA Center for Health Policy Research in collaboration with the California Department of Public Health (CDPH) and California Department of Health Care Services (DHCS) on a continuous basis that takes two years to complete a full data cycle, with over 50,000 Californians surveyed. From each participating household, an adult, teen, and child are randomly selected to interview. The selected adult respondent must be the parent or legal guardian of children and/or adolescents living in the household in order for children and/or adolescents to be selected. The interviews are conducted in multi-languages including English, Spanish, Chinese (Mandarin and Cantonese dialects), Tagalog, Vietnamese, and Korean. The large CHIS sample includes people from many racial and ethnic groups across the 58 counties of California. The survey provides high quality data that accurately represents California's diverse populations and geographic areas. For more information, please visit CHIS: http://healthpolicy.ucla.edu/chis/Pages/default.aspx

Methodology:

Adult respondents were asked about the presence of smoking inside their home. Household data is extrapolated to children and teen respondents.

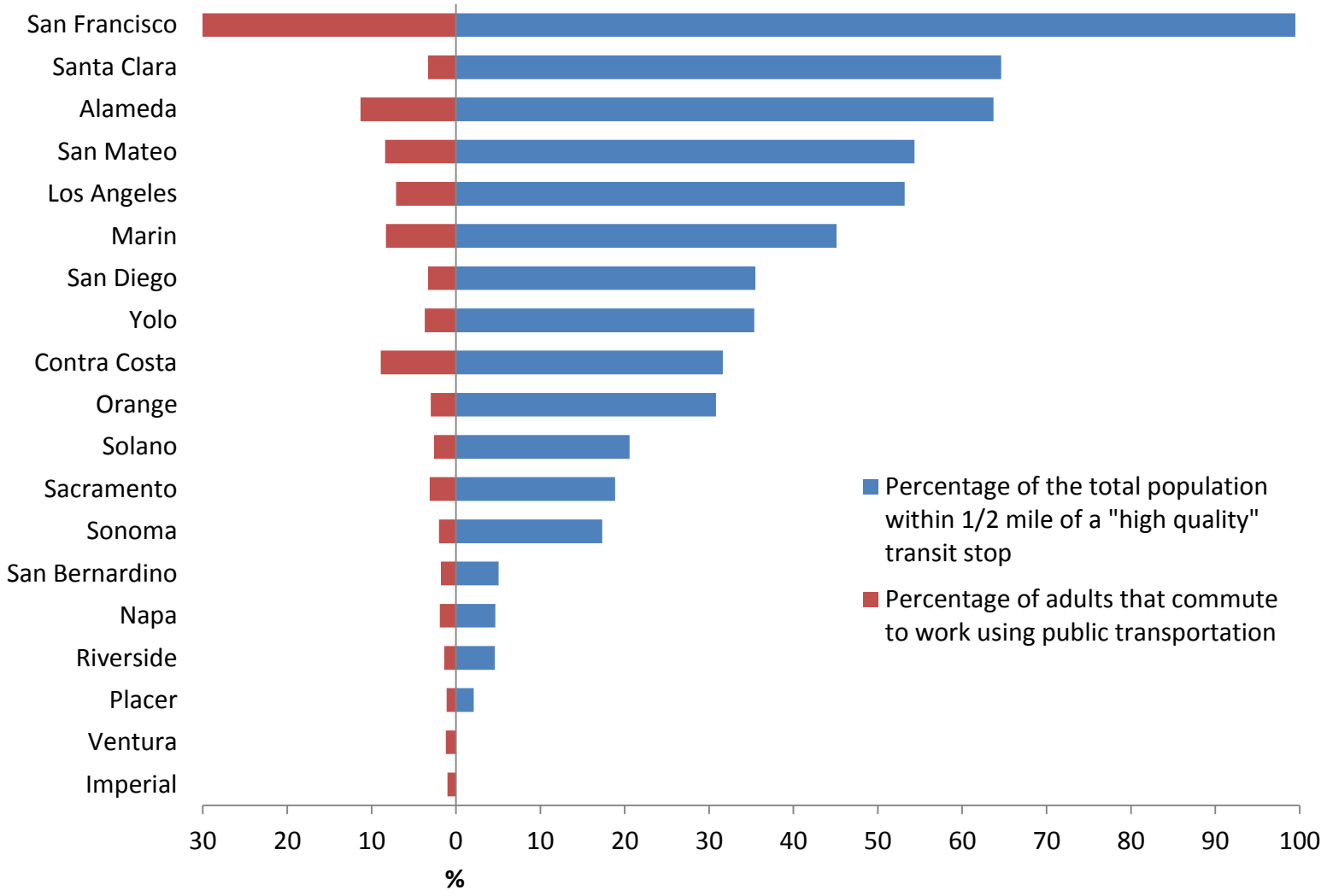
Definition:

N/A

Reference:

1. Secondhand smoke facts. Center for Disease Control and Prevention. Available at: http://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/general_facts/

Figure 6a. Public Transportation Use and Access in California by Counties of the Metropolitan Planning Organizations: SANDAG, SCAG, MTC, and SACOG



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

F. Accessible Built Environment – Figure 6 (a-d)

Description of significance:

Access to variety of safe transportation options can potentially save lives by preventing chronic diseases, reducing and preventing motor-vehicle-related injury and deaths and improving environmental health[1]. Public transportation systems minimize the number of vehicles travelled by a single-occupant, reduce the production of automobile emissions, increase incidental physical activity, and particularly minimize pedestrian and bicycle injuries[1].

Data source:

American Community Survey 2006-2010, U.S. Census Bureau, 2010 Census, transit data from Southern California Association of Governments, 2012, San Diego Association of Governments, 2012, Metropolitan Transportation Commission, 2012, and Sacramento Area Council of Governments, 2008. Analysis by CDPH-Office of Health Equity and University of California San Francisco (UCSF), Healthy Community Indicators Project.

Brief description of Healthy Community Indicators Project (HCI):

Project funded by Strategic Growth Council (SGC) provides statistical data that can be used to plan healthy communities and evaluate the impact of plans, projects, policy, and environment changes on community health. The HCI is a collaboration between CDPH and the University of California San Francisco (UCSF) to create and disseminate indicators linked to the Health in All Policies Healthy Communities Framework. This framework identifies key attributes (i.e. housing, transportation, health care, nutrition, environmental quality, and social and economic development) of a healthy community through all stages of life. For more information, visit HCI at: http://www.cdph.ca.gov/programs/Pages/HealthyCommunityIndicators.aspx

Methodology:

1) Public transportation access is the percent of residents (total) who have access to high quality public transportation such as those who residing within ½ mile of bus/rail/ferry stop with the waiting time of less than 15 minutes during peak commute hours.
- Transit data were collected from SANDAG, MTC, SCAG, and SACOG
- Transit stops included one or more fixed route transit service with a frequency of 15 minutes or less during peak hours (6-9am, 3-6pm), and for SCAG and MTC regions, stops with multiple routes with average frequency 15 minutes or less were included.
- Geospatial software (ArcMAP 10.1) was used to identify census blocks with centroids inside ½ mile from transit stops
- Block-level 2010 Census was merged with blocks inside the transit access area, and population counts were aggregated by census tract, city/town, county, and region

2) Public transportation use is the percent of residents who used public transportation to commute to work
- Public transportation data was downloaded from 2006-2010 American Community Survey.
- The denominator was the total population aged 16 years and older that had a paid job in the week previous to the survey, and the numerator was the number of people within that population who used public transportation.

Definition:

MPOs – Metropolitan Planning Organizations
SANDAG – San Diego Association of Government
SCAG – Southern California Association of Government (region includes Imperial, Los Angeles, Orange, Riverside, San Bernardino, and Ventura)
SACOG - Sacramento Area Council of Governments (region includes Sacramento, Placer, Yolo)
Bay Area Metropolitan Transportation Commission (MTC) - (region includes Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, Sonoma)

Reference:

1. Centers for Disease Control and Prevention. CDC recommendations for improving health through transportation policy. National Center for Environmental Health. 2008; 1-11.

Figure 6b. Percentage of Residents within a Half-Mile of a Major Transit Stop*, Cities and Towns in Selected Southern California Counties in SCAG, 2012

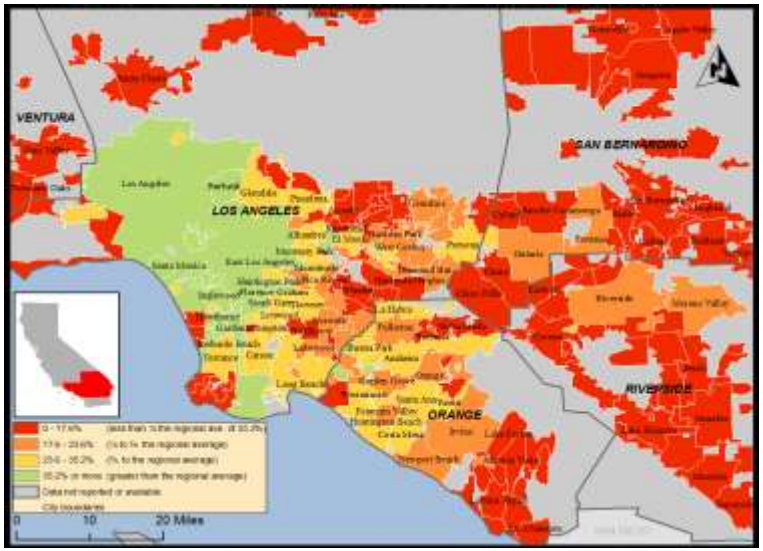


Figure 6c. Percentage of Residents within a Half-Mile of a Major Transit Stop*, Cities and Towns of Bay Area Counties in MTC, 2012

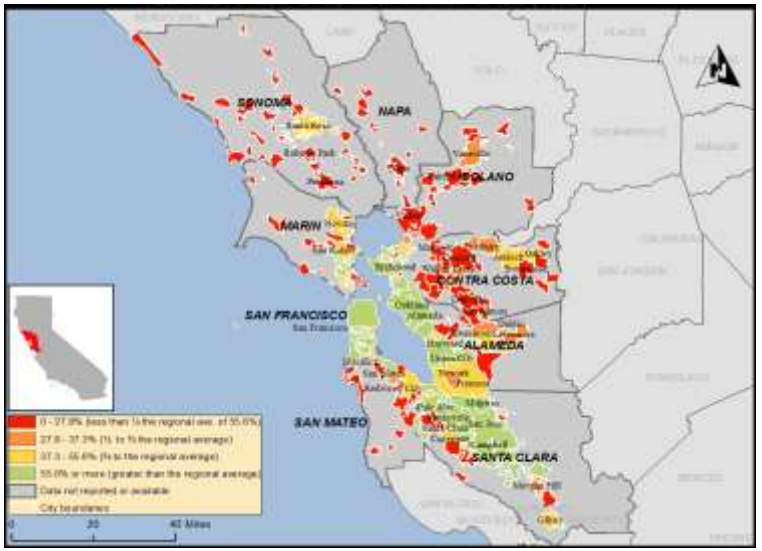
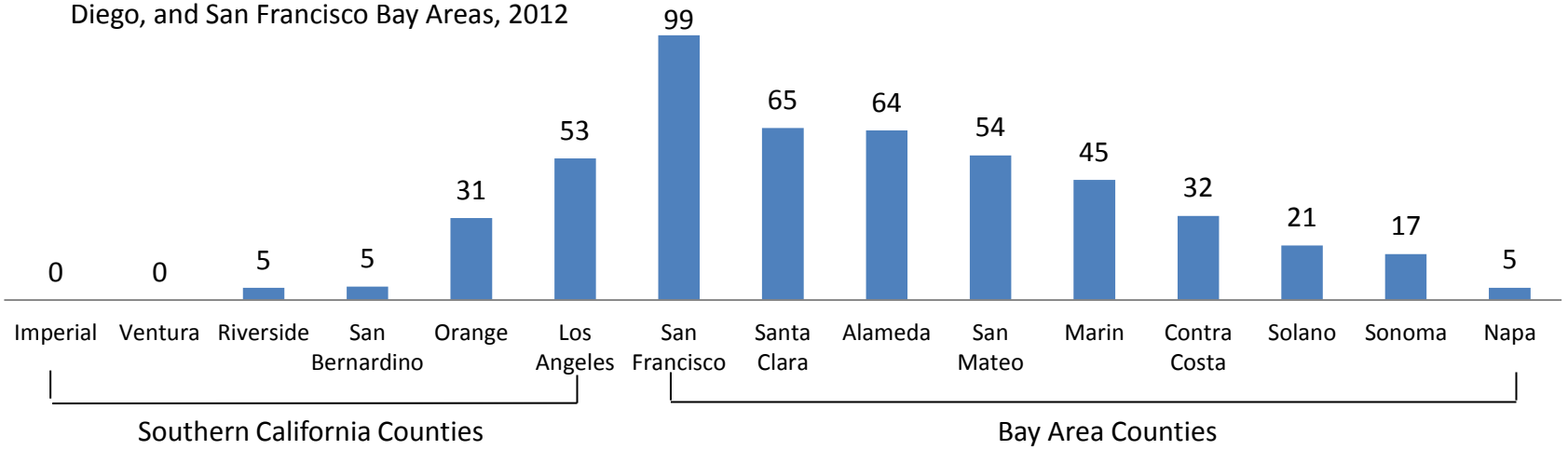


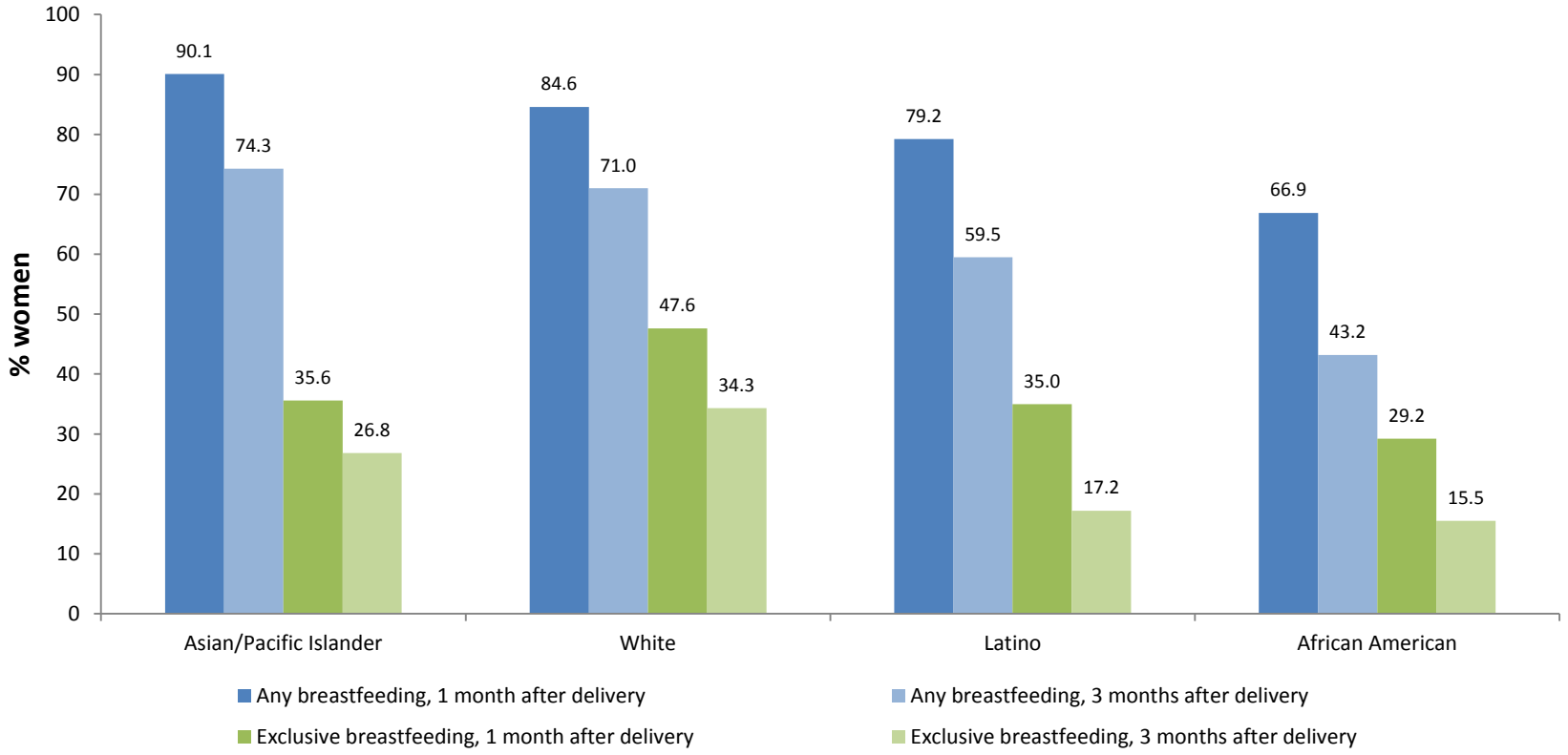
Figure 6d. Percentage of County Residents with Access to High Quality Public Transit, Southern California, San Diego, and San Francisco Bay Areas, 2012



Source: American Community Survey 2006-2010, U.S. Census Bureau, 2010 Census, transit data from Southern California Association of Governments, 2012, San Diego Association of Governments, 2012, Metropolitan Transportation Commission, 2012, and Sacramento Area Council of Governments, 2008. Analysis by CDPH-Office of Health Equity and UCSF, Healthy Community Indicators Project.

*15 minutes or less headways during peak commute hours

Figure 7a. Percentage of California Women Who Ever Breastfed or Fed Breast Milk by Race/Ethnicity, 2012



Source: California Department of Public Health, Center for Family Health, Maternal, Child and Adolescent Health Program - Maternal and Infant Health Assessment (MIHA), 2012
Note: Indicators for breastfeeding at 3 months postpartum limited to women whose infant was at least 3 months old at the time of survey

H. Prevention Efforts – Figure 7a

Brief description of significance:

Breastfeeding reduces the likelihood and severity of many common infections in babies and breastfeeding is associated with a reduced risk of atopic dermatitis (eczema)[1]. It is estimated that 27% of hospitalizations for lower respiratory tract infections could be prevented each month by exclusive breastfeeding. Similarly 53% of diarrhea hospitalizations could be prevented each month if babies were exclusively breastfed[2]. Breastfed babies have a reduced risk of infections of the middle ear[1] and urinary tract[3]. Breastfeeding also protects babies' future health. Babies who are exclusively breastfed for the first three months of life are less likely to develop coeliac disease in the first 7 years[4]. Exclusive breastfeeding is causally associated with reduced blood pressure in children[5]. It is associated with a reduced risk of being overweight or obesity or developing insulin dependent (type I) diabetes mellitus[5]. Breast milk has a particularly significant impact for babies born pre-term. It contains specific factors that are needed for brain and eyesight development in the early days[6]. Premature babies who received only breast milk were 6–10 times less likely to develop necrotizing enterocolitis (a life threatening bowel disorder) than babies fed formula milk[7]. There are long term health benefits for women as well[1]. The risk of breast cancer, some forms of ovarian cancer, type II diabetes1 and post-menopausal osteoporosis leading to hip fracture is lower in women who have breastfed[4].

By race/ethnicity, prevalence of breastfeeding initiation in 2000 was 47.4% among blacks, 71.8% among whites, and 77.6% among Hispanics. By 2008, the percentage of infants who ever breastfed had increased among blacks to 58.9% and among whites to 75.2%; and among Hispanics to 80.0%. From 2000 to 2008, breastfeeding at 6 and 12 months increased among all racial/ethnic populations. Although the gap between black and white breastfeeding initiation narrowed, black infants still had the lowest prevalence of breastfeeding initiation and duration[8].

Data Source:

Maternal and Infant Health Assessment (MIHA)

Brief description of Maternal and Infant Health Assessment (MIHA):

The Maternal and Infant Health Assessment, or MIHA, is an annual, statewide-representative survey of women with a recent live birth in California. MIHA collects self-reported information about maternal and infant experiences and about maternal attitudes and behaviors before, during and shortly after pregnancy. MIHA is a collaborative effort of the Maternal, Child and Adolescent Health (MCAH) and the Women, Infant and Children (WIC) Programs of the California Department of Public Health and the Center on Social Disparities in Health at the University of California, San Francisco. MIHA collects data that are used to monitor progress towards achieving Healthy People 2020 objectives for breastfeeding initiation, duration and exclusivity, and hospital and worksite support for breastfeeding mothers and infants. These data are used to celebrate successes and to identify opportunities to better protect, promote, and support breastfeeding in California.

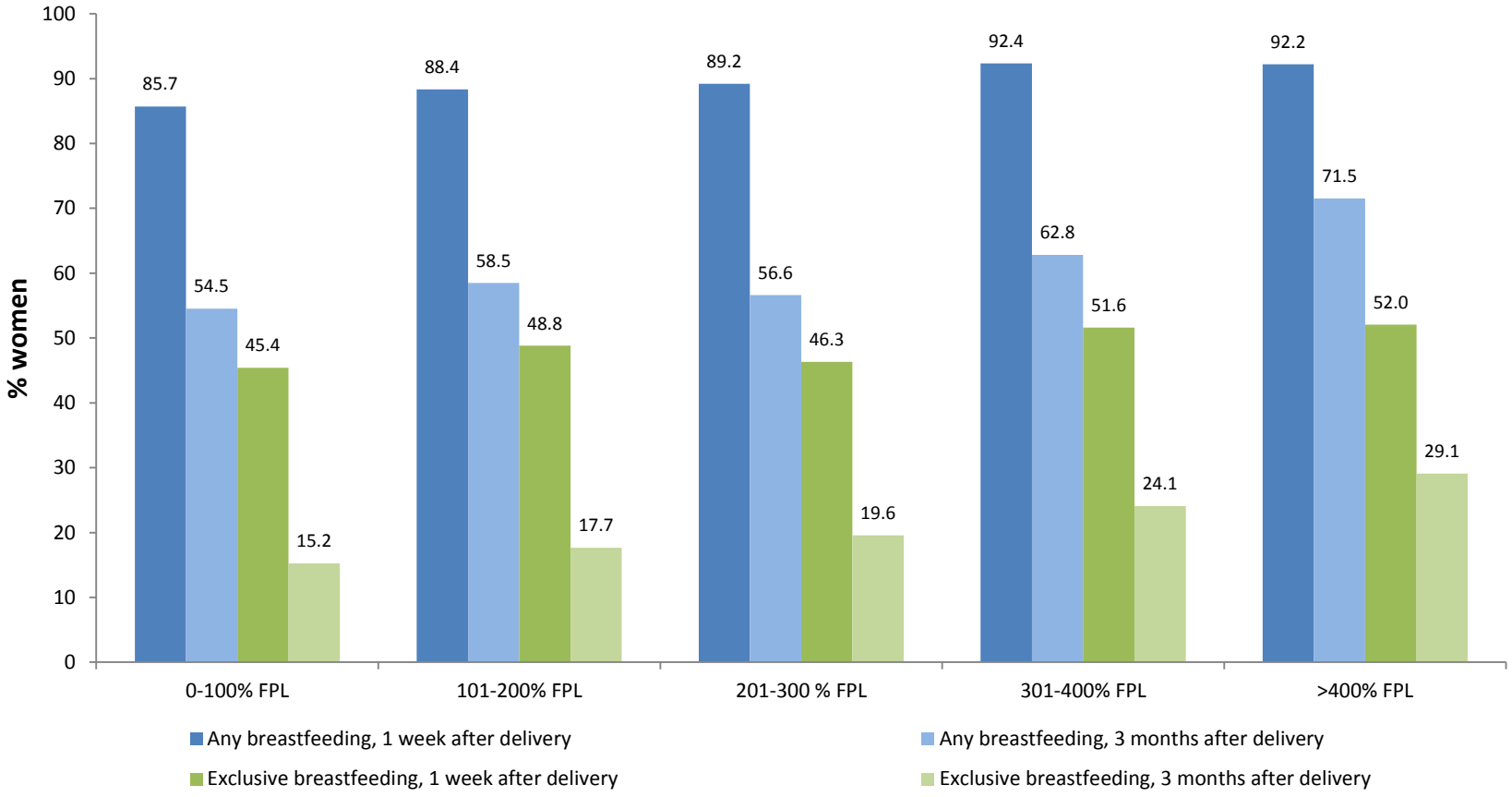
Methodology:

Percentages shown in the graph are based on the question asked: Was your new baby breastfed or fed breast milk? and the response is "yes" for Any breastfeeding 1 month after delivery, Exclusive breastfeeding 1 month after delivery, Any breastfeeding 3 months after delivery, and Exclusive breastfeeding 3 months after delivery by race/ ethnicity. Indicators for breastfeeding at 3 months postpartum limited to women whose infant was at least 3 months old at the time of survey completion.

Reference:

1. Chung M, Raman G et al. *Breastfeeding and maternal and infant health outcomes in developed countries. Evidence Report/Technology Assessment No 153.* Rockville, MD: Agency for Healthcare Research and Quality; 2007. Available from: http://www.ahrq.gov/clinic/tp/brfouttp.htm
2. Quigley MA, Kelly YJ, Sacker A. Breastfeeding and hospitalization for diarrheal and respiratory infection in the United Kingdom millennium cohort study. *Pediatrics* 2007;119(4):e837-e842.
3. Duncan B, Ey J, Holberg CJ, et al. Exclusive breast-feeding for at least 4 months protects against otitis media. *Pediatrics* 1993;91(5):867-72.
4. Akobeng AK, Heller RF. Assessing the population impact of low rates of breast feeding on asthma, coeliac disease and obesity: the use of a new statistical method. *Arch Dis Child* 2007;92(6):484-5.
5. Horta BL, Bahl R, Martines JC et al. *Evidence on the long-term effects of breastfeeding: systematic reviews and meta-analyses.* Geneva: World Health Organization; 2007. Available from: www.who.int/child-adolescenthealth/publications/NUTRITION/ISBN_92_4_159523_0.htm
6. Makrides M, Neumann M, Simmer K, et al. Are long-chain polyunsaturated fatty acids essential nutrients in infancy? *Lancet* 1995;345(8963):1463-8.
7. Lucas A, Cole TJ. Breast milk and neonatal necrotising enterocolitis. *Lancet* 1990;336(8730):1519-23.
8. Centers for Disease Control and Prevention, Progress in Increasing Breastfeeding and Reducing Racial/Ethnic Differences — United States, 2000–2008 Births. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6205a1.htm?s_cid=mm6205a1_w

Figure 7b. Percentage of California Women Who Ever Breastfed or Fed Breast Milk by Federal Poverty Level (FPL), 2012



Source: California Department of Public Health, Center for Family Health, Maternal, Child and Adolescent Health Program - Maternal and Infant Health Assessment (MIHA), 2012.
Note: Indicators for breastfeeding at 3 months postpartum limited to women whose infant was at least 3 months old at the time of survey completion.

H. Prevention Efforts – Figure 7b

Description of significance:

Breastfeeding reduces the likelihood and severity of many common infections in babies and breastfeeding is associated with a reduced risk of atopic dermatitis (eczema)[1]. It is estimated that 27% of hospitalizations for lower respiratory tract infections could be prevented each month by exclusive breastfeeding. Similarly 53% of diarrhea hospitalizations could be prevented each month if babies were exclusively breastfed[2]. Breastfed babies have a reduced risk of infections of the middle ear[1] and urinary tract[3]. Breastfeeding also protects babies' future health. Babies who are exclusively breastfed for the first three months of life are less likely to develop coeliac disease in the first 7 years[4]. Exclusive breastfeeding is causally associated with reduced blood pressure in children[5]. It is associated with a reduced risk of being overweight or obesity or developing insulin dependent (type I) diabetes mellitus[5]. Breast milk has a particularly significant impact for babies born pre-term. It contains specific factors that are needed for brain and eyesight development in the early days[6]. Premature babies who received only breast milk were 6–10 times less likely to develop necrotizing enterocolitis (a life threatening bowel disorder) than babies fed formula milk[7]. There are long term health benefits for women as well[1]. The risk of breast cancer, some forms of ovarian cancer, type II diabetes1 and post-menopausal osteoporosis leading to hip fracture is lower in women who have breastfed[4].

Data Source:

Maternal and Infant Health Assessment (MIHA)

Brief description of The Maternal and Infant Health Assessment (MIHA):

The Maternal and Infant Health Assessment, or MIHA, is an annual, statewide-representative survey of women with a recent live birth in California. MIHA collects self-reported information about maternal and infant experiences and about maternal attitudes and behaviors before, during and shortly after pregnancy. MIHA is a collaborative effort of the Maternal, Child and Adolescent Health (MCAH) and the Women, Infant and Children (WIC) Programs of the California Department of Public Health and the Center on Social Disparities in Health at the University of California, San Francisco. MIHA collects data used to monitor progress towards achieving Healthy People 2020 objectives for breastfeeding initiation, duration and exclusivity, and hospital and worksite support for breastfeeding mothers and infants. These data are used to celebrate successes and to identify opportunities to better protect, promote, and support breastfeeding in California.

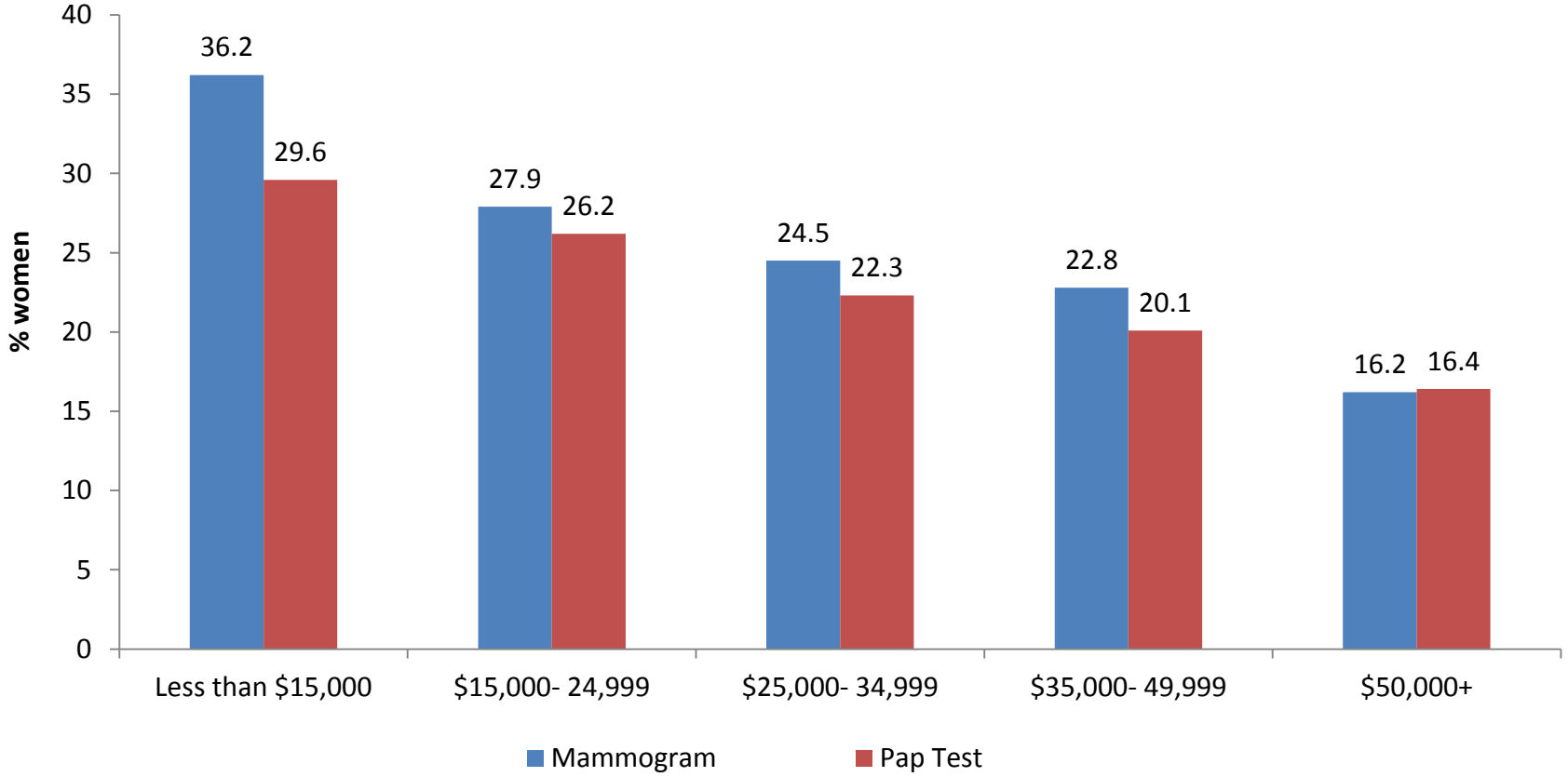
Methodology:

Percentages shown in the graph are based on the question asked: Was your new baby breastfed or fed breast milk? and the response is "yes" for Any breastfeeding 1 week after delivery, Exclusive breastfeeding 1 week after delivery, Any breastfeeding 3 months after delivery, Exclusive breastfeeding 3 months after delivery by federal poverty level (FPL). Indicators for breastfeeding at 3 months postpartum limited to women whose infant was at least 3 months old at the time of survey completion.

Reference:

1. Chung M, Raman G et al. *Breastfeeding and maternal and infant health outcomes in developed countries. Evidence Report/Technology Assessment No 153.* Rockville, MD: Agency for Healthcare Research and Quality; 2007. Available from: http://www.ahrq.gov/clinic/tp/brfouttp.htm
2. Quigley MA, Kelly YJ, Sacker A. Breastfeeding and hospitalization for diarrheal and respiratory infection in the United Kingdom millennium cohort study. *Pediatrics* 2007;119(4):e837-e842.
3. Duncan B, Ey J, Holberg CJ, et al. Exclusive breast-feeding for at least 4 months protects against otitis media. *Pediatrics* 1993;91(5):867-72.
4. Akobeng AK, Heller RF. Assessing the population impact of low rates of breast feeding on asthma, coeliac disease and obesity: the use of a new statistical method. *Arch Dis Child* 2007;92(6):484-5.
5. Horta BL, Bahl R, Martines JC et al. *Evidence on the long-term effects of breastfeeding: systematic reviews and meta-analyses.* Geneva: World Health Organization; 2007. Available from: www.who.int/child-adolescenthealth/publications/NUTRITION/ISBN_92_4_159523_0.htm
6. Makrides M, Neumann M, Simmer K, et al. Are long-chain polyunsaturated fatty acids essential nutrients in infancy? *Lancet* 1995;345(8963):1463-8.
7. Lucas A, Cole TJ. Breast milk and neonatal necrotising enterocolitis. *Lancet* 1990;336(8730):1519-23.

Figure 7c. Percentage of California Women Who Have Not Had a Mammogram or a Pap Test by Annual Income Level, 2012



Source: Behavioral Risk Factor Surveillance System, 2012
Definitions: Mammogram - Women aged 40+ who have not had a mammogram within the past two years . Pap test - Women aged 18+ who have not had a pap test within the past three years.

H. Prevention Efforts – Figure 7c

Brief description of significance:

Improving health care services includes increasing access to and use of preventive services[1,2]. Preventive services are services that prevent illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention), and detect a disease at an earlier, and often more treatable, stage (secondary prevention)[3]. Clinical Preventive Services include disease screening, immunizations, and counseling by healthcare professionals[2]. Also educating people about health and promoting healthy behaviors through community level can help postpone or prevent illness and disease. In addition, detecting health problems at an early stage increases the chances of effectively treating them, often reducing suffering and costs[2].

Getting a high-quality screening mammogram and having a clinical breast exam (an exam done by a health care provider) on a regular basis are the most effective ways to detect breast cancer early. Early detection of breast cancer with screening mammography means that treatment can be started earlier in the course of the disease, possibly before it has spread. Results from randomized clinical trials and other studies show that screening mammography can help reduce the number of deaths from breast cancer among women ages 40 to 70, especially for those over age 50. Black women have the highest breast cancer death rates of all racial and ethnic groups and are 40% more likely to die of breast cancer than white women[4]. According to Centers for Disease Control and Prevention (CDC), cervical cancer is the easiest female cancer to prevent, with regular screening tests and follow-up.

Data Source:

Behavioral Risk Factor Surveillance System, 2012

Brief description of The Behavioral Risk Factor Surveillance System (BRFSS):

The Behavioral Risk Factor Surveillance System (BRFSS) is the world's largest, on-going telephone health survey system conducted by the Centers for Disease Control and Prevention (CDC). Currently data are collected monthly in all 50 states, the District of Columbia, American Samoa, Palau, Puerto Rico, the U.S. Virgin Islands, and Guam.

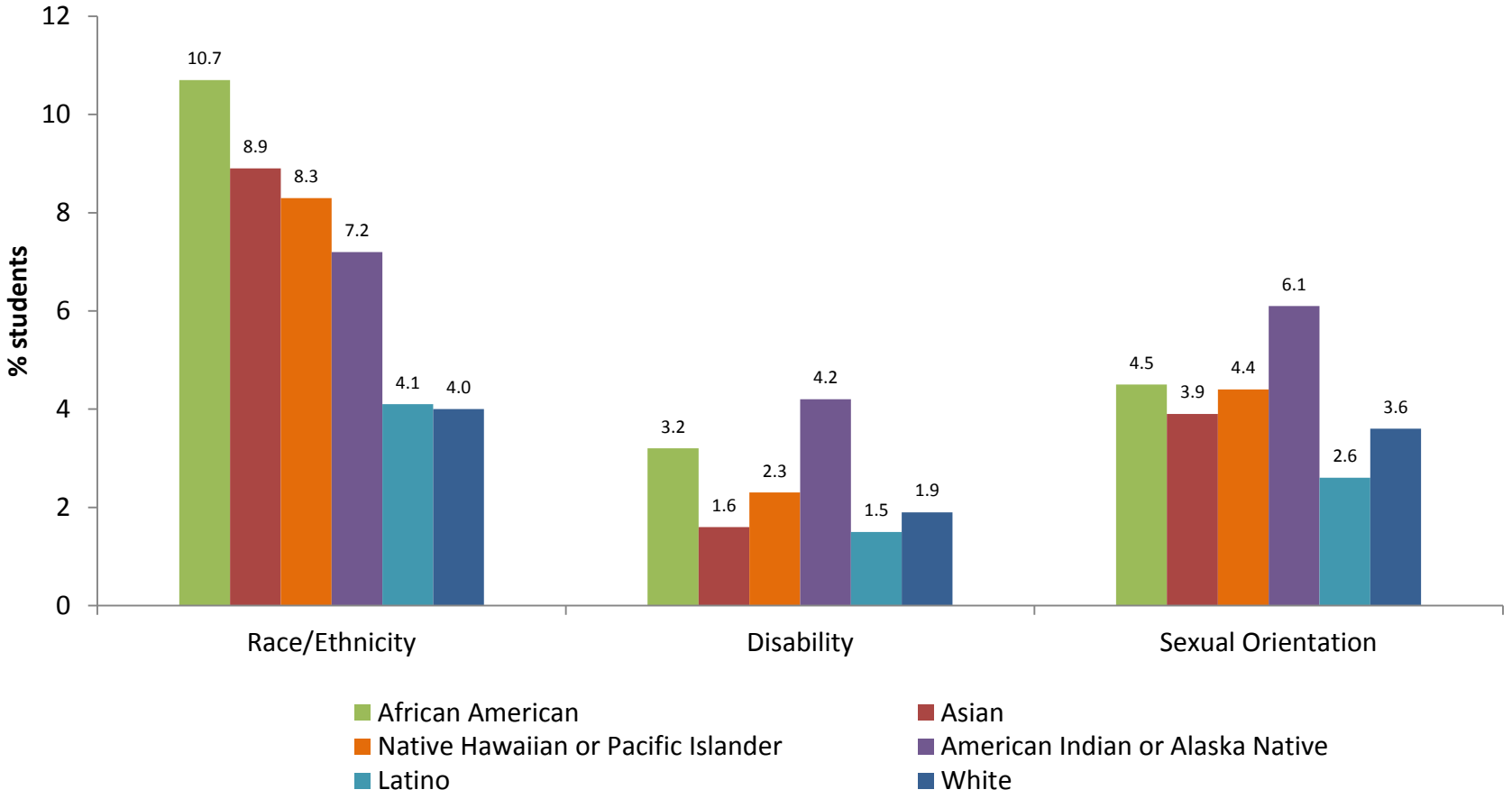
Methodology:

Mammogram – The question was asked about women aged 40 or older who have had a mammogram within the past two years. The response was in two levels: Yes or No. The percentage of women aged 40 or older who have not had a mammogram within the past two years was included in the graph. Pap test - The question was asked about women aged 18 or older who have had a pap test within the past three years. The response was in two levels: Yes or No. The percentage of women aged 18 or older who have not had a mammogram within the past two years was included in the graph.

Reference:

1. National Commission on Prevention Priorities. Preventive care: A national profile on use, disparities, and health benefits. Washington, DC: Partnership for Prevention; Aug 2007.
2. National Commission on Prevention Priorities. Data needed to assess use of high-value preventive care: A brief report from the National Commission on Prevention Priorities. Washington: Partnership for Prevention; Aug 2007.
3. Rose DJ, Lantz PM, House JS, et al. Health care access and the use of clinical preventive services. Paper presented at: Annual Meeting of the American Sociological Association; 2006 Aug 10. Available at: http://www.uspreventiveservicestaskforce.org/uspstf08/methods/procmanual.htm
4. Mandelblatt JS, Cronin KA, Bailey S, et al. Effects of mammography screening under different screening schedules: model estimates of potential benefits and harms. Annals of Internal Medicine. 2009;151(10):738-747

Figure 8a. Percentage of Students Who Reported Being Bullied or Harassed Because of Their Race/Ethnicity, Disability, or Sexual Orientation by Race/Ethnicity, California, 2008-2010



Source: California Healthy Kids Survey, 2008-2010
Definition: Percentage of students in grades 7, 9, and 11 reporting that 4 or more times in the past 12 months they have been bullied or harassed at school.

I. Ongoing Discrimination – Figure 8a

Brief description of significance:

The growing body of research on discrimination and health indicates a deleterious effect of discrimination on various health outcomes[1]. Research indicates that discrimination is associated with poor health status, and the association is strongest in the case of mental health. Higher levels of discrimination were associated with higher levels of illness and health risk[2]. Bullying and harassment can have both short and long term harmful effects on children and youth[3,4]. In addition to the risk of physical injury, research shows that victims of bullying are at higher risk of depression, suicidal ideation, and suicide attempts than those not involved in or exposed to bullying[3]. They also are more likely to experience physical health problems and difficulties with academic performance and school engagement[5].

Data Source:

California Healthy Kids Survey, 2008-2010

Brief description of The California Department of Education, California Healthy Kids Survey (CHKS):

The CHKS, funded by the California Department of Education, is the largest statewide survey of resiliency, protective factors, and risk behaviors in the nation. It provides a comprehensive, data-driven, decision-making process that helps guide the development of more effective health, prevention, and youth development programs. CHKS is a student self-reporting tool that collects data on attitudes, behaviors, experiences related to school and learning, school connectedness, development supports and opportunities, safety, violence and harassment, substance abuse, and physical and mental health. The survey is conducted in grades 5, 7, 9, and 11 because most health-risk behaviors increase or change with age.

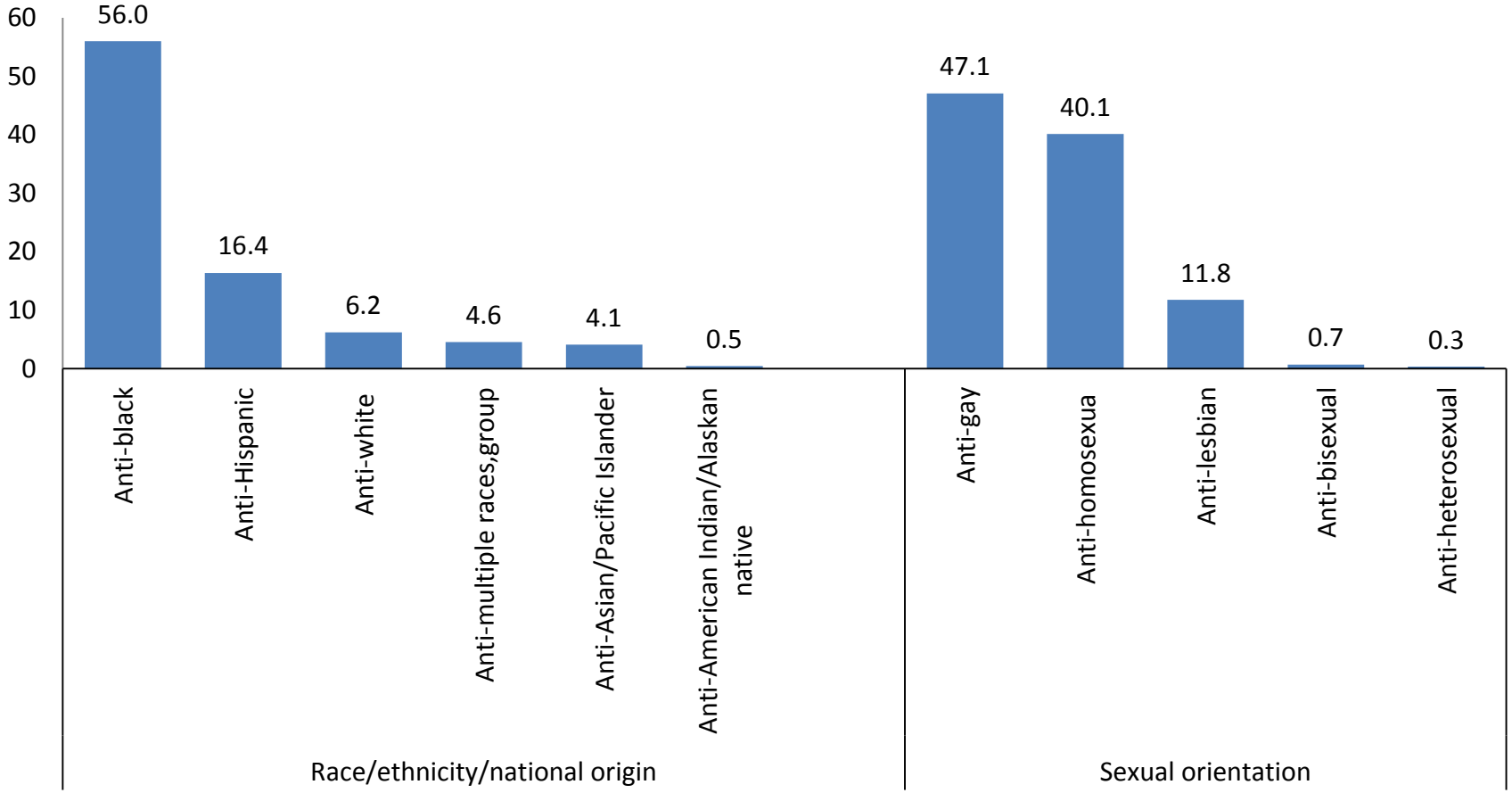
Definition:

Percentage of students in grades 7, 9, and 11 reporting that they have been bullied or harassed at school four or more times in the past 12 months.

References:

1. Ro AE, Choi KH. Social status correlates of reporting gender discrimination and racial discrimination among racially diverse women. Women Health. 2009;49(1):1-15.
2. Williams D, Neighbors HW, Jackson JS. Racial/Ethnic Discrimination and Health: Findings From Community Studies. American Journal of Public Health. 2003 Feb;93(2):200-8.
3. Klomek AB, et al. Bullying, depression, and suicidality in adolescents. Journal of the American Academy of Child and Adolescent Psychiatry. 2007; 46(1), 40-49.
4. Vanderbilt D, Augustyn M. The effects of bullying. Paediatrics and Child Health. 2010;20(7), 315–320.
5. U.S. Department of Health & Human Services, Stopbullying.gov. (nd). Effects of bullying. Available at: http://www.stopbullying.gov/at-risk/effects/index.html1.

Figure 8b. Percentage of Hate Crime Victims by Race, Ethnicity, or National Origin and Sexual orientation, California, 2012



Source: Hate Crime in California, 2012, Table 4, California Department of Justice
Note: Victim Type by Bias Motivation. Anti-multiple races and groups are not included in the graph.

I. Ongoing Discrimination – Figure 8b

Brief description of significance:

Discrimination has a broad impact on health and mental health with consequences for the individuals, their families, and the society. The disadvantages, obstacles and difficulties that people face due to discrimination on the basis of their age, gender, race, ethnicity, education, disability, sexual orientation, income, or location of residence, in the public and private domain, reduces their economic, social, and cultural enjoyment. This situation makes even worse when the intersectional discrimination which is interact two or more forms of discrimination together, (example race and gender discrimination) is persisted.

The growing body of research on discrimination and health indicates a deleterious effect of discrimination on various health outcomes[1]. Research indicates that discrimination is associated with poor health status, and the association is strongest in the case of mental health. Higher levels of discrimination were associated with higher levels of illness and health risk.[2]. Most sexual orientation hate crimes were perpetrated in public settings by one or more strangers, but victimization also occurred in other locales, and perpetrators included neighbors, coworkers, and relatives[3].

In California, hate crimes with a race/ethnicity/national origin bias are consistently the most common type of hate crime in the last ten years, accounting for 56.8 percent of all hate crime events in 2012. Within this category, hate crimes with an anti-black bias motivation continue to be the most common hate crime, accounting for approximately one-third of all hate crime events since 2003. Hate crimes with a sexual orientation bias were the second most common type of hate crime in California, comprising 25.3 percent of hate crimes reported in 2012. Within this category, hate crimes with an anti-homosexual motivation have increased 23.9 percent since 2003[4].

Data Source:

Hate Crime in California, 2012, Table 4, California Department of Justice

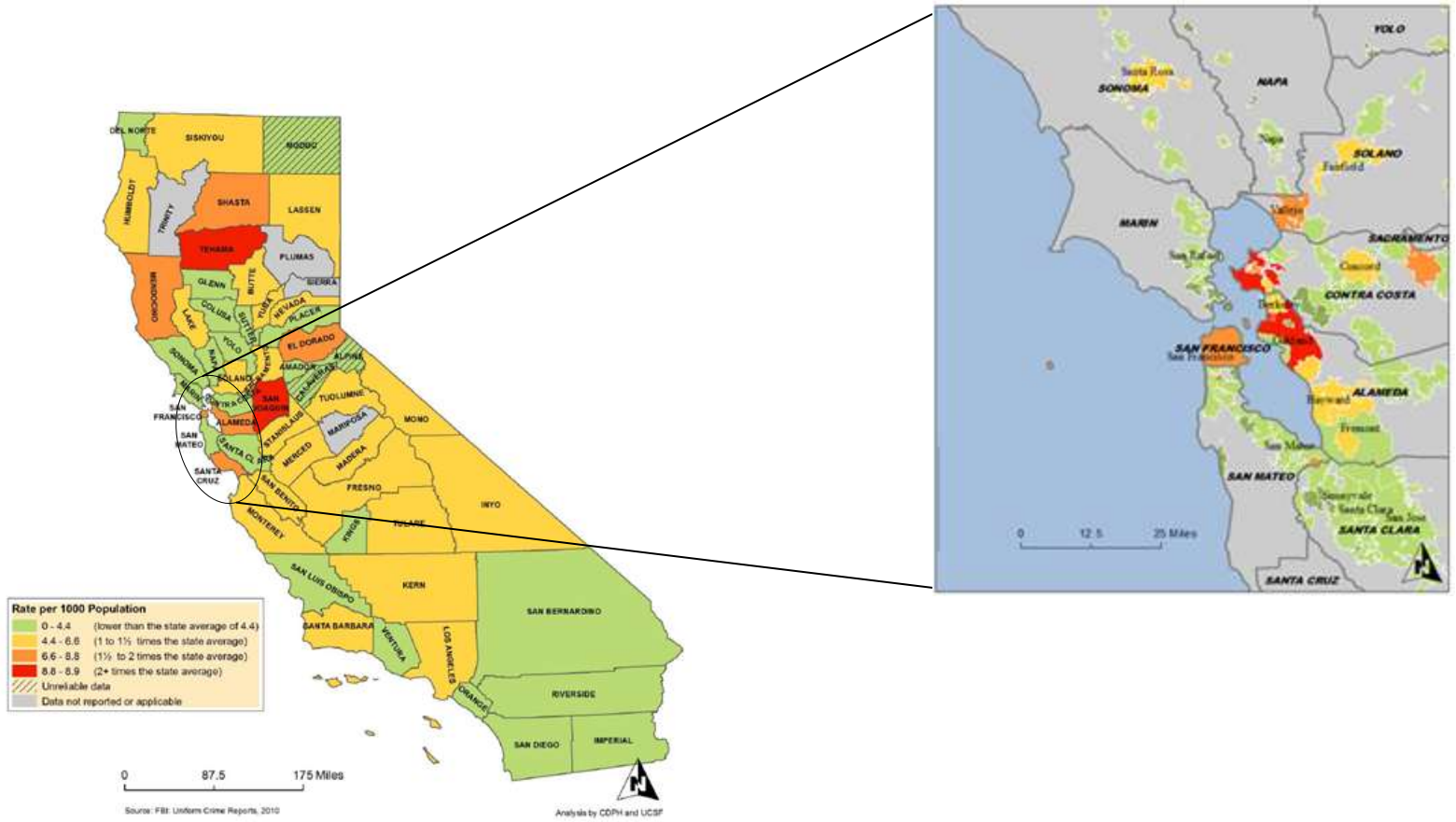
Methodology:

Figure 8b includes the total number of Victim Type by Bias Motivation. This total number includes any event occurs in individually, in business or financial institution, government place, religious organization, or in a other place. Anti-multiple races and groups are not included in the race, ethnicity, or origin section of the graph.

Reference:

1. Ro AE, Choi KH. Social status correlates of reporting gender discrimination and racial discrimination among racially diverse women. Women Health. 2009;49(1):1-15.
2. Williams D, Neighbors HW, Jackson JS. Racial/Ethnic Discrimination and Health: Findings From Community Studies. American Journal of Public Health. 2003 Feb;93(2):200-8.
3. Herek, GM, Cogan JC, Gillis JR. Victim Experiences in Hate Crimes Based on Sexual Orientation. Journal of Social Issues. 2002; 58 (2):319–339.
4. Hate Crime in California, 2012, California Justice Information Services Division, Bureau of Criminal Information and Analysis, Criminal Justice Statistics Center, California Department of Justice. Available at: https://oag.ca.gov/sites/all/files/agweb/pdfs/cjsc/publications/hatecrimes/hc12/preface12.pdf

Figure 9. Number of Violent Crimes per 1,000 Population by County, California, 2010



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

J. Neighborhood Safety and Collective Efficacy – Figure 9

Description of significance**:**

Higher rates of crimes make neighborhoods less safe for walking, biking, and social interacting that promote health[1]. Unsafe neighborhoods increase the risk of obesity among younger children by limiting their outdoor play and increasing indoor activity such as TV watching[2]. Youth growing up in unsafe neighborhoods are more likely than other youth to become victims or perpetrators of violent crime[2]. In addition, witnessing violence and crime is related to higher levels of aggression, stress, withdrawal, and lower levels of school achievement[2]. Violence contributes to negative perceptions of neighborhoods and impacts real estate, housing, and economic development[3].

Data Source:

Federal Bureau of Investigation: Uniform Crime Reports, 2010. Analysis by CDPH-Office of Health Equity and University of California San Francisco (UCSF), Healthy Community Indicators Project.

Brief description of Healthy Community Indicators Project (HCI):

Project funded by Strategic Growth Council (SGC) provides statistical data that can be used to plan healthy communities and evaluate the impact of plans, projects, policy, and environment changes on community health. The HCI is a collaboration between CDPH and the University of California San Francisco (UCSF) to create and disseminate indicators linked to the Health in All Policies Healthy Communities Framework. This framework identifies key attributes (i.e. housing, transportation, health care, nutrition, environmental quality, and social and economic development) of a healthy community through all stages of life. For more information, visit HCI at: http://www.cdph.ca.gov/programs/Pages/HealthyCommunityIndicators.aspx

Methodology:

- Uniform Crime Reports (UCR) were downloaded from FBI website
- Violent crime rate per 1,000 populations was calculated for each town/city by dividing the number of violent crimes with the total population and multiplying by 1,000.
- City and town were assigned a 5-digit U.S. Census place code based on a database that matched city names in the UCR file to a reference file of California place names, census city and county FIPS codes, and population counts from 2010 Census.
- County rates are determined using the number of violent crimes and population of cities (aggregated by county FIPS codes) Region rates were determined using the number of violent crimes and population of counties (aggregated by county FIPS codes conforming to the metropolitan transportation organizations (MPO) regions.

Definition:

N/A

Reference:

1. Burdette HL, Whitaker RC. A national study of neighborhood Safety, outdoor play, television viewing, and obesity in preschool children. Journal of American Academy of Pediatrics. 2005;116 (3), 657-662.
2. Neighborhood safety. Child Trends Data Bank. 2013. Available at: www.childrensdatabank.org.
3. Violent crime rate. Healthy Community Indicators Project. 2010. Available at: http://www.cdph.ca.gov/programs/Pages/HealthyCommunityIndicators.aspx

OHE CALIFORNIA DEMOGRAPHIC REPORT - INDICATOR MATRIX

	Key factors related to health and mental health disparities and inequities: Assembly Bill 1467 - Section 131019.5. (d)(2) Topics (A-N)	Stratified By Vulnerable Groups defined by AB 1467:	Data Sources
(A)	***Income security such as living wage, earned income tax credit, and paid leave***		
	Income & poverty		
	Total household net worth, 2010	Race/ethnicity	
	Ratio of income to poverty level in the past 12 months	Race/ethnicity	American Community Survey (ACS)
	% families whose annual household income is below the poverty level	Trend 2005-2012	American Community Survey (ACS)
	% living below poverty level	Age	American Community Survey (ACS)
	% children (<18yrs) living below poverty level	Race/ethnicity	American Community Survey (ACS)
	% families living below the living wage	Race/ethnicity	Healthy Community Indicator (HCI)
	Median household income in the past 12 months	Race/ethnicity	American Community Survey (ACS)
	Median annual earnings	Gender	American Community Survey (ACS)
	Employment/unemployment		
	% individuals filing charges claiming multiple types of employment discrimination	Trend 2009-2012	U.S. Equal Employment Opportunity
	Employment status	Race/ethnicity, gender, disability	American Community Survey (ACS)
	Unemployment rate among population age 16 and over	Race/ethnicity	American Community Survey (ACS)
	% Poverty and unemployment	Race/ethnicity	American Community Survey (ACS)
	Occupation by sex and median individual earnings for the past 12 months	Sex	American Community Survey (ACS)
	% families with householder working full-time living below poverty level	Race/ethnicity	American Community Survey (ACS)
	Median annual individual earnings, unemployment, and poverty	Educational level	American Community Survey (ACS)
	Median annual individual earnings, unemployment, and poverty	Disability	American Community Survey (ACS)
(B)	***Food security and nutrition such as food stamp eligibility and enrollment, assessments of food access, and rates of access to unhealthy food and beverages.***		
	Food security (ability to afford enough food)		
	Avg. household food security rate	Comparison (US & CA)	United States Department of Agriculture (USDA)
	% children (<18yrs) living in food insecure households	Comparison (US & CA)	Feeding America
	% food insecurity	Race/ethnicity, disability, type of families	California Health Interview Survey (CHIS)
	Food affordability for female-headed household with children (<18 yrs)	Race/ethnicity	HCI
	Behaviors indicating food insecurity	Sex, age, race/ethnicity, education level, income, overweight status	California Dietary Practicices Survey (CDPS)
	Dietary practices (healthy/unhealthy food consumption)	Sex, age, race/ethnicity, education level, income, overweight status	CDPS
	CalIFresh		
	% CalFresh households	Race/ethnicity	California Department of Social Services
	% used CalFresh to buy food in the last 12 months	Sex, age, race/ethnicity, education level, income, overweight status	CDPS
	Estimated number of income-eligible individuals, avg. monthly CalFresh participants, and estimated number of income-eligible non-participant	County	California Food Advocates
	Food access		
	Fast food restaurant access	County	USDA, Community Common
	Grocery store, farmer's market, supercenter & club store access	County	USDA, Community Common
	Population with low food access	County	USDA, Community Common
	Retail food index	County	USDA
	Convenience store access	County	USDA
(C)	***Child development, education, and literacy rates, including opportunities for early childhood development and parenting support, rates of graduation compared to dropout rates, college attainment, and adult literacy.***		
	Children ages 3 to 4 who are not attending preschool	Race/ethnicity, CA Trend data	KIDS COUNT Data Center, http://datacenter.kidscount.org/topics
	Percentage of Graduation Compared to Dropouts, Class of 2011-12	Race/Ethnicity, Gender	California Department of Education, Data Reporting Office, http://dq.cde.ca.gov/dataquest/
	Children who have difficulty speaking English by children in immigrant families	Children in immigrant families Compared to Children in US Born Families	KIDS COUNT Data Center, http://datacenter.kidscount.org/topics
	Adult (Ages 18-64) Literacy: Education level completed	Education level completed by Race Ethnicity	California Health Interview Survey (CHIS): http://healthpolicy.ucla.edu/chis/Pages/default.aspx
	Children Attend Preschool, Nursery School, or Head Start at least 10 hrs/wk	Race/ethnicity, Federal Poverty Level (FPL)	California Health Interview Survey (CHIS): http://healthpolicy.ucla.edu/chis/Pages/default.aspx
	Fourth graders who scored below proficient reading level	Race ethnicity (Trend data), family income, disability status, geographic location	KIDS COUNT Data Center, http://datacenter.kidscount.org/topics
	High school students not graduating on time - Grades 8-12	Race ethnicity, Trend Data	KIDS COUNT Data Center, http://datacenter.kidscount.org/topics

OHE CALIFORNIA DEMOGRAPHIC REPORT - INDICATOR MATRIX			
	Key factors related to health and mental health disparities and inequities: Assembly Bill 1467 - Section 131019.5. (d)(2) Topics (A-N)	**Stratified By Vulnerable Groups defined by AB 1467:**	**Data Sources**
	Graduation and Dropout Rates for the Class of 2001-2002	Race ethnicity	KIDS COUNT Data Center, http://datacenter.kidscount.org/topics
	The single-year dropout rate by grades 9–12 for students in foster care compared to all students in California public schools, 2009-2010	By Grades compared to all students in California public schools	The Invisible Achievement Gap Education Outcomes of Students in Foster Care in California's Public Schools by Vanessa X. Barrat and BethAnn Berliner.
	Children living in linguistically isolated households by children in immigrant families	Children in Immigrant Families Compared to Children in US Born Families	KIDS COUNT Data Center, http://datacenter.kidscount.org/topics
	Children in foster care	Race/Ethnicity, Age, Children in foster care waiting for adoption by race/ethnicity	KIDS COUNT Data Center, http://datacenter.kidscount.org/topics
	Children in poverty	by race and ethnicity, Trend Data	KIDS COUNT Data Center, http://datacenter.kidscount.org/topics
	Student Poverty (Percentage) - 2011-2012	Trend Data for CA	School Level Data Files, California Department of Education.
	Students Who Ate Breakfast in the Past Day	Race/Ethnicity	California Department of Education, California Healthy Kids Survey
	Children in families where the household head lacks a high school diploma	Race/Ethnicity	KIDS COUNT Data Center, http://datacenter.kidscount.org/topics
	Children whose parents all have less than a high school degree by children in immigrant families	by children in immigrant families Compared to Children in US Born Families, Trend data	KIDS COUNT Data Center, http://datacenter.kidscount.org/topics
(D)	***Housing, including access to affordable, safe, and healthy housing, housing near parks and with access to healthy foods, and housing that incorporates universal design and visitability features.***		
	Own or Rent Home	Race Ethnicity	2011 - 2012 California Health Interview Survey
	Children living in crowded housing	CA Trend Data, US data	KIDS COUNT Data Center, http://datacenter.kidscount.org/topics
	Children living in crowded households by children in immigrant families	CA Trend Data, US data	KIDS COUNT Data Center, http://datacenter.kidscount.org/topics
	Children in low-income households where housing costs exceed 30 percent of income	CA Trend Data, US data	KIDS COUNT Data Center, http://datacenter.kidscount.org/topics
	California Share of the U.S Homeless Population	Top five State including California	The 2012 Point-in-Time Estimates of Homelessness, Volume I of the 2012 Annual Homeless Assessment Report, The U.S. Department of Housing and Urban Development Office of Community Planning and Development.
	Top 10 Highest Percentages of Unsheltered Homelessness in US	10 States including California	The 2012 Point-in-Time Estimates of Homelessness, Volume I of the 2012 Annual Homeless Assessment Report, The U.S. Department of Housing and Urban Development Office of Community Planning and Development.
	Top 20 Homeless Hospitalizations in California	ICD_9 codes, Race Ethnicity	Source: Office of Statewide Health Planning and Development ,Patient Dischage Data, 2010
	Condition of Walkways in Home Neighborhood	Gender, Age, Race Ethnicity, Income	2011 California Dietary Practices Survey (CDPS)
	Access to Safe Exercise Facilities in Home Neighborhood	Gender, Age, Race Ethnicity, Income	2011 California Dietary Practices Survey (CDPS)
	Access to Quality, Affordable, and Fresh Fruits and Vegetables in Neighborhood	Gender, Age, Race Ethnicity, Income	2011 California Dietary Practices Survey (CDPS)
	Nearby Park or Playground Safe During the Day	Race Ethnicity, FPL	2011 - 2012 California Health Interview Survey
	Nearby Park or Playground Safe at Night	Race Ethnicity, FPL	2011 - 2012 California Health Interview Survey
	Walking Distance to Park, Playground, or Open Space Compared by Race Ethnicity - All adolescents and children age 1 or older	Race Ethnicity, FPL	2011 - 2012 California Health Interview Survey
(E)	***Environmental quality, including exposure to toxins in the air, water, and soil.***		
	Environmental quality		
	Annual unhealthy 8-hr ozone days	California region (trend 2000-2013)	American Lung Association
	Annual unhealthy PM2.5 days	California region (trend 2004-2013)	American Lung Association
	Reductions in high ozone and high PM days	County	American Lung Association
	Estimated number of all ages affected by maximum contaminant level (MCL) water quality violations for CA water systems per 100,000 population	County	Kids Data
	Fatal occupational exposure to harmful substances or environment	Race/ethnicity	California Department of Industrial Relations
	Indoor air quality (indoor smoking)		
	% youth who reported being exposed to second-hand smoking within the past 7 days	Race/ethnicity, grade level	County and Statewide Archive of Tobacco Statistics (C-STATS)
	% respondents who reported the presence of smoking inside their home	Race/ethnicity	CHIS

	OHE CALIFORNIA DEMOGRAPHIC REPORT - INDICATOR MATRIX		
	Key factors related to health and mental health disparities and inequities: Assembly Bill 1467 - Section 131019.5. (d)(2) Topics (A-N)	**Stratified By Vulnerable Groups defined by AB 1467:**	**Data Sources**
(F)	***Accessible built environments that promote health and safety, including mixed-used land, active transportation such as improved pedestrian, bicycle, and automobile safety, parks and green space, and healthy school siting***		
	% of population within 1/2 mile of park, beach, open space, or coastline	Race/ethnicity	HCI
	% county residents with access to high quality public transit	County (Southern CA and Bay Area)	HCI
	Walkability score		
	Mode of transportation to work (public transportation, bicyle, walk)	County	ACS
	% population within 1/2 mile of a park	County	
	Motor vehicle traffic-related pedestrian fatalities and non-hospitalizations (rate per 100,000)	Age, race/ethnicity, gender	CDPH-EpiCenter
	Access vs. usage of public transportation		HCI
(G)	***Health care, including accessible disease management programs, access to affordable, quality health and behavioral health care, assessment of the health care workforce, and workforce diversity.***		
	Rates of Uninsurance During Last 12 Months by Race/Ethnicity Among Nonelderly Persons, Ages 0-64, California , 2001-2009*	Race/Ethnicity for years 2011-2009	CHIS - All three figures are from SA Lavarreda, L Cabezas, K Jacobs, DH Roby, N Pourat, GF Kominski. The State of Health Insurance in California: Findings from the 2009 California Health Interview Survey. Los Angeles, CA: UCLA Center for Health Policy Research, 2012. This is the link to the actual report - http://healthpolicy.ucla.edu/publications/Documents/PDF/shic2009-apr2012.pdf, that also has more figures and text. The first figure is the best general representation of access for California adults during the past decade,
	Rates of Employment-Based Health Insurance During Last 12 Months by Race/Ethnicity Among Nonelderly Persons, Ages 0-64, California , 2001-2009	Race/Ethnicity for years 2011-2009	
	Rates of Medi-Cal or Healthy Families Coverage During Last 12 Months by Race/Ethnicity Among Nonelderly Persons, Ages 0-64, California , 2001-2009	Race/Ethnicity for years 2011-2009	
	OSHPD, HWDD, Healthcare Workforce Clearinghouse - information via Fact Sheets on health professions including fact sheets for Occupational Employment Projections, Registered Dental Hygienists, Registered Dental Assistants, Dentists, Doctors of Osteopathy, Respiratory Care Practitioners, Physician Assistants, Psychiatric Technicians, Physicians and Surgeons (MDs), Vocational Nurses, Registered Nurses are on the Clearinghouse website. Other profession Fact Sheets will be posted as available. Clearinghouse is working on a Latino Physicians Needs Assessment and a in-depth report on Physician Assistants both of which will be released later in 2014. In addition there is information on some health professions student enrollments and degrees awarded on the site.	The data used in Clearinghouse is from numerous sources and not all sources provide OSHPD with the same data. Some licensing boards ask and report on race/ethnicity and/or language and others do not. The Fact Sheets reflect what data was provided from sources. For example if race/ethnicity, language or gender is not on a Fact Sheet it is because it was not available from the data provider.	http://oshpd.ca.gov/HWDD/HWC/index.html
(H)	***Prevention efforts, including community-based education and availability of preventive services.***		
	Breastfeeding and Breastfeeding practices	Race and Ethnicity, FPL, and Age	Maternal and Infant Health Assessment (MIHA) Survry, 2011
	children 5-11 - Number of days physically active at least one hour (past week)	Race and Ethnicity, FPL	2011 - 2012 California Health Interview Survey
	Current smoking status - adults and teens	Race Ethnicity, FPL	2011 - 2012 California Health Interview Survey
	Adults aged 65+ who have ever had a pneumonia vaccination	Race/ethnicity, income	BRFSS 2012, http://apps.nccd.cdc.gov/brfss/index.asp
	Women aged 40+ who have had a mammogram within the past two years	Race/ethnicity/Income	CA Women's Health Survey-2012, BRFSS 2012 - http://apps.nccd.cdc.gov/brfss/index.asp, Outcome: http://www.cancer-rates.info/ca/index.php
	Pap (Papanicolaou) smears	Race/ethnicity/Income	CA Women's Health Survey-2012, BRFSS 2012 - http://apps.nccd.cdc.gov/brfss/index.asp, Outcome: California Cancer Registry, http://www.cancer-rates.info/ca/index.php
	Colorectal Cancer Screening - blood stool test, sigmoidoscopy, or colonoscopy	Race/ethnicity, income	BRFSS 2012 - http://apps.nccd.cdc.gov/brfss/index.asp, Outcome: California Cancer Registry, http://www.cancer-rates.info/ca/index.php
	Time since last dental visit compared by Race Ethnicity -children 3-11 years of age, and also asked of children 2 years of age who have teeth	Race Ethnicity, FPL	2011 - 2012 California Health Interview Survey
(I)	***Assessing ongoing discrimination and minority stressors against individuals and groups in vulnerable communities based upon race, gender, gender identity, gender expression, ethnicity, marital status, language, sexual orientation, disability, and other factors, such as discrimination that is based upon bias and negative attitudes of health professionals and providers.***		
	Race, Ethnicity or National Origin as Reason for Bullying/Harassment	Race/Ethnicity, Gender, and Grade Level	California Department of Education, California Healthy Kids Survey, http://chks.wested.org/indicators
	Disability as Reason for Bullying/Harassment	Race/Ethnicity, Gender, and Grade Level	California Department of Education, California Healthy Kids Survey, http://chks.wested.org/indicators
	Sexual Orientation as Reason for Bullying/Harassment	Race/Ethnicity, Gender, and Grade Level	California Department of Education, California Healthy Kids Survey, http://chks.wested.org/indicators

OHE CALIFORNIA DEMOGRAPHIC REPORT - INDICATOR MATRIX

	Key factors related to health and mental health disparities and inequities: Assembly Bill 1467 - Section 131019.5. (d)(2) Topics (A-N)	Stratified By Vulnerable Groups defined by AB 1467:	Data Sources
	Mental Health: Depression-Related Feelings of Sadness or Hopelessness	Race/Ethnicity, Gender, and Grade Level	California Department of Education, California Healthy Kids Survey, http://chks.wested.org/indicators
	Arrests - Truancy Age 10-17	Trend Data by Race Ethnicity	California Department of Justice, https://oag.ca.gov/crime/cjsc/stats/arrests
	Percent of Hate Crimes - Victim Type by Bias Motivation	Race/ethnicity/national origin, Sexual Orientation, Physical/Mental disability, Gender	California Department of Justice, Hate Crime in California, 2012, http://oag.ca.gov/sites/all/files/agweb/pdfs/cjsc/publications/hatecrimes/hc12/preface12.pdf?
	Experience of discrimination Againt Women	Race/ethnicity	CA Women's Health Survey-2012
	Percentage of Individuals Filing Charges Claiming Multiple Types of Discrimination	Trend and Aggregated data by Race, Sex (including pregnancy), National origin, Color, Age (40 and older), Disability or genetic information	US Equal Employment Opportunity Commission, http://www.eeoc.gov/
	Children who are confirmed by child protective services as victims of maltreatment	Race/Ethnicity, Age, Gender, maltreatment by Type	KIDS COUNT Data Center, http://datacenter.kidscount.org/topics
	Dr. Vickie Mayes (UCLA) - discrimination (data pending)		California Quality of Life Survey
(J)	***Neighborhood safety and collective efficacy, including rates of violence, increases or decreases in community cohesion, and collaborative efforts to improve the health and well-being of the community.***		
	Neighborhood security (safety of nearby park/playground during the day and at night)	Race/ethnicity, age, FPL	CHIS: http://healthpolicy.ucla.edu/chis/Pages/default.aspx
	Collective efficacy (have people in the neighborhood to trust, to help, or to look out for children)	Race/ethnicity, gender, age, FPL	CHIS: http://healthpolicy.ucla.edu/chis/Pages/default.aspx
	Community involvement	Race/ethnicity, FPL	CHIS: http://healthpolicy.ucla.edu/chis/Pages/default.aspx
	Reported crime rate by type of crime- Number of Violent Crimes per 1000 Population	County	HCI: http://www.cdph.ca.gov/programs/Pages/HealthyCommunityIndicators.aspx
	Liquor store access	County	Community Common
(K)	***The efforts of the Health in All Policies Task Force, including monitoring and identifying efforts to include health and equity in all sectors.***		
	Health in All Policies reports to the Strategic Growth Council		Public reports
(L)	***Culturally appropriate and competent services and training in all sectors, including training to eliminate bias, discrimination, and mistreatment of persons in vulnerable communities.***		
	DHCS-in the future can be retrieved from Cultural Competence Plan Requirements (CCPR) Information	MHP s will submit Cultural Competence Plans (CCP) to DHCS by mid-2014; plans will contain information about outreach to vulnerable populations, alternate service provision and workforce competence	Information will be made available on DHCS website
	Cultural Appropriateness Report by Health Care Service Plans (per H&S Code Section 1367.07)	requirement for health plans (per statute)	http://www.dmhc.ca.gov/library/reports/med_survey/car.pdf
	Second Biennial Report to the Legislature on Language Assistance	Information on cultural appropriateness reports by health plans begins on page 23 (qualitative information only)	http://www.dmhc.ca.gov/library/reports/news/11rpt2legisla.pdf
(M)	***Linguistically appropriate and competent services and training in all sectors, including the availability of information in alternative formats such as large font, braille, and American Sign Language.***		
	Health plan compliance with language assistance requirements (Managed Care Plans, DMHC)	Compliance by health plan type (language assistance only, does not include i	http://healthhelp.ca.gov/library/reports/news/labr1112.pdf
	Mental Health Services Division-Program Oversight & Compliance Branch (POCB): Information from Triennial Compliance Reviews on beneficiary information material available in English and MHP Threshold Language	Compliance (yes/no) per Mental Health Plan	Reports not posted but available upon request
	Frequency of Threshold Language Speakers in the Medi-Cal Population by County (October 2011)	Threshold languages by County (Medi-Cal population only)	http://www.dhcs.ca.gov/dataandstats/statistics/Documents/RASB_Issue_Brief_Annual_Threshold_Language_Report.pdf
(N)	***Accessible, affordable, and appropriate mental health services.***		
	Information regarding Access to Services form the External Quality Review Organization's (EQRO) Annual Report FY 2012/2013 : The EQRO review for FY12-13 looks at trends for service accessibility/timeliness and appropriateness. These domains are illustrated by Mental Health Plan (MHP) practices in the area of cultural competence and in activities related to integration and collaboration. These practices are assessed by looking at penetration rates and program implementation (i.e. Multi-Function Telemedicine Services, Culturally Congruent Services, etc.). Focus Group findings are also included, which accounts for the consumer's experiences in acquiring services, consumer involvement in decision-making, progress through level of care and discharge, and family member participation in treatment planning.	Race/Ethnicity	EQRO Data Analysis; Reports can be found at www.caeqro.com

OHE CALIFORNIA DEMOGRAPHIC REPORT - INDICATOR MATRIX		
Key factors related to health and mental health disparities and inequities: Assembly Bill 1467 - Section 131019.5. (d)(2) Topics (A-N)	**Stratified By Vulnerable Groups defined by AB 1467:**	**Data Sources**
Substance Abuse and Mental Health Services Administration (SAMHSA) Uniform Reporting System (URS) Output Tables: Information from the Client and Services Information (CSI) system, State Hospitals, and Consumer Perception Surveys (CPS) are compiled and reported to SAMHSA. The URS tables include the following domains: • Access to Services/Capacity: Number of Persons Served by Demographic Characteristics • Stability in Housing (Residential Status) • Readmission to State Hospital • Adult Employment and Children's School Attendance/Education • Criminal Justice Involvement • Perception of Care (or services) • Use of Evidence-Based Practices	Race, ethnicity, gender, age	SAMHSA URS Output Tables; Reports available at http://www.samhsa.gov/dataoutcomes/urs/ * MHSD is in the process of stabilizing the data in the CSI Data System.
California Health Interview Survey (CHIS)		CHIS Questionnaires can be found at: http://healthpolicy.ucla.edu/chis/design/Pages/questionnaires.aspx *MHSD is looking into the availability of source data.
OSHPD, HPEF, MHLAP		Health Professions Education Profession http://oshpd.ca.gov/HPEF/
OSHPD, HWDD, MHSA Workforce, Education and Training Program (WET)		http://oshpd.ca.gov/HWDD/WET.html

* California renamed the federal food stamp program (aka SNAP) as CalFresh.

Vulnerable communities: women, racial or ethnic groups, low-income individuals and families, individuals who are incarcerated and those who have been incarcerated, individuals with disabilities, individuals with mental health conditions, children, youth and young adults, seniors,