THE LANDSCAPE OF OPPORTUNITY

Cultivating Health Equity In California

CPEHN

California Pan-Ethnic Health Network

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CULTIVATING HEALTH EQUITY

Overview

California's communities of color have made up the majority of the population since 2000. Today, California is home to the largest Asian and Pacific Islander community, and fifth largest African American community.[1] Almost half of California's population speaks a language other than English.[2] Latinos constitute more than half of the youth population in the state. In the next several years, important demographic changes will continue, propelling communities of color to become an estimated 62 percent of the state's population by 2030.[3] Within those shifts, California's senior communities are expected to grow to 19 percent of California's population in the next decade, and to include greater proportions of Latino, Asian American, and African American seniors.[4] The Latino community is projected to make up almost half of the state's population by 2045.[5] Therefore, the policy and planning decisions made today must have these communities' needs in mind.

Historically, communities of color, low-income communities, Limited English Proficient, the disabled, and the Lesbian, Gay, Bisexual, Transgender (LGBT) communities have experienced continual race—and identity-based violence and trauma. Laws have been implemented to deprive these communities of opportunity, and violence against these communities has been ignored or condoned. Historical trauma is a phenomenon that researchers have defined as massive group trauma shared across generations.[6] Significant research has focused on the impact of historical trauma on Native American and Alaskan Native communities, who have significant health disparities.[7] The communities most impacted by violence and trauma also have the least investment of resources to respond to these challenges. When resources to respond to violence and social needs are insufficient, communities continue to face the same struggles.

When CPEHN was established, close to 25 years ago, our founders had an important and forward-looking vision. They saw the powerful potential of their respective communities as the majority of California's population was becoming more diverse. They knew that national health care reform offered opportunities to improve the health of communities of color through expanded coverage. In addition, they experienced the racial strife between their communities while systemic injustices were routinely committed against them collectively. To achieve large scale change would require amassing the strength of their communities. Over time and with strong community mobilization, policies have shifted, leading to greater opportunities in health, housing, employment opportunities, and education.

Still today, the future of our health depends upon our collective voice for change. Together, communities of color are the majority in California; separately our communities experience political disenfranchisement, less investment by local and state governments, and the potential to be pitted against each other. Together, we are a strong force for change.

Glossary of Terms

HEALTH
Refers to physical, mental, and oral health.

HEALTH DISPARITIES
Health and health care disparities refer to differences in health and health care between population groups.[8] Disparities occur across many dimensions, including race/ethnicity, socioeconomic status, age, location, gender, disability status, and sexual orientation.[9] Policy can influence disparities in physical, mental, and oral health.

HEALTH INEQUITIES
Disparities in health that are not only unnecessary and avoidable but, in addition, are considered unfair and unjust.[10] Health inequities are rooted in social injustices that make some population groups more vulnerable to poor health than other groups.[11]

INTERSECTIONALITY
Intersectionality is a concept that enables us to recognize the fact that perceived group membership can make people vulnerable to various forms of bias, yet because we are simultaneously members of many groups, our complex identities can shape the specific way we each experience that bias.[12]

An intersectional lens in policy focuses on viewing inequalities experienced by race, gender, class, sexuality, and other vulnerabilities in tandem with each other, rather than distinctly. It means understanding what is created and experienced at the intersection of two or more axes of oppression, rather than just looking through one distinct lens.[13]

HEALTH EQUITY
The absence of structural inequalities that drive disparities in health between groups with different levels of social advantage/disadvantage.[14]

Policy Wins Provide Seeds for Growth

During the past five years, California has seen tremendous changes in policy that promise a strong foundation upon which to improve our communities' health. The passage of the Affordable Care Act (ACA), has expanded access to health care for over 3 million Californians, and recent efforts to expand access to children regardless of immigration status ensure that our most vulnerable children have continuity of coverage. Strengthened language access policies, translated enrollment and outreach materials, and enforceable consumer protections ensure that our communities can get the care they need in the language they speak.

In addition to being among the first in the nation to be a leader in health care implementation, California has led nationally on climate change through the passage of several key legislative initiatives including the Global Warming Solutions Act of 2016[15] and Sustainable Communities Strategies (SB 375),[16] both of which require critical reductions in Greenhouse Gas Emissions (GHG), and greater coordination of land use and transportation strategies. The state is also adopting a more explicit focus on addressing health in land use, climate change, and transportation policies at the state level, all of which create the possibility for a brighter future. Over the past few years, California has seen important changes to our education funding through the Local Control Funding Formula (LCFF), reforms to our criminal justice system through Proposition 47, and the elimination of a restrictive, sexist policy that punished women in poverty through the repeal of the Maximum Family Grant.

While a strong policy foundation for improved health equity has been set, our communities continue to face significant challenges. Employment rates among communities of color continue to lag despite overall increases and an improved economy. Immigrant communities remain locked out of federal health care reform both in accessing subsidies to purchase health insurance and through their ineligibility for the Medicaid program. Even worse, they continue to be left in limbo without a pathway to citizenship. On a daily basis we see and hear about men and women of color, especially within the African American and LGBT communities, falling victim to violence — at

climbed significantly to 13%, at a similar rate to that of 1992 following the Rodney King verdict.[17]

To truly seize the momentum for change, we need a collective voice to call out and call upon our policymakers to ensure our communities are at the forefront of their decisions. Rather than continue to operate according to the status quo, we must advocate for the new majority to be the focus of policy efforts. This means we must integrate with equity in mind. We are a diverse California, with a richness of language and culture. These practices and considerations — indeed, the communities themselves — should no longer be ignored, but embraced as we look towards health care reform and integration.

We must do so with a deeper examination and understanding of how the socio-economic, physical environment, and health care structures in place impact our health. As individuals and communities, we each hold different identities, relating to such factors as our race and ethnicity, language, gender, age, sexual orientation, national origin, and ability. As multi-identity, multicultural individuals and communities, we encounter systems differently, in ways that either support or hinder our health. Certain systems and structures also have embedded within them biases that can perpetuate racism, homophobia, sexism and other forms of discrimination. When these biases are left unchecked, families, individuals, and communities are harmed. To achieve health equity, policy change must be developed with these multiple lenses in mind to begin to eliminate avoidable injustices, inequities, and disparities.

A Framework to Advance Health Equity

This report outlines the current state of health for Californians for whom opportunities for health equity have been hindered, or even rendered non-existent, as a result of policies, or lack thereof, at play in our socio-economic, physical environment, and health service systems and structures. The report proposes policy solutions that take into account the intersecting identities of Californians, and the structural inequities that must be addressed to build on California's momentum and achieve health equity for all.

times by the very people who have sworn to protect them. The daily stress, fear, and anxiety of being a victim of violence weigh heavily on our mental and physical health, and while our health care system is moving towards better access to care and coverage, it remains woefully understaffed in providers who speak our languages and understand the diversity of our cultures. The communities we live in are often without the resources to promote health and we are facing unprecedented levels of displacement and gentrification due to the continued housing crisis. Even when housing is available, communities of color more often live in neighborhoods that lack access to affordable public transportation, and are more exposed to toxins. As a result of our negative health outcomes and conditions, our communities struggle with political disenfranchisement and discriminatory institutional practices. In addition, our country's perception of race relations and racism as a significant problem has

Health equity should be viewed through a lens that shows the intersections and interconnectedness of health. We must shift towards an "upstream" approach that creates equitable and just systems and structures. An intersectional focus shows how inequalities such as race, gender, class, sexuality, and other vulnerabilities are often experienced in tandem with each other, rather than distinctly.[18] It strives to have us understand what is created and experienced at the intersection of two or more axes of oppression, rather than having us look through just one distinct lens. Thus rather than just focusing on race or ethnicity, we are beginning to look at race and ethnicity AND gender, sexual orientation, age, or ability. Throughout this report, and informed by an empirical research perspective, we focus on data and case studies to begin to identify some of those places of intersection, and provide a more informed view of systems of discrimination.

Health Equity Happens When

COMMUNITY ENGAGEMENT

EDUCATION & OUTREACH

WHO WE ARE
Leads The Change
RACE • GENDER
SEXUAL ORIENTATION
NATIONALITY • ABILITY • AGE

POLICY & SYSTEMS

RESEARCH & COMMUNICATIONS

WHO WE ARE

Demographic Profile of California

We all experience health differently depending on a variety of factors that interact and intersect, including our race/ethnicity, age, gender, sexual orientation, immigration status, language and ability. Together these identities and our experiences with systems have the ability to either advance or limit our health and health outcomes.

MAP 1
Communities of Color in California

	12% - 25%
	25% - 45%
	45% - 61%
	61% - 87%

Data Source: 2010-2014 American Community Survey (5-year)

Del Norte
Siskiyou
Modoc
Humboldt
Trinity
Shasta
Lassen
Tehama
Plumas
Mendocino
Glenn
Butte
Sierra
Nevada
Colusa
Yuba
Lake
Sutter
Placer
Sonoma
Yolo
El Dorado
Napa
Sacramento
Amador
Alpine
Solano
Calaveras
Marin
Contra Costa
San Joaquin
Tuolumne
Mono
San Francisco
Alameda
Stanislaus
Mariposa
San Mateo
Santa Clara
Merced
Santa Cruz
Madera
San Benito
Fresno
Inyo
Monterey
Tulare
Kings
San Luis Obispo
Kern
San Bernardino
Santa Barbara
Ventura
Los Angeles
Riverside
Orange
San Diego
Imperial

Communities of color are the majority in California, making up 61% of the total population. Imperial (87%), Los Angeles (73%), and Merced (69%) counties have the highest percent of communities of color.

CHART 1

California Population by Race /Ethnicity[19]

Other & 2+ Races 2.9%
Native American .04%
African American 5.7%
API 13.7%
White 39.2%
Latino 38.2%

CHART 2

Population by Age[23]

65 & Over 12.1%
0-17 years 24.2%
18-64 years 63.7%

Gender

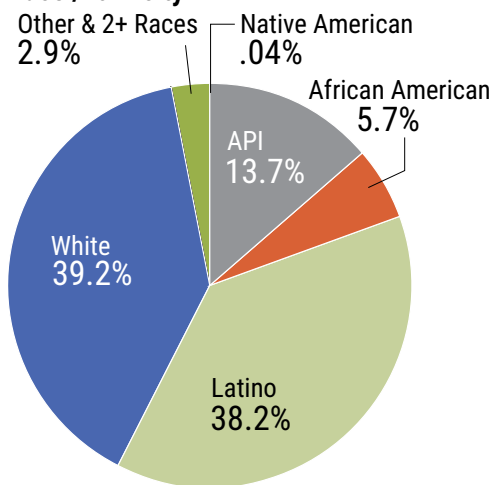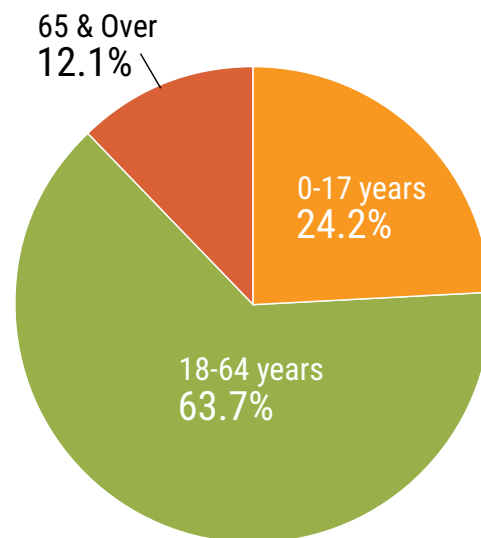In California Males make up 49.6% and Females make up 50.4%.[20]

Sexual Orientation

Approximately 4% of the population identifies as gay or bi-sexual across race/ethnicities. 95% identify as straight or heterosexual, with 2.3% gay or lesbian and 2.2% bisexual.[21]

Persons with Disability

10% of the population in California is considered disabled. The majority (76%) are persons ages 65 years old or over.[22]

The largest age population in California is 18-64 years old (63.7%) with Latinos making up 37% and Whites 40%. Among youth, Latino's make up the largest group of 0-17 year olds. The aging population, over 65, is currently predominantly Whites. Though as the population ages, we will see the demographics of the senior population shift as those ages 18-64 years are now predominately Latino and White.[24]

Nationality

There are an estimated 10,290,636 foreign born citizens, which is more than a fourth of California's population. Undocumented immigrants make up approximately 7% of California's population today.[25]
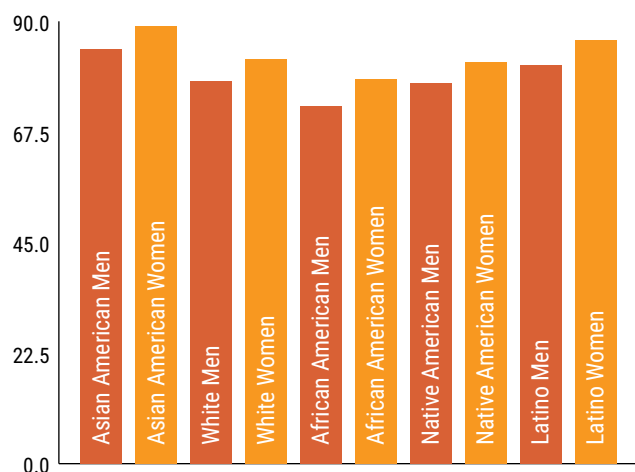
Limited English Proficiency

44% of California's population over the age of 5 speak another language. 11% report speaking English less than "very well" (meaning "not well" or "not at all"). Of the 3.7 million that speak English less than "very well," 71% are Spanish speaking, 6% Indo-European, and 21% API.[26]

Life Expectancy

**Life Expectancy at Birth (years) by Race/Ethnicity & Gender**

Life expectancy at birth in California is 81.2 years, compared to 79 years for the United States. African American men (72.8 years) have the lowest life expectancy among men and women. Asian American women (89.1 years) and Latino women (86.1 years) have the longest life expectancy among men and women.[27]

Poor or Fair Health Status

Self Reported Health Status[28, 29]
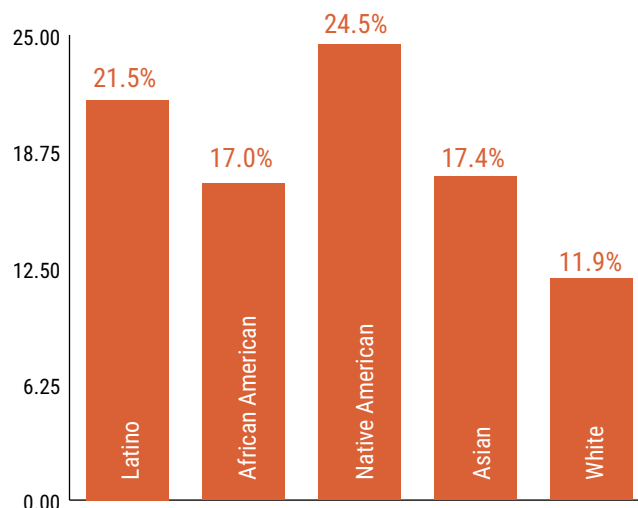
Communities of color are more likely to report poor or fair health status compared to Whites. Both men and women of color are more likely to report poor or fair health status compared to White men and women. Self-reported health status has been shown to be a key indicator of health. Generally, those who report poor or fair overall health tend to have worse health outcomes.

Infant Mortality

The infant mortality rate from 1996 to 2013 has decreased across the state, but African Americans' rates are still more than twice that of other race ethnicity groups. Black infant mortality between 2009-2013 was 10.2%, whereas White infant mortality was 4.0%.[30]

CASE STUDY
Having Our Say

Having our Say was established in 2007 to ensure culturally diverse voices were included in the health reform debate. Over 30 diverse organizations are a part of the coalition and are involved in educating policymakers, their local communities, and the media about the impact of health policies on communities of color. While achievements in health care coverage have been made, Having Our Say works towards access to health care and coverage remaining equitable. In addition, Having Our Say focuses on assuring high quality and affordable health care for all, ensuring efficiency in the health care system and prioritizing the creation of healthy communities. For more information see http://cpehn.org/having-our-say

SEIZING MOMENTUM TOWARDS GREATER HEALTH EQUITY

The health inequalities seen impacting our communities are driven by the multiple structural and systemic factors that we face daily. These factors, which often occur together with discrimination and other societal "isms", shape individuals' and entire communities' access to equitable opportunities for upward mobility and better health outcomes. Many of these are "upstream" factors that if addressed could prevent avoidable health problems from ever developing. While not exhaustive, the structural and systemic inequities highlighted, along with recent advances and proposed policy recommendations, demonstrate the need for us to continue to challenge the status quo in order to improve the health of all Californians for decades to come.

SOCIO-ECONOMIC FACTORS

Poverty and income inequality, educational attainment, and civic participation are key predictors for health. In fact, poverty is the single biggest predictor of lowered health status. By shifting greater resources and investments into job creation, better education, and local community engagement, we can begin to create the early foundation for better health.

ECONOMIC SECURITY

Income inequality within communities can have broad health impacts. Communities living in poverty often have an increased risk of mortality, poorer health, and greater incidence of cardiovascular disease risks.[31] Inequalities in a community can accentuate differences in social class and status and serve as a social stressor. Communities with greater income inequality can experience loss of social connections, develop problems in how individuals relate to one another, and see decreases in trust or social support, and experience a weakening of the sense of community for all residents.[32] One could argue this is where health disparities begin for communities of color and individuals whose multi-identities shape the opportunities available to them.

Long term systemic policies have denied communities of color opportunities to build wealth towards entrance into the middle class, or the achievement of higher economic standing. Public policies, from redlining in real estate and banking to inequitable K-12 education funding, have long disadvantaged communities of color.[33] Despite the end of legal segregation, gaps in wealth between White, Black, and Latino households have actually increased.[34]

According to the Pew Research Center[35], wealth inequality has widened along racial and ethnic lines since the Great Recession of 2008. Fueled by the housing and financial crises, the recession was universally hard on the majority of American families. However, the resulting economic recovery has not benefited all households equally. The wealth of White households was 13 times the median wealth of Black households in 2013,

growing from eight times the wealth in 2010. Likewise, the wealth of White households is now more than 10 times that of Latino households. In 2012, the California economy would have been $670 billion dollars larger if there had been no racial gaps in income.[36] More needs to be done to address wealth inequality as a way to improve health for all Californians.

INCOME & POVERTY IN CALIFORNIA

Median Household Income by Race/Ethnicity

The highest median household income ($72,061) is held by White households. For every one dollar a White household earns, an African American household earns 60 cents, American Indian/Alaska Native earn 63 cents, Asian households earn 96 cents, and Latino households earn 66 cents.[37]

CHART 5

Median Household Income by Race/Ethnicity

Race/Ethnicity	Median Household Income
White	$72,061
African American	$43,476
Latino	$47,206
Asian	$69,010
Native American	$45,319
Other	$51,869
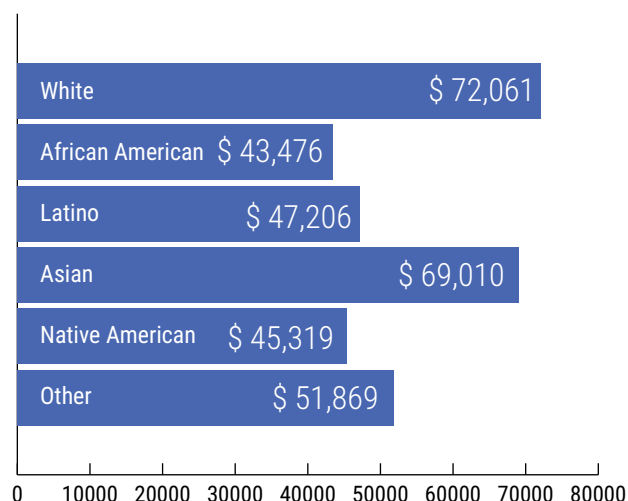
MAP 2

Median Household Income and Communities of Color

Legend:
- HIGH % Communities of Color and Low Median Household Income
- HIGH % Communities of Color and HIGH Median Household Income
- LOW % Communities of Color and LOW Median Household Income
- LOW % Communities of Color and HIGH Median Household Income

Data Source: 2010-2014 American Community Survey, 5-year

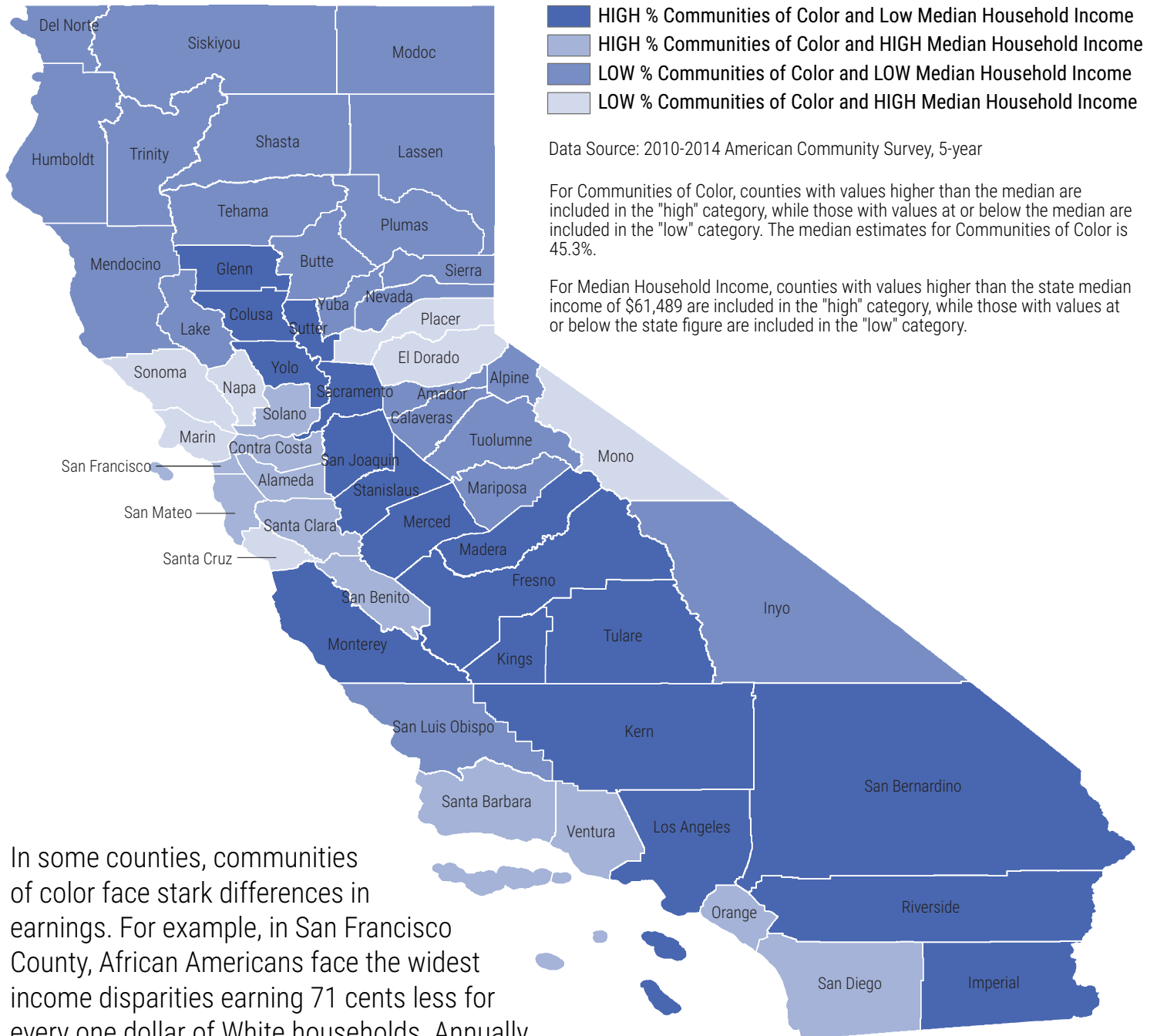For Communities of Color, counties with values higher than the median are included in the "high" category, while those with values at or below the median are included in the "low" category. The median estimates for Communities of Color is 45.3%.

For Median Household Income, counties with values higher than the state median income of $61,489 are included in the "high" category, while those with values at or below the state figure are included in the "low" category.

In some counties, communities of color face stark differences in earnings. For example, in San Francisco County, African Americans face the widest income disparities earning 71 cents less for every one dollar of White households. Annually this equates to a $71,491 wage gap between African American and White households. Latinos fare worse in Sierra County (62 cents less) and American Indian/Alaska Native in Mono County (81 cents less).[38]
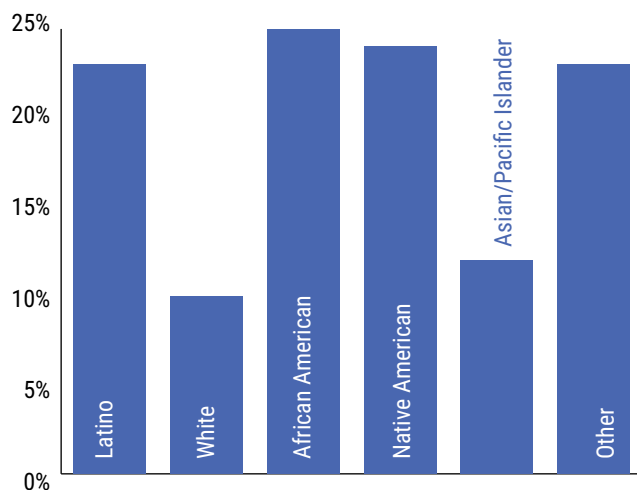
Median Annual Pay by Gender and Race/Ethnicity

The median annual pay for a woman who holds a full-time, year-round job is $42,486, while median annual pay for a man who holds a full-time, year-round job is $50,539. This means that women in California are paid 84 cents for every dollar paid to men, amounting to an annual wage gap of $8,053.[39]

The wage gap can be even larger for women of color. Among California's women who hold full-time, year-round jobs, African American women are paid 63 cents, Latinas are paid 43 cents and Asian women are paid 72 cents for every dollar paid to White men.[40]

Poverty by Race/Ethnicity

Income in the Past 12 Months Below Poverty Level [41]

Chart: Bar chart showing percentages by race/ethnicity. Latino: ~23%, White: ~10%, African American: ~25%, Native American: ~24%, Asian/Pacific Islander: ~12%, Other: ~23%.
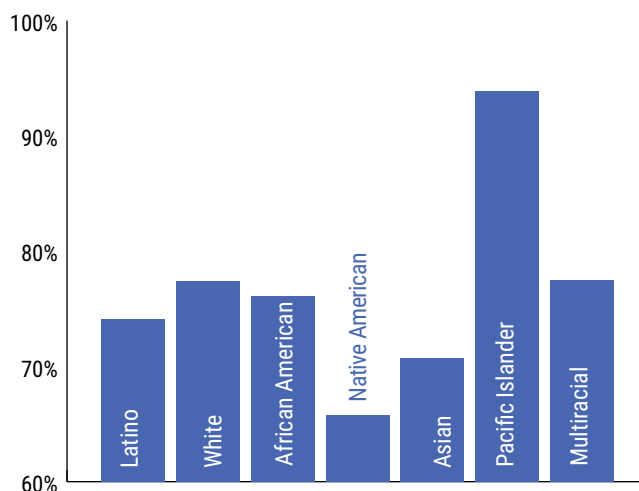
Every one in four African Americans live below the 100% federal poverty line (FPL). Nearly one in four American Indians/Alaska Natives (24%) and more than one in five Latinos (23%) live below the FPL ($11,880/year for an individual and $24,300/year for a family of four in 2016). The federal poverty guidelines determine a family's eligibility for a number of critical public safety net programs, including programs such as Medi-Cal and CalFresh.

HEALTH IMPACT

Poor or Fair Health Status by Race/Ethnicity & Living at or below 200% of the Federal Poverty Level[42]

Overall Health Status by Race/Ethnicity (200% FPL)

Chart: Bar chart showing percentages by race/ethnicity. Latino: ~74%, White: ~77%, African American: ~76%, Native American: ~66%, Asian: ~71%, Pacific Islander: ~94%, Multiracial: ~77%.
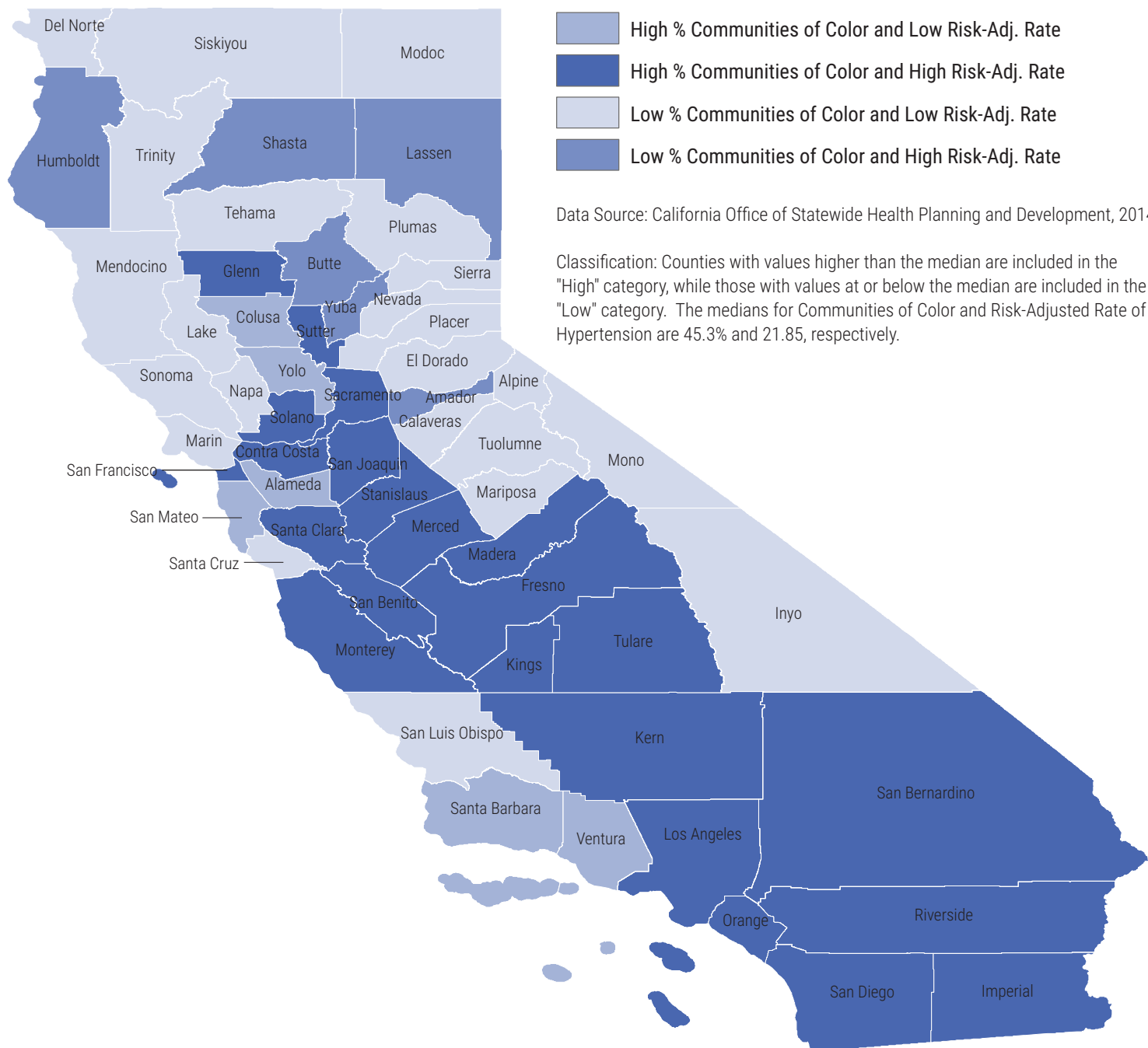
Hypertension

Hypertension increases the risk of heart disease. Factors such as smoking, stress, sedentary lifestyle and poor nutrition can contribute to hypertension. Inadequate screenings, lack of access to healthy foods and green space for physical activity can lead to hospitalizations that could have been avoided. Of the 9,013 preventable hospitalizations for hypertension, the state-adjusted rate[43] for avoidable hospitalizations is 32.6.[44] There were 13 counties with rates above the statewide average, with the highest being Merced at a rate of 44.5.[45]

MAP 3

Preventable/Avoidable Hypertension Hospitalizations and Communities of Color

Legend:

- High % Communities of Color and Low Risk-Adj. Rate
- High % Communities of Color and High Risk-Adj. Rate
- Low % Communities of Color and Low Risk-Adj. Rate
- Low % Communities of Color and High Risk-Adj. Rate

Data Source: California Office of Statewide Health Planning and Development, 2014

Classification: Counties with values higher than the median are included in the "High" category, while those with values at or below the median are included in the "Low" category. The medians for Communities of Color and Risk-Adjusted Rate of Hypertension are 45.3% and 21.85, respectively.

Statewide adjusted rate for avoidable hypertension hospitalizations is 32.6; 13 counties had rates above and the highest was Merced 44.5[46]
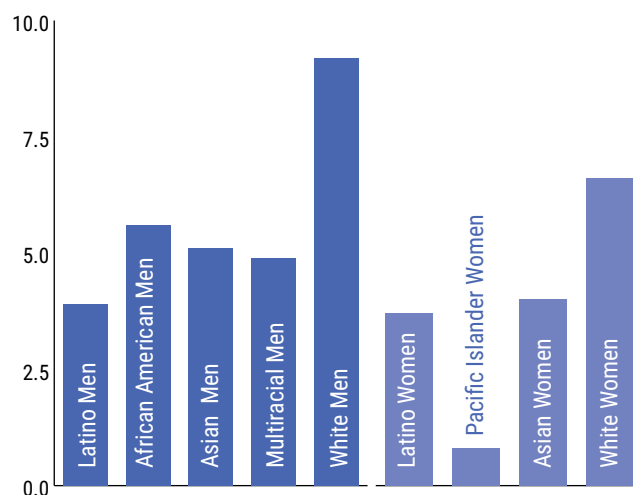
Heart Disease

Heart Disease is the cause of death for every 100.9 deaths per 100,000 in California.[47] Male and female persons of color have lower rates of diagnosis for heart disease compared to Whites. However, it is the leading cause of death for Whites, African Americans, and Native Americans/Alaskan Natives, and the second cause of death for Asian/Pacific Islanders and Latinos. Mariposa County has the highest rate of Heart Disease in the state, 200.7 and the lowest rate, 37.1, is in Mono County.[48]

CHART 8

Heart Disease Diagnosis

Latino (3.9%), African American (5.6%), Asian (5.1%) males, and males that identify with two or more races (4.9%) have statistically significant lower rates of heart disease compared to White males (9.2%). Latino (3.7%), Native Hawaiian/Pacific Islanders (0.8%), and Asian (4.0%) females have statistically significant lower rates of heart disease than White females (6.6%).[49]

MOMENTUM TOWARDS EQUITABLE POLICIES
Economic Justice

California has been working to decrease the wage gap and provide critical employment protections. In 2013, California passed a landmark bill to extend overtime protections to domestic workers, a majority of whom are workers of color, who had previously been excluded from these protections. Under the law, childcare providers, house cleaners, and personal attendants who care for children, seniors, and people with disabilities can now qualify for overtime pay. In 2014, California became a national leader by requiring employers to provide paid sick leave. The law, which took effect in July 2015, requires employers to give part—and full-time workers at least three paid days of sick leave each year. This was a huge win for the 6.5 million Californians (close to 40% of the workforce) forced to choose between working while ill or losing pay in order to care for themselves or a loved one. The law exempts employees covered by qualifying collective bargaining agreements, In-Home Supportive Services providers, and certain employees of air carriers. Most recently, in 2016, California became one of the first states to raise the minimum wage over the next six years, rising to $15 an hour by 2022. Raising the minimum wage has the potential to promote economic security among low-income families.

EDUCATIONAL ATTAINMENT
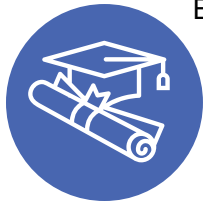
Educational attainment is the foundation for one's future potential earnings and employment opportunities. Ample research shows that furthering one's education beyond high school has both positive financial and health outcomes. Each additional year of schooling represents an 11% increase in income.[50] An additional four years of education reduces a range of health risks, leading to, for example, decreases in incidences of diabetes, heart disease, excessive or extra personal body weight, and smoking.[51] Strong academic achievement among children is associated with positive health and economic outcomes.

On the other hand, children who start out with fewer resources often face greater obstacles to success in school, and are less likely to go on to receive a college education.[52] Research shows that an intergenerational cycle of poverty and low educational achievement can compound poor health and perpetuate existing inequities.[53] Setting up for financial and educational success in adulthood begins early on in life and has a long-lasting impact on one's health. Children who participate in high-quality, early education programs benefit directly and indirectly through cognitive and social-emotional gains that are associated with improved mental health and greater academic achievement, both of which can lead to improved long-term health.[54]

For low-income communities of color, barriers to learning occur throughout our educational system. For example, accessing childcare and pre-school slots can be particularly difficult for low-wage, immigrant working parents.[55] Language barriers, immigration status, and costs can put child care and early education programs out of reach for many families. In a study with garment workers in Los Angeles, subjects reported that the cost of child care consumes one third of their weekly income, and that they were often unable to pay their providers.[56] Workers also reported difficulty navigating the child care system, with most receiving little to no government financial supports.[57] Securing child care and early education not only benefits early learning for children but enables parents to successfully work without worrying about the care of their children.

Mastering language and reading skills is essential for future academic success. Language and reading proficiency has been linked to academic achievement, fewer grade retentions, higher graduation rates and enhanced productivity in adult life.[58] Achievement gaps in reading by race/ethnicity, income, disability, and English Learner status that persist throughout one's primary and secondary education have long-term impacts. Disparities seen today in language and reading proficiency can limit one's ability to communicate, engage, and advance in economic and social settings.

To ensure all children have a great start, our school system needs to provide a comprehensive and supportive educational experience. However, California has consistently underfunded our K-12 educational system. Compared to other states, California ranked 42nd in 2014-15 in per pupil spending. California ranks 48th in teacher-to-pupil ratios, meaning the number of qualified teachers, principals, librarians, and nurses is not enough to meet the needs of students. Underfunding also means there are fewer supports and resources to help children succeed in school, learn key skills to prepare them for further education and life, and complete their high school diploma. In California public schools, only 34% of Black and 42% of Latino students feel a sense of school connectedness, compared to 54% of Whites.[59] An average of 55,000 students drop out of high school each year, resulting in a cost of $392,000 over their lifetime, which is a loss of $22 billion in revenue for the state.[60] As a result of the state's lack of investment in public schools, our children's education suffers. California continues to rank towards the bottom in reading and math assessments (46th in 4th grade reading and 42nd in 8th grade math), which translates into a lack of college readiness. For example, 57% of Black students and 68% of Latino students attend high schools with the full range of math and science courses available, compared to 71% of White students and 81% of Asian American students.[61] Only 42% of students who graduate from high school have met the minimum requirements for entrance into the University of California or California State University schools. For Latinos and African American students the rates are much lower, at 32% and 31% respectively.[62]

While there are many career pathways one may take to earn a living, to compete in the ever-changing job market, the growing global economy will continue to call for more college-educated workers. A recent study

found that at current levels of production, the U.S. economy will suffer a shortfall of 5 million college-educated workers by 2020.[63] In addition, 65 percent of all jobs will require bachelor's or associate's degrees or some other education beyond high school, particularly in the fastest growing occupations — science, technology, engineering, mathematics, health care, and community service,[64] and 44 percent of jobs in California will require at least an AA degree or higher.[65]

The cost of attending college is also often out of reach without additional financial supports in the form of grants and student loans. The result is a burden of debt that is fundamentally unequal; low-income, Black and Latino students almost universally must borrow to attain a degree, while White, middle—and upper-class students are far less likely to need to borrow.[66] Additionally, borrowing for educational needs may not even be an option for immigrant, undocumented students. A study of young workers in Los Angeles found that low wages and high educational costs have led many to take out loans and carry debt,[67] leaving them struggling to pay for school and complete their education.[68] While education can enhance upward mobility, the cost contributes to the continued widening of the racial income and wealth gaps we see today, along with their concomitant impacts on health. Therefore we must prioritize investments in our educational system to ensure children have opportunities for the future.
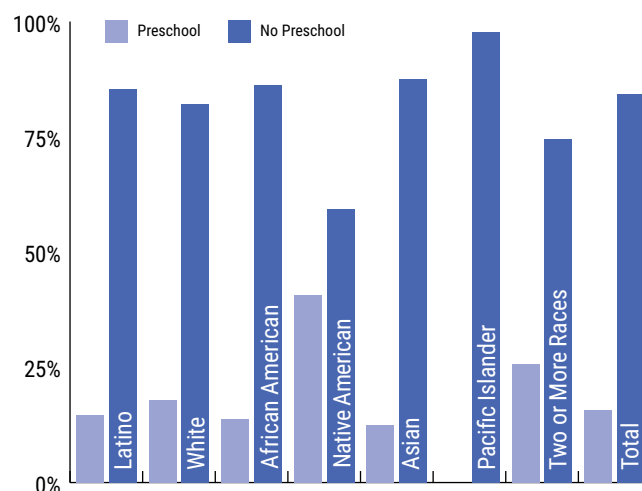
EDUCATION ATTAINMENT IN CALIFORNIA

Preschool Attendance by Race/Ethnicity

Preschool attendance across all races/ethnicities is low in California. Over 50% of children 6 years of age or younger **do not** attend preschool, nursery school, or Head Start at least 10 hours a week.[69]
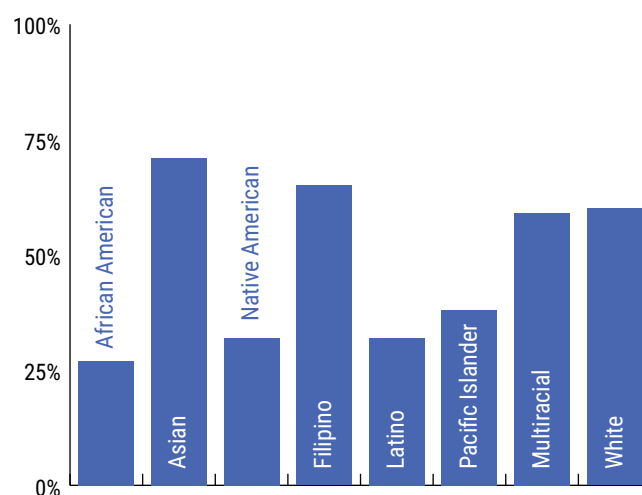
Reading Proficiency

CHART 10

Students Meeting or Exceeding Grade-Level Standard in English Language Arts, by Race/Ethnicity[71]

Bar chart, y-axis from 0% to 100%. Categories: African American, Asian, Native American, Filipino, Latino, Pacific Islander, Multiracial, White.

Among racial/ethnic groups, proficiency rates were highest among Asian American students (71%), and lowest among African American students (27%).[70]

Of those 25 and older, Latinos (38.5%) are least likely to have received a High School diploma.[72] Communities of color are also least likely to acquire a BA/BS degree after attending college. Among persons of color and Whites, Asians are the most likely to have acquired a bachelor's degree.

MOMENTUM TOWARDS EQUITABLE POLICIES
Education Justice

After years of budget cuts and disinvestment in the public education system resulting in California ranking in the 50th percentile in student spending, California voters approved additional funding for education through Proposition 30. Passed in 2012, the measure temporarily increased income tax for highest earners and raised the state's sales tax by .25% until the end of 2018. The measure is projected to raise over $37 million of funding for K-12 education and community colleges, ending years of painful cuts to education spending.[73,74] Proposition 55 on the November 2016 ballot, would extend the income tax increase until 2030.

Also noteworthy is the fact that the Governor and State Legislature approved a new, more equitable way of funding school districts and charter schools in 2013 that will be phased in over an eight-year period. The Local Control Funding Formula (LCFF) is a national model that provides more equitable school funding with local flexibility and greater community engagement. It accomplishes this by providing a base grant (which refers to per student funding), and supplemental and concentration grants depending on the percentage of English learners and low-income students. An additional 20% of the base grant will be allocated through supplemental grants for each English learner, low-income, and foster youth (EL/LI/FY) student in the district, while districts with over 55% EL/LI/FY students will receive an additional 50% of the base rate for every student over 55% of full enrollment. The LCFF also establishes new transparency and accountability requirements on how school districts spend these additional funds, including relying on local participation in decision making. At this time, the impact of the policy on communities of color, who often lack the ability to participate in decision making, is unclear.

California also invested in its undocumented DREAMER students. In 2014, the legislature passed the Dream Loan Program to provide loans to undocumented University of California students. Funding for the program was made available for the first time in 2016, allowing undocumented students to reduce financial barriers to accessing higher education.[75] The legislature is currently considering a proposal that would allow undocumented health professionals including medical school DREAMERS to access student loans and scholarships.

EMPLOYMENT OPPORTUNITIES

A secure job often facilitates health in many ways, from offering stable and affordable health benefits to helping families put a roof over their heads. California's unemployment rate at 7.5% is slightly higher than the national average of 6.2%.[76,77] Within California's counties there is a wide range of employment opportunities. For example, Imperial, Tulare, and Colusa County have the highest rates of unemployment in the state, with Imperial at a staggering 23.6%. San Mateo and Marin Counties have the lowest unemployment rates at 4.2% and 4.3% respectively.[78, 79]

Estimates show that the health care sector is expected to grow by 27%, especially among allied health professionals, compared to 17% in all other sectors.[80] While some programs exist to assist students through options such as loan forgiveness for additional training, meeting the current and future demands within the health care system is a smart investment for California. Some counties have already identified programs for both addressing the high unemployment rates of African American men and focussing on future health care workforce needs. In addition, some of our most disadvantaged and disenfranchised communities that struggle to obtain secure employment include men and women with criminal backgrounds.

A recent study by the UCLA Center on Young Workers found that Latino and young Black workers, aged 18-29, have higher unemployment rates than the county average, at almost 17%. Young Black workers experience unemployment at the enormous rate of 28%. While 1 in 3 young workers are heads of household and 18% are parents, they tend to be concentrated in low wage employment with average hourly wages of $9.04 compared to $20.07 per hour for all other workers.[81]

While the state has made recent gains in protections for low-wage workers through expanded paid sick leave, increases to the state's minimum wage, and protections for domestic workers, there are still many low-wage workers who remain unprotected. For example, California's farm workers are still unable to receive overtime pay, despite their working long hours for poor remuneration. In addition, many workers who provide in-home supportive services are also living at or below the poverty line. We must do more to provide our communities, especially low-wage, young, and communities of color, opportunities to build careers, wealth, and stability.
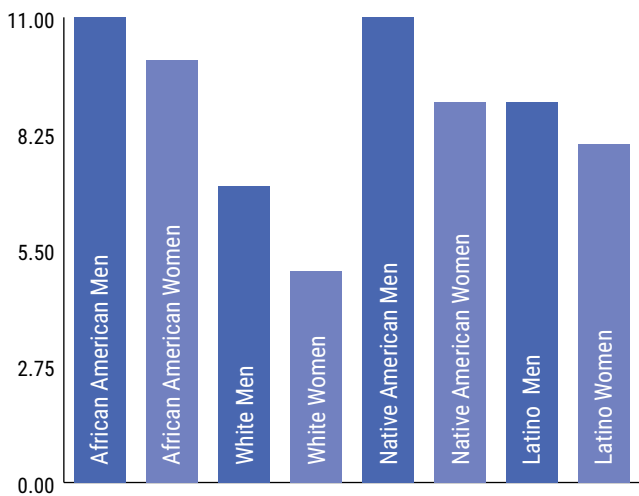
EMPLOYMENT IN CALIFORNIA

Employment Status

CHART 11

Unemployment by Race/Ethnicity

The unemployment rate in California for African American men is 11% and African American women 10%, whereas White men are unemployed at a rate of 7% and White women at 5%. For American Indian/Alaska Native men the rate is also at 11% unemployment and for American Indian/Alaska Native women, it is 9%. Latino men are at 9% and Latino women are at 8%.[82]

Momentum Towards Health Equity

Employment & Workers Justice

Recent efforts by the Equal Employment Opportunity Commission are providing some guidance on how we can work to expand opportunities to individuals with criminal backgrounds.[83] Rather than using a blanket exclusion of these individuals, the Equal Employment Opportunity Commission (EEOC) has advocated for an individualized assessment of criminal background information including criminal background checks that *are job-related* and *specific to business necessity,* and that other rehabilitative factors be taken into consideration.[84] Some government entities, including Covered California, have passed guidelines for certified enrollment counselors who provide enrollment assistance to consumers.[85] Another promising program is the Alameda County Public Health Department's Emergency Medical Services Corp program which trains young men of color with criminal backgrounds on emergency medical training, life coaching, and internship opportunities to prepare them to enter the health care workforce. Approximately 90% of participants have gone on to attend college, find internships, and secure employment in the medical field.[86]

CIVIC PARTICIPATION
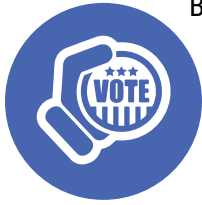
Building leadership and connecting within a community are important and often less-thought-of ways to improve health. When political and community processes are inclusive and transparent, individuals are more likely to participate in improving their community, creating a sense of universal responsibility. Voting, volunteering, or activism help to connect individuals and families to feelings of empowerment and ownership. The voices of communities of color, low-income communities, the young, and immigrants are often missing from community dialogues and at the polls. Voters in California tend to be older, White, college educated, affluent, and homeowners.[87] They also tend to identify themselves as "haves" — rather than "have nots" — when asked to choose between these two economic categories,[88] leaving many who do not fit this profile feeling powerless. Nonvoters tend to be younger, Latino, renters, less affluent, and less likely to be college educated than likely voters — and they generally identify themselves as "have nots."[89]

The consequences of failing to have robust civic participation are far-reaching.[90] The very concept of democracy is premised on having an inclusive process of deliberation and widespread engagement in electoral and other civic processes.[91] The strength of the nation's civil society, and the ability to protect one's interests, derive in large part from how we realize our political ideals.[92] Therefore a community's resilience is linked to its level of civic engagement.[93] Some of the barriers that keep individuals from participating include lack of language access, limited time off from work, pressing child—or dependent-care needs, lack of money and transportation, and disenfranchisement. Active participation — engagement around a shared issue — builds community knowledge, skills, and resources.

VOTER ENGAGEMENT IN CALIFORNIA

Voter Turnout

73% of eligible voters are registered in CA[94]

CA ranks 43rd in voter turnout[95]

California's electorate does not reflect the size, the growth, or the diversity of California's population.[96] Likely voters are disproportionately White.

TABLE 1

Likely Voters in California

Race/Ethnicity	Population (%)	Likely Voters (%)
African-Americans	6%	6%
Asians	14%	12%
Latinos	34%	18%
Other/Multiracial	3%	4%
Whites	43%	60%

Four in 10 (39%) infrequent voters are White, and 30% are Latino. Six in 10 unregistered adults are Latino; fewer are White (22%), Asian (13%), or Black (3%).[97]

Policy Recommendations

Advance Wealth Building Opportunities for Low-Income Communities of Color:

We must support efforts to increase wages and promote sustainable careers. Efforts to strengthen social services and supports that assist individuals and families seeking to improve their life course or who have fallen on hard times are also critical. The federal, state and local governments must improve systems for measuring poverty based on the true cost of living, and provide working families with opportunities to thrive. This is particularly true in California which is a high cost-of-living state. The Self-Sufficiency Standard shows, for example, that a family of four would need to earn $63, 979 to cover basic expenses — which is almost three times more than a family of four nationally under the Federal Poverty Guidelines. Additionally, the latest Social Security Trustees' report suggests that the Social Security program will have exhausted its trust funds by 2034 — we must review and strengthen the program. California should develop a plan for prioritizing poverty reduction with robust, measurable goals that engages multiple agencies and departments.

Strengthen Investments in Education from Universal Preschool through College Readiness:

Quality, affordable, preschool that is geographically accessible — especially to low-income children of color — is essential. In addition, California must continue to invest in public K-12 education by extending Proposition 30 and continue to ensure children have quality teachers, healthy facilities and other educational and health resources. The state and local governments should ensure that the Local Control Funding Formula and other funding streams provide equitable resources to meet the needs of students of color, limited English proficiency students, students with disabilities, and foster youth. This includes teachers who reflect the diversity of the student population and who are well-prepared to teach. It also includes providing underserved students with access to afterschool activities, including sports, which have been shown to promote health, safety, and academic success.[98] In addition, we should identify resources to expand school-based health centers which often provide a variety of primary, behavioral, reproductive, and oral health care services to students and families in need. Federal efforts to make tuition free at public colleges and universities would expand equitable access to higher education and allow low-income students of color to pursue secondary education debt-free and without the economic burden of student-loans. Finally, to make higher education accessible to all, admissions requirements must value diversity, and scholarships and financial aid programs must help with tuition, books, and cost-of-living expenses.

Increase Job Opportunities in Low-Income Communities:

Finding a job may be easy, but finding a good-paying job may be more elusive than ever. We need to work with local and statewide policymakers to create new job opportunities and ensure that low-income people are paid a living wage that will allow them to live where they work. We should ensure that businesses and enterprises are located in, and hire, from low-income communities and communities of color. One approach is to require the development of new "green" jobs in these neighborhoods. The federal Department of Transportation's new rules on local hiring is another important lever. California advocates should continue efforts to embed workforce inclusion goals into California's active transportation projects, as these can greatly help disadvantaged workers and result in healthier communities. California also needs to invest in a long-term strategy to improve job development — for example by strengthening career pathways for low-wage workers in the growing health care sector. Efforts should be made to increase job training and expand access to scholarships and loans in the health and allied health professions by making them available to all Californians regardless of immigration status. Additionally, by investing in California's public infrastructure initiatives, such as rebuilding roads, schools, libraries, community centers, and affordable housing, we can create jobs and stimulate the economy with long-lasting benefits for all Californians.

Strengthen Labor Protections for Low-Wage Workers and Workers in the New Economy:

We need to strengthen labor protections for low-wage workers by extending the Domestic Workers Bill of Rights and ensuring all workers are paid overtime, including farm workers whose employers have long been exempted from overtime laws. We must also ensure all corporations, including those in the new online economy, are not exploiting communities that lack economic security and stable, full-time jobs by misclassifying workers as independent contractors. As we move to a new economy with new types of job opportunities, we must also ensure that workers, especially low-income, communities of color, immigrant and women workers are all extended full employment protections.

Actively Engage Civic Participation:

In order to build community resilience and opportunity, we should expand programs that seek to assist vulnerable groups in becoming more active in local decision-making systems. Yet people often don't feel welcome at city council meetings or other government gatherings. Foundations and local governments should consider programs to train new immigrants, re-entry populations, youth, Limited English Proficient, women and women of color, and other vulnerable communities to become engaged. Our government and social programs work better when they meet the needs of all their residents.

PHYSICAL ENVIRONMENT FACTORS

Our physical environment has a tremendous effect on our health through the impacts of climate change, air quality, exposure to toxic waste, and the quality of our drinking water. The physical environment often sets the stage for our health, providing us with the essential elements we need for survival including fresh air, clean water, and green space. We can and must work together to create a healthy foundation and environment for all.

CLIMATE CHANGE

Climate change, resulting from increasing levels of emissions that arise from both natural and human activities,[99] poses multiple risks to our health. These emissions, or "greenhouse gases," trap heat close to the earth's surface, resulting in disruptions to the climate.[100] The average temperature of the planet has been steadily rising over the past century, with the most recent decade recorded as our nation's warmest.[101]

Urban centers are often surrounded by heat-trapping surfaces such as asphalt, concrete and tall buildings which intensify the levels of heat. Studies have shown that communities of color are more likely to live in these types of heat-trapping areas than Whites.[102] During a heat wave these communities become "heat islands," where heat is magnified and the possibility of heat stroke and dehydration is increased.[103] For a person who is already at risk for heart disease or high blood pressure, dehydration or heat stroke can be life-threatening. In fact, the rate of emergency room visits increases during extreme heat waves, especially among individuals with existing health conditions and the elderly.

Another troubling aspect of climate change is the increased number of dangerous substances in the air—including particulate matter, nitrogen oxides, and sulfur dioxide—most of which have been linked to asthma, other chronic respiratory illnesses, and some cancers.[104] California has some of the most polluted air in the country. A recent analysis by the American Lung Association gave 23 of 58 counties in the state failing grades for ozone pollution, with 18 counties receiving failing marks for particle pollution.[105] Many counties with poor air quality are in the Central Valley, a region with some of the highest asthma rates in the state.[106] The costs of asthma are tremendous: $11.8 million in missed workdays and $1.2 million missed school and daycare days each year, with an estimated annual cost to the state of $11.3 billion.[107] As the planet gets warmer, we are exposed to greater health risks from poor air quality and heat-related illnesses due to worsening smog levels, and longer allergy seasons.[108]

In addition to the health consequences, low-income communities and communities of color are impacted economically by climate change. Low-income families already spend a higher proportion of their income on basic necessities such as food, electricity, and housing. With climate change, the price of these necessities is projected to increase, and low-income people who are already paying relatively more for these items will most likely face disproportionately higher economic impacts.[109] The results of climate change, such as longer summers and warmer temperatures, could result in poor communities spending an even higher proportion of their income on electricity and housing.[110] Further, property situated in the vicinity of dump or other toxic sites is often devalued.

ENVIRONMENTAL RISKS

California is already experiencing a number of consequences of climate change, including a water crisis. Prolonged periods of dry climate and inconsistent rainfall results in drought, and California has been experiencing drought for the last 5 years.[111] The health impacts of the drought can include reductions in the quality of

food, water, and air, as well as increased incidences of disease and illness.[112] Groundwater provides over a third to almost one half (38%-46%) of California's water resources ,[113] which cities mostly rely on for fresh drinking water. During times of drought, over-reliance and over-usage of groundwater creates future risks if demand for water increases without reserves being replenished by rain. Further, many disadvantaged communities in agricultural districts rely 100% on groundwater.[114] In some cases, the drought has resulted in increased water prices for residents. Overuse of groundwater can cause the surrounding land to sink, resulting in additional environmental harm.[115]

Our water supply is also at risk for contamination through various sources including pollution, aging pipes and inadequate cleaning systems. Toxic spills and other hazardous waste events can also threaten our water supply. While some level of pollutants is acceptable, high levels of uranium, mercury and lead can limit overall water quality and lead to adverse health consequences. Infants and children are at particular risk for lead poisoning. Even at low levels it can cause behavior and learning problems, hyperactivity and other issues.[116] Many communities of color and low-income groups are more likely to live near toxic waste areas,[117] which are the result of dangerous chemicals produced by various industries including manufacturing and farming, and from common items such as batteries and leftover paints or pesticides being disposed of improperly. The toxins from these sources seep into the environment and can cause harm to people, animals, and plants.[118] The accumulated effects of toxic exposures can compromise immune systems, and cause chronic illness and mental health problems. Environmental justice is a term now in accepted usage when discussing the disproportionate impacts that environmental pollution has on the health and well-being of low-income communities and communities of color compared with other populations. Environmental justice communities are those that bear the greatest share of environmental and social problems associated with polluting industries.[119] Much more needs to be done to ensure that environmental justice communities are prioritized when allocating resources to mitigate the impact of toxic waste.
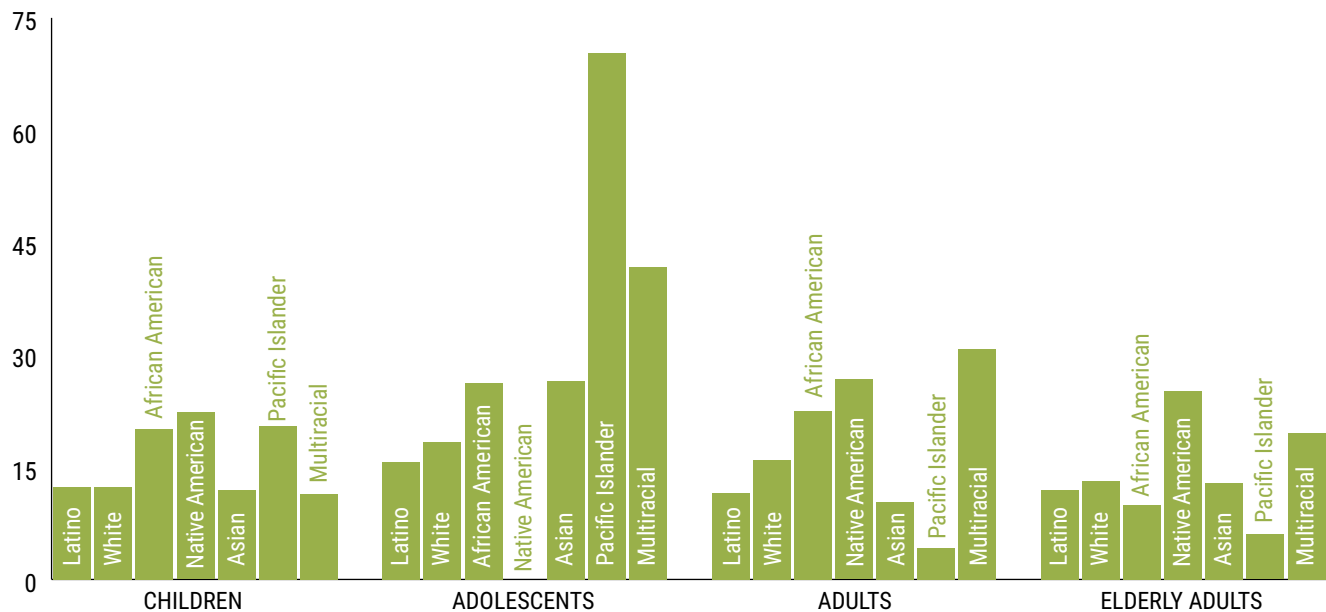
MAP 4
Clean Water & Communities of color

High % Communities of Color and Low Contaminants

High % Communities of Color and High Contaminants

Low % Communities of Color and Low Contaminants

Low % Communities of Color and High Contaminants

Data Source: Cal Enviroscreen 2.0, October 2014

Classification: Counties with values higher than the median are included in the "High" category, while those with values at or below the median are included in the "Low" category. The medians for Communities of Color and Drinking Water Contaminants are 45.3% of people and 362.7 in contamination score, respectively.

Drinking water contamination is an exposure indicator developed by CalEnviroScreen at the Census tract level. Scores were aggregated to the county level and then averaged over a period of year.

The California Communities Environmental Health Screening Tool (CalEnviroScreen) uses 19 indicators to measure census tracts disproportionately impacted by multiple sources of pollution using socio-economic disadvantage and the level of health and environmental vulnerability. Tracts that score in the 75th percentile are given priority for enhanced funding to reduce toxic exposures and pollution in our land, air and water.[120]

Map county labels: Del Norte, Siskiyou, Modoc, Humboldt, Trinity, Shasta, Lassen, Tehama, Plumas, Mendocino, Glenn, Butte, Sierra, Lake, Colusa, Yuba, Nevada, Sutter, Placer, Sonoma, Yolo, El Dorado, Alpine, Napa, Sacramento, Amador, Marin, Solano, Calaveras, San Francisco, Contra Costa, Tuolumne, Mono, Alameda, San Joaquin, San Mateo, Stanislaus, Mariposa, Santa Clara, Merced, Santa Cruz, Madera, San Benito, Fresno, Monterey, Inyo, San Luis Obispo, Kings, Tulare, Kern, Santa Barbara, San Bernardino, Ventura, Los Angeles, Orange, Riverside, San Diego, Imperial

Health Impact

CHART 12

Asthma Diagnosis by Age

Asthma is a chronic disease with no known causes but is triggered by environmental factors such as air pollution, allergens and tobacco smoke. Asthma accounts for a large share of missed days of work, school and avoidable hospitalizations.

Compared to Whites, African Americans and individuals who identify as 2 or more races have a higher rate of asthma diagnosis. Asthma: African American (22.5%) adults and those that identify with two or more races (30.8%) have a significantly higher rate of Asthma diagnosis than White adults (16.0%).
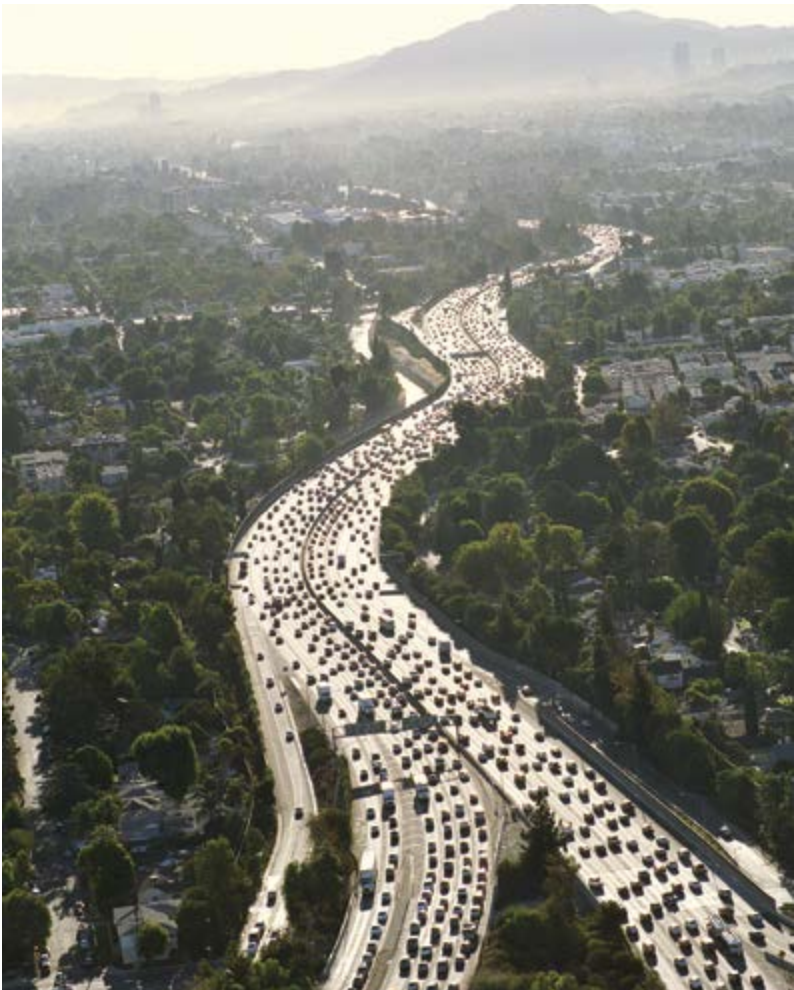
Momentum Towards Equitable Policies
Environmental Justice

The passage of the California Global Warming Solutions Act of 2006, Assembly Bill 32[121] (Nunez), marked a historical, bold step forward in California's fight against pollution. This cutting edge law committed California to significantly reducing greenhouse gas (GHG) emissions that damage our climate by 2020 — a reduction of approximately 15 percent[122] below emissions currently forecast if no action is taken. The bill directed the California Air Resources Board to develop a Scoping Plan[123] — which must be updated every five years — to map out California's strategy for meeting its goals. A major strategy of the scoping plan is a 'cap and trade' market system, which places a limit on emissions and a price on carbon.[124] By doing so, heavy polluters pay for their emissions and must purchase a permit or an allowance for emissions over the limit. The total number of permits is "capped" and permits can be traded so that companies can buy more during auctions. By placing a price on emissions, the program seeks to reflect the real cost of pollution that is borne by the environment and our communities. Any revenue generated must be strategically invested in projects that further the goals of AB 32 by reducing GHG emissions, and these proceeds are appropriated by the Legislature and the Governor. A later law added a requirement to the "cap and trade" funding (Senate Bill 535 by de León), requiring that in addition to reducing GHG emissions, a minimum of at least 25% of revenue generated from the 'cap and trade' market system — also known as the Greenhouse Gas Reduction Fund (GGRF) — must benefit disadvantaged communities,[125] with an additional minimum of 10% going to projects located directly within, and providing benefits to, disadvantaged communities. This re-investment in California's most vulnerable communities is only the first of the steps necessary towards improving the poor living conditions often faced by these communities.

A more comprehensive strategy to reduce GHG emissions by incorporating land use and transportation planning at the regional level has also been adopted. (Senate Bill 375[126] by Senator Steinberg). This unprecedented legislation specifically directs the Air Resources Board to set GHG emission reduction targets for each California region with a metropolitan planning organization (MPO). The MPOs must include a "Sustainable Communities Strategy" in the regional transportation plan to demonstrate how the region will meet the greenhouse gas emission targets.

To address California's water crisis, in 2012, Governor Jerry Brown signed legislation that established California's "Human Right to Water" Act, which declares that "every human being has the right to safe, clean, affordable, and accessible water adequate for human consumption, cooking, and sanitary purposes."[127] While the law requires relevant state agencies to consider this right when implementing water policy, it exempts public water systems and local governments.[128] State agencies have begun to make strides in implementing the legislation, and recent budgetary allocations have provided critical resources necessary for communities struggling with contaminated water sources and increasing water costs.[129] In 2014, Proposition 1, the Water Quality, Supply, and Infrastructure Improvement Act, was passed. Through Proposition 1, the Water Bond will provide crucial funding for local projects focused on improving water systems, specifically in disadvantaged communities. A large share of the bond, will go directly to projects dedicated to water storage, water conservation and safe drinking water. The California Water Commission will allocate the funding through a competitive process that will begin in 2017. Much remains to be done to help many of California's unincorporated communities, who often stand at a crossroads between inattentive local water authorities and future development projects.[130]

Policy Recommendations

Acknowledge and Address the Disproportionate Impacts of Climate Change on Communities of Color:

Climate change policies must acknowledge and prioritize the needs of low-income communities and communities of color, who are the majority of Californians and will be the most negatively impacted. Policy proposals should identify the positive and negative health impacts of policy decisions and include health indicators to measure the progress of policy decisions to ensure health disparities are not exacerbated. Community leaders have strong ideas on policy solutions and can provide recommendations that should be included in policymaking processes. To ensure policies reflect community need, communities of color, low-income, Limited English Proficient, and other vulnerable groups must be actively engaged in the state's vision-setting and implementation processes.

Strengthen GHG Reduction Policies:

We must build upon the current momentum for better air quality and climate change strategies by extending current GHG reductions policies to 2050. We must also ensure that current laws aimed at reducing GHG emissions through better coordination of land use and transportation planning (including AB 32 and SB 375) are fully implemented and not rolled back. The state should also consider expanding the current laws to the agricultural industry. To ensure that low-income residents can access economic, employment, and healthy opportunities, state and local planning priorities must focus on equitable development, which means prioritizing communities in need. We must expand the reach of recent policies such as SB 535 (de León), which sets aside funding for disadvantaged communities to ensure that more of those in need have the resources to address decades of disinvestment and human exposure to toxic waste.

Expand Urban and Community Greening:

By planting trees, increasing green space, and improving other green infrastructure in communities, temperatures and urban heat island effects are reduced. In addition, communities can enjoy reductions in noise and air pollution. We must promote community and urban greening efforts through grants, and conduct outreach on its benefits especially within disadvantaged, low-income and communities at risk of urban heat islands. We should also consider expanding green zone and tax incentives or credits for businesses that seek to improve greening as part of their business model. We should also work with housing developers to provide incentives for creating trails, greenways and other greening initiatives. We should also extend these to programs dedicated to refurbishing or improving affordable housing units. We must seek to remove barriers to community greening efforts and work with city councils and boards of supervisors to provide local opportunities to advance greening.

Ensure the Equitable Implementation of the Human Right to Water Act:

Water is a basic necessity for survival, yet in many communities, especially poor, under-resourced communities, families are faced with little to no access to fresh, affordable drinking water. Communities situated in unincorporated areas especially need to be prioritized. We must work to ensure that residents who rely on small and private wells are eligible for financial supports, and that local governments are held accountable for their actions in meeting the water needs of residents. We need to promote greater water conservation efforts including continuing to mandate water reduction efforts among households and businesses, and seek to work with the agricultural industry to identify their plans to conserve water. Water management and recycling efforts that help to clean stormwater for reuse must also be improved.

Incorporate and Prioritize Environmental Justice:

Critical and effective strategies are underway in our communities to improve air and water quality while also empowering communities, especially low-income communities and communities of color. The state has made small environmental justice grants available to communities and should continue these investments. We must also prioritize reductions in pollution generated through ports, high-volume roadways, and railroads. The state should also continue to develop performance indicators and reporting standards so as to compare sustainable communities' plans and develop best practices in promoting health, equity, and environmental justice.

NEIGHBORHOOD SAFETY AND VIOLENCE

Community safety in the neighborhoods in which we live, play, and work is integral to one's overall quality of life. Safety within our neighborhoods promotes social cohesion, which leads to trust, a sense of community, and the ability to be outside and active in our communities. It also results in a decrease in negative health factors, such as alcohol consumption, elevated stress levels, and the witnessing of acts of violence.

SAFE AND CONNECTED NEIGHBORHOODS

Research indicates that developing relationships, feeling a sense of belonging, and our being able to enjoy support from those around us, promote health by reducing stress, improving mental health, increasing healthy behaviors, and also lead to the expansion of access to services and amenities.[131] Building connections in communities is dependent on individuals feeling safe within their neighborhoods, schools, workplaces, and having a shared sense of community. If individuals do not trust their neighbors or are afraid to be out in their communities due to violence, real or perceived, the opportunities for engagement and building connections within communities can be hindered.

Positive, trusting, police and community relations are important for communities to feel safe and protected from violence. In many communities of color, police and community relations have been tentative at best

and have been shattered in many neighborhoods due to repeated racial injustices and a lack of public accountability and transparency. If what the U.S. Department of Justice's investigation of the Baltimore City Police Department (BPD) has found is indicative of police departments across the country, then communities in California are likely to share similar experiences with police.[132] The investigation found behavior patterns in the BPD driven by systemic deficiencies in the policies, training, supervision, and accountability structures that fail to equip officers with the tools they need to police effectively and within the bounds of federal law.[133] The inequities that exist in the basic functioning of the criminal justice system such as the use of force and aggressive policing, arrest and prosecution policies, and the severity of criminal sentences, all have a disparate impact on communities of color, particularly among men of color, but more recently also against women of color and the LGBTQ community.[134] The effect is that a deep-seated sentiment has grown within communities of color that the criminal justice system is inherently rigged against them and that the institutions supposedly designed to protect them are failing them, or even worse, targeting them.[135]

Communities that have historically been, and are currently marginalized based on their race/ethnicity, in addition to other social identities such as sexuality, immigration status, age and gender, continue to be at risk. During traffic stops, people of color are more likely to be searched than their White counterparts.[136] National survey data shows that Blacks and Latinos are three times more likely to be searched than Whites. Blacks are searched in 6 percent of traffic stops and Hispanics are searched in 7 percent of stops, whereas Whites are searched only 2

percent of the time.[137] Women, and transgender women of color in particular, are routinely profiled and stopped by the police under suspicion of trading sex — a phenomenon known as "walking while trans."[138] Acts of violence and fear of violence can destabilize communities and inhibit not only the health of individuals but entire communities from generation to generation.

Research shows that children and youth who are exposed to violence, inside or outside the home, suffer from developmental and behavioral issues which can in turn impact their academic success.[139] Both adults and children living in a heightened state of stress, anxiety, or depression may engage in substance use as a coping mechanism. However, when attempting to access services to help with these conditions, communities of color are less likely to be able to receive treatment, particularly culturally appropriate services that are equipped to address trauma and violence, linguistically appropriate care, and domestic violence services. One in ten requests for domestic violence services go unanswered, primarily in rural communities, poor communities, and communities of color.[140] Nearly 92% of adults in California who speak another language and do not speak English well or at all had the highest rates of unmet needs for mental health services, with about 70% receiving no treatment.[141] African Americans disclose less to White therapists than Black therapists, and Latinos, Asian Americans, and African Americans are significantly more likely to report problems communicating with a doctor than Whites.[142]

Communities of color are also disproportionately targeted with the sale of products which are linked to negative neighborhood conditions. The highest density of alcohol outlets is in non-White neighborhoods.[143] Likewise, cigarette advertising and promotions are more often targeted at communities of color.[144] The tobacco industry also markets menthol cigarettes, which may be more harmful but are preferred by 9 out of 10 African American smokers, through cultural messaging and additional shelf space in predominantly African American neighborhood retail establishments.[145] Gun violence also has a disparate impact on these neighborhoods, and in response youths are more likely to carry a concealed weapon.[146] In order to create safe and viable communities, we must concentrate on positive ways to reduce violence in our neighborhoods and work with communities to build upon their assets to create stronger social cohesion.

Neighborhood Safety in California

CHART 13

Youth Safety at Parks
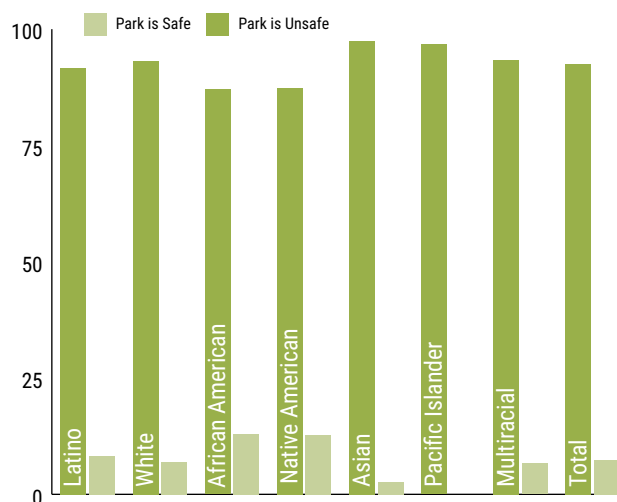
Feeling Safe at Park

The majority of teens, regardless of race/ethnicity reported feeling safe at park during the day. Of those reporting feeling unsafe, 13% of African Americans felt unsafe compared to only 3% of Asians and 7% of Whites. (Note: *There are no statistically significant differences between racial/ethnic groups for perception of park safety in the day).*[147]

Hate Violence

In a national survey, "Hate Violence in 2013" by The National Coalition of Anti-Violence Programs (NCAVP), almost three-quarters (72%) of homicide victims were transgender women, and more than two-thirds (67%) were transgender women of color.[148]

NCAVP also reported transgender people of color were 2.7 times more likely to experience police violence and 6 times more likely to experience physical violence from the police compared to White cisgender[149] survivors and victims.[150]

Health Impact

Homicide

Homicide is the cause of death for every 5 per 100,000 deaths in California. San Joaquin County has the highest rate at 10.4, and the lowest rate, 1.9 is in Orange County.[151] In 2014, African Americans and Latinos accounted for 70% of homicide victims.[152]

Homicide victims are most likely to be male. In 2014, 81.8% of homicide victims were male, 18.2% were female.[153]

Of those homicides where the victim's race/ ethnicity was identified, 41.4% of victims were Latino, 30.2% were Black, 21.3 percent were White, and 7.1% were categorized as "Other."[154]

Homicide Victims by Race/ Ethnicity
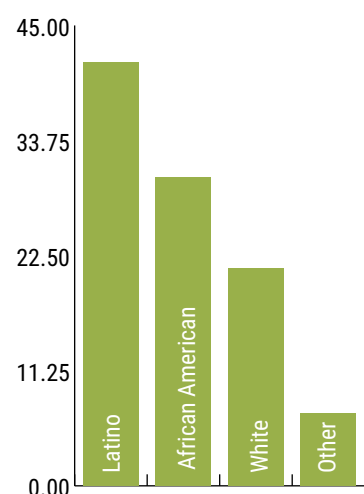
The largest proportion of Hispanic and Black victims were aged 18-29 (47.9% and 47.3%, respectively); over half (57.2%) of White victims were 40 years of age or older.[155]

PROPORTIONAL PUNISHMENT

California's criminal justice system is charged with protecting the public. It is meant to deter and prevent crime, incarcerate those who commit crime, and integrate released prisoners back into society.[156] However, our current criminal justice system is marred by explicit and implicit bias, leading it to be another mechanism for oppressing and incarcerating specific populations. We have established a system that disproportionately affects people of color, young men, and undocumented immigrants and creates significant barriers to opportunity for people with criminal records.[157] People of color, particularly African Americans and Latinos, are unfairly targeted by the police and face harsher prison sentences than their White counterparts.[158] We have a system that fails to deliver an equal and just system for all.

Consequently, incarceration magnifies disparities that communities of color already face. Chronic conditions including asthma, diabetes, and hypertension could be exacerbated during incarceration. Similarly, the likelihood of exposure to infectious diseases, such as hepatitis and tuberculosis, is also heightened. Many prisoners face the burden of co-occurrence of mental illness and drug dependency in and out of prison. For example, 72% of people in jail with a serious mental illness also have substance use disorders.[159] Women face a greater burden of disease than incarcerated men, which is partly explained by disturbingly high rates of sexual victimization, substance use, and trauma.[160]

Restorative Justice in Schools

Case Study

Santa Ana Building Healthy Communities' Restorative Justice (RJ) in Schools campaign aims to transform the way schools address disciplinary issues and the way schools go about improving school climate. By focusing on implementing RJ based, culturally-relevant and trauma-informed alternatives to suspensions and expulsions, they have been able to actually decrease the number of suspensions and expulsions at the district level while improving the socio-emotional well-being of students. The campaign has worked hard to educate school board members and district staff about how socio-emotional supports and indicators are just as important as, and can even increase academic indicators. In order to prepare students to be 21st century global citizens, the campaign focuses on making serious and determined efforts to provide all students with adequate supports and to give equal importance to socio-emotional and mental health indicators. For more information on SA-BHC visit http://www.sa-bhc.org/.

Punishment in California

For every White male incarcerated, two Latino men are behind bars.[167]

CHART 15

Incarceration by Gender

Male Prisoners

- Other 6.4%
- White 22.5%
- African American 29.5%
- Latino 41.7%

Female Prisoners

- Other 5.9%
- White 33.4%
- African American 27.8%
- Latino 33%

Source: Prison Census 2013, California Department of Corrections and Rehabilitation

Men are 22 times more likely to be incarcerated than women. Latino men make up 42% of the male prison population, followed by African Americans who make up 30%. Latina and White women make up 66.4% of the female prison population.[168]

The prison population is aging and along with it their health needs will continue to grow while incarcerated and upon returning to their communities. Between 1990 and 2013, the percentage of California prisoners age 50 and older grew from 4% to 21%.[161] At the same time, the percentage of prisoners age 25 and younger fell from 20% to 13%.[162] Older adults have higher rates of chronic conditions and mental and physical disabilities.[163] Given that aging offenders tend to have greater health care needs, these trends present a particular challenge with respect to providing constitutionally mandated adequate health care and controlling prison health care costs.[164]

The report "Who Pays? The True Cost of Incarceration" by the Ella Baker Center for Human Rights, Forward Together, and Research Action Design[165], revealed that the stigma, isolation, and trauma associated with incarceration also has direct impacts across families and communities. About one in every two formerly incarcerated persons and one in every two family members surveyed experienced negative health impacts related to their own or a loved one's incarceration. Families, including their incarcerated loved ones, frequently reported post-traumatic stress disorder, nightmares, feelings of hopelessness, depression, and anxiety. Yet families have little institutional support for healing this trauma and becoming emotionally and financially stable during and after incarceration. Many of the health and economic costs and penalties associated with incarceration continue long after incarceration ends and reach far beyond the individual being punished, with negative impacts upon families and communities. The costs are felt most deeply by women, low-income families, and communities of color.[166] We need to shift resources to include education, job training and the safety-net of preventing incarceration and supporting re-entry.
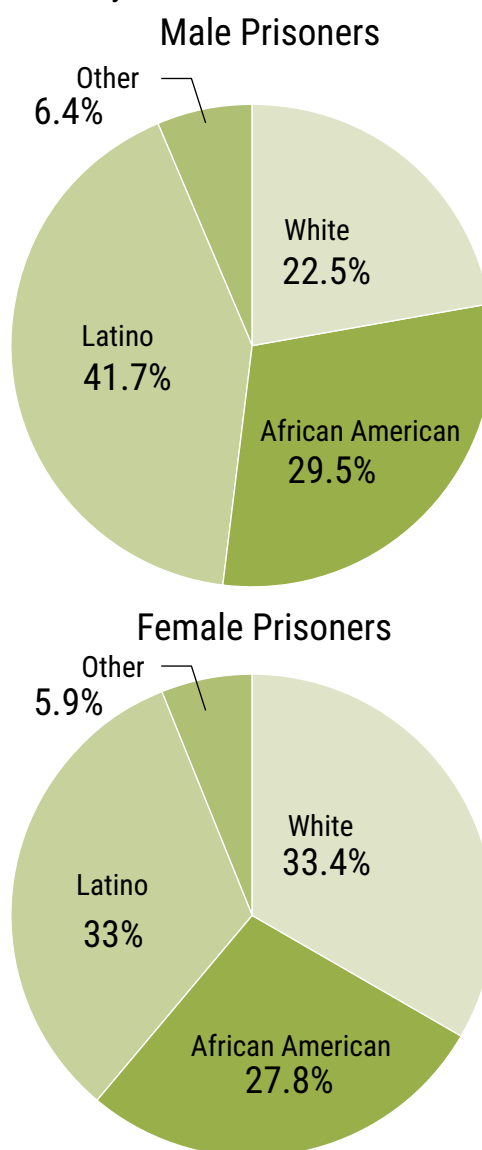
Los Angeles contains 35% of the prison population in the state.[169]

Health Impact

The report "Understanding the Public Health Implications of Prisoner Reentry in California, State of the State" by the RAND Corporation found:

About two-thirds of California inmates reported having a drug abuse or dependence problem, but only 22 percent of those inmates reported receiving treatment since admission to prison.

More than half of California inmates reported a recent mental health problem, with about half of those reporting receiving treatment in prison.[170]

Momentum Towards Equitable Policies

Criminal Justice

Reform efforts to reverse policy decisions that have led to decades of mass incarceration, overcrowding of prisons, and unjust punishments, largely impacting communities of color, are moving forward in California. The passage of Public Safety Realignment in 2011 (AB109) mandates non-serious, non-violent or non-sex offenders serve sentences in county jails instead of state prisons. For youthful offenders, SB 260 (2013) and SB 261 (2015) now allow individuals who committed their crime before the age of 23 to be eligible for earlier parole hearings.[171] Coupled with the passage of Proposition 36 (Three Strikes Reform Act of 2012) and Proposition 47 (Reduced Penalties for Some Crimes) in 2014, California has seen the prison population decline by 45,000 inmates — a 26 percent drop since its peak in 2006, bringing it to a level not seen since the mid-1990s.[172] At midyear 2013, 90% of inmates had a current or prior violent or serious felony conviction, and 16% were registered sex offenders.[173] As of March 2015, the state's penal system is operating at 135.8% of their design capacity.[174] This is below the court-mandated cap of 137.5%.

As the prison population decreases, safety net supports for inmates in county jails and community re-entry programs are critical for overall success and reducing recidivism. As part of the 2014-15 budget package, the Governor and legislators lifted the lifetime ban on receiving CalWORKs and the partial ban on CalFresh participation for people with felony drug convictions, removing a significant challenge that Californians with low-level criminal histories face when returning to the community following incarceration.[175] To better facilitate the enrollment of jail inmates in public health insurance prior to release, AB 720, was passed as a complement to the Affordable Care Act and California's expansion of Medi-cal to low-income, childless adults.[176] AB 720 provides local corrections systems with new tools to reduce costs, lower recidivism, and improve public health.[177]

Policy Recommendations

Shift from Punishment to Prevention:

Our focus needs to shift from punishment and incarceration to prevention and opportunity. This begins in schools, where children of color are the most likely to be disciplined and pushed out before graduation, causing a significant racial achievement gap that has yet to be significantly ameliorated.[178] It is essential to replace zero tolerance and other harsh suspension and expulsion policies that jeopardize the health and achievement of students of color, and to reduce the presence of law enforcement on school campuses. It is important that schools have strong policies and programs to prevent bullying and harassment, and to teach students how to use behavioral health resources when needed. In addition, our cities and counties should approach violence prevention in comprehensive and innovative ways by engaging all stakeholders, especially public health officials, youth leaders, and law enforcement. We must identify ways to reduce factors that threaten individual and community well-being while building trust and creating partnerships.

Invest in Neighborhoods to Build Community Connectedness:

Investment in our communities is needed to increase safety, create stability, and build local capital. We must identify and strengthen community assets, including neighborhood organizations, schools, cultural groups, health care providers, libraries, and places of worship. State and local policy must ensure that economic development advances equity by reinvesting in these community supports and strengthening local assets, including increasing rates of home and small business ownership in communities of color,[179,180] diversifying the local workforce, and creating career pathways. Building social capital, in addition to economic capital, in vulnerable communities is vital to improving neighborhood safety and health outcomes, and increasing political engagement. By building partnerships between residents, community organizations, and local governments, we can identify strategies to address local conditions through place-based community approaches. At the same time, as we are building local supports and resources, we must prohibit and limit the harmful practices of targeting vulnerable communities for unhealthy and unsafe products such as weapons, tobacco, and alcohol. Through zoning and advertising restrictions, we can ensure that vulnerable communities are not preyed upon.

Ensure Greater Access to Mental Health and Social Supports:

By actively and visibly providing mental health services, schools can work to reduce stigma and create a positive association with behavioral, mental and substance use care. In that regard, we must work to increase the integration of behavioral health services and create greater coordination of care for those in need. We must ensure that our health care systems, from primary to mental health, are meeting communities where they are at for all levels of care. We should look to fund and expand community-defined mental and behavioral health services to complement evidence-based care.

Transform Policing Practices with Supportive Alternatives:

We must seek to reform the culture of policing by making it reflective of, and responsive to, the communities it serves. This includes employing law enforcement officers from the local community, coupled with meaningful civilian oversight. Communities of color have suffered centuries of trauma — trauma which is still evident today as a result of our policing and our health care delivery. Both systems must evolve, acknowledging this reality and taking meaningful steps to address it. Law enforcement should effectively partner with culturally responsive mental and social service providers to cater to community members with acute needs.[181] For example, individuals

who lack stable housing, live with mental illness, or are victims of trafficking should be approached with compassion, understanding, and with an awareness of addressing their larger health needs. The court system should work towards helping victims of trauma and poverty when sentencing, and expand successful alternative court models, such as drug court.[182] People working both in the police and health care systems should undergo training in cultural competence and appropriateness when dealing with vulnerable communities, including communities of color, LGBTQ communities, immigrant, and LEP communities. As a state, we must shift our spending from jails and prisons, to community investment, mental health and substance use treatment programs, and job training and development. At the same time, jails and prisons must provide adequate health and mental health care, addressing the high rates of both infectious disease and trauma found in these institutions. Finally, we should continue to eliminate sentencing laws that target people of color and those living with mental illness and substance use disorders, including sentence enhancements, parole violation sanctions, and criminal penalties for social conditions such as homelessness and addiction.

Acknowledge and Address Racial Disparities in Criminal Justice:

The criminal justice system disproportionately impacts communities of color through over-policing, unfair sentencing, and lack of legal representation. Once released, there is a void of rehabilitation and re-entry programs to help transition individuals back into a stable life and community. California has made some progress in recent years, including through legal action and voter mandate,[183,184] but the impact of mass incarceration on communities of color continues to be devastating. In order to reduce the incarceration of these communities, we must first acknowledge that the problem is driven by race and racism.

Invest in Efforts to Assist with Re-entry:

It is time to remove the barriers to housing, employment, education and parenting faced by formerly incarcerated individuals by prohibiting the consideration of criminal background checks. This means moving from the use of sanctions and re-arrests and engaging in more intensive use of services when necessary. Probation and parole terms should be flexible to meet the needs of re-entry individuals who may be faced with behavioral health needs. Policies that educate and incentivize businesses to recruit and employ formerly incarcerated individuals in the community should be explored. We should also provide career training in the health care industry, that helps to diversify that field and promote cultural competency while also meeting the needs of the re-entry community. We should invest in job training and recruitment, affordable housing, and behavioral health care services in the most impacted communities. Service providers must collaborate with the criminal justice system to ensure a seamless transition for individuals re-entering the community. This will help to enable families impacted by incarceration to step out of poverty and ultimately improve health outcomes for children and families.

COMMUNITY AND NEIGHBORHOOD DESIGN

AFFORDABLE, HEALTHY, SECURE HOUSING

Quality, affordable housing is key to our health. Housing that shelters us from the elements and also provides a sense of protection, stability, and safety is a fundamental need. A home is where we spend time making memories with our families, and are able to rest and rejuvenate. Thus, affordable, quality housing can reduce stress and improve mental health, which in turn leads to better overall health. Yet too many low-income households spend more than half their income on housing costs, which means fewer resources for food and health care.[185] Many more families throughout the state are without a home. Cities are reporting growing numbers of homelessness over the past few years due to increases in rents, depleted affordable housing funds, and the combined effect of low wages and continued unemployment.[186]

The condition of the housing itself is also imperative to our health. For example, high quality housing reduces a person's exposure to environmental toxicants that can have a deep effect on a person's health.[187] Poor quality housing can increase exposure to lead poisoning which has irreversible effects on brain and nervous system development, leading to learning and reading disabilities.[188] Water leaks, pest infestations, mold, and other allergens can result in, and further trigger, asthma and other respiratory conditions.[189] Additionally, violence in and around one's home can lead to social isolation, which is particularly difficult for seniors and the elderly.[190] Adults living in unaffordable housing are more likely to describe themselves as being in fair or poor health compared to similar individuals living in affordable housing.[191]

Among people of all ages, researchers have found a connection between longer residential tenures and improved mental and behavioral health. Many studies have shown that homeowners generally have better physical and mental health outcomes than renters.[192] Yet more often, Black and Latino families are less likely to own their homes compared to Whites. The impact of the Great Recession resulted in nearly twice as many

African Americans and Latinos facing foreclosure compared to Whites. Roughly half of African American (53.7%) and Latino (46.5%) borrowers receiving higher-rate mortgages for single-family homes, compared to just one-fifth of White borrowers (17.7%).[193] Research and analyses have shown that inequities between higher and lower income families have been widened throughout the housing recovery with low-income communities falling starkly behind.[194]

Gentrification and displacement also cause numerous health impacts. Gentrification is generally described as that which happens in neighborhoods that are seeing decreases in the number of low-income people and people of color due to an influx of high-income individuals and families who are willing and able to pay higher rents.[195] Members of communities facing gentrification experience financial distress as housing costs rise, and often also suffer a loss of community services and institutions.[196] Displacement occurs when individuals or families are forced to leave their homes through eviction under the guise of late payment default, or other reasons sometimes legally protected such as persistently noisy children or excessive requests for repairs. In Matthew Desmond's book, *Evicted*, he notes how eviction can brand a person for life, making them an undesirable tenant and condemning them to ever more filthy, decrepit housing.[197] The detrimental effects of displacement include relocation costs, longer commutes, disruptions to health care, loss of community support networks, and homelessness. All of this impacts mental and psychological well-being.[198] To ensure complete health for our families and communities, our priorities as a state must include meeting our basic, human need for shelter, and striving towards providing affordable, healthy homes.

Housing in California

CHART 16

Homeownership by Race/Ethnicity
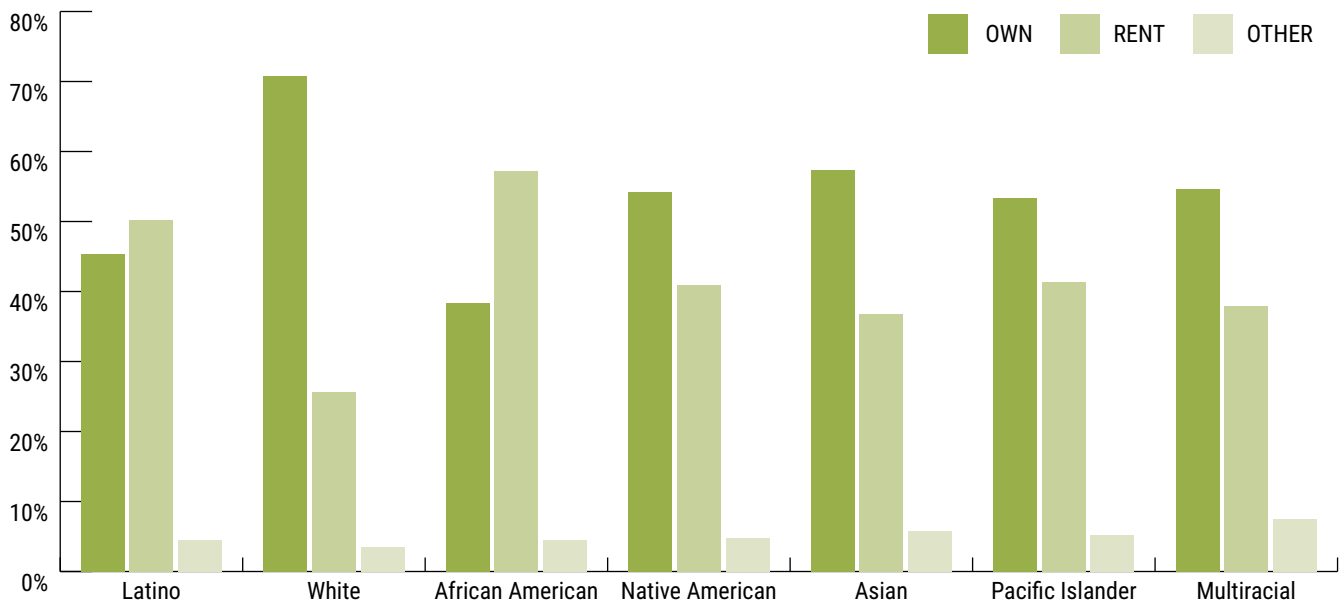
Homeownership

Whites are more likely to own their home compared to communities of color.[199]

Affordability

A home is typically considered affordable when the costs consume no more than 30% of household income. Of the selected counties highlighted here, households are spending more than 30% of their income on housing. When combined with transportation costs, many households in California are spending well over 50% of their income on housing and transportation.

Housing & Transportation Costs % of Household Income for Select Counties in California[200]		
County	**Average Housing Costs**	**Average Housing & Transportation Costs**
Alameda	32%	48%
Fresno	35%	64%
Humboldt	39%	73%
Los Angeles	37%	57%
Monterey	37%	61%
Riverside	37%	63%
Sacramento	32%	52%
San Bernardino	35%	60%
San Diego	37%	58%
San Francisco	32%	44%
San Joaquin	36%	61%
Santa Clara	32%	47%
Communities of color represent 50% or more of the population for all counties listed with the exception of Humboldt County.		

ACCESS TO HEALTHY FOOD

Equitable access to fresh and healthy foods is key to avoiding and managing a number of chronic health conditions like high blood pressure, obesity, diabetes, and depression. Neighborhoods with fewer grocery stores and less fresh produce, relative to fast food restaurants and convenience stores, have been shown to have a higher prevalence of obesity and diabetes.[203] Grocery stores and farmers markets that stock fresh fruits and vegetables and are less likely to be found in low-income neighborhoods. Studies have found that for every additional supermarket in a census tract, produce consumption increases by 32% for African Americans and 11% for Whites.[204] According to the USDA, vehicle access is perhaps the most important determinant as to whether or not a family can access affordable and nutritious food.[205] While this impacts both urban and rural communities, rural communities can often be more isolated due to lack of transportation. Seniors and disabled individuals also find themselves isolated from healthy foods due to proximity and transportation issues. These findings support the importance of access to fresh

fruits and vegetables, but the lack of nearby healthy food outlets, compounded with limited transportation options, compromise our ability to eat nutritiously.

Another barrier to accessing fresh fruits and vegetables is the higher cost of products. When available, healthy food may be more expensive, and there is greater potential for waste with more perishable items, whereas refined foods (grains, sugars, fats), and nutrient-poor foods are generally inexpensive and readily available in low-income neighborhoods.[206] Nationally, low-income zip codes have 30% more convenience stores than middle-class zip codes.[207] The lack of access to healthy, nutritious foods often leads to the consumption of high-fat, high-sugar foods, which promotes dental caries[208] and can increase the likelihood of developing a chronic health condition.[209] The impact of the lack of access to fresh and affordable fruits and vegetables is striking. According to the Centers for Disease Control and Prevention, obesity rates for African Americans is 51% higher than that of Whites, and diabetes risk in African Americans and the rates of death from heart disease and stroke are almost twice as high among African Americans.[210] A multistate study found that people with

access to supermarkets only or to supermarkets and grocery stores have the lowest rates of obesity and body weight issues, and those without access to supermarkets have the highest rates.[211] In California, obesity and diabetes rates are 20% higher for those living in the least healthy "food environments" controlling for household income, race/ethnicity, age, gender, and physical activity levels.[212]

Aside from the health benefits of having grocery stores in all neighborhoods, there are economic benefits to having food retailers in underserved communities. Research suggests that approximately 24 new jobs are created for every 10,000 square feet of retail grocery space. The average supermarket is between 20,000-50,000 square feet. Therefore, one new grocery store has the potential to create anywhere from 48 to 120 new jobs.[213] In addition to job creation, proximity to grocery stores can also increase home values. Access to healthier food options can help reduce the prevalence and cost of diet-related diseases, and promote the overall health and well-being of communities.

Access to Healthy Food in California

Availability of Fresh Food

African Americans, Asians, and Latinos are more likely to never or only sometimes have access to fresh foods compared to Whites.[214]

CHART 17

Access to Healthy Food
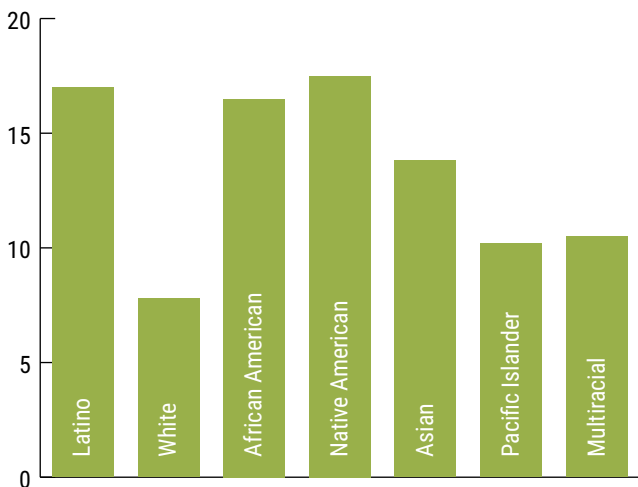
Affordability

Of adults who eat and have access to fresh fruits/vegetables, African Americans, American-Indians/Alaska Natives, and Latinos are more likely to find fresh foods either **not affordable or only sometimes affordable** compared to Whites. [215]

CHART 18

Fresh Food Affordability
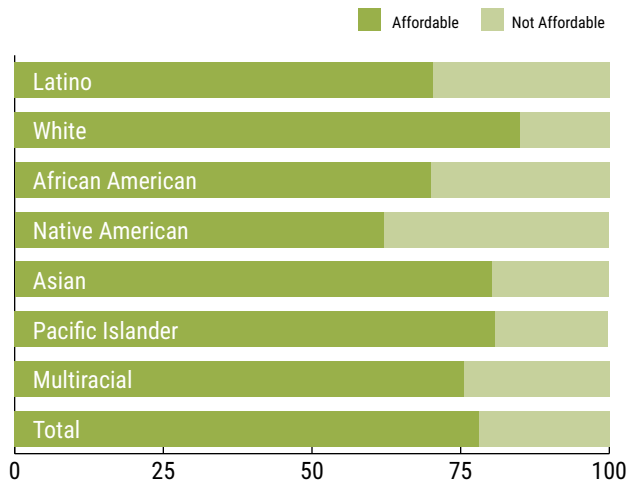
Health Impact

Diabetes has had a tremendous impact on communities of color due to the high cost of treatment and hospitalizations. African Americans and Latinos are more likely to be diagnosed with Diabetes compared to Whites.

CHART 19

Diagnosed With Diabetes
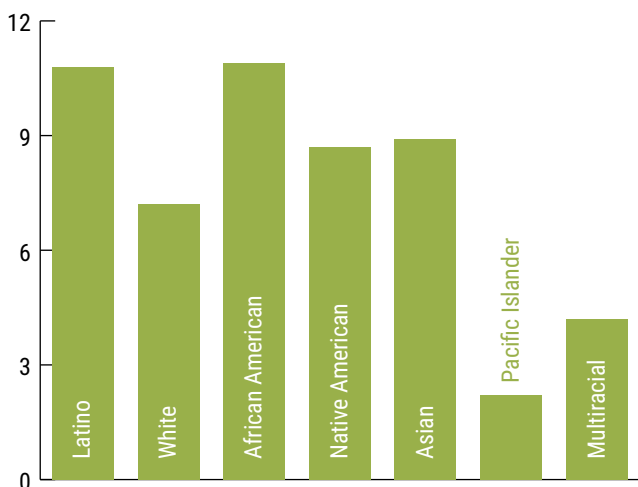
African Americans (10.9%) and Latinos (10.8%) have significantly higher rates of Diabetes diagnosis than Non-Latino Whites (7.25%).[216]

SAFE AND AFFORDABLE TRANSPORTATION

Transportation planning impacts our health directly and indirectly. In addition to improving air quality by reducing Vehicle Miles Traveled (VMT), health and equity-focused transportation planning can increase community cohesion and improve mental and physical health while also protecting pedestrians and bikers. Walking, biking, and other forms of active transportation are also an affordable means of getting around. Living in a neighborhood with sidewalks, pedestrian-friendly traffic patterns, and convenient public transportation makes it easier to be active and to access important services.[217] Low-income individuals have the highest rates of walking and bicycling to work; however, low-income individuals are twice as likely to experience fatalities as high-income individuals.[218] Almost one-third of transit users get the recommended amount of physical activity by walking to and from transit stops.[219]

In addition, transportation planning can positively impact how people interact through the location of activities and the pathways that connect them (called the "public realm").[220] These areas such as sidewalks, public transportation, and walkways offer people the ability to build positive relationships with others, to be physically active in their communities, access healthy food options and live in affordable homes.

Such interaction and engagement can also reduce crime rates. Per capita crime rates tend to decline in more compact, mixed, walkable communities, partially due to residents looking out for each other.[221] In addition, studies suggest that children's emotional and intellectual development accelerates in more walkable and mixed-use communities.

Unfortunately, transportation policies have often limited the life chances of low-income communities and communities of color by preventing access to certain places and opportunities.[222] Studies show that members of these communities are more likely to use public transportation, yet funding has not supported its expansion, particularly that of bus lines.[223] At the same time, transportation costs continue to rise, which is burdensome for low-income households who spend approximately 42% of their annual income on transportation compared to the 22% that middle-income households spend.[224] Unreliable and sparse transit systems can further limit social and economic upward mobility as transit systems are often unable to connect people to their final destination. Additionally, public transportation caters primarily to commuters so those who work outside of the traditional nine-to-five range may have trouble utilizing public transportation. The cost of public transportation not only hurts low-income families' budgets but it has other potentially harmful effects: when families and low-income individuals, especially seniors, cannot access affordable transportation they must limit trips to the doctor, social

visits with friends (which is important for limiting the social isolation of seniors), and face increases in commute times, often leading to increases in stress levels and less sleep.

In key state highway and road funding programs, the safety, health, and mobility needs of low-income communities and communities of color tend to be eclipsed in favor of goods movement. Greater community engagement and collaboration between businesses and residents are critical to ensuring equitable, health-driven investments in disadvantaged communities.

Safe and Affordable Transportation in California

Affordability

Typically a household's second-largest expenditure, transportation costs, are largely a function of the characteristics of the neighborhood in which a household chooses to live.[225] In dispersed areas, such as Humboldt, Fresno, and Riverside, households need to own more vehicles and travel farther distances which also drives up the cost of living.

Average Transportation Costs % of Household Income for Select Counties in California[226]	
Alameda	16%
Fresno	29%
Humboldt	35%
Los Angeles	20%
Monterey	24%
Riverside	26%
Sacramento	21%
San Bernardino	25%
San Diego	21%
San Francisco	11%
San Joaquin	26%
Santa Clara	15%

Communities of color represent 50% or more of the population for all counties listed with the exception of Humboldt County.

Health Impact

Pedestrian Accidents and Fatalities

Los Angeles county has the highest number of pedestrian accidents (38%) and pedestrians killed (29%) in the state.[227] Los Angeles county's population is 73% communities of color, the second highest in the state.[228] San Diego (9% of accidents, 10% killed) and San Francisco (6% of accidents, 2% killed) follow as the two counties with the second and third highest numbers with over 50% of their population communities of color.[229]

Momentum Towards Equitable Policies

Transportation Justice

Regional Transportation Plans (RTPs), are long-range transportation plans developed by planning agencies across the state, and shape how transportation money is to be spent. Recent legislation has required that these plans address public health impacts (AB 441 Monning) and develop Sustainable Community Strategies to reduce pollution, curb sprawl, and to meet the needs of residents (SB 375 Steinberg). Regional transportation planning and state-funded transportation infrastructure projects offer opportunities to correct longstanding patterns of disinvestment and neglect that have frequently left rural and urban low-income communities and communities of color without the most basic elements of a safe and healthy environment.

ACTIVE, HEALTHY LIVING

Access to safe outdoor spaces, like parks and playgrounds, is an integral part of a person's health. Regular physical activity and access to outdoor spaces have been shown to reduce the risk of early death from heart disease, high blood pressure, some cancers, mental health conditions, and diabetes.[230] Yet studies show that the motivations to pursue physical activity are complex.[231] For example, people in cities often feel stressed and prefer a natural environment for a restorative experience.[232]

Low-income communities tend to have limited access to green space, recreational programs, and facilities for regular exercise and active living.[233] Communities of color and low-income groups typically live in urban centers or suburban areas where green space is either scarce or poorly maintained,[234] thereby limiting opportunities to access outdoor spaces, especially for those who do not drive, such as children, teens and seniors. However, access alone does not determine whether individuals utilize parks or green space for physical or recreational activities. The safety, design, amenities, and quality of spaces can influence the use of park or open spaces in communities. Parks with walking paths, trees, picnic tables, equipment, and organized recreational programs invite more use and activity. Addressing poor park and green space access in communities of color and low-income households can, however, create an urban green space paradox.[235] As more green space becomes available, the positive benefits such as improving attractiveness and public health increase, and neighborhoods become more desirable.[236] In turn, housing costs can rise and potentially lead to gentrification: the displacement and/or exclusion of the very residents the green space was meant to benefit.[237]

As a result, and what we continue to see more often, residents may face higher rents or become precariously housed, while those who are actually displaced and forced to leave their communities end up in another less desirable neighborhood with similar park-poor problems.[238] If designed with community needs and characteristics in mind, parks and open spaces can serve as a critical resource that meets both the physical and mental health needs of individuals and communities without leading to future displacement.

MAP 5
Youth Access to Parks and Communities of Color

Legend:

- High % Communities of Color and Low Access to Parks
- High % Communities of Color and High Park Access
- Low % Communities of Color and Low Park Access
- Low % Communities of Color and High Park Access

Data Source: California Health Interview Survey, 2013-14

Classification: Counties with values higher than the median are included in the "High" category, while those with values at or below the median are included in the "Low" category. The median values for Communities of Color and Youth Access to Parks are 45.3% and 75.25% of people, respectively.

17 counties were grouped into three clusters. The first includes Del Norte, Siskiyou, Lassen, Trinity, Modoc, Plumas, and Sierra. The second cluster includes Tuolumne, Calaveras, Amador, Inyo, Mariposa, Mono, and Alpine. The third includes Tehama, Glenn, and Colusa.

2014 CHIS data found that 85.9% of teens in California lived within walking distance to a park or other open space.[239] However in rural areas there is lower access to parks compared to urban areas.

Physical Activity

The Centers for Disease Control and Prevention (CDC) recommends children and adolescents should have 60 minutes or more of physical activity each day.[240]

A higher percentage of Latinos (56.6%) that do not live within walking distance to a park take in no physical activity during a week. Whites (11.6%) who do not live within walking distance to a park are active 2 or fewer days a week (no/minimum physical activity), on average.[241]

No Physical Activity Compared by Distance to Park or Open Space (Teens, Park within/not within walking distance)

Park Access and Physical Activity

Legend: No physical activity, within walking distance | No physical activity, not within walking distance
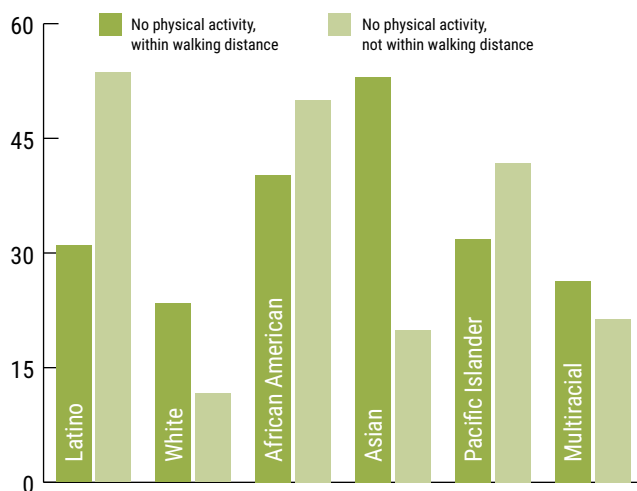
Health Impact

Being overweight or obese is related to many adverse health conditions, including asthma, diabetes and hypertension and is a key indicator for future health outcomes. Communities of color are more likely to be overweight and obese than Whites.

Latinos (72.5%), African Americans (73.4%), and American Indians/Alaska Natives (80.3%) showed statistically significant higher rates of being **overweight/ obese (**by BMI definition) than Whites (57.5%). Asians (43.2%) showed a statistically significant lower rate of being **overweight/obese** than Whites (57.5%).

Differences were statistically insignificant for Native Hawaiians/Pacific Islanders (60.2%) and those that identify with two or more races (50.8%)

OVERWEIGHT or OBESE by Race/Ethnicity[242]
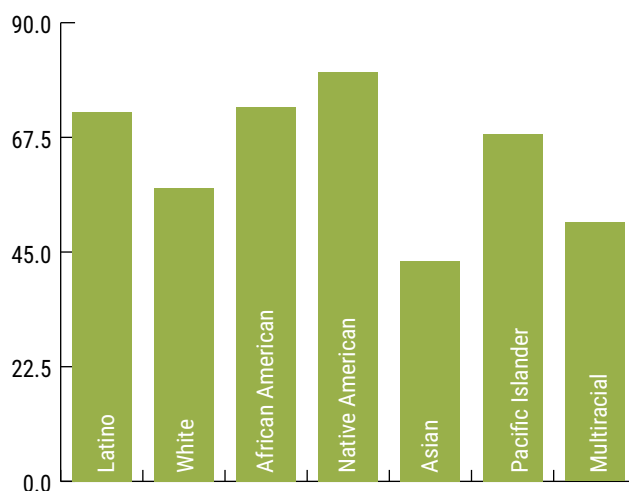
There are statistically significant differences from White males (64.4%) for Latino (77.0%), African American (74.2%), and Asian (54.5%) males. There are statistically significant differences from White females (50.7%) for Latino (68.0%), African American (72.7%), and Asian (33.4%) females.

OVERWEIGHT or OBESE by Gender[243]

Policy Recommendations

Prioritize Affordable Housing in Low-Income Communities:

As we look to produce more housing, we must consider non-market approaches to housing and community development, such as community land trusts (CLT) and the penalizing of speculative investment.[244] CLTs and other co-operative land and housing arrangements, such as Limited Equity Housing Co-Ops (LECs), are created, sometimes in partnership with a city or county, to provide affordable housing by holding land in a trust for the benefit of a community. We must also ensure that there are resources dedicated to preserving housing stock, particularly in low-income communities. Local and state planning processes must be transparent. They should include a requirement that the needs of vulnerable communities be considered, and that the addressing of the problem of displacement be a regional priority. Finally, we must ensure that racial and economic equity are central to future land use and housing planning processes.

Protect Low-Income Families from Displacement:

As we consider opportunities to address our state's housing needs we must ensure there are baseline protections for our most vulnerable residents, including policies that protect tenants and homeowners in the face of gentrification pressure, provide access to supportive services during times of transition, provide just compensation, and grant the right to return in cases of displacement. We must ensure there are strong anti-harassment policies to prevent tenants from being intimidated or forced out of their homes. We must tighten protections on predatory lending and offer assistance for families facing the potential for foreclosure. We must create and support more rent control policies and provide clear legal paths for tenants to exercise their rights. In addition, we must anticipate the health needs of residents as they go through transitions and ensure there are referrals to social and health care services when health is at stake.

Improve Access to Healthy, Fresh Foods:

There are many opportunities at the local, state, and federal levels to improve access to healthy food, for example, by incentivizing healthy food retail in low-income neighborhoods through tax credits or rebates for equipment

costs and other assistance, such as energy audits which can help small businesses save money by reducing the energy use associated with refrigeration equipment needed for fresh foods. We can also ensure that local farmers markets accept food assistance programs and help individuals and families leverage assistance. We can fund education and assistance programs through fees or taxes on sugary, sweetened beverages while encouraging a decrease in the consumption of high calorie, non-nutritious foods and beverages. It is also important that when our neighborhoods, communities, cities, and counties are initially developed, that the needs of the community are foremost in planners' minds — needs that inform planning processes with regard to gaps in food access, and areas with a high density of liquor stores and their accompanying high proportions of chronic conditions such as diabetes and heart disease.

Prioritize Investments in Low-Income and Disadvantaged Communities:

Many low-income communities and communities of color have faced the impacts of long-term disinvestment in infrastructure such as sidewalks and paved roads, as well as the complete displacement of communities to build highways. Funding for transportation infrastructure has been a key priority for the State Legislature and Governor in recent years.[245] Given the current and potential future investment in this area, it is important to consider the wide-ranging impacts this funding could have on advancing equity. In addition to identifying disadvantaged communities to invest in through new programs such as ATP and AHSC, state and local governing bodies should invest in expanding recent pilot projects that encourage local hiring policies for housing, transportation and community development projects. Local hiring is a promising practice that provides local communities — often communities of color and poor communities — with employment and skill-development opportunities on construction and transportation projects in their neighborhoods.[246] Local hiring builds both the community asset of the project itself and increases the wealth and employment prospects of local residents.

Provide Greater Resources for Public Transportation:

Communities of color and low-income communities often utilize public transportation at higher rates than higher income communities. Yet funding for public transportation is not prioritized and is often the first service to be decreased in times of economic downturn. This hurts communities of color and low-income communities in multiple ways, furthering persistent health disparities. Therefore, we must increase the maintenance and operation of public transportation services, without raising fares on riders. Additionally, we need to prioritize funding and incentives to those local agencies that are creating or expanding free or reduced public transportation fares for youth and students. It is critical that the state continue to set aside dedicated funding for planning and community engagement for active transportation, particularly in disadvantaged communities. Going forward, we must also ensure that there is adequate funding in the active transportation program (ATP) for non-infrastructure activities, such as education, outreach and the monitoring of community programs such as Safe Routes to Schools. Further, it is essential that low-income, under-resourced communities are prioritized when implementing and funding "complete streets," or streets designed for the access and safety of all road users.

Expand Green Space for Community Cohesion:

In order to help expand access to green space, especially in low-income communities and communities of color, it is critical that we address safety issues that might limit or reduce access. By including community members on local boards and commissions, we can ensure that the community voice is heard and concerns are addressed. We must also support research and public education on the importance of parks and recreation facilities in underserved areas. Our local streets and neighborhoods also provide an opportunity to add green space. We can look to expand, create, and improve long-term sustainable strategies for urban greening efforts. This includes ensuring all neighborhoods have the opportunity to benefit from planting street trees and installing sidewalk gardens.

EQUITABLE HEALTH CARE SYSTEMS

HEALTH COVERAGE

Health care coverage is important for the prevention and treatment of illness. Since the implementation of President Obama's Patient Protection and Affordable Care Act (ACA) of 2010, nearly 3.4 million previously uninsured Californians now have health coverage through the state's Medicaid program, Medi-Cal or the new health insurance marketplace, Covered California.[247] Communities of color that were disproportionately uninsured prior to the ACA have had the most to gain from its implementation. The majority of Medi-Cal beneficiaries today (80%) are from communities of color and more than a third (40%) speak English less than very well.[248] In Covered California, communities of color make up the majority (66%) of the exchange's membership, and close to three-quarters (70%) of its members are low-income (earning less than 250% FPL).[249]

The ACA has brought peace of mind and economic stability to California's working families, cutting in half the number of uninsured adults in our state. The rate of uninsurance in California dropped from 23.7 percent in 2013 to 11.1 percent at the end of 2015.[250] Through Covered California alone, 800,000 households received an average of $5,200 per covered household, for health care coverage in 2014.[251]

In many ways, California has gone further than most states in improving access to health coverage by expanding Medi-Cal to all low-income adults earning less than 138% FPL, including permanent residents, and providing state-funded health coverage in Medi-Cal for undocumented children. Despite these huge gains, Latinos and Asians still have higher rates of being uninsured.[252] Recent studies indicate that affordability and eligibility for coverage continue to be significant barriers for those remaining uninsured. While as many as half (47%) of the remaining uninsured are eligible for health coverage, cost was cited as the main reason why they did not enroll.[253] Additionally, undocumented immigrants continue to comprise one-third (32%) of the remaining uninsured, with the majority being Latino and limited English proficient.[254] Unfortunately, many undocumented immigrants are reluctant to enroll in coverage or use health care services because of fear of deportation.[255] Moving forward, it is critical that we prioritize access to comprehensive services for the estimated 1 million undocumented residents in our state, and a greater focus on keeping health care affordable is needed to stem the threat of the erosion of economic gains made by the ACA.
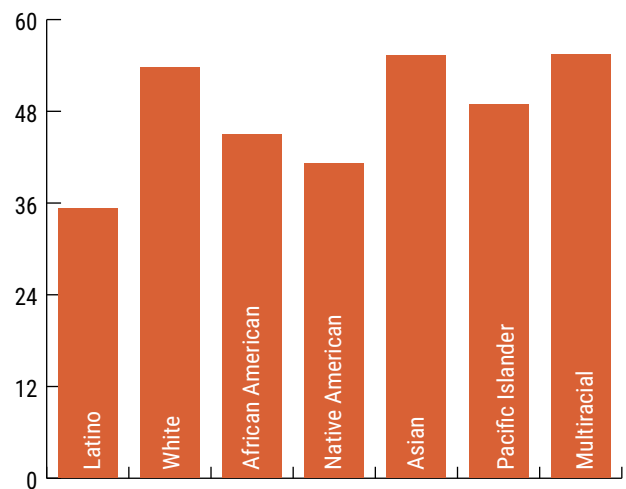
MAP 6

Insurance Status and Communities of Color[256]

Legend:
- High % Communities of Color and Low Uninsured Rate
- High % Communities of Color and High Uninsured Rate
- Low % Communities of Color and Low Uninsured Rate
- Low % Communities of Color and High Uninsured Rate

Data Source: 2014 CHIS and American Community Survey, 5-year, 2010-2014

Classification: Counties with values higher than the median are included in the "High" category, while those with values at or below the median are included in the "Low" category. The median values for Communities of Color and Uninsured Rate are 45.3% people and 15% uninsured, respectively.

Latinos (19.8%) and Asians (11.5%) showed statistically significant higher rates of being uninsured than Whites (7.2%). These numbers are down from 2012, for Latinos (22.2%) and Whites (8.3%).

CHART 23

Uninsured by Race/Ethnicity[257]

Pie chart:
- Latino 59.9%
- White 21.7%
- Asian 11.7%
- African American 4.2%
- Multiracial 1.7%
- Pacific Islander 0.5%
- Native American 0.3%
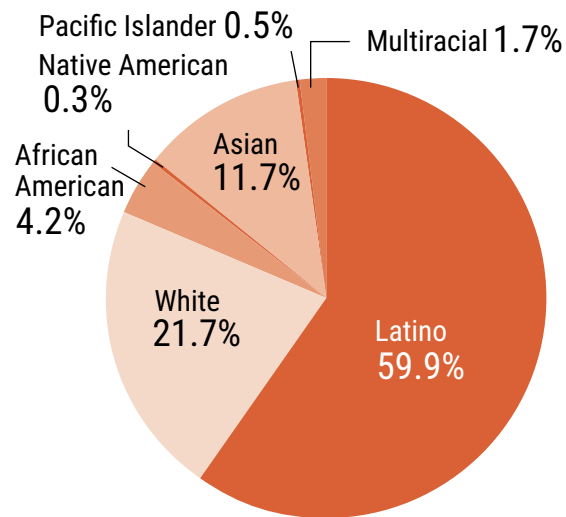
Communities of color make up the majority of those who are uninsured.

CHART 24

Covered CA Enrollment

Pie chart:
- White 39.5%
- Latino 28.4%
- Asian 22.6%
- Other 7.1%
- African American 2.4%
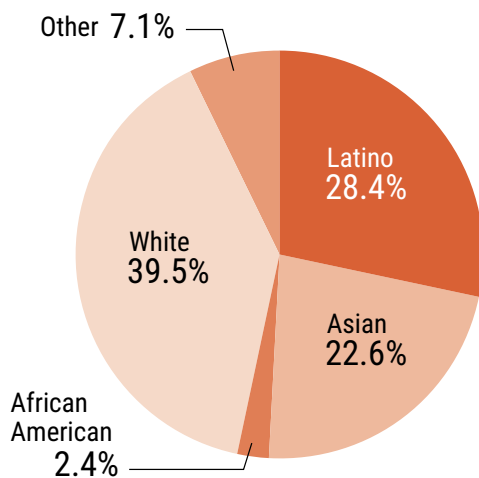
Communities of color make up the majority of those enrolled in Covered California.

CHART 25

Employer-based Health Insurance by Race/Ethnicity[259]

Bar chart with categories: Latino, White, African American, Native American, Asian, Pacific Islander, Multiracial

Latinos (35.3%), African Americans (45.0%), and American Indians/Alaska Natives (41.2%) showed statistically significant lower rates of employer-based coverage than Whites (53.7%). Differences for Asians, Native Hawaiians/Pacific Islanders, and those that identify with two or more races were statistically insignificant.

Momentum Towards Equitable Policies

Health Care Justice

California was the first state to implement an exchange and has gone much farther than the ACA, expanding Medi-Cal coverage to legal permanent residents and undocumented children, and overturning a federal law excluding undocumented immigrants from purchasing health insurance through state exchanges. Beginning in 2014, tens of thousands of low-income childless adults earning less than 138% FPL including qualified immigrants and PRUCOL (who include Deferred Action for Childhood Arrival, or DACAs) became eligible for full-scope Medi-Cal in California. On May 16, 2016, Medi-Cal was expanded again to allow all low-income undocumented children and youth under the age of 19 to enroll in full-scope Medi-Cal. Thanks to the new law, up to 170,000 children in California will be able to access comprehensive health-care coverage including preventive care for the first time.[260]

California also approved historic legislation in 2016 allowing Covered California to apply for a federal waiver to sell exchange products to undocumented immigrants and DACA recipients. If approved by the Federal government, these individuals would be able to shop for and purchase an unsubsidized health plan through Covered California with their subsidy-eligible family members making coverage more accessible and obtainable for families with mixed immigration status. While these victories are an important first step, undocumented immigrant adults still remain excluded from accessing full-scope comprehensive Medi-Cal coverage or subsidies through Covered California, ensuring coverage is still out of reach for many individuals.

In California's recently approved Section 1115 waiver, Medi-Cal 2020, the Centers for Medicaid and Medicare Services (CMS) approved a payment reform called the Global Payment Program to provide flexibility with existing local and federal funding streams to encourage primary and preventive care for the remaining uninsured through the public health system. The flexibility in funding seeks to promote more efficient and effective care for individuals who remain uninsured.[261]

CASE STUDY

Nile Sisters Development Initiative

Every year, thousands of refugees from cross-cultural backgrounds are resettled in San Diego County; the largest resettlement site in California. The Nile Sisters Development Initiative (NSDI) is a clearinghouse for refugees and other underserved populations. The organization serves as a bridge between health care providers and newly-arrived populations that are hard-to-reach due to cultural and language barriers, and who experience difficulty in navigating complex health care systems. With its 15-year track record, NSDI provides health literacy and health insurance literacy programs which enable disadvantaged populations to access needed care. In 2014 alone, NSDI performed outreach to nearly 600 consumers and assisted many to access health insurance through California's health exchange program. For more information, see www.nilesisters.org.

INTEGRATING HEALTH CARE

While our health is connected and intertwined by many factors, primary health care is often treated separately from behavioral and oral health. Many chronic health conditions are caused or often co-occur with mental health issues like depression and stress, which can compromise the immune system. Stress can lead to unhealthy behaviors such as smoking, substance use, unhealthy eating and a sedentary lifestyle, all of which can contribute to adverse health outcomes including oral health issues like gingivitis and gum disease. There is a reciprocal pattern between behavioral, oral and primary care, which are all are important for whole-person care.

Disparities in behavioral health outcomes exist between communities of color and Whites. People of color experience behavioral health issues at the same rate as Whites, but disparities in access to treatment have been well-documented.[262] National and state disparities data post-ACA continue to show gaps in access to treatment for mental and behavioral health services. For example, 16.4% of Latinos and 17.3% of African Americans needed help for emotional/mental health problems or use of alcohol/drugs, compared to a similar number of Whites (17.9%).[263] But when comparing whether they were able to find the help they needed, 48.2% of Latinos and 52.3% of African Americans sought help but did not receive treatment, compared to 37% of Whites.[264]

Our fragmented health care system is a major factor. However, other persistent issues such as lack of culturally and linguistically appropriate providers, a lack of patient preferences and stigma, and discrimination, all contribute to unequal access to behavioral health services. In California, counties provide mental health and substance use disorder treatment services, which are "carved out" and offered through separate county mental health plans. While this has contributed to innovations in behavioral health care and is a locally-focused approach that is potentially beneficial, it also presents challenges. Integration of these services is a promising strategy to improve behavioral health care for communities of color, by not only providing behavioral health screening and services through primary care, but incorporating a team-based and culturally appropriate approach to behavioral health delivery. Team-based care

can utilize community health workers and incorporate the medical specialists who address each medical condition with which the individual lives, and focus on the social conditions that contribute to health, such as housing and transportation.

Oral health disparities are also prevalent among communities of color. While 65% of Californians reported visiting a dentist in the last year, people of color and low-income community members often delay seeking dental care.[265] California has the largest percentage of dentists in the country, but rural and poor communities experience a shortage.[266] Tooth decay is one of the most common chronic illnesses for school-aged children, and can lead to pain, nutritional problems, and poor concentration.[267] Poor oral health can also impact a family's finances and overall quality of life through lost work days, the presentation of a negative appearance during job searches, and can contribute to a lack of sleep due to pain. Oral health problems are also linked to chronic conditions such as diabetes[268] and heart disease[269] and is associated with low-birth weight.[270] An example of a new integrative model in oral health that is designed to improve access for underserved populations is the Virtual Dental Home (VDH) model.[271] Under the VDH model, individuals needing preventive care or simple dental care services are seen by a dental assistant or dental hygienist after a telehealth consultation with an offsite dentist. The dentist utilizes technology to make diagnostic treatment decisions to determine the best treatment. This model of care allows allied health professionals to provide dental care within their scope of practice, consulting with a dentist on issues that may be beyond their range of expertise. The patient is able to access oral health care within their community. The VDH pilot project was begun in 2010 by The University of the Pacific School of Dentistry through the California Office of Statewide Planning and Development (OSHPD) Health Workforce Pilot Project Program. After a large-scale pilot project demonstrated that early dental disease prevention can be safely and effectively provided through this model of care,[272] it was expanded statewide in California in 2015.[273]

Accessing and comprehending care systems by vulnerable populations, including the elderly, low-income, rural and LGBTQ communities, is often a challenge due to cost, feelings of stigma and discrimination, and lack of culturally and linguistically competent care.

Many individuals and families struggle to to find local providers in convenient locations to receive affordable high-quality care. Integrating primary, oral and behavioral health care is an important endeavor we must undertake for our most vulnerable communities. The ACA provides support for integrated approaches, including whole-person care, expanded substance use services, "health homes", and other new models of delivery that provide new hope for better health.

Integrating Health Care in California

Mental Health Needs
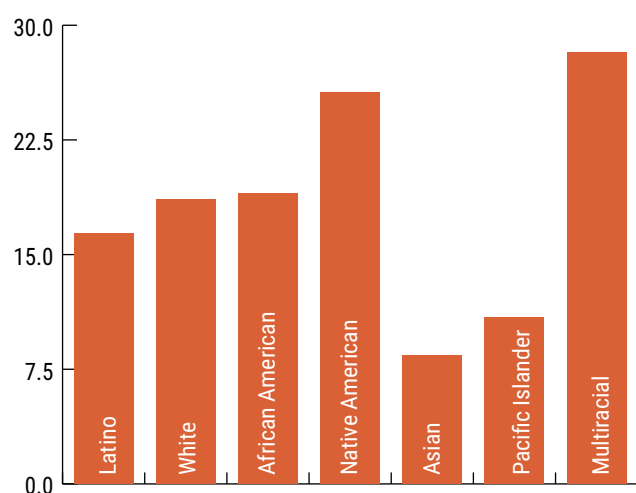
Psychological Distress

American-Indian/Alaska Native (21.9%) adults have statistically significant higher rates of psychological distress during the past month than White adults (9.3%). Asian (4.5%) adults have statistically significant lower rates of psychological distress during the past month than White adults (9.3%). Elderly Latinos (8.4%) have statistically significant higher rates of psychological distress during the past month than elderly Whites (2.4%).[274]

Mental Health Use & Race/Ethnicity[275]
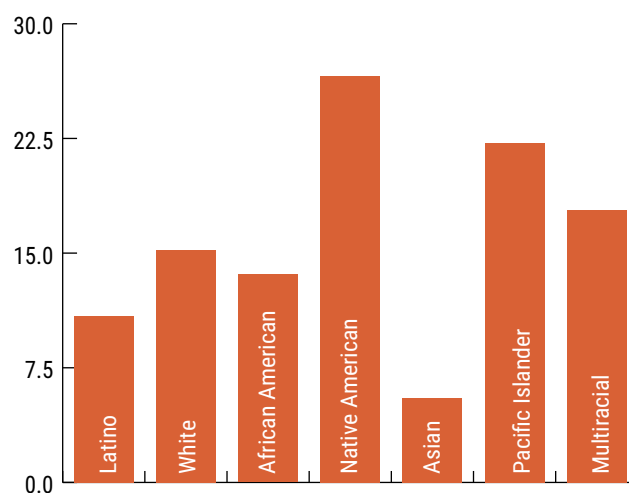
Latinos (10.9%) and Asians (5.5%) show statistically significant lower rates of utilization than Whites (15.2%).

A large share of uninsured adults with mental health needs (68.5%) received no mental health treatment in the past year — significantly higher than for adults with mental health needs who had public (39.8%) or private (46.1%) insurance coverage all year. [276]

There are differences in **oral health utilization**, 15.9% of African Americans, 24.8% of Latinos, 17.3% of Native Americans and 23.4% of Native Hawaiians/Pacific Islanders reported visiting the dentist 2 or more years ago compared to 14.4% of Asians and 14.5% of Whites.[277]

Health Impact

Suicide is the cause of death for every 10.5 deaths per 100,000 in California.[278]

QUALITY HEALTH CARE

The ACA has accomplished much more than expanding access to health care for millions. The law is also creating tremendous momentum towards reforming how health care is delivered. Much attention has been given to the 'Triple Aim,' a delivery system framework that promises better health care quality, lower health-care costs and improved population health. Under this quality framework, the ultimate measure of success is whether individuals are receiving the right care at the right time.

We know that having health care coverage does not always guarantee access to quality care. Although more Californians are covered than ever before, disparities in access to providers and utilization of services are pervasive.[279] A report by the California HealthCare Foundation, for example, found that Spanish-speaking Medi-Cal beneficiaries had the greatest difficulty finding either a doctor or a specialist who would accept them as a new patient.[280] Communities of color are also more likely than non-Hispanic Whites to report experiencing poorer quality patient-provider interactions — a disparity particularly pronounced among the millions with limited English proficiency.[281] A high proportion of Asians (28%) for example, report that their doctor does not usually listen carefully, as compared to 15% of all Medi-Cal enrollees.[282] When patients lack access to culturally and linguistically-appropriate care, they are less likely to understand their outpatient regimens. This is particularly problematic in a state as diverse as California.

One way to improve quality for these communities is through an expanded and diverse health care workforce. A key provision of the ACA mandates expanding the health care workforce, particularly in underserved areas.[283] In many low-income communities and communities of color, where a person lives matters because of proximity to care and availability of quality services.[284] Although California has one of the largest supply of physicians, in some counties, like in in the Inland Empire and San Joaquin Valley, the number of physicians is below the recommended ratio, and there are more physicians concentrated in coastal

communities.[285] Despite comprising the majority of the state, people of color are highly underrepresented in health-related professions, and as a result, cultural and linguistic challenges exist. In California only 7% of physicians represent Latino and African American communities.[286] Statewide, less than 20% of physicians speak Spanish, and physicians who speak Chinese or other Asian languages are far less prevalent.[287] In addition, many available physicians are less likely to serve Medi-Cal, Medicare, and uninsured patients in their practices than privately insured patients.[288] In California, we are taking steps to identify physician shortages but more needs to be done to support students from communities of color in entering the expanding health care sector.

Additionally, the ACA is reforming the way care is delivered through the development of patient-centered medical homes. Medical homes help coordinate patient treatment through a primary care physician to ensure patients receive the necessary care when and where they need it, and in a manner they can understand. This shift away from funding medical services towards funding better care coordination and improved health outcomes can help to ease some of the challenges faced by communities of color. The ACA has also created significant incentives and opportunities to increase the role of community health workers, who are much more likely to come from the communities they serve, in providing preventive care, particularly to Medi-Cal beneficiaries.

All of these health care delivery reforms have the potential to improve health outcomes for diverse communities, but only with the careful measurement and evaluation of changes in health outcomes. An explicit focus on reducing health disparities as part of quality improvement efforts is needed to ensure plans and providers are not just being rewarded for improving care for the healthiest patients. Covered California and California's Medi-Cal program have begun efforts to analyze quality metrics by patient demographics including race and ethnicity. Having better data, resources, and commitments from state agencies and health care providers will assist in providing high quality care for our most vulnerable communities.
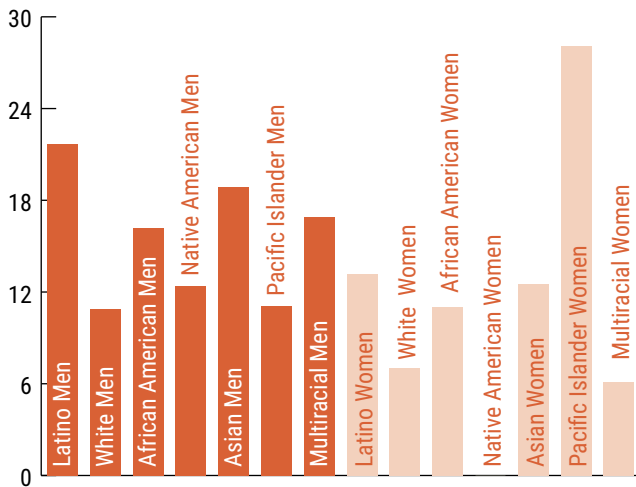

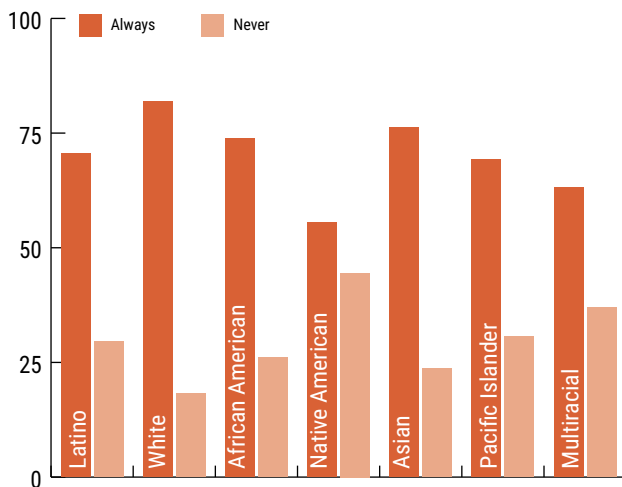## Quality Health Care in California
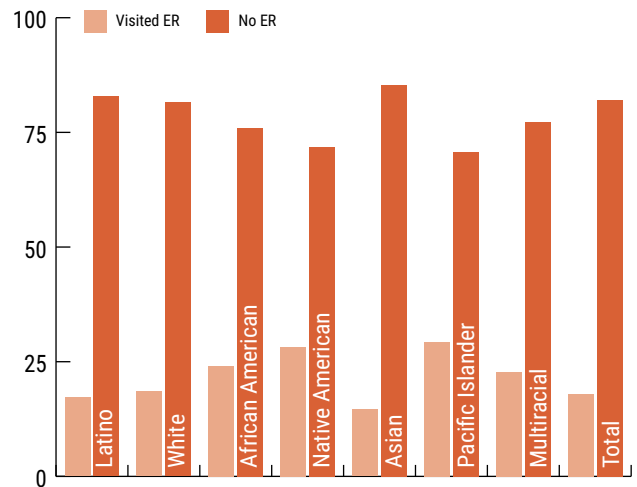
Usual Source of Care by Race/Ethnicity[289]
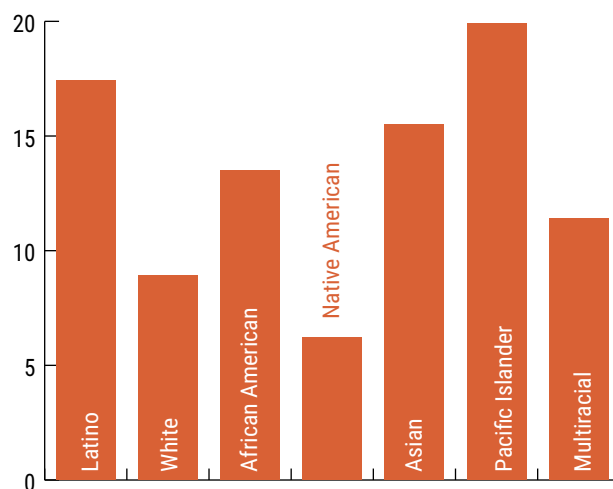
According to CHIS, Latinos (17.4%), African Americans (8.9%), and Asians (15.5%) show statistically significant higher rates of no usual source of care compared to Whites (8.9%). Overall, males tend to report no usual source of care more often.

CHART 29

No Medical Home by Race/Ethnicity & Gender

Chart 29 bars (by category): Latino Men, White Men, African American Men, Native American Men, Asian Men, Pacific Islander Men, Multiracial Men, Latino Women, White Women, African American Women, Native American Women, Asian Women, Pacific Islander Women, Multiracial Women

According to CHIS, Latinos (5.6%) and Asians (4.2%) have statistically significant higher rates of difficulty understanding their doctors during their last visits than Whites (1.9%)

CHART 30

Scheduling Appointments[290]

Legend: Always, Never. Categories: Latino, White, African American, Native American, Asian, Pacific Islander, Multiracial

Latinos (29.5%), American-Indians/Native Alaskans (44.5%), and respondents that identify with two or more races (36.9%) have statistically significant higher rates of difficulty scheduling appointments within two days with their doctors, compared to Whites (18.2%). Data for Native Hawaiians/Pacific Islanders was unstable. African American and Asian data was statistically insignificant.

CHART 31

Emergency Room Visits by Race/Ethnicity[291]

Legend: Visited ER, No ER. Categories: Latino, White, African American, Native American, Asian, Pacific Islander, Multiracial, Total

African Americans (24.1%) have a statistically significant higher rate of ER visits in the past 12 months than Whites (18.5%). Asians (14.6%) have a statistically significant lower rate of ER visits than Whites (18.5%).

Health Impact

CHART 32

Low Birthweight Births and Race/Ethnicity

Categories: Latino, White, African American, Native American, Asian/Pacific Islander, Multiracial
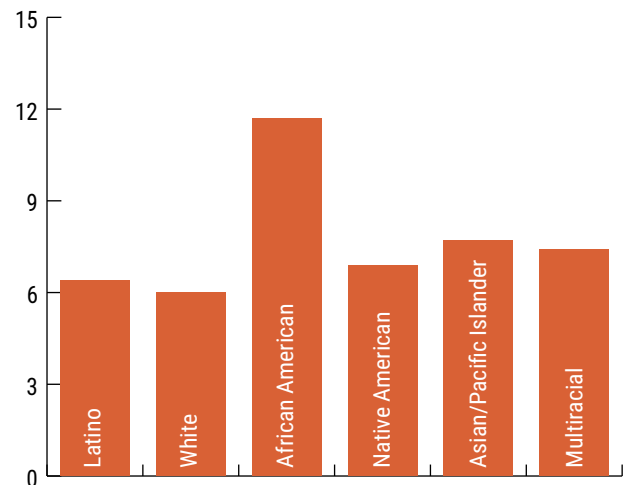
African Americans are more likely to have low birthweight babies in the United States and California compared to Whites. This gap has remained consistent for the past 20 years. African-Americans have the highest 11.7% and Whites have the lowest 6.0%.[292]

Momentum Towards Equitable Policies

Health Care Justice

California's health benefit exchange, Covered California, has committed to reducing health disparities as part of its core mission, vision and values. This commitment is reflected in exchange policies and practices which have placed an emphasis on reducing disparities in accessing health care coverage and improving health outcomes. As part of this commitment, Covered California's Board recently voted to tie financial incentives to year-over-year improvements in health disparities in key target areas including diabetes, hypertension, asthma and depression, starting in 2017. In order to set accurate benchmarks, Covered California has imposed an additional requirement on health plans to achieve at least 80% self-reported race and ethnicity data from enrollees by 2019 and has formed a workgroup with plans to explore strategies and best practices to achieve this goal. The exchange will consider extending incentives to the reduction of disparities in additional areas including income, disability status, sexual orientation, gender identity and Limited English Proficiency (LEP) in the future. Expanding this model across all payers in California could result in real change for traditionally underserved communities who cycle between programs, as it is estimated that a large portion (over 40%) of Exchange enrollees will move between various coverage sources, including job-based coverage and Medi-Cal, in a given year.[293]

Policy Recommendations

Expand Access to Health Care for All:

While California has made great strides in strengthening access to health care for all children, efforts must continue to ensure low-income, undocumented adults and those unable to afford current health care options are able to access comprehensive health-care services. Expanding access to health coverage will address health needs before they become costly and potentially life-threatening emergencies.

Ensure Equity is Central to Quality Improvement Efforts:

In order to advance health equity, state and local agencies, health plans, and providers must prioritize the reduction of health disparities in all quality-improvement initiatives. We must hold health systems accountable for year-over-year improvements in the elimination of health disparities, without penalizing those providers who care for the sickest communities. Covered California's pay-for-performance health disparities reduction initiative is a model for the state and the rest of the nation. Given that many individuals and families move between various coverage sources, we must expand this model across all payers in California. Doing so could result in real change for traditionally underserved communities who cycle between programs.[294]

Invest Adequately in Safety-Net Providers:

Federal and state agencies must continue to invest in safety-net institutions to ensure they can compete in the health care marketplace and are able to provide quality health-care services. While the ACA has expanded access to health coverage and lowered uninsurance rates, the need for continued federal and state funding for California's designated public health system remains. Additionally, as more and more quality initiatives are tied to payment incentives, hospitals and providers that serve low-income, and ethnically-diverse populations are more at risk of underperforming on quality measures and losing vital funding because they may be under-resourced and are caring

for a sicker population. An analysis of CMS data from the Medicare Hospital Readmissions Reduction Program for example, showed that safety-net hospitals were nearly 60% more likely to be penalized for readmission rates than non-safety-net hospitals for all three years of the program.[295] California policymakers should consider adopting the National Quality Forum's recommendation to risk-adjust for sociodemographic (SES) factors on some quality performance assessments in order to avoid penalizing providers caring for traditionally poor and underserved populations.[296]

Integrate Care Across the Spectrum:

Behavioral and oral health are important components of our overall health and must be viewed as part of a continuum of care to best meet the needs of underserved populations. As many people with chronic conditions also face mental health challenges, it is vital to integrate behavioral and primary health services in the same setting to ensure that needs are being met comprehensively and efficiently. Co-location of behavioral health services in settings that are familiar to consumers, including community health centers, faith settings, and schools, is key to meeting community members where they are. We must also look towards further care coordination efforts by the evaluation and scaling up of successful programs such as the Whole Person Care pilots, the expansion of substance use treatment services, the Dental Transformation Initiatives and the behavioral health integration efforts in Medi-Cal.[297] These efforts must continue with the concept of health equity at the forefront to advance integration while also reducing disparities.

Improve Access to Culturally and Linguistically Appropriate Care:

We continue to face a shortage of licensed physicians and other key health professionals to meet the new demand for health care services. Additionally, our future health care workforce, whether in primary, behavioral, or oral health, needs to be developed to address the cultural and linguistic health care needs of patients. Health care pipeline programs and training stipends are essential for meeting future workforce needs, and must also include non-traditional providers working with a team-based approach. California should continue to invest in and expand scholarship and loan programs to ensure members of low-income communities of color are able to pursue their dreams in the field of health care. Additionally, California should take better advantage of federal funding options to increase our workforce. Finally, more providers, plans, and hospitals should offer cultural-competency and unconscious-bias trainings such as those currently utilized at some medical schools.[298] With an increased focus on developing our future workforce, we also have the opportunity to offer new employment opportunities to communities while meeting the needs of our diverse patient populations.

TOWARDS EQUITY FOR ALL

This third edition of the Landscape of Opportunity Cultivating Health Equity in California presented an examination of the current health status of California's diverse communities. While much progress has been achieved in expanding health care coverage, improving climate change efforts, and reforming education and criminal justice, many communities of color and low-income communities still experience persistent health disparities. Differences in health outcomes force us to take into account structural inequities related to other aspects of our lives. Our health is dependent on our income and education, where we live, and how we are treated on a daily basis. Historical discrimination and bias continue to operate by limiting access to resources, which can increase our health risks.

As discussed, factors such as socio-economic status, physical environment and social systems can contribute to our health and well-being in both direct and indirect ways. In addition, our landscape is changing, we are layered and complex. We must examine other aspects of our lives that may ultimately impact health. We must consider how intersecting identities operate to determine health. Not only is race and ethnicity at play, gender, sexual orientation, age, language, and immigration status are also intricately linked and contribute to how health is experienced and defined.

We must continue to expand policy solutions that build on the momentum we've gained towards equity, in order to ensure the future of health for all. As advocates for health, we must consider policy solutions that not only focus on health outcomes, but also those that can impact multiple gaps for our communities. Throughout this report we offered policy recommendations for achieving that vision. While there is not one single solution for health equity, we offer the following recommendations as overarching policy opportunities:

Analyze New and Existing Policies within an Equity Framework:

In order to realize positive change for all Californians, our most vulnerable communities must be the focal point of policy and systems change. We must put the needs of these communities first as we identify our vision forward. To do so thoroughly, we must incorporate other lenses of potential inequity including sexuality, gender, age, language, and focus on developing the ability to ensure that no person or community is left behind. Any vision for the development of our state, region, or county must explicitly acknowledge future population shifts. For example, as young people of color become the majority of the workforce in California, we should think about their needs and how policy decisions around workforce needs, education reform, climate change, active transportation, housing, and health will impact their future decisions and opportunities.

Improve Data Collection, Analysis, and Reporting:

The cornerstone of good decisions and policymaking is having the data to understand the needs and problems. Data is an important tool for identifying challenges, allocating resources, and developing the outcomes we hope to achieve. State and local governments are making progress in improving data collection but more needs to be done when making analyses to ensure communities such as limited English proficiency, sexual orientation, the young, the aging, and persons with disabilities are not overlooked. We must identify ways to collaborate across programs, departments, and governments to share population statistics, estimates, and projections in ways that help plan for the future while being protective of confidentiality. With important, reliable, and disaggregated data, we can do much more to help communities in need, and plan for a tomorrow that puts equity at the forefront of our considerations.

Target Resources to Low-Income, Communities of Color:

The state recently made great strides forward in designating funds for communities facing serious health, environmental, and educational needs. Targeted grants for planning and technical assistance to help groups apply for infrastructure funding opportunities has been essential in improving communities, such as communities of color, that have long faced disinvestment, resulting in a poorer quality of life. As a state with diverse needs and considerations, we must put those most vulnerable first. We must build upon, and strengthen efforts to allocate resources, technical assistance, and financial reforms so as to benefit those communities that have long suffered. Through stronger investments we can begin to see the promise of change.

Create Opportunities for an Inclusive Democracy:

Our community members are experts in the needs of their communities; therefore, their voices need to be front and center in any decision-making body whether at the local, state or federal levels. Our local, regional, and state governing bodies often require outreach to the public; however, guidance on how to conduct outreach is usually focused on the administrative scope, such as the number of meetings a body must hold. As we move towards advancing health equity, those who are most impacted by health disparities must be at the policy table. Community residents often feel their voices go unheard or can't participate in public meetings due to transportation, childcare, or work priorities. Yet community members want a central role in oversight and planning decisions, funding allocations, and investments that impact their family's lives. Governing bodies at all levels of government should improve the *depth* of public outreach. It is critical that adequate notification and early education efforts be conducted about important meetings, and in multiple languages. We must find ways to hold important meetings during times when residents are able to attend, and ensure notifications are reader-friendly, accessible to low literacy levels, and in multiple languages. We should explore new ways of including community in the policymaking process such as by working with facilitators experienced in race and power inequities, working with community health workers or other local community organizations who can help identify resident leaders, exploring the use of participatory budgeting practices, encouraging public disclosure of investments, and building the capacity of community leaders to serve on governing bodies.

Establish Measures and Processes for Monitoring and Accountability:

One of the weakest links in the policymaking process is monitoring, evaluating, and enforcing policies. In short, we need greater accountability. Community organizations are increasingly asked to act as a "watchdog" and to help facilitate the implementation process to ensure that policy intentions are carried out. While we recognize that accountability is a shared responsibility between public, private, and community sectors, it is also important for governing bodies to appropriately document their public outreach and community engagement processes as a step towards better accountability. This means that we should identify ways to work with community members before and during the planning process rather than just before important votes are taken. We must also identify and strengthen requirements for governing and implementing bodies to document and share decisions about how feedback was or was not accepted. As we move towards implementing important policies that have the promise of equity, we must ensure the tools are present to make the dream a reality.

ACKNOWLEDGEMENTS

DATA LIMITATIONS

The overarching research questions guiding this report and the data presented herein include:

1. What are the key contributing factors that need to be considered to ensure health equity?

2. Who is at greatest risk of poor health based on these factors?

3. Where do inequities and disparities exist among specific populations and identities across these factors?

Data from the American Community Survey (5 Year) 2014 and 2013-2014 California Health Interview Survey (CHIS) are the primary sources utilized in the report. When possible, gaps in the two primary data sources were filled with substitutions from a variety of other sources. The availability of data by Race/Ethnicity and other social identities (e.g. sexual orientation, age, gender, ability, national origin) continues to be limited for many health factors. Statewide statistics are available for most of the data sources and are presented in the report. When available, county level data is also presented. Given this is a statewide snapshot of the health landscape in California and the data is limited, data is not presented for lower geographies (e.g. Legislative Districts, ZIP codes). Readers who are interested in accessing smaller geographic data sets, are invited to visit CHIS Neighborhood Edition's select indicators at: http://askchisne.ucla.edu/ or Advancement Project California's Healthy City site at: http://www.healthycity.org/.

It is important to note that there are limitations with the data available for comparative, intersectional analysis due to data collection methods and sampling sizes. For example, at times it was necessary to combine race/ethnicity data when making comparisons with other health indicators, so the races would correspond. Therefore in some instances, Asian and Native Hawaiian and Other Asian Pacific Islander, as well as Some Other Race and Two or More Races have been combined under one race category (e.g. Asian or Other). In other instances, data were not presented due to limitations in drawing conclusions. Given the small sample size, it was especially true for sexual orientation data that drawing conclusions from these cuts would actually be very close, if not identical to the data set produced without a sexual orientation cut and just by race/ethnicity.

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