

The Landscape of Opportunity:



Cultivating Health Equity in California



California Pan-Ethnic Health Network

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Introduction

California began as a land of opportunity: to many, it offered the prospect of a new beginning, a place where anyone could achieve success. Before long, we experienced unprecedented growth and became the most populous and prosperous state in the nation as millions flocked west for a chance to improve their lives. But along the way it became apparent that the state's good fortune was not available to everyone. Inequities in employment, education, and income have created a society in which the places we live and work not only determine our success, but also how healthy we will be and how long we will live. Low-income communities, which often have higher numbers of people of color, have seen opportunities diminish and disparities grow.

Initially published in 2009, this update of *The Landscape of Opportunity: Cultivating Health Equity in California* takes a look at California's demographics and the socioeconomic conditions that led us to a society with such disparate outcomes. Using health as a lens, we examine everything from education to housing, neighborhood safety to availability of healthy foods, and green space to health care access—and connect the dots between these factors and how they impact our ability to live healthy lives. There are no quick or easy solutions, but this report allows us to look at health more comprehensively to address the inequities that have diverted California's original promise as a land of opportunity for all.

To help lead the way to a more equitable California, we offer a number of policy recommendations. The state has already taken a positive step toward improving the wellbeing of its residents through the work of the Health in All Policies Task Force, which provides guidance on how government agencies can work together to create a healthier, more sustainable state. Our recommendations provide advocates and community leaders with a guide to working with policymakers toward a common goal. Whether we specialize in health, education, transit, or housing, we strive to improve the lives of all Californians. CPEHN's mission has always been to find strength in our diversity; we are now reaching out, across not only many cultures but across many different movements, to join efforts to remake California as a more just, equitable, and healthy place to live.

Mapping Health Equity

This brief is accompanied by a companion section at our Multicultural Health Web Portal at www.cpehn.org, where you can map many of the indicators discussed in this report.



Cultivating Health Equity

In updating this brief, CPEHN wanted to examine the key factors that impact our health and the causes of California’s health disparities. Using the data available to us and our knowledge of the state’s communities of color, we study 13 factors, depicted on the following page, and discuss how to improve each of them to create a healthier and more equitable society.

Life Expectancy

In California, life expectancy can vary dramatically. White men (76.9 years) live about seven years longer than African American men (70.2 years).

Life Expectancy at Birth



SOURCE: A Portrait of California. American Human Development Project. 2011.

Figure 1

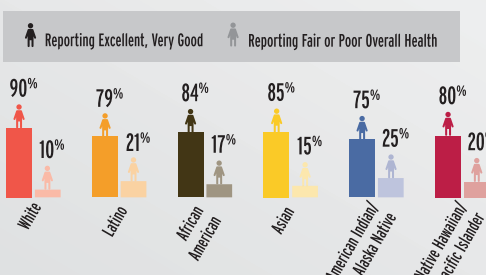
This examination of health-influencing factors will help us tell the story behind California’s health inequities. Our state’s unique multicultural makeup plays a key role in this story. Subtle—and sometimes not so subtle—institutionalized racism and discrimination continue to restrict opportunities for many in our communities.

While we fight to overcome these barriers, we are often constrained by all the strands that make up our lives and influence our health. Socioeconomic status is a fundamental factor in our ability to live healthy lives. Education, jobs, and income all combine to directly influence our access to both social and economic resources: better education leads to better jobs, and better jobs lead to higher incomes.

Overall Health Status

A person’s opinion of his or her own health is a key indicator of continued wellbeing. People of color are less likely than Whites to report being in good or better health, with 21% of Latinos and 25% of American Indians/Alaska Natives rating their health as poor or fair, compared to 10% of Whites.

Overall Health Status



SOURCE: 2009 CHS

Figure 2

Disparities in health outcomes driven by these socioeconomic factors include noticeable differences in life expectancy and overall health status (see *Figures 1 and 2*). While there is no single, overarching factor that influences life expectancy, chronic stress from economic uncertainty, inability to afford healthy foods, increased exposure to health risks, and different patterns of risk behavior can cut the life expectancy of those with less education and limited financial resources. This can lead to dramatic disparities between communities in the same region, with studies showing significantly higher life expectancy in areas with more college degrees and higher annual earnings. For example, in the Los Angeles metro area, a resident of the Newport Beach–Laguna Hills area in Orange County is fifteen times more likely to have a bachelor’s degree, earns \$33,000 more per year, and can expect to live fifteen years longer than a resident of Watts in Los Angeles, as little as 30 miles away. This earnings gap equals more than

the total annual wages and salary of the typical worker in the U.S. today.¹ The inequities between these neighborhoods also highlight stark racial and

Cultivating Health Equity



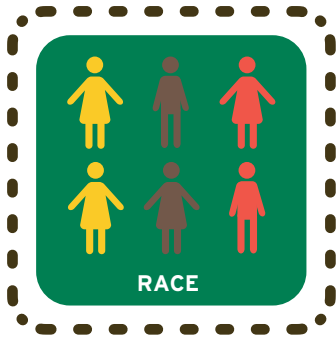


ethnic disparities, as people of color make up over 99% of the population of Watts,² while Newport Beach is over 87% White.³

We see conditions like this all across the state. As we explore the patterns of health in our communities, it becomes clear how closely they follow race, income, and other social and environmental factors. All too often, this distribution also matches the neighborhoods where communities of color live. This report is designed to help focus the discussion on the policy changes needed to reverse health inequities and build a healthier California for ourselves and our children.

We begin with a brief examination of race and the state's sociodemographic makeup, followed by sections on each of the social and environmental factors. Interspersed throughout are summaries of health conditions influenced by these factors and stories illustrating successful community-based strategies that work to combat health disparities.





DEMOGRAPHIC AND SOCIOECONOMIC FACTORS

The Color of Inequity

California’s unique diversity is one of its greatest assets. Walking through our neighborhoods, we can hear numerous languages and see the positive results that come from welcoming so many different, vibrant cultures. The 2010 Census confirmed that communities of color are increasingly the majority in California (see *Figure 3* and *Map 1* on page 7). Just 30 years ago, the 1980 Census found that communities of color represented slightly over one-third (33.4%) of the state’s population.⁴ After three decades of steady growth, our communities now represent close to 60% of all Californians.⁵ This trend is likely to continue, as people of color make up nearly three quarters (72.6%) of people under the age of 18 in the state. But as our diversity grows, we have a responsibility to address the state’s current inequities. Institutional racism in the form of housing segregation, employment discrimination, unequal wages, and other discriminatory practices has created persistent inequalities that limit opportunities for communities of color.

California Population by Race/Ethnicity

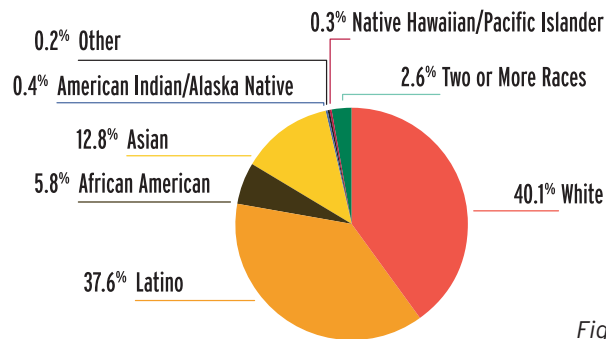


Figure 3

SOURCE: 2010 Census

This institutional racism is a root cause of some of the disparities faced by our communities. The stress brought on by diminished opportunities and pervasive discrimination can worsen all health outcomes, particularly birth-related ones. For example, studies controlling for education, income, and insurance status show African American women experience much higher rates of low birth weight births and infant mortality than women of other races (see *Figures 4* and *5* on page 9).⁶ In addition, institutional policies and practices rooted in racism have an impact on the health of communities of color by affecting our income, insurance coverage, and access to housing and other resources.

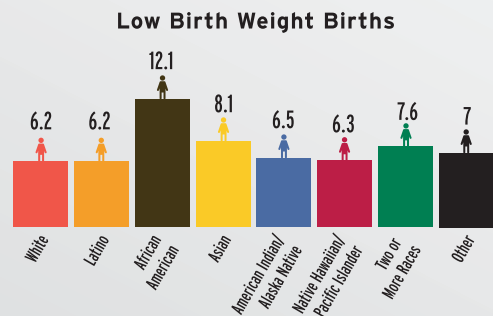


Another unique aspect of California’s multicultural society is the number of immigrants coming to our state each year. More than a quarter of Californians (27%) are immigrants, accounting for nearly 10 million people.

We have benefitted greatly from the entrepreneurship of immigrants—Google, Sun Microsystems, and Yahoo! were all either founded or co-founded by immigrants—and immigrant workers make up a large portion of those involved in our state’s agriculture, manufacturing, and repair and personal services industries.⁷ People of color also own approximately 450,000 small businesses in California.⁸ Despite the prominence of immigrants in California, this population as a whole faces additional challenges. Undocumented immigrants, in particular, must deal with prejudice and the specter of harsh immigration laws, and are often limited in their access to the health and social services afforded to others in our state.

Low Birth Weight Births

Infants born at a low weight experience health complications at much higher rates than babies born at a normal weight. African Americans have by far the highest percentage of low-weight births (12.1%), twice as many as Whites (6.2%).

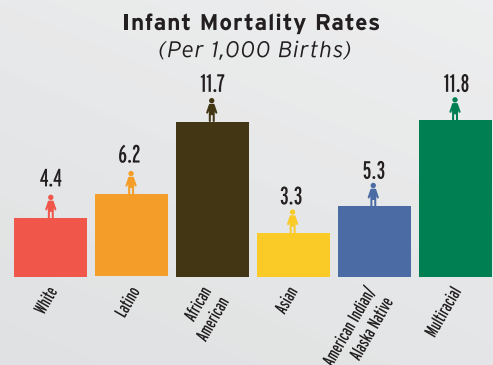


SOURCE: 2009 California Department of Public Health Birth Records, via www.KidsData.org

Figure 4

Infant Mortality

In California, infant mortality rates for African Americans are unacceptably high and are more than twice that of Whites (11.7 and 4.4 out of 1,000 births, respectively). Infant mortality has been linked to the underlying health of the mother and to the availability and use of prenatal and perinatal services. Both African American (77.9%) and American Indian/Alaska Native infants (69.8%) had mothers who received early prenatal care at rates much lower than that of their White counterparts (87.3%).⁹



SOURCE: 2009 California Department of Public Health Birth Records, via www.KidsData.org

Figure 5



Speaking the Language of Equity

Race is not the only sociodemographic characteristic that sets our state apart as the most diverse in the country. California residents speak over 100 different languages. More than 40% of Californians speak a language other than English at home, and nearly seven million are limited-English proficient (LEP), meaning they speak English less than very well. For some populations, such as those who speak Vietnamese, Korean, Thai, Cambodian, and Laotian, over half are LEP. Additionally, over 4.5 million Spanish speakers are LEP.¹⁰

For those who are limited-English speakers, everyday activities can be more difficult due to language barriers. Whether opening a bank account, applying for a job, or simply accessing public transportation to get to school or the doctor, language issues can result in significant frustration.

Language can be a key barrier when applying for public programs, such as Medicare, Medicaid, and the Supplemental Nutrition Assistance Program (SNAP or food stamps), as seen in national studies. For example, nearly half of Spanish-speaking parents who began an application for Medicaid reported that they did not complete the enrollment process because the forms and information were not translated into their language (46%).

Further, national surveys have shown that half of Spanish-speaking parents (50%) said that their belief that application materials would not be available in their language discouraged them from even trying to enroll their child.¹¹

Language barriers can also impact our ability to get quality health care. When most of us go to the doctor, we take for granted that the doctor will be able to understand us when we talk about what ails us, and that we will be able to understand and follow instructions or prescriptions. But limited-English speakers often face communication barriers that can lead to increased risk of misdiagnoses and misunderstandings, resulting in lower-quality care and reduced adherence to medication and discharge instructions. A lower number of Latinos (45%) reported that it was “very easy to understand” information from their doctors, compared to Whites (59%). This disparity exists even within the same ethnic group: a larger number of Latinos (43%) who primarily speak Spanish reported communication problems with their physicians, compared to 25% of those who primarily speak English.¹² Research has also found that LEP patients are more likely than English-speaking patients to experience an adverse event that caused some medical harm (49% vs. 30%).¹³

Speaking the Language of Mental Health

Community leaders had long noted that utilization of mental health services were critically low among the Latino community in Los Angeles County despite a persistent need. Their advocacy convinced the LA County Department of Mental Health to try a new culturally and linguistically appropriate model to outreach to the community. In 2011, PALS for Health was selected to design and implement a demonstration project, Promotoras de Salud Mental. Six months into this project, the team has made a difference for community members seeking mental health information and services. The project recently helped a family dealing with the attempted suicide of one of their children, connecting each family member with a Spanish-language therapist. They also helped a neighborhood group have a dialogue on community violence and trauma after a drive-by shooting, showing that when services are patient-centered, community members will use them.

For more information on PALS for Health visit: www.palsforhealth.org.



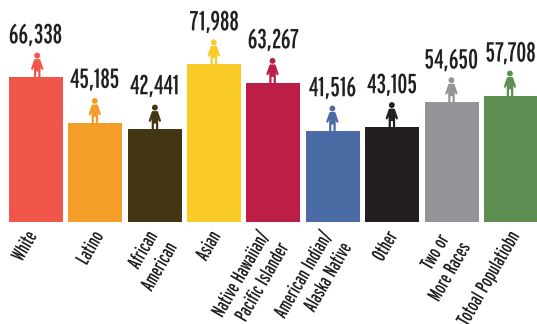
Affording Equity

The effect that racism, bigotry, and other sociodemographic factors have on our everyday lives is illustrated in the stark wealth and income disparities in California. Having a steady paycheck, money in the bank, and savings for our children’s education provides us with peace of mind and the resources to plan for the future. A family’s wealth and assets are often built over generations, which contributes to the unequal footing of communities of color.

The overarching effect of the economic downturn can be seen in the fact that the overall median household income has fallen from \$59,948 in 2007 to \$57,708 in 2010, a drop of nearly 4%.¹⁴ While income has fallen across all racial and ethnic groups, disparities still remain. In California, median household income for American Indians/Alaska Natives (\$41,516), African Americans (\$42,441), and Latinos (\$45,185) was roughly two-thirds of the median income of Whites (\$66,638), as shown in *Figure 6*.



Median Household Income by Race/Ethnicity



SOURCE: 2010 ACS

Figure 6

Map 2 on page 13 shows where Californians live and their median income. Some areas, such as the Inland Empire and San Joaquin Valley, with lower median income, highly correlate with where communities of color live. In fact, nearly 50% of African Americans and Latinos are living in “asset poverty,” meaning they do not have enough financial reserves (in bank accounts, home or business equity, retirement savings, or stocks) to manage at the Federal Poverty Level (FPL) for three months, compared to only 17.8% of Whites.¹⁵ These families are one paycheck, one car accident, or one medical emergency away from financial ruin.¹⁶

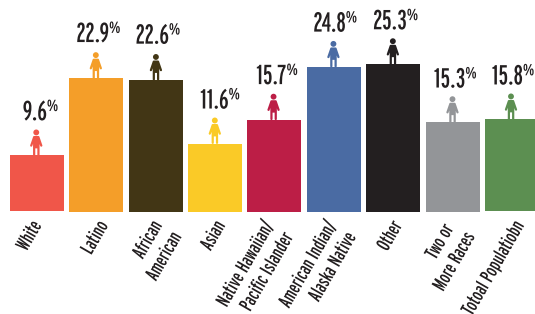
In addition, since family wealth, particularly in communities of color, is most often tied to home ownership, the recent collapse of the housing market has had disproportionate effects across the state. As a result of plummeting home values, particularly in California, the median wealth of White households in America is now 20 times that of African American households and 18 times that of Latino households. The median net worth of Latinos in the five states that saw the greatest decreases in housing



values (including California) fell from over \$51,000 in 2005 to just over \$6,000 in 2009, a staggering decrease of 88%.¹⁷

As shown in *Figure 7*, nearly one in four American Indians/Alaska Natives (24.8%) and more than one in five Latinos (22.9%) and African Americans (22.6%) live below FPL (\$11,170/year for an individual and \$23,050/year for a family of four in 2012).

Population Living Below the Poverty Line



SOURCE: 2010 ACS

Figure 7

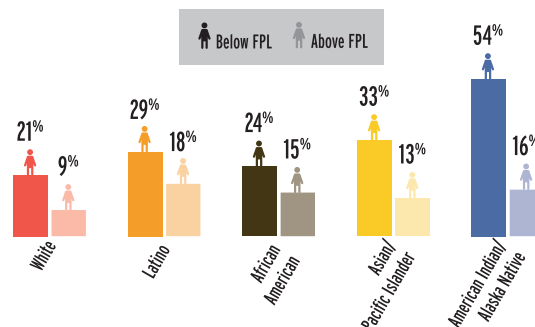
Investment in Future Generations

Recently, EARN partnered with Families in Schools, Greenlining Institute, Long Beach Interfaith Community Organization, and PICO federations in the Central Valley to host 70 listening sessions throughout California. Nearly 1,000 constituents shared their experiences with developing skills to improve family wealth. Many constituents believe that financial education is an asset that can provide a better and more secure future for themselves and their children. EARN and its partners are using these stories to develop a policy agenda that addresses improving access to financial education for low-income families. Thanks to these efforts many more organizations, individuals, and families who previously did not focus on wealth building for low-income individuals and families are now prioritizing this issue. As a result, EARN has expanded its children's matched savings account program for low-income families outside the Bay Area to connect more families to education savings.

For more information about EARN visit: www.earn.org.

Rates of self-reported poor or fair overall health are much higher for those who are living below the poverty level (see *Figure 8*). For example, American Indians/Alaska Natives living below FPL perceive their health as poor or fair twice as often as those above FPL (54% vs. 16%). The same is true for Asians living below FPL, who report being in poor or fair health at nearly triple the rate (33% vs. 13%).

Poor or Fair Overall Health Compared by Poverty Level



SOURCE: 2009 CHIS

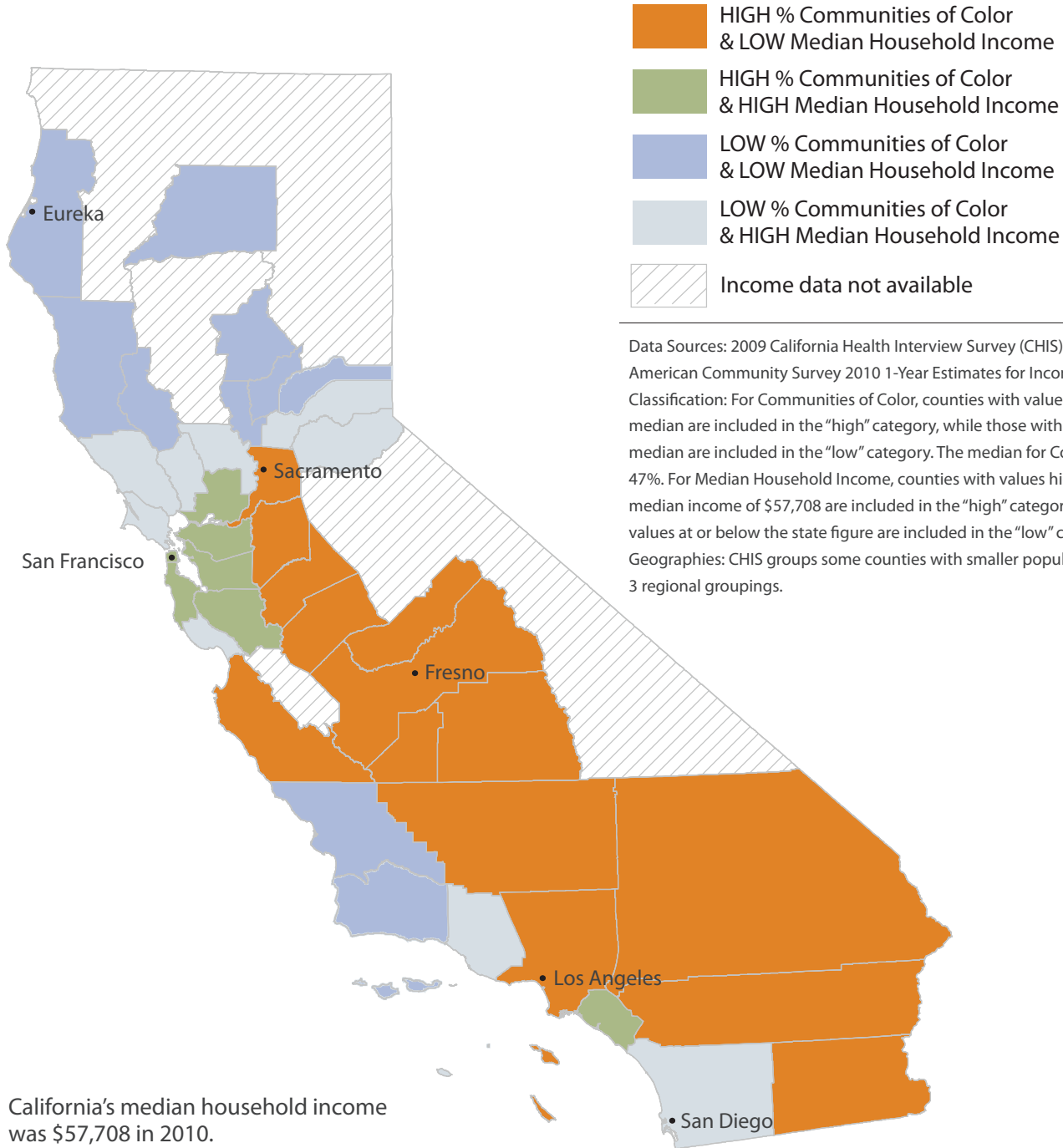
Figure 8

In addition, many see FPL as an outdated measure that does not take into account what families need to earn to meet basic needs. A more realistic analysis of what families need is the Self-Sufficiency Standard, developed in 1996 by Dr. Diana Pearce and updated in 2008 with support from the Insight Center for Community Economic Development. This standard ranges, depending on county, from roughly \$37,000 to \$63,000 for a family of two adults and one child, and is a better indicator of how much money a family needs to pay for basics like food, housing, medical care, and other expenses. With 52% of households suffering from insufficient income, Latinos have the highest rate of income inadequacy in California, followed by African Americans (39%), American Indians/Alaska Natives (34%), Native Hawaiians/Pacific Islanders (31%), Asians (26%), and Whites (18%).¹⁸



Map 2

Median Household Income and Communities of Color



California's median household income was \$57,708 in 2010.

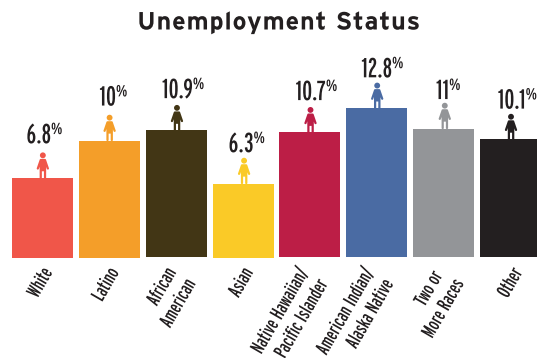
Merced, Tulare, and other counties in the San Joaquin Valley have some of the state's lowest median household incomes. These counties also have some of the highest numbers of communities of color.



Employing Equity

Our economic wellbeing largely depends on the employment opportunities available to us. A well-paying job helps us put a roof over our heads and healthy food on the table. In addition, good jobs can provide health-promoting benefits, including health insurance, paid sick leave, vacation time, and retirement savings to help us when we get older. Unfortunately these quality jobs are few and far between. The economic downturn has seen unemployment rates rise across all racial and ethnic groups, with one in five Californians (21.6%) either unemployed or working part-time due to a lack of full-time job opportunities.¹⁹

Limited by continued racism, housing segregation, lack of access to quality education, and language barriers, members of our communities often struggle to find jobs. Even harder to come by are jobs that pay a living wage and are situated near our homes, offer regular hours, or extend sick leave or vacation time to employees.²⁰ Even the unemployment numbers for those who work as little as one hour per week show significant disparities. As of 2010 in California, one in ten American Indians/Alaska Natives (12.8%), African Americans (10.9%), Native Hawaiians/Pacific Islanders (10.7%), and Latinos (10%) were unemployed, compared to only 6.8% of Whites (see *Figure 9*).



SOURCE: 2010 ACS

Figure 9

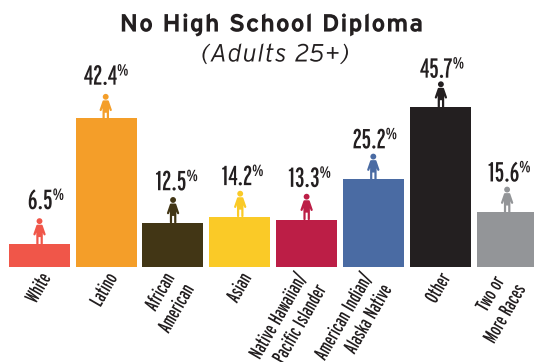
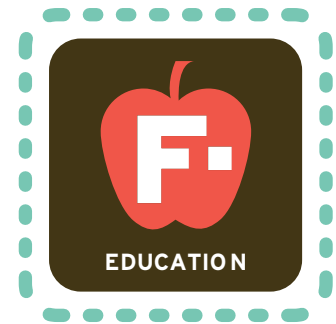
But even when we are steadily employed, our jobs may not provide us with benefits that promote health. Over 5 million workers in California (about 40% of the workforce) go without paid sick leave, forcing them to make an impossible choice: between getting better or losing pay, between keeping a job or infecting others.²¹ To address this issue, San Francisco adopted the first mandatory paid sick leave policy in 2007, requiring all employers in the city to provide paid sick leave to their employees. In the policy’s first four years, 59,000 workers, or 17% of San Francisco’s labor force, who previously did not receive paid sick days now do. African American, Latino, and low-wage workers were the most likely to benefit from the new policy, but were also the most likely to report employer non-compliance. Despite the reluctance of some employers to offer paid sick leave, two-thirds of the city’s employers support the ordinance.²² The San Francisco policy is just the beginning, and efforts are ongoing to expand paid sick leave on state and national levels.



From Homeroom to Health

The ability to secure quality jobs hinges in large part on our level of educational attainment, and the quality of the education we receive.²³ Often, communities of color have limited options in the types of schools we can attend, and schools in low-income communities are likely to be of lower quality.²⁴

Educational disparities begin early in California. Roughly one-third of African American, Latino, and American Indian/Alaska Native students scored proficient or advanced on the third-grade state language arts exam, compared to three-fifths of White students.²⁵ These disparities continue as students progress through the school system. More than two out of every five Latino adults in California do not have a high school diploma, and at only 10%, Latinos are the least likely to hold bachelor's degrees. African American and American Indian/Alaska Native adults also lack diplomas at higher rates than Whites, and are far less likely to have a bachelor's degree. These numbers are greatly impacted by California's drop-out rate, which is the third highest in the nation, behind Mississippi and Texas.²⁶ As you can see in *Figure 10*, the percentage of Latinos without high school diplomas is over six times that of Whites, and the number of American Indians/Alaska Natives is nearly four times that of Whites. African American, Asian, and Pacific Islander adults also lack high school diplomas twice as often as their White counterparts. Studies show some of the factors that correlate with high dropout rates include the school district's poverty level, poor teacher quality, and a lack of student competitiveness.²⁷ Not finishing high school can have significant long-term effects. Students who do not graduate high school are less likely to have regular, steady jobs, and they earn less when they have jobs compared to their peers who graduate.³⁸



SOURCE: 2010 ACS

Figure 10



Poor graduation rates are not the only challenge facing California's educational system. Over the past several years, public education has been dramatically impacted by the state's ongoing budget crisis. From K-12 to community colleges to the UC System, funding cuts have decreased both the quality and affordability of the education our children receive. California ranks 46th out of the 50 states in spending per student on K-12 education.²⁹ Perhaps hit hardest by budget cuts is the state's community college system, which low-income families and people of color rely heavily upon. Since the 2008-09 fiscal year, California has cut funding to its 112 community colleges by nearly \$1 billion, forcing the system to reduce enrollment by 284,000 students.³⁰ These cuts have hurt our communities' ability to receive job training and English as a second language classes, which contributes to elevated unemployment rates. If California cannot raise the revenues to adequately fund public education, our school system will continue to deteriorate and enrollment in higher education will cease to be an option for millions of Californians.

Many communities of color are also underrepresented in California's public university system. These disparities are the result of Proposition 209, passed in 1996, which ended affirmative action in admissions and financial aid at state schools. This decision had immediate repercussions—in the first three years, admissions of African American, Latino, and American Indian/Alaska Native undergraduates dropped over 50% at schools like UC Berkeley and UCLA. While the percentages of undergraduate students from these communities have grown in the decade since, their numbers have never fully recovered. For example, at UC Berkeley in 1995, these groups made up 27% of the student population, compared to just 17% today.³¹





Policy Recommendations

Demographic and Socioeconomic Factors

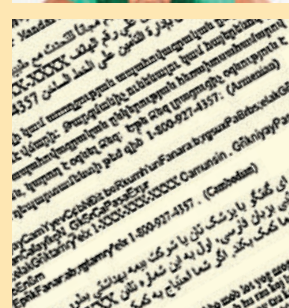
Improvements to our education system and increased job opportunities could have a deep impact on health inequities. Quality education for all, especially within low-income communities, will likely improve access to higher paying jobs. This will result in more options for where we live, whether we can go to the doctor, and what foods we eat.

- **Ensure Culturally and Linguistically Appropriate Services:**

Culturally competent services in all sectors are critical to meeting the needs of California's diverse population, helping ensure that equal access to quality services are provided to everyone regardless of their race, ethnicity, language, and other characteristics such as sexual orientation, gender, and disability. Cultural competency includes understanding the population served, recruiting a workforce that reflects that population, and training current staff on how to most effectively communicate with diverse clients. In addition, programs and services at all levels of government must be accessible to people with limited-English proficiency. We must allocate sufficient resources within state agencies and departments to implement current language access laws, such as Dymally-Alatorre and Title VI, and make sure these requirements are fully enforced.

- **Improve Data Collection:** Data collection is essential in identifying and tracking inequalities in income, job opportunity, education, and health care. We must institute standard systems to collect and analyze race, ethnicity, and language data to identify patterns of discrimination and develop policies and practices to promote equal opportunity and access. Because of the state's diversity, California must go above the federally required data categories and collect granular data on subpopulations, as recommended by the Institute of Medicine's report, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*.³²

- **Modernize the Federal Poverty Level:** The current poverty level does not reflect the true cost of living today. The Self-Sufficiency Standard shows that a family of two adults and one child can require an annual income from \$37,000 to \$63,000—well above the amount of the Federal Poverty Level—to cover basic expenses.³⁶ Changing the federal poverty level to reflect an income level that meets current basic needs and geographic differences would help individuals and families access services they need to thrive.





- **Increase Job Opportunities in Low-Income Communities:** We need to work with local and statewide elected officials to create short- and long-term job creation plans that offer stable jobs and a living wage to those hardest hit by the economic downturn. Hiring credits have been an effective tool in addressing high levels of unemployment and could provide a powerful short-term boost.³² However, we also need to think about California's long-term strategy to improve job development. In doing so, we should be innovative in our approach by identifying growing job sectors and determining how best to train students and displaced workers for these positions. For example, the health care industry has the potential to create an estimated five million new jobs nationally through innovative approaches to primary care, chronic disease management, and geriatric services.³⁴ We could see many of these jobs opening up in our state. Additionally, by investing in California's public infrastructure, 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.³⁵
- **Improve Quality Education:** Early childhood education provides the foundation for lifelong learning and academic success. Affordable preschool that is geographically accessible, especially to low-income children of color, is essential. Funding for California's K-12 schools ranks lower than most states. While long-term solutions will require a restructuring of the funding system for schools, in the short term education funding must at least be increased to reflect the national average. Additional resources should be provided to assist with academic needs, especially for students living in poverty and those learning English as a second language. Fully-prepared teachers will also help students succeed. We must ensure that our educators are ready for the classroom and that we have enough teachers for every school district in the state. Students should also be prepared for higher education as early as possible through rigorous curricula and academic and social supports throughout their school career. Additionally, students and their families must have readily available information about the costs, requirements, options, and opportunities associated with higher education. 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.



ENVIRONMENTAL FACTORS

Breathing Easy

In addition to the socioeconomic factors that influence our wellbeing, our environment also determines how healthy we are. The air we breathe, in particular, has a tremendous impact on our health.³⁷ Studies have shown that communities of color and low-income communities are more likely to live in areas with high exposure to pollutants, which can lead to higher levels of asthma and other respiratory conditions as well as cardiovascular events, low birth weight, and premature deaths.^{38, 39} Six of the ten most ozone-polluted counties in the U.S. are in California, and correlates closely with where communities of color live.⁴⁰ Not coincidentally, as seen in *Figure 11*, certain communities of color in the state are also among those more likely to experience higher rates of asthma. The majority of air pollution in California comes from vehicles, power plants, and industrial and agricultural activities.

In an effort to combat air pollution across the state, California passed Senate Bill 375 (Steinberg) in 2008. This unprecedented legislation focuses on the development of sustainable communities strategies, which attempt to meet greenhouse gas reduction targets for long-term regional land use and transportation plans. If implemented properly, SB 375 has the potential to vastly improve our quality of life in California. This legislation can also help the state deal with population growth more efficiently by confronting traffic congestion, declining air quality, increases in greenhouse gas emissions, and the distance we travel between our jobs and our homes.⁴¹ In addition, reductions in fuel, infrastructure, energy, and water costs could save the average family \$3,000 to \$4,000 each year.⁴²

By integrating transportation, land use, affordable housing, and climate goals, SB 375 has dramatically increased public participation in regional planning by bringing together stakeholders from each of these sectors.⁴³ Stakeholder input is crucial for SB 375 to accomplish its intended goals and improve air quality in regions of the state where pollution has already resulted in higher rates of asthma and other respiratory conditions.

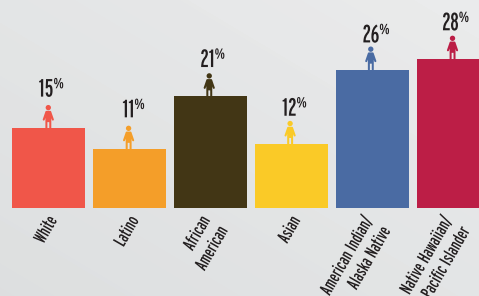
SB 375 is just a start toward improving air quality in California, and more needs to be done to curb motor vehicle emissions, a major source of pollution in the state. Living in heavy traffic areas exposes individuals to air



Asthma

Rates of doctor-diagnosed asthma are highest in Native Hawaiians/Pacific Islanders (28%), American Indians/Alaska Natives (26%), and African Americans (21%). In addition, the rate of preventable hospitalizations for asthma in the African American community is over three times that of any other race or ethnic group, due in part to lower quality out-patient care.⁴⁴ And while the asthma rate for Latinos is the lowest in the state, this could be the result of high numbers of undiagnosed cases.⁴⁵

Ever Diagnosed with Asthma



SOURCE: 2009 CHIS

Figure 11



pollutants which can irritate the lungs, especially for people with respiratory diseases. Traffic exhaust from gasoline- and diesel-powered engines can damage sensitive tissues, and can lead to hospitalizations and missed work or school. It is more common for people of color to live near high-traffic areas due to a lack of affordable housing options in lower-traffic areas. Latino children with asthma are more than twice as likely to live near high-traffic areas (28%) as White children (12%). African American children also face this disparity, with 20% living near high-traffic areas.⁴⁶

The state's position as the nation's foremost agricultural producer also has a profound impact on air quality, particularly in the San Joaquin Valley. Agriculture-related pollution stems from activities like land cultivation, pesticide application, and harvesting.⁴⁷ As a result, in the Valley—which suffers from some of the worst air quality in the country—air pollution increasingly leads to premature deaths from respiratory disease, and asthma is quickly becoming an epidemic. The asthma rate for the eight San Joaquin Valley counties (17.3%) is over 20% higher than the average for the state (13.7%).⁴⁸ This is due in part to the Valley's unique topography trapping harmful emissions both from agricultural work and other vehicles. These higher asthma rates can lead to missed school and work, increased health care costs, and ultimately death.⁴⁹

Importing food from outside the state also poses serious health risks due to emissions from freight transport. For example, approximately 950 cases of asthma, 16,870 missed schools days, 43 hospital admissions, and 37 premature deaths could be attributed to the worsened air quality from food imports, according to projections by the California Air Resources Board.⁵⁰

Map 3 shows the counties that do not meet the state air quality standard for particulate matter (PM) pollution. Particulate matter consists of microscopic particles that can bypass the body's natural defenses and go deep into the lungs. This matter has a particularly harmful effect on children, the elderly, and people with respiratory or cardiac conditions. Studies have shown that PM may worsen asthma in children, and prolonged exposure may affect the growth and functioning of children's lungs.

As seen in the map, areas such as Los Angeles and the San Joaquin Valley, where high concentrations of people of color live, also have the highest levels of particulate matter in the air. Within each of the counties, exposure to the PM varies considerably. Low-income and people of color are often closer to sources of particulate matter.⁵¹



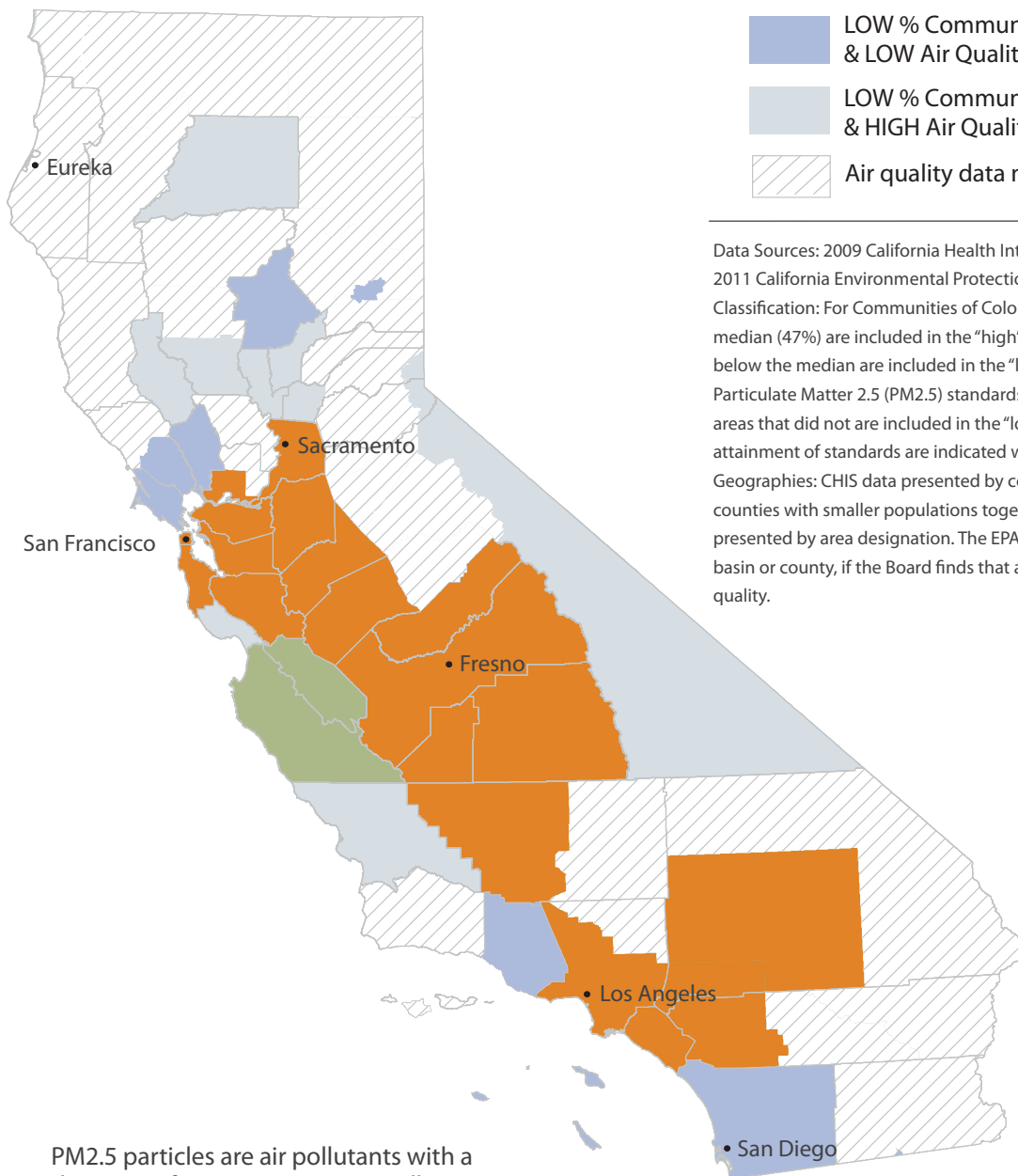


Map 3

Air Quality and Communities of Color

- HIGH % Communities of Color & LOW Air Quality (PM2.5)
- HIGH % Communities of Color & HIGH Air Quality (PM2.5)
- LOW % Communities of Color & LOW Air Quality (PM2.5)
- LOW % Communities of Color & HIGH Air Quality (PM2.5)
- Air quality data not available

Data Sources: 2009 California Health Interview Survey (CHIS) for Race/Ethnicity, 2011 California Environmental Protection Agency (EPA) for Air Quality
 Classification: For Communities of Color, counties with values higher than the median (47%) are included in the "high" category, while those with values at or below the median are included in the "low" category. For Air Quality, areas that met Particulate Matter 2.5 (PM2.5) standards are included in the "high" category while areas that did not are included in the "low" category. Areas with unclassified attainment of standards are indicated with hash marks.
 Geographies: CHIS data presented by county or county groups. CHIS groups some counties with smaller populations together into 3 regional groupings. EPA data presented by area designation. The EPA may designate areas smaller than an air basin or county, if the Board finds that a smaller area has distinctly different air quality.



PM2.5 particles are air pollutants with a diameter of 2.5 micrometers, small enough to enter even the smallest airways. The state standard for PM2.5 is less than 12 micrograms per meter cubed as an annual average.

Statewide only 15% of area designations achieved PM2.5 air quality standards in 2009.



Healthy Homes, Healthy People

While our environment can seriously affect our health, our immediate living conditions also have a profound impact. We all want to have a place we can call home, where we spend time with family and feel safe and secure. Some Californians live in homes they can easily afford, with enough room for every member of the family, and minimal exposure to pollutants or allergens that make them sick.⁵² Quality, affordable housing relieves us of the stress of struggling to make rent and ensures that we have enough money left over to pay for transportation to work, health insurance, and other necessities that contribute to our wellbeing. The generally accepted definition of affordability from the U.S. Department of Housing and Urban Development states that a household should pay no more than 30% of its annual income on housing. Despite this, over 40% of Californians pay more than that on their housing each year.⁵³ As a result, many in low-income areas and communities of color live in substandard housing conditions and often do not have the means to make improvements and alleviate conditions that are making them sick in their own homes.⁵⁴

A number of factors related to housing—from quality to affordability—can affect our health in many ways. Dilapidated housing can lead to increased exposure to lead, asthma triggers (including mold, moisture, dust mites, cockroaches, and rodents), and violence and social isolation.⁵⁵ These environmental triggers are more present in communities of color.

Our ability to afford quality housing—free of environmental triggers—has been dramatically curtailed due to the recent recession, with the housing crisis disproportionately impacting people of color. Though representing just 30% of homeowners in the state, African Americans and Latinos make up half of those who have gone through the foreclosure process. In 2010, nearly one out of every eight homes in California was in foreclosure, with African Americans and Latinos facing foreclosure rates twice that of Whites. These numbers are particularly noteworthy when you consider that fewer than half of African Americans and Latinos in the state own their homes, compared to nearly three-quarters of Whites.⁵⁶ These disparities are the result of predatory lending practices by banks that led to 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%).⁵⁷

The lack of quality, affordable housing can lead to family stress and related conditions, such as hypertension and poor mental health. Families who are behind on rent or mortgage payments are nearly three times more likely to forego needed medical care. They are also far more likely to experience food and energy insecurity.⁵⁸ Foreclosures damage families through displacement and decreased generational wealth. Overcrowding, another symptom of the lack of affordable housing, can adversely impact health by causing stress, respiratory illnesses, and a decrease in overall health.⁵⁹

Smoke-Free Housing in Sonoma County

On December 3, 2011, Sonoma County's new smoke-free outdoor areas ordinance went into effect, making it one of the strongest smoke-free ordinances in California. Beginning January 12, 2013, smoking will be banned in all existing units of multi-unit residences. The ordinance was a big win for the Sonoma County Asthma Coalition, which has made smoke-free multi-unit housing one of its key priorities over the last three years. Sonoma County ranks in the top five least affordable counties for housing in the nation, leading to overcrowding and shared housing, and increasing the likelihood of exposure to secondhand smoke for low-income and Latino families.

For more information about the Sonoma County Asthma Coalition visit: www.sonomaasthma.org.

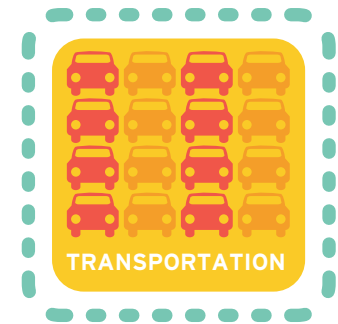


The Road to Wellness

Where we live also impacts how we get around our cities and towns. Living in a neighborhood with sidewalks, pedestrian-friendly traffic patterns, and convenient public transportation makes it easier to be active and access important services.⁶⁰ Residents in low-income areas and communities of color are often less likely to own a car, so they may rely more on public transportation to go to work, the doctor, or the grocery store.⁶¹ African Americans (12%) are four times more likely than Whites (3%) to not own a car, and Latinos and American Indians/Alaska Natives are three times more likely (10% each).⁶² People making between \$20,000 and \$30,000 annually typically spend almost a third of their income (31%) on transportation, compared to just 8% for those making over \$100,000.⁶³

Better pedestrian safety would encourage more walking and biking in California, where 6,957 pedestrian fatalities occurred between 2000 and 2009. Using the National Safety Council's estimate that each traffic death is equal to about \$4.3 million in economic costs and diminished quality of life, pedestrian fatalities have cost California \$29.9 billion over the last decade. These deaths disproportionately impact communities of color: from 2000 to 2007, the average pedestrian death rate for Latinos was 3.1 per 100,000 people and for African Americans it was 2.8, considerably higher than the rate for Whites (1.6).⁶⁴ See *Map 4* on page 24 for a representation of where pedestrian fatalities occur in California and where people of color live.

California has an opportunity to dramatically reduce pedestrian accidents. As many as 67% of pedestrian deaths in the state occurred on roads that are eligible to receive federal funding for construction and improvement because they are part of the federally defined national highway system (as opposed to local streets and minor connectors).⁶⁵ It is important that the state use this funding to create safe streets for all users, using sidewalks, dedicated bike paths, and traffic calming measures to make it safer and easier to bike or walk to school and other activities and services. In the last forty years, the number of school children who walked or bicycled to school has dropped from 50% to about 15%.⁶⁶



Community Involvement Leads to Healthier, Safer South Merced

The dangerous intersection of Highway 59 and Childs Avenue in Merced had long been in need of a traffic signal and crosswalk. Due to bureaucracy, this traffic signal never materialized until community residents, as part of the Healthy South Merced project, and Golden Valley Health Centers' clinic staff gathered signatures for a petition and spoke before the City Council to voice their concerns about the hazards drivers and pedestrians face every day. As a result of the residents' advocacy for safe streets for all users, the traffic signal was finally installed in September 2009 and the crosswalk is close to completion.

For more information about the Healthy South Merced project and Golden Valley Health Centers visit: www.gvhc.org.

Map 4

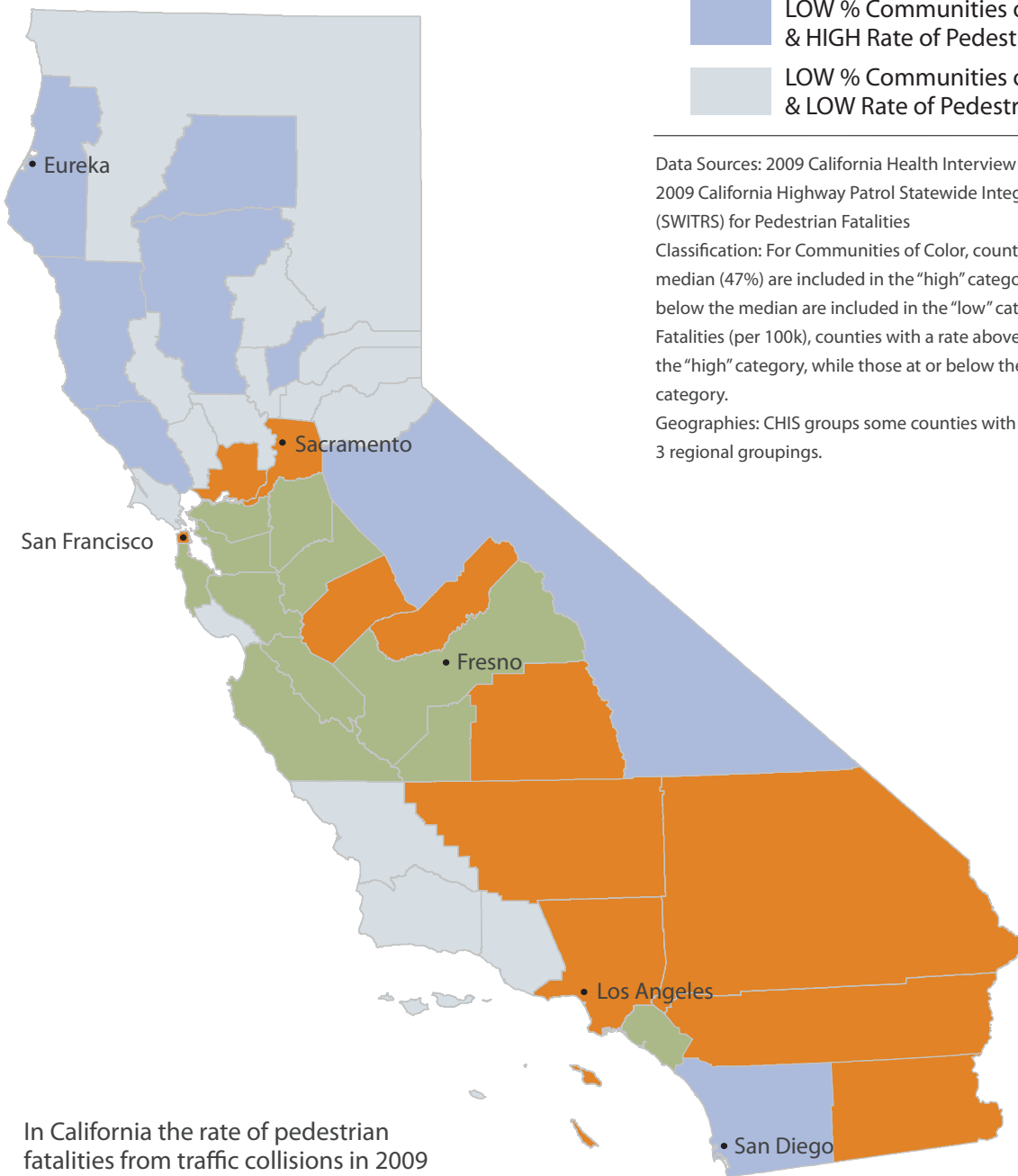
Pedestrian Fatalities and Communities of Color

- HIGH % Communities of Color & HIGH Rate of Pedestrian Fatalities
- HIGH % Communities of Color & LOW Rate of Pedestrian Fatalities
- LOW % Communities of Color & HIGH Rate of Pedestrian Fatalities
- LOW % Communities of Color & LOW Rate of Pedestrian Fatalities

Data Sources: 2009 California Health Interview Survey (CHIS) for Race/Ethnicity, 2009 California Highway Patrol Statewide Integrated Traffic Records System (SWITRS) for Pedestrian Fatalities

Classification: For Communities of Color, counties with values higher than the median (47%) are included in the "high" category, while those with values at or below the median are included in the "low" category. For the Rate of Pedestrian Fatalities (per 100k), counties with a rate above the state rate of 1.6 are included in the "high" category, while those at or below the state rate are included in the "low" category.

Geographies: CHIS groups some counties with smaller populations together into 3 regional groupings.



In California the rate of pedestrian fatalities from traffic collisions in 2009 was 1.6 deaths per 100,000 persons.

Los Angeles County has the highest number of pedestrian fatalities, as well as high numbers of communities of color.



Policy Recommendations

Environmental Factors

Improving our physical surroundings would promote better health. Ensuring that we can live in healthy homes, breathe clean air, and can easily get around in our neighborhoods will help to reverse the trend of inequities we face every day.

- **Incorporate Health in Land Use Planning:** Careful neighborhood planning can have long-term positive effects on our health. Public health officials and community members should advocate for the inclusion of health-promoting features into General Plans, Regional Transportation Plans, Sustainable Community Strategies, and other land use policies. For example, by including a Health Element in General Plans—or ensuring that health is considered in existing elements—cities and counties will be better equipped to make neighborhoods more walkable, increase access to healthy food retail, protect residents from pollution, and connect residents to jobs and services via transit.
- **Integrate Health into State Decision-Making Processes:** There are many ways in which the state can invest resources to promote health and healthy communities. One way is to encourage state agencies and departments to incorporate health and equity into grant applications, review criteria, and performance measures for state funding. The state can also prioritize training and technical assistance to state and local agencies on how to incorporate health into multiple planning processes. By facilitating collaboration between local and state departments, such as public health, traffic and safety, and air quality boards, we can encourage data and information sharing and innovative partnerships. We must continue to support state government efforts to take a “health in all policies” approach and encourage interagency collaboration. Finally, as community members increasingly engage in regional and local planning processes, state and local agencies should provide meaningful access to all residents, including holding meetings in local communities, near public transportation, at after-work meeting times, and providing interpreters for limited-English proficient residents.
- **Improve Air Quality:** We can improve our air quality by reducing our dependence on motor vehicles and promoting a broader range of transportation choices, including public transit. We must also prioritize reductions in pollution generated through ports, high-volume roadways, and railroads. The state should take the lead by investing in programs to reduce emissions from our existing fleet of trucks such as retrofitting diesel





vehicles and requiring effective inspection and maintenance programs for medium- and heavy-duty vehicles. We must also support renewable energy sources and strengthen fuel efficiency policies.⁶⁷

California has been a leader in developing standards to reduce greenhouse gas (GHG) emissions. Most recently, several state and regional agencies have been active in implementing SB 375, which requires each region to develop a plan for reducing GHG emissions from cars and light trucks through integrated land use, transportation, and housing planning. As regions begin adopting their strategic plans, state agencies should work together to develop performance indicators and reporting standards to make it easier to understand and compare plans. Finally, state agencies should work closely to ensure the requirements of SB 375 are met.⁶⁸

Prioritizing Health in Transportation Projects

Transportation projects, such as freeways and railyards, planned in close proximity to homes, schools, and senior centers pose increased health risks. In low-income communities of color in Commerce, Long Beach, and East Los Angeles, East Yard Communities for Environmental Justice (EYCEJ) has used empowerment, education, and policy change to ensure that the community and public health is at the forefront when planning transportation-related projects. Their tenacious advocacy has resulted in a proposed redesign of the I-710 Freeway Expansion Project that could significantly reduce displacement of community members. A coalition of advocates is also conducting a Health Impact Assessment of the Expansion Project, the first assessment of a freeway infrastructure project in the nation. This stands as a model so that the local residents have the opportunity to grow pollution free in safe and healthy environments.

For more information on East Yard Communities for Environmental Justice visit: www.eycej.org.

- **Improve the Condition of Neighborhood Housing:** We must prioritize ways to improve the availability of healthy, affordable housing. To accomplish this, we must first identify permanent sources of funding for affordable housing to ensure there are enough resources and outreach to disadvantaged communities for emergency housing assistance and loan assistance programs.⁶⁹ The state should promote sustainable development through “smart” housing siting, providing incentives like funding for infill and transit oriented developments.⁷⁰ We should also concentrate on healthier community development by designing neighborhoods that have access to community gardens and are within walking distance of grocery stores, parks, and other community resources.

State agencies should continue to work together through the Strategic Growth Council and the Health in All Policies Taskforce to mitigate adverse environmental and public health impacts in housing developments situated near urban roadways and transportation corridors.⁷¹

- **Encourage Healthy Transportation Policy:** Transportation policy should encourage safe streets for all users, including bike paths, sidewalks, and trails. We must encourage all government-funded road infrastructure projects to address the safety and mobility of our communities by prioritizing practices that promote traffic calming and improve pedestrian safety. Additionally, we should work with regional planning organizations to ensure that health and equity factors are integrated in local and regional planning processes so we can understand the health impacts of transportation policies as they are being envisioned.



NEIGHBORHOOD SAFETY AND VIOLENCE

Safety First

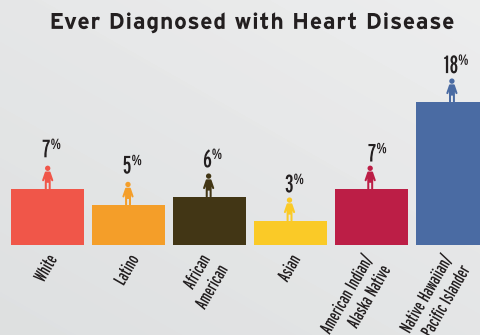
In order to create safe communities that encourage physical activity and social interaction, we must concentrate on reducing violence in our neighborhoods. The safer our communities are, the more likely we are to walk or bike in our neighborhood, socialize with our neighbors, and take public transit.⁷² Conversely, the fear of violence—real or perceived—leads to increased isolation, psychological distress, and prolonged elevated stress levels.⁷³ Increased violence in our neighborhoods also leads to high incarceration rates, which destabilize our communities by removing parents, children, brothers, and sisters. By breaking up families and support systems, we see higher rates of financial instability, poorer housing conditions, and higher levels of stress, one of the factors that can increase risk of heart disease (see *Figure 12*).

Current research indicates that developing relationships, feeling a sense of belonging, and being able to rely on those around us for support all promote wellbeing by reducing stress, improving mental health, increasing positive health-related behaviors, and expanding our access to services and amenities.⁷⁴ Strong community ties help buffer against the ill effects of stress by having a positive impact on what we eat, our level of physical activity, and whether we smoke.⁷⁵ Residents of connected neighborhoods also benefit from a stronger political voice, which can be used to better advocate for their needs. Through coordinated advocacy, these communities can be more successful in their efforts to reduce crime, increase safety, and bring health-promoting resources into their neighborhoods.⁷⁶



Heart Disease

American Indians/Alaska Natives suffer from heart disease at higher rates than any other group, with 18% of the population receiving a diagnosis. This rate is over twice that of Whites at 7%. Despite a relatively low 6% heart disease diagnosis rate, cardiovascular diseases rank as the number one cause of death for African Americans, accounting for more than one-third of all deaths.⁷⁷



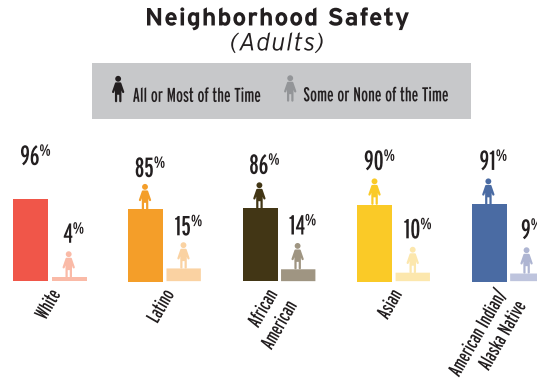
SOURCE: 2009 CHIS

Figure 12



Neighborhood Safety

As we see all too often as a pattern across the state, there are noticeable differences in how safe we feel at home based on our race and ethnicity. A higher percentage of people of color report feeling unsafe in their own neighborhoods than do Whites. Roughly one out of every seven African American and Latino adults feels safe only some of the time or not at all (14% and 15%, respectively) compared with far fewer Whites (4%) who feel the same way (see Figure 13).



SOURCE: 2009 CHIS

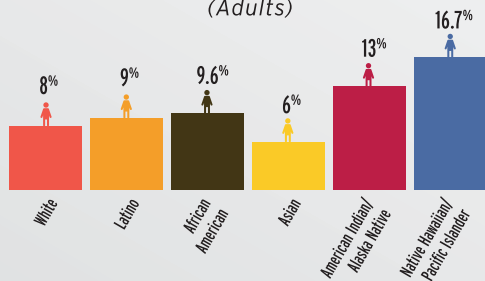
Figure 13

Not feeling safe in one's neighborhood is correlated with increased levels of psychological distress. For example, as seen in Figure 14, American Indians/Alaska Natives who perceive their neighborhood as unsafe are more than twice as likely to experience psychological distress as those who perceive their neighborhood as safe (25% vs. 10%). In addition, American Indians/Alaska Natives have twice the rate of mental health needs of Whites (16.7% vs. 8%) (see Figure 15).

Mental Health

Our mental health affects our wellbeing, with depression, anxiety, and other conditions posing severe threats. As many as 2.2 million Californians report mental health needs, with some significant disparities among the state's diverse population groups. Adults with mental health needs are 1.5 times more likely to have high blood pressure, heart disease, or asthma compared to other adults.⁷⁸

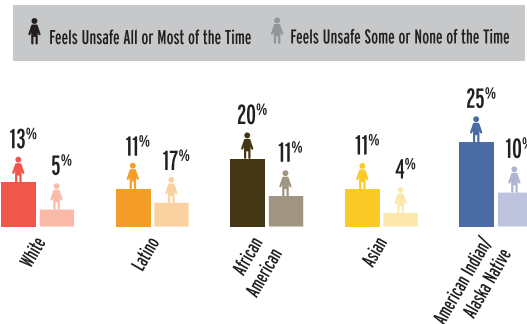
Mental Health Needs (Adults)



SOURCE: "Adult Mental Health Needs in California: Findings from the 2007 California Health Interview Survey." UCLA Center for Health Policy Research. November 2011.

Figure 15

Psychological Distress and Neighborhood Safety (Adults)

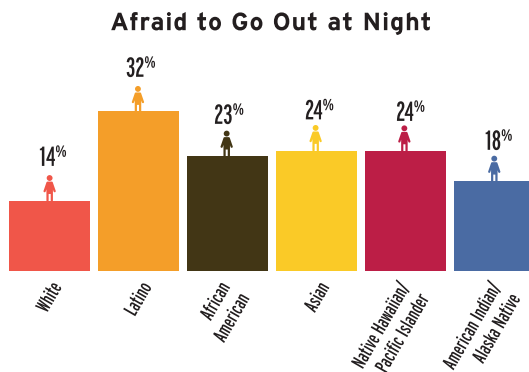


SOURCE: 2009 CHIS

Figure 14



Living in a neighborhood that is perceived to be unsafe at night creates an additional barrier to regular physical activity and social cohesion, especially among women living in urban low-income housing.⁷⁹ People of color are more likely than Whites to report being afraid to go out at night. Over one in five Latinos, African Americans, Asians, and Native Hawaiians/Pacific Islanders report being afraid to go out at night compared to only 14% of Whites (see *Figure 16*). *Map 5* on page 30 shows where teens who feel safe in nearby parks at night live, which inversely correlates to where communities of color reside.



SOURCE: 2003 CHIS

Figure 16

Neighborhood Values

People of color are more likely to report that they do not share the same values or get along with their neighbors. For instance, fewer people of color report they trust their neighbors than Whites. Only 75% of Latinos, American Indians/Alaska Natives, and African Americans agreed with the statement compared to 90% of Whites—a difference of one in four people finding their neighbors untrustworthy, compared to one in ten.⁸⁰

Over one in four Latinos (28%) reported that their neighbors don't get along, compared to less than one in ten Whites (9%). Other racial/ethnic groups also report higher rates of not getting along with their neighbors than Whites, ranging from 14% to 20%.⁸¹

Approximately half of Asians (51%), Latinos (50%), American Indians/Alaska Natives (48%), and African Americans (45%) living in California report that their neighbors don't share their values.⁸²

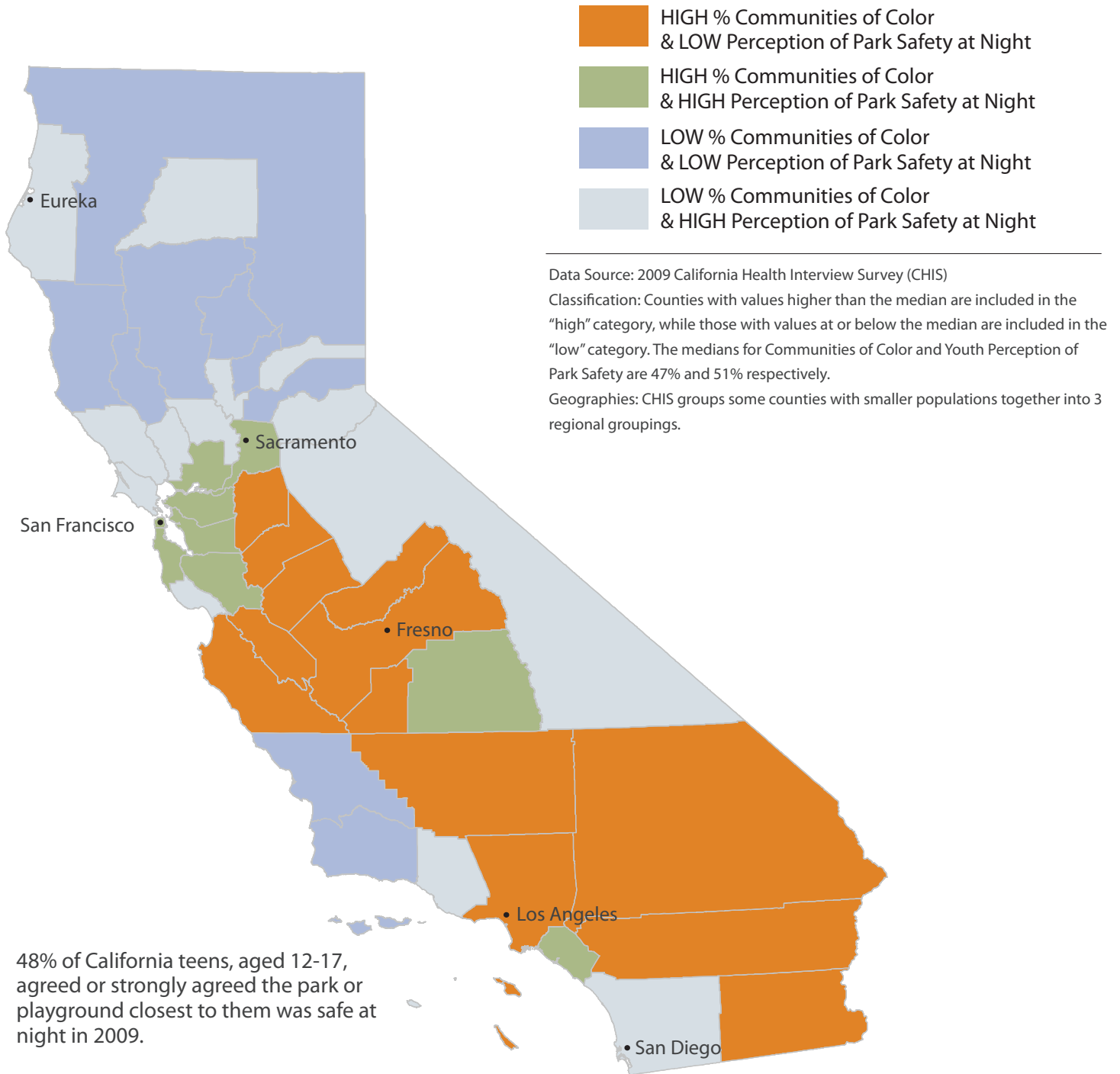
Healthy Planning in Fresno

As the City of Fresno works to adopt a Downtown Neighborhoods Community Plan and its 2035 General Plan Update, Fresno Metro Ministry has been working with a coalition of partner organizations to engage a wide spectrum of community members in the planning processes. Through the Smart Valley Places Community Leadership Institute and the Building Healthy Communities collaboration, Fresno Metro Ministry has kept health outcomes, safety, and quality of life for residents of neglected neighborhoods at the center of the discussion. Dozens of Spanish and Hmong residents packed a Fresno City Council meeting in April 2012 to speak out in support of a plan that directs resources to improve existing neighborhoods. And their advocacy was a success: in mid-April, the Fresno City Council picked a theme for the 2035 general plan update that stresses infill development and higher-density living, saying goodbye to future sprawl.

For more information on Fresno Metro Ministry visit: www.fresnetmin.org.

Map 5

Teen Perception of Park Safety at Night and Communities of Color



48% of California teens, aged 12-17, agreed or strongly agreed the park or playground closest to them was safe at night in 2009.

San Joaquin Valley teens, such as those in Merced County, have the lowest perception of park safety at night in the state, as well as high numbers of communities of color.



Crime and Unequal Punishment

Violence in our communities and our current criminal justice system have far-reaching effects on communities of color. Low-income individuals and people of color tend to live in neighborhoods with higher rates of crime, which can have a significant impact on how often we leave our homes, whom we befriend, and our mental wellbeing.^{83, 84}

Crime and violence in our communities have many different roots, but a lack of jobs and income, oppression, and poor mental health are among the most prevalent.⁸⁵ The experience of crime can directly affect health through bodily harm, economic hardship, and emotional trauma. Fear of crime can indirectly affect health by increasing stress and social isolation, and preventing physical activity and access to services.⁸⁶

Violent death and injury rates are higher among people of color. For African American men in California, homicide is third on the list of causes of death, accounting for 5.3% of deaths, just behind heart disease and cancer. For Latino men, homicide is the seventh leading cause of death, at 4.2% of all deaths. By contrast, for White men, homicide is not in the top 10 causes of death.⁸⁷

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.⁸⁸

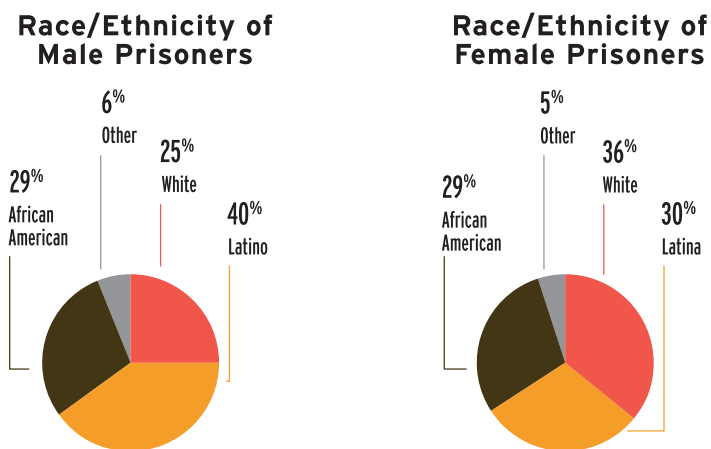
However, increased rates of incarceration have disproportionately impacted people of color. Three out of every four male prisoners in the state's correctional facilities are non-White. Though they represent just 6% of the adult population, African Americans make up 29% of the state's male and female prison population (see *Figure 17*).⁸⁹ African Americans are incarcerated at over six times the rate of Whites (2,992 per 100,000 compared to just 460).⁹⁰



A Time For Change

Working to break the cycles of homelessness and recidivism, Time For Change Foundation has been changing the lives of homeless women and children since 2002. Time For Change emphasizes advocacy along with its direct services. Because Time For Change focuses on advocacy and leadership development, it is creating leaders to be agents of change, empowering women to make a difference. One example is Juanita, who was trained as an advocate and went on to testify before the California Assembly's Budget Committee on the importance of providing access to food stamps for people returning home from prison. Thanks to the hard work of Juanita and other advocates, the bill to expand access to food stamps continues to make it through the legislature, and hopefully it will become law by the end of the year.

For more information about the Time For Change Foundation visit: www.timeforchange.org.



SOURCE: "Just the Facts: California's Changing Prison Population." Public Policy Institute of California. July 2011.

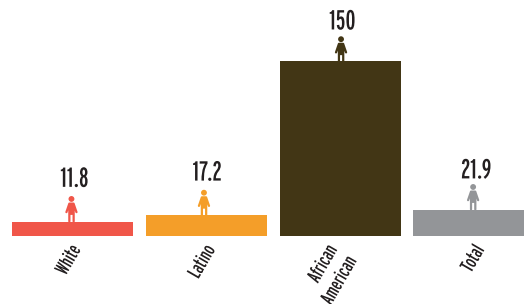
Figure 17



But over the last two decades, the state's prison population has grown rapidly. Between 1990 and 2005, California's prison population grew at a rate three times that of the general population.⁹¹ Though it has stabilized in the last five years, the state's penal facilities are still operating at 175% of their design capacity. These circumstances led the United States Supreme Court to rule in 2011 that the state's overcrowded prisons constitute cruel and unusual punishment and therefore violate the Eighth Amendment.⁹² In part due to high recidivism rates, California has struggled to reduce its prison population. Over two-thirds (67.5%) of those released are rearrested within three years. That number rises to nearly three quarters (74.3%) of the 18- and 19-year-olds released from prison.⁹³

California's Three-Strikes law, enacted in 1994, has contributed to the disproportionately higher rates of incarceration for people of color. This law, the harshest in the country, was originally intended to be tougher on violent crimes, such as rape and murder, by imprisoning repeat offenders for 25 years to life. But instead, 65% of those imprisoned under the law were sentenced for nonviolent crimes.⁹⁴ The inequity among racial and ethnic groups and Whites is stark—the rate of incarceration under Three-Strikes for African Americans (150 per 100,000 residents) is over 12 times that of Whites (11.8). Latinos (17.2) are also incarcerated under Three-Strikes at a higher rate than Whites (see *Figure 18*).

Incarceration Rates Under Three-Strikes Laws
(Per 100,000 Residents)



SOURCE: 2005 Bureau of Justice

Figure 18



Health and Incarceration

Incarceration has many direct and indirect health impacts for both the incarcerated and their families. In addition to high rates of chronic conditions (including asthma, diabetes, and hypertension) and infectious diseases (hepatitis and tuberculosis), many returning prisoners face the burden of mental illness and drug dependency. Roughly two-thirds of California's prison population reported having a drug abuse problem, but only 22% of those inmates had received treatment since entering prison.⁹⁵

The formerly incarcerated are likely to face increased stigmatization, unemployment, housing problems, and other barriers that can impact how healthy they—and their families—can be.⁹⁶ Implementation of the Affordable Care Act (ACA) will eliminate a critical barrier to receiving health care for many former prisoners. The ACA expands Medicaid eligibility to include all citizens under the age of 65 with incomes up to 133% of the Federal Poverty Level, including those with criminal records. This will allow many former prisoners, who were previously ineligible for Medicaid, to access drug treatment services, preventive care, and wellness programs.⁹⁷



Policy Recommendations

Neighborhood Safety and Violence

The disproportionate amount of violence in communities of color coupled with high rates of incarceration impact health in many ways—and both have their roots in the social and physical environments in which we live. By increasing the safety of our neighborhoods and reforming our criminal justice system, we can make our communities more conducive to improved health and wellbeing.

- **Work for More Cohesion in Our Neighborhoods:** Building social capital in vulnerable communities is vital to improving neighborhood safety 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. Additionally, we must empower residents to become engaged in local planning processes and encourage local governments to ensure that the public participation process is accessible to working families and limited-English speaking residents. We must also work on developing violence prevention strategies in our schools and offer violence prevention training to providers of community services including police officers and local government officials.⁹⁸ We must promote neighborhood watch programs and decrease access to unhealthy and unsafe products such as weapons, tobacco, and alcohol through zoning and advertising restrictions.⁹⁹
- **Prioritize the Prevention of Violence:** Our focus needs to shift from punishment and incarceration to prevention and opportunity. Innovative programs that engage youth, such as conflict mediation, job training opportunities, and after school activities, must be a priority in order to prevent violence and to provide youth with leadership opportunities. Additionally, 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. They must identify ways to reduce factors that threaten individual and community wellbeing while building trust and creating partnerships. To be effective, violence prevention strategies must integrate the needs, policies, and systems that affect the individual, family, and community and strengthens these support systems in multiple ways.¹⁰⁰



- **Acknowledge and Address Racial Disparities in Criminal**

Justice: Several current correctional and criminal justice policies disproportionately punish people of color, from the point of police contact through incarceration, including California's Three-Strikes Law. We must acknowledge the effect that race has in our criminal justice system¹⁰¹ and encourage greater communication and coordination among all stakeholders, including community members, the legal system, and law enforcement, to develop systemic change.¹⁰² For example, we should develop strategies to reduce incarceration rates (such as arrest alternatives and sentencing reforms) and eliminate policies that punish individuals returning to their communities from incarceration, like the federal law that prohibits formerly incarcerated persons with drug convictions from obtaining student loans. Advocating for policies that help individuals successfully re-enter our communities and obtain gainful employment, such as permitting nonviolent drug offenders to expunge their records, would go a long way to reducing inequities.

- **Reduce Recidivism:** We need to promote programs that connect individuals returning to their communities after incarceration with the social, health, and educational supports and vocational services they need. Substance abuse treatment programs should also be more accessible to those in the criminal justice system, as well as to the general population in need of those services, to help break the cycle of drug use and incarceration. Additionally, probation programs should focus on models that incorporate relationships with community-based organizations, promote leadership development, and include appropriate risk management assessments.¹⁰³



PHYSICAL ACTIVITY SPACES AND HEALTHY FOODS

Green Space for All

The more safe places—green space, parks, and playgrounds—that are available to us, the more likely we are to be physically active.¹⁰⁴ Regular physical activity has been shown to reduce the risk of early death from heart disease, high blood pressure, some cancers, mental health conditions, and diabetes.¹⁰⁵ With childhood obesity rates more than doubled in California since 1980, and 12% of teens in the state classified as either overweight or obese and at risk for Type 2 diabetes (a disease usually only seen in adults), regular physical activity is vital for reversing these trends.

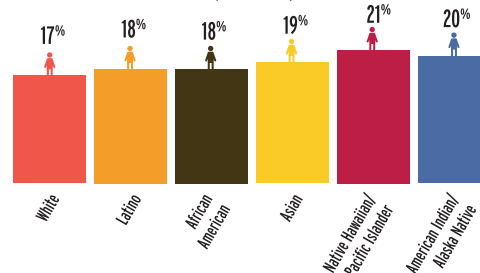
However, communities of color and low-income neighborhoods often lack access to physical activity spaces.¹⁰⁶ *Figure 19* shows that communities of color are less likely to live within walking distance of a park or open space. One in five American Indians/Alaska Natives and Native Hawaiians/Pacific Islanders do not live within walking distance from a park, playground, or open space. Not surprisingly, these same populations also have the highest rates of high blood pressure (*Figure 22* on page 38), obesity (*Figure 24* on page 40), and diabetes (*Figure 25* on page 42). *Map 6* shows where youth in California have a park within walking distance in relation to where communities of color live.

Increasing Access to Safe, Open Spaces

Limited access to safe, open spaces to engage in physical activity has contributed to the growing obesity epidemic impacting Latino communities in Los Angeles. In an effort to support the development of healthy communities, the Alliance for a Better Community (ABC) developed the Joint Use Generating Activity & Recreation Initiative (J.U.G.A.R., or the Spanish word for to play), which expands joint use partnerships in two high-need Latino communities: Pico Union and Boyle Heights. ABC convened a broad-based coalition of stakeholders—school administrators, students, parents, and civic leaders—and partnered with the Los Angeles Unified School District (LAUSD) to provide recommendations to strengthen LAUSD’s shared use policies for greater access to school grounds to the community during non-school hours. This partnership has led to four pilot projects in Pico Union and Boyle Heights, with over 1,000 community members accessing health and wellness resources, and more than 100 students and families participating in weekly J.U.G.A.R. activities hosted on their school campuses.

For more information about J.U.G.A.R. visit the Alliance for a Better Community at: www.afabc.org.

Park or Open Space Not Within Walking Distance (Adults)

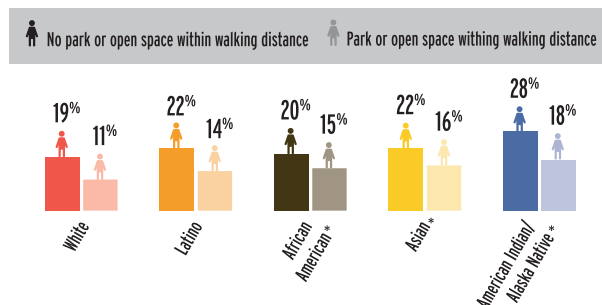


SOURCE: 2007 CHIS

Figure 19

In addition, those who do not have a park or open space within walking distance report higher rates of no physical activity. Latinos without a park or open space within walking distance were more likely to report no physical activity (22%) compared to those who were within walking distance to a park or open space (14%), as seen in *Figure 20*.

No Physical Activity Compared by Distance to Park or Open Space



*Comparison within race/ethnicity is not statistically significant
SOURCE: 2007 CHIS

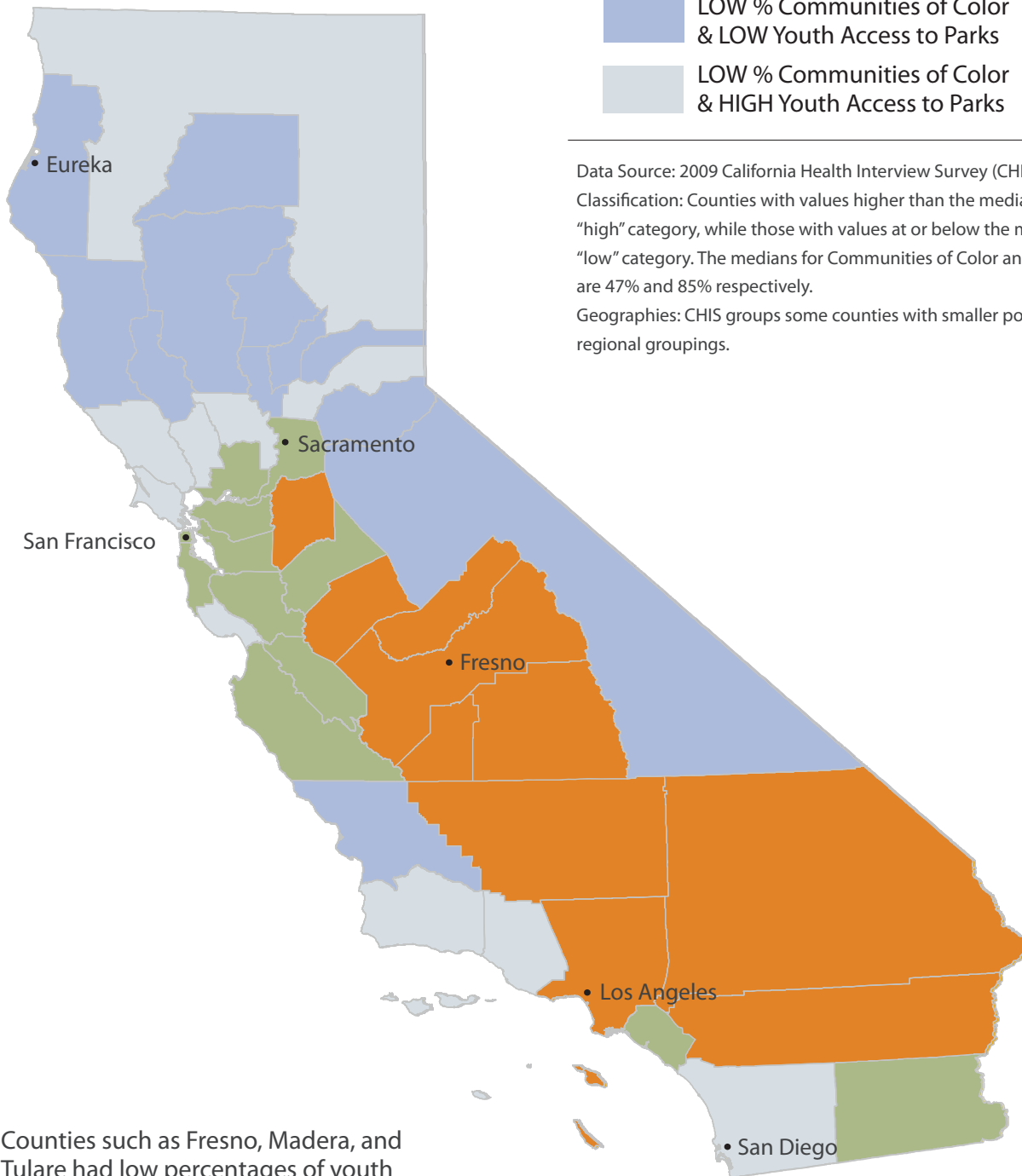
Figure 20



Map 6

Youth Access to Parks and Communities of Color

- HIGH % Communities of Color & LOW Youth Access to Parks
- HIGH % Communities of Color & HIGH Youth Access to Parks
- LOW % Communities of Color & LOW Youth Access to Parks
- LOW % Communities of Color & HIGH Youth Access to Parks

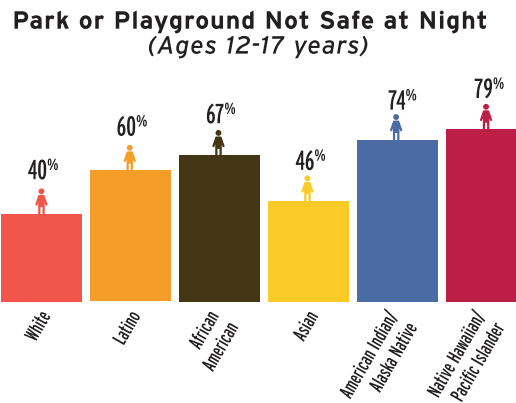


Data Source: 2009 California Health Interview Survey (CHIS)
 Classification: Counties with values higher than the median are included in the "high" category, while those with values at or below the median are included in the "low" category. The medians for Communities of Color and Youth Access to Parks are 47% and 85% respectively.
 Geographies: CHIS groups some counties with smaller populations together into 3 regional groupings.

Counties such as Fresno, Madera, and Tulare had low percentages of youth with access to a park in walking distance, and high numbers of communities of color.



Even if community members live in close proximity to parks and open spaces, these areas are more likely to be unsafe at night, preventing activities like taking children out to play after work. As seen in *Figure 21*, well over half the youth of color in California do not feel their nearest park or playground is safe at night. This is well above the 40% of Whites who feel their parks are unsafe.



SOURCE: 2009 CHIS

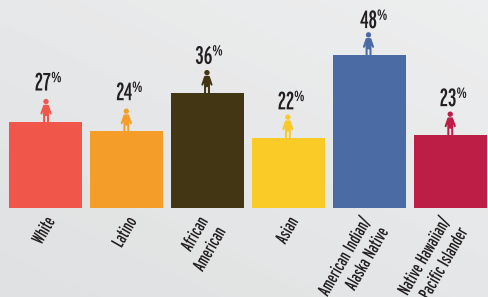
Figure 21

Opening up spaces like school grounds to the community and surrounding neighborhood is one way to increase places for children to be physically active. Unfortunately, the practice is often hampered by barriers such as cost, staffing, and liability concerns.

High Blood Pressure

The causes of hypertension are unknown, but several factors including smoking, genetics, stress, poor nutrition, and physical inactivity may contribute.¹⁰⁹ Nearly half of American Indians/Alaska Natives (48%) and over one-third of African Americans (36%) have been diagnosed with high blood pressure.

Ever Diagnosed with High Blood Pressure (Adults)



SOURCE: 2009 CHIS

Figure 22

The U.S. Centers for Disease Control and Prevention (CDC) recommend at least 60 minutes of moderate to vigorous physical activity a day for children and adolescents.¹⁰⁷ Physical activity in school is important to accomplish these goals, and has proven to help students learn the value of being physically active early on. California requires schools to provide physical education for their students, but their benchmarks fall short of the CDC's recommendations. The current state laws mandate at least 20 minutes of physical education per day in elementary schools and 40 minutes per day in middle and high schools, yet many of California's schools are not meeting even these requirements. Audits of 188 school districts between 2004 and 2009 found that exactly half were not enforcing the physical education requirements.¹⁰⁸



An Appetite for Equity

Physical activity is only part of the solution to the rising rates of conditions like high blood pressure, obesity, and diabetes. Access to healthy foods—through grocery stores that stock fresh fruits and vegetables, farmers’ markets, nutritious school lunches, and other sources—leads to healthier meals and healthier people. These sources are less likely to be found in low-income neighborhoods for a variety of reasons, including the exodus of grocery stores because of low profit margins.¹¹⁰ The lack of nearby healthy food outlets, compounded with limited transportation options, compromises our ability to eat nutritiously. 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.¹¹¹ Since communities of color often lack access to healthier food options, there are noticeable disparities in rates of high blood pressure, obesity, and diabetes (see *Figures 22, 24, and 25, respectively*).

To determine the health impact of local food environments in a community, researchers have examined health outcome data from the 2007 California Health Interview Survey (CHIS) with locations of retail food outlets. By comparing the number of outlets offering healthy foods with those featuring unhealthy options, they have developed a Retail Food Environment Index (RFEI) for each adult respondent in the CHIS survey.¹¹² The RFEI is a ratio of the number of food outlets that mostly offer unhealthy foods (specifically, fast food restaurants, liquor stores, pharmacies, dollar stores, gas stations, warehouse stores, and convenience stores) relative to the number of food outlets where healthier foods are likely to be sold (such as grocery stores and produce vendors) near a person’s home. For example, someone with a RFEI of 9.0 has nine times as many fast-food restaurants and convenience stores nearby compared to grocery stores and produce vendors. They then used this index to determine the availability of healthy food options for populations across California. The study shows that the average RFEI for California was 9.4—but it also shows that people of color have higher RFEIs. African Americans had the highest RFEI; at 10.3, they were the only racial or ethnic group to break into double-digits. Latinos also surpassed the



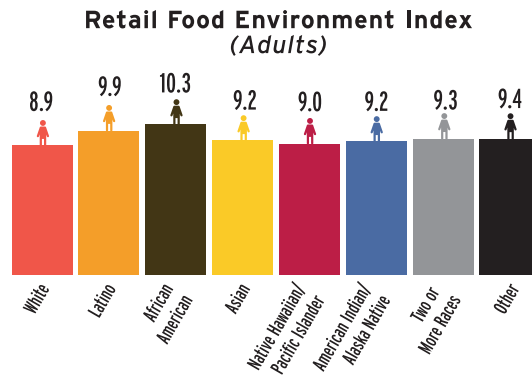
People’s Grocery

A nonprofit organization at the intersection of health and economic development, People’s Grocery’s mission is to improve the health and local economy of West Oakland through investing in the local food system. Since its founding, the organization has increased access to healthy foods for over 9,000 West Oakland residents. To accomplish this, People’s Grocery began three neighborhood gardens that offer community members new opportunities to grow and enjoy fresh produce. To improve health outcomes throughout their community, People’s Grocery has collaborated with public hospitals and health clinics reaching vulnerable communities with specific cultural needs through its cooking classes, nutrition demonstrators’ project, community celebrations, and workshops.

For more information on People’s Grocery visit: www.peoplesgrocery.org.



statewide RFEI at 9.9, while Whites had the lowest score of any racial or ethnic group at 8.9 (see *Figure 23*).

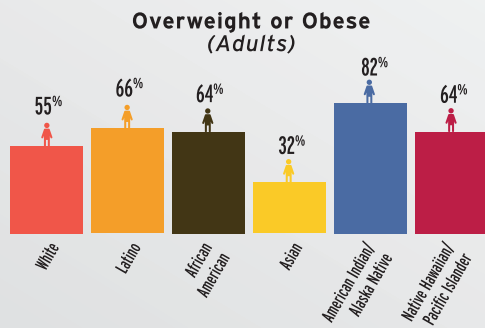


SOURCE: 2007 CHIS *Figure 23*

Map 7 shows a strong correlation between areas with high RFEIs and where communities of color live.

Overweight and Obesity

Overweight and obesity have reached epidemic proportions in the state, particularly in communities of color and low-income areas. For example, over four out of every five (82%) American Indians/Alaska Natives in California are either overweight or obese.



SOURCE: 2009 CHIS *Figure 24*

Studies have shown that areas with higher RFEIs tend to have higher rates of obesity and diabetes, and that the prevalence of obesity and diabetes can be related to some extent to the number of fast-food restaurants and convenience stores in a community relative to grocery stores and places to buy fresh fruits and vegetables.¹¹³

Our children spend a great deal of their lives at school, with limited options for healthy meals other than what is available at the cafeteria or what we send to school with them. During these critical developmental years, it is important that they have access to nutritious foods. In January 2012, the U.S. Department of Agriculture raised the nutritional standards for school meals for the first time in 15 years. These requirements include offering fruits and vegetables every day of the week, limiting calories and portion sizes to age-specific levels, and reducing the amount of saturated fats.¹¹⁴

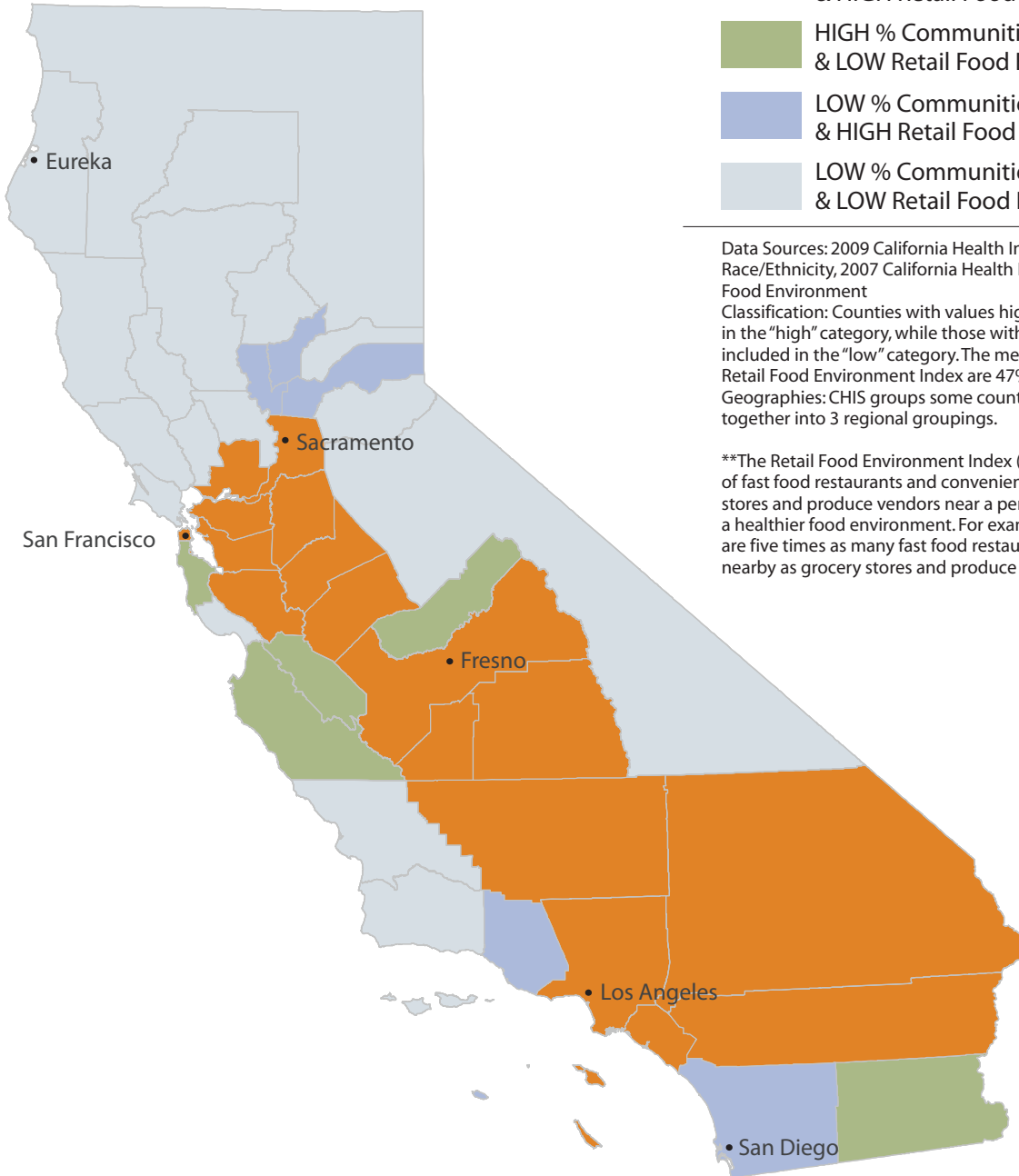
In California, over three million children are eligible for free or reduced-price school lunches.¹¹⁵ The new federal standards will lead to healthier food options for a large portion of the public school population. Statewide health advocacy efforts have led to eliminating the sale of sugar-sweetened beverages in schools, and other campaigns are underway to eliminate the availability of electrolyte drinks in schools as well, which would improve the health of our students.





Map 7

Food Environment** and Communities of Color



- HIGH % Communities of Color & HIGH Retail Food Environment Index
- HIGH % Communities of Color & LOW Retail Food Environment Index
- LOW % Communities of Color & HIGH Retail Food Environment Index
- LOW % Communities of Color & LOW Retail Food Environment Index

Data Sources: 2009 California Health Interview Survey (CHIS) for Race/Ethnicity, 2007 California Health Interview Survey (CHIS) for Food Environment

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 Retail Food Environment Index are 47% and 7.1 respectively.

Geographies: CHIS groups some counties with smaller populations together into 3 regional groupings.

**The Retail Food Environment Index (RFEI) is a ratio of the total number of fast food restaurants and convenience stores compared to grocery stores and produce vendors near a person’s home. A lower value indicates a healthier food environment. For example, a score of 5 means that there are five times as many fast food restaurants and convenience stores nearby as grocery stores and produce vendors.

Counties such as San Bernardino, Riverside, and Tulare had a high RFEI, meaning they had a higher number of unhealthy food outlets than healthy food outlets. These counties also had high numbers of communities of color.

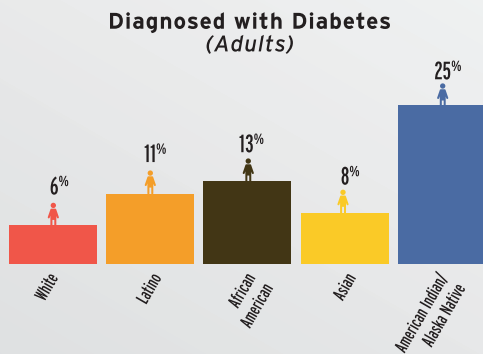


Efforts are also moving forward to improve the availability of healthy foods in our workplaces. Studies have shown that there is a relationship between our workplace environments and our health.¹¹⁶ With nearly half of our waking hours spent at the workplace,¹¹⁷ the foods available in employee cafeterias, vending machines, and work-sponsored events frequently determine what we eat throughout the day. Healthier food options in our workplaces can help reduce the prevalence and cost of diet-related diseases, and promote the overall health and wellbeing of our workforce.

On March 24, 2011, as part of First Lady Michelle Obama’s Let’s Move Initiative, the U.S. Department of Health and Human Services (DHHS) unveiled their new healthy food service guidelines. These guidelines are being implemented with DHHS departments and the National Park Service. There have also been a number of healthy food procurement policies adopted in California over the past decade. Baldwin Park, Los Angeles County¹¹⁸, South El Monte, and Chula Vista require that 100% of foods sold in vending machines meet minimum nutritional standards. In addition, Los Angeles County has also passed policies that require healthy foods in their public hospitals and clinics, and that all 37 county departments consult with the Department of Public Health on their food service contracts.

Diabetes

Rates of diabetes or pre-diabetes are notably higher in American Indians/Alaska Natives (25%), African Americans (13%), and Latinos (11%) than in Whites (6%). In fact, the rate for American Indians/Alaska Natives is over four times the rate of Whites.



SOURCE: 2009 CHIS

Figure 25





Policy Recommendations

Physical Activity Spaces and Healthy Foods

Many aspects of our neighborhoods can dramatically influence health outcomes, in particular the lack of public spaces for physical activity and limited options for healthy foods.

- **Expand Spaces for Physical Activity:** Decreasing obesity, diabetes, and other chronic conditions requires opportunities for people to be physically active. We must work with local governments to increase access to parks and facilities for physical activity in communities that have limited open space. We should also work with local community organizations to identify cost-effective ways to minimize vandalism and maintain safety in parks.¹¹⁹ Schoolyards offer an accessible, safe place for families and communities to be physically active and build community cohesion, particularly in those neighborhoods without parks. We must equip school districts with the tools they need to provide community access to school grounds and facilities so that community members have safe, clean places to be active. Further, state and local governments should explore opportunities to increase outreach and assistance to low-resourced schools to encourage their successful participation in Safe Routes to School programs that ensure children and their families can walk to school safely. Additionally, we must ensure that transportation developments incorporate safe and accessible ways for individuals to walk and bike by including greenways, walking paths, and bicycle lanes into their designs. Finally, state agencies should work together to incorporate health into planning for housing, school siting, land use, and transportation, and leverage opportunities to create green space around our homes, schools, and transit.
- **Expand Access to Healthy Food Retail:** Access to healthy foods promotes good nutrition and can help our communities' health and wellbeing. We can improve access to healthy foods by making it easier for small and local farmers to distribute their produce through farmers' markets and sell to local institutions, particularly in communities lacking access to healthy foods. Additionally, the state should increase acceptance of electronic benefit transfers (EBT) in the CalFresh and WIC programs. We should promote school and community gardens, including streamlining application and permit processes. We must also limit the number of fast food restaurants and liquor stores in our communities while encouraging more neighborhood stores to offer healthy food options through local government support such as tax incentives, streamlined permitting, and zoning changes.¹²⁰





State and local governments can also play an important role by adopting healthy procurement programs. Properly directed government resources can increase a neighborhood's access to nutritious foods; decrease consumption of low-nutrient, high calorie foods; and add dollars to the local economy. We must identify best practices and provide training and technical assistance on implementation of healthy food procurement policies locally and statewide.¹²¹



HEALTH CARE

A Health Care System for Everyone

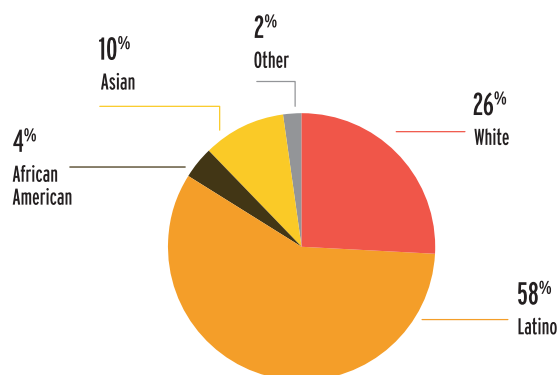
In March 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (ACA), a landmark piece of legislation that represented the first real reform of our health care system in decades. The new law, which will take full effect in 2014, will make health coverage available to about seven million Californians who will be eligible for expanded Medi-Cal or subsidies to purchase insurance in the newly established Health Benefit Exchange (the Exchange).¹²² The law also makes considerable investments in workforce diversity and prevention, and takes proactive steps to reduce health care costs and improve quality.



Insurance Status

Having comprehensive health insurance—whether through an employer or a public program—can give us peace of mind; we know that a serious illness will not result in severe debt. It means we can go to the doctor without having to worry about how we are going to pay for the visit, and fewer visits to the emergency room. In addition, being insured can reduce mortality by 5–15%, and can improve annual earnings by 10–30%, as well as increase educational attainment.¹²³ Even with both private and public programs, nearly one out of every five Californians remains uninsured, with the burden disproportionately borne by communities of color. Despite representing roughly 60% of the total population, communities of color represent 74% of the state's uninsured population (see *Figure 26*). Latinos have the highest rates of uninsured, hovering at one in three, compared to roughly 11% of the White population. *Map 8* on page 46 shows the statewide distribution of California's insured, which is inversely correlated to where communities of color live.

Race/Ethnicity of California's Uninsured



SOURCE: "California's Uninsured." The California HealthCare Foundation. 2011.

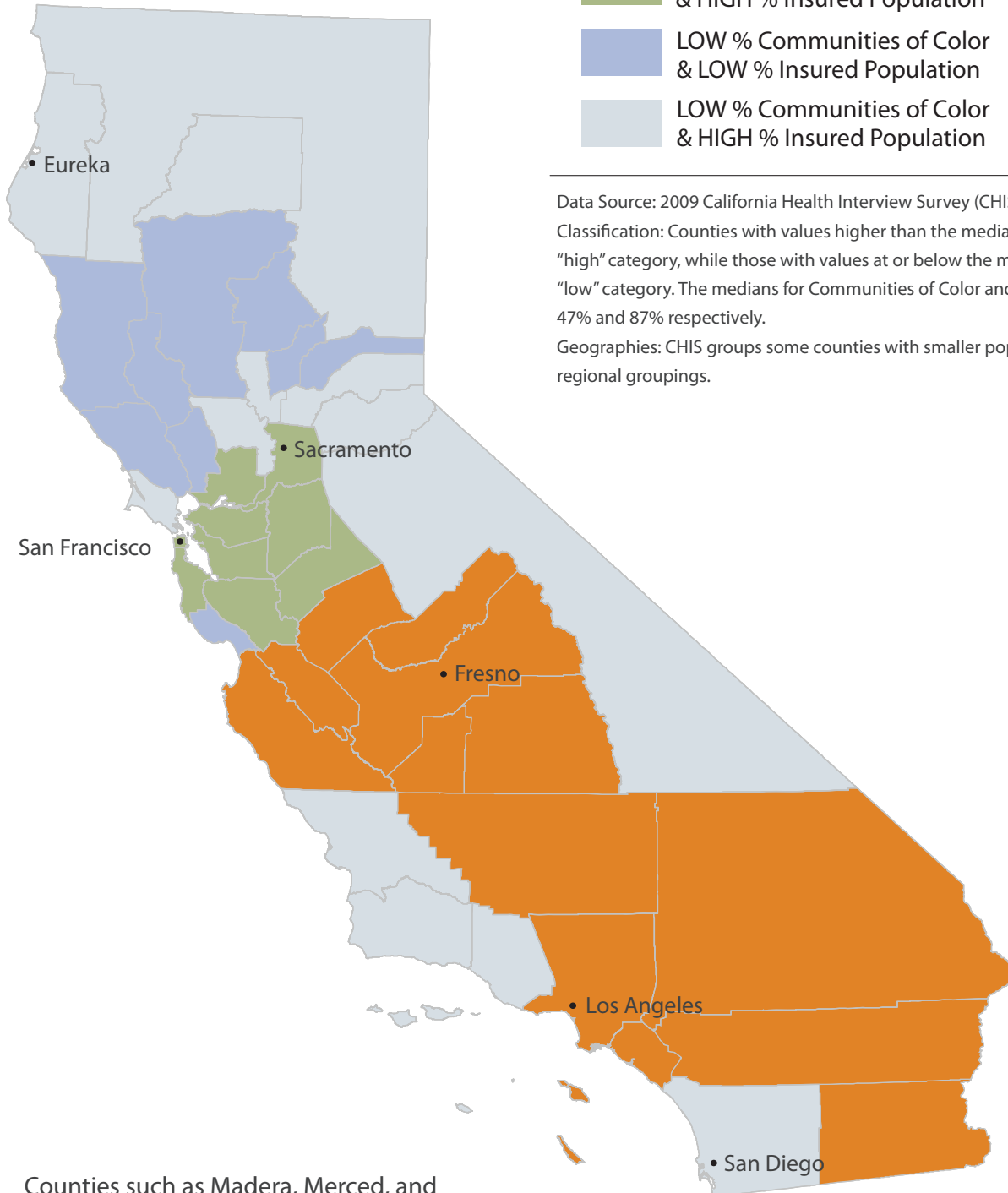
Figure 26



Map 8

Insurance Status and Communities of Color

- HIGH % Communities of Color & LOW % Insured Population
- HIGH % Communities of Color & HIGH % Insured Population
- LOW % Communities of Color & LOW % Insured Population
- LOW % Communities of Color & HIGH % Insured Population



Data Source: 2009 California Health Interview Survey (CHIS)

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 Insurance Status are 47% and 87% respectively.

Geographies: CHIS groups some counties with smaller populations together into 3 regional groupings.

Counties such as Madera, Merced, and Imperial had low percentages of insured and high numbers of communities of color.



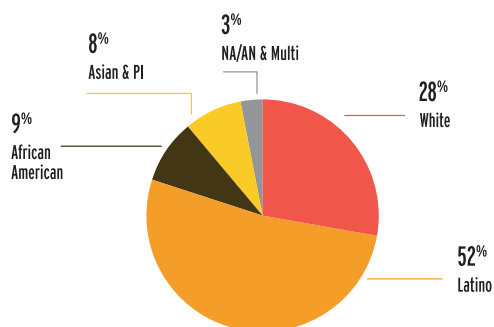
These lower levels of health insurance have a direct impact on the health inequities experienced by our communities. Without insurance we are more likely to have poor health status, forego preventive services, risk being diagnosed at later stages, and die earlier. In addition to the detrimental health effects of being uninsured, the financial burden is also great, with almost 50% of personal bankruptcy filings attributed to medical expenses.¹²⁴

Unfortunately, even with all of the expanded coverage options through the ACA, many Californians, especially undocumented immigrants, will still be uninsured. These individuals will continue to rely on our safety-net providers, such as community health centers and public hospitals. It will be important that adequate resources are available to maintain the infrastructure and services provided by our safety net.

Medi-Cal Expansion and the Low-Income Health Program (LIHP)

Millions of low-income Californians are not currently eligible for Medi-Cal, although they are citizens and permanent residents of the state, mainly due to the program's exclusion of childless adults, half of whom make less than \$16,300 a year.¹²⁵ Many of them will be eligible for coverage in 2014, when the ACA expands Medi-Cal to include everyone who makes less than 133% of the Federal Poverty Level (FPL). This expansion will provide approximately 4.1 million Californians access to coverage. As seen in *Figure 27*, 72% of these newly eligible will be people of color. In addition, over one-third (36%) of the eligible adults will speak English less than very well.¹²⁶

Eligible for Medi-Cal Expansion by Race/Ethnicity



SOURCE: UCLA Center for Health Policy Research. 2012.

Figure 27



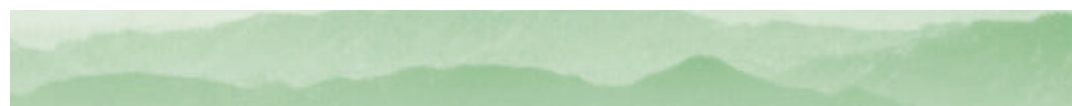
Though the expansion of Medi-Cal and the establishment of the Health Benefit Exchange do not take full effect until 2014, the renewed §1115 Waiver, also known as “The Bridge to Health Reform,” allows California’s counties to identify and enroll low-income, uninsured individuals into coverage between now and 2014 under the Low Income Health Program (LIHP). The LIHP offers a core set of benefits—including hospital services, physician treatment, labs and x-rays, and mental health services. On January 1, 2014, those enrolled in the LIHP will be transitioned into either Medi-Cal or the Exchange based on their eligibility.

The LIHP has already become an important source of coverage for California’s low-income communities, the majority of whom are people of color—as of February 2012, over 274,289 Californians have enrolled, 67% of them people of color and close to 30% percent who speak English less than well.¹²⁶

The California Health Benefit Exchange

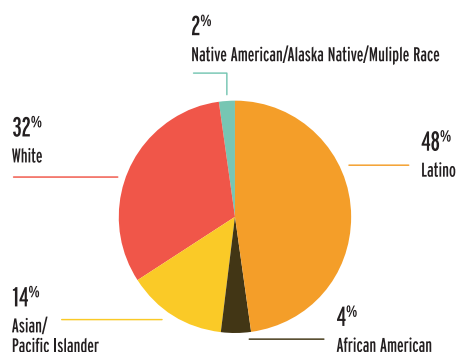
The higher rate of uninsurance among communities of color is attributable in large part to lower rates of job-based insurance, which covers 67% of Whites but only 35% of Latinos and 41% of American Indians/Alaska Natives.¹²⁸ Non-citizens often suffer higher rates of uninsurance compared to citizens (62% vs. 31%) due to their work in low-wage jobs that are less likely to offer health coverage and restrictions on eligibility for public coverage.¹²⁹

Effective January 2014, the California Health Benefit Exchange will give uninsured individuals, the majority of whom come from working families, the opportunity to shop for and buy comprehensive health coverage in a state-regulated marketplace. Low-income families will be eligible for federal tax credits to help keep the costs of coverage affordable. Over 2.6 million Californians will be able to use this benefit to purchase coverage, with people of color representing two-thirds of this population (1.7 million), as seen in *Figure 28*. Over one million adults who speak English less than very well will be eligible to participate in this subsidized Exchange.¹³⁰ With people of color and limited-English speakers eligible for these benefits in the Exchange, the success of the program hinges in large part on how the state conducts outreach and education to these diverse populations.





Eligible for Subsidies in the California Health Benefit Exchange by Race/Ethnicity (In 2013)



SOURCE: UC Berkeley-UCLA CalSIM Version 1.5 projections. 2012.

Figure 28

Workforce Diversity

With millions of Californians eligible for coverage under the ACA, the focus shifts to developing a health care workforce that can adequately meet the needs of the newly insured. California currently faces a severe shortage of primary care physicians, and the problem may be getting worse. Nearly one out of every three physicians in the state is over 60 years old, a higher percentage than any other state. Compounding this shortage is the fact that only half of the state's primary care physicians are accepting new Medi-Cal patients.¹³¹ The ACA specifically targets this lack of primary care physicians by increasing Medicare and Medicaid reimbursement rates and by offering scholarships, loan repayments, and other investments to increase the primary care workforce.¹³²

As the most diverse state in the nation, communities of color are woefully underrepresented in our health care workforce. While African Americans, Latinos, and American Indians/Alaska Natives make up 43% of California's population, they represent only 9% of practicing physicians in the state.¹³³ A vibrant, diverse workforce improves and promotes cultural competency in medical settings. Physicians of color are also more likely to serve in communities of color and other underserved communities, in both rural and urban areas, which helps improve access to care.¹³⁴

The ACA has provisions specifically designed to improve workforce diversity. To encourage people of color to enter the health care workforce, the ACA provides funding to develop and operate training programs in community-based settings. Programs funded through this initiative will prioritize training individuals from underrepresented, disadvantaged, or rural backgrounds and emphasize increasing patients' understanding of their care.¹³⁵



Policy Recommendations

Health Care

The passage of the Affordable Care Act (ACA) provides a tremendous opportunity to expand coverage to millions of Californians. Communities of color are among those who stand to benefit the most from the ACA. Research shows that these communities are less likely to know about the benefits of the ACA but once informed are very enthusiastic about enrolling.¹³⁶ Having health insurance and being able to go to a doctor who understands our culture and speaks our language is a vital part of staying healthy and receiving quality care. By making the most of the new health care expansion, we can help our communities get better and stay healthy.

- **Ensure Culturally and Linguistically Appropriate Services from Outreach to Care:** Language barriers impact enrollment and participation in health care programs by communities of color. As our state continues to establish its Health Benefit Exchange, we must provide accurate, thorough, and easily understandable information to the newly eligible to help them enroll in health coverage. We should target resources to the communities who will benefit the most from health care reform but also face additional challenges navigating the process, particularly those who speak English less than very well. Additionally, we must prioritize training and certification of medical interpreters and ensure that our health care professionals are prepared to work with California's diverse communities.
- **Maximize Enrollment in Health Coverage:** We must take advantage of the opportunities available under health care reform to extend coverage to newly-eligible Californians by using fast, confidential, and effective methods to ensure timely enrollment. Eligible individuals in publicly-funded programs should be identified and pre- or auto-enrolled into the new health coverage options available to them in 2014. We must also maximize enrollment of low-income, uninsured individuals under the Low Income Health Program (LIHP) between now and 2014. Strong collaboration between state and local government agencies and providers across public programs should be encouraged so that programs such as the LIHP, CalFresh, and others that already collect data on citizenship, income, and eligibility criteria can help accelerate enrollment.



- **Protect California's Safety Net:** Public hospitals, community health centers, and government clinics have been a relied upon source of care for the uninsured and communities of color. Safety-net providers often offer the needed cultural and linguistic services to ensure access and quality care, and they are a trusted source of care for their patients. We need to make sure that California's safety net has adequate resources to maintain and expand their infrastructure and services to meet the demands of both the insured and remaining uninsured.
- **Expand and Diversify the Health Professions:** To ensure that the new demands on the health care system are met and address diverse patient needs, we need to build a new health care workforce by establishing programs to train, recruit, and retain people of color. We must also ensure adequate reimbursement rates for Medi-Cal providers. The state should seek funding to implement the recommendations of the Office of Statewide Health Planning and Development's Health Workforce Development Council.

Cultivating Health Equity



PHYSICAL ACTIVITY SPACES



HEALTH CARE ACCESS



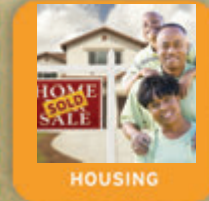
TRANSPORTATION



FOOD ACCESS



SAFETY & VIOLENCE



HOUSING



LANGUAGE



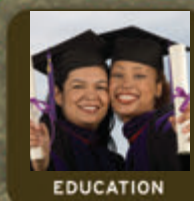
AIR QUALITY



CRIMINAL JUSTICE



JOBS



EDUCATION



RACE



WEALTH & INCOME



Summary of Policy Recommendations

Community leaders and activists are increasingly working on a spectrum of issues, rather than just focusing on their traditional silos. No policy lives in a vacuum: education policy is health policy, just as transportation, criminal justice, and housing policies all have profound implications for our health and wellbeing. Anything that touches our everyday lives impacts our health, and efforts addressing these seemingly disparate issues are all critical in rectifying decades of inequality.

Our recommendations focus on local and statewide actions that will cumulatively promote health throughout California. Most of these are long-term strategies that require investments of time, energy, and patience. We must work together to overcome our challenges, share our strategies, and celebrate our successes. Improvements to community wellbeing will not happen overnight but we must make every effort to continue our efforts for the health of our families and future generations.

Demographic and Socioeconomic Factors

- 1. Ensure Culturally and Linguistically Appropriate Services:** We should work to ensure a culturally competent workforce throughout government programs and services, including recruiting and training diverse staff. State programs and services must comply with current language access laws and must be made accessible to limited-English proficient communities.
- 2. Improve Data Collection:** California must collect the necessary race, ethnicity, and language data to identify patterns of discrimination and disparities in public programs and services, and develop policies and practices to promote equal opportunity and access.
- 3. Modernize the Federal Poverty Level:** The current poverty level does not reflect the true cost of living in society today. Changing the Federal Poverty Level to reflect our current basic needs and geographic differences would help individuals and families access services they need to thrive.
- 4. Increase Job Opportunities in Low-Income Communities:** We must work with local and statewide elected officials to develop job creation plans to provide communities of color and low-income communities stable job opportunities and a living wage. We should be innovative in our approach by identifying growing job sectors and determining how best to train students and displaced workers for these new positions.



5. Improve Quality Education: We need to improve the quality of education at every level across the state. There are a number of strategies we can take, from increasing funding for K-12 schools to the availability and affordability of higher education.

Environmental Factors

6. Incorporate Health in Land Use Planning: Planning our neighborhoods with health in mind can lead to positive results and improved health outcomes. Public health officials and community members should advocate for the inclusion of health factors into General Plans and other local and regional land use policies.

7. Integrate Health into State Decision Making Processes: California should prioritize health as a consideration across all state agencies. By doing this, we can facilitate collaboration between departments to promote health and healthy communities. The guidance and leadership of the state's Health in All Policies Task Force will help provide a health focus to statewide policies.

8. Improve Air Quality: We must reduce our dependence on motor vehicles and promote broader transportation choices. We should also prioritize reductions in pollution generated through ports, high-volume roadways, and railroads. The state can take the lead by investing in programs to reduce emissions from its existing fleet of trucks. Finally, we must support renewable energy sources and strengthen fuel efficiency policies.

9. Improve the Condition of Neighborhood Housing: We must prioritize ways to improve access to healthy, affordable housing. We should find permanent sources of funding for affordable housing programs and adopt a "health in all policies" strategy to consider health in housing planning decisions. One way to promote healthier community development is by designing neighborhoods that are walking distance to grocery stores, parks, and other community resources necessary for healthy living.

10. Encourage Healthy Transportation Policy: Transportation policy should encourage walk- and bike-friendly communities through the development of bike paths, sidewalks, and trails. We must encourage government-funded road infrastructure projects to address the safety of all users, prioritize practices that promote traffic calming, and improve pedestrian safety.



Neighborhood Safety and Violence

- 11. Work for More Cohesion in Our Neighborhoods:** We must build social capital in vulnerable communities to improve neighborhood safety and increase political engagement. By building partnerships between residents, community organizations, and local governments, we can identify strategies to address local conditions and empower residents to become engaged in local planning processes, which must be accessible to working families and limited-English speaking residents.
- 12. Prioritize the Prevention of Violence:** Our focus needs to shift from punishment and incarceration to prevention and opportunity. We must approach violence prevention through innovative approaches that include all stakeholders, especially public health officials, youth leaders, and law enforcement to identify the factors that threaten community wellbeing.
- 13. Acknowledge and Address Racial Disparities in Criminal Justice:** We must acknowledge the existence and effect of racial disparities in the criminal justice system on communities of color. We must encourage communication among community members, the legal system, and law enforcement to address disparities that occur in all levels of the system.
- 14. Reduce Recidivism:** We need to promote programs that connect individuals returning to their communities after incarceration with the social, health, educational, and vocational services they need.

Physical Activity Spaces and Healthy Foods

- 15. Expand Spaces for Physical Activity:** Decreasing obesity, diabetes, and other chronic conditions requires opportunities for people to be active and exercise. We can make progress by promoting joint-use agreements for school facilities and ensuring our schools meet minimum requirements for physical education.
- 16. Expand Access to Healthy Foods:** We need to focus on increasing access to healthy foods in low-income areas and communities of color throughout California. We can do this by increasing the number of farmer's markets, limiting fast food outlets and liquor stores, and promoting school and community gardens. California should also lead by example and develop healthy procurement policies for food in its state buildings.



Health Care

17. Ensure Culturally and Linguistically Appropriate Services from

Outreach to Care: As our state continues to implement the Affordable Care Act, we must provide accurate, thorough, and easily understandable information to those newly eligible for public programs such as Medi-Cal and the Health Benefit Exchange and help them enroll. We should target resources to the communities who will benefit from health care reform but also face challenges navigating the process, particularly communities who speak English less than very well.

18. Maximize Enrollment in Health Coverage: We have an opportunity to expand coverage to nearly seven million newly eligible Californians thanks to the ACA, but we must move quickly to establish systems to ensure enrollment in new programs. We need to maximize opportunities for collaboration among state and local government agencies that already collect data on citizenship, income, and eligibility criteria to help accelerate enrollment.

19. Protect California's Safety Net: Safety-net providers will continue to be an important source for care for both the insured and remaining uninsured. It is critical that our safety net has the resources to maintain their infrastructure and services to meet these demands.

20. Expand and Diversify the Health Professions: We must address our primary care physician shortage and develop a healthcare workforce that is capable of meeting the needs of California's diverse population. We must establish programs to train, recruit, and retain people of color in the medical and allied health professions and work to ensure adequate reimbursement rates for Medi-Cal providers.



Endnotes

1. "A Portrait of California." American Human Development Project. 2011. December 30, 2011 <www.measureofamerica.org/docs/APortraitOfCA.pdf>.
2. "Watts Profile." The Los Angeles Times. December 30, 2011 <projects.latimes.com/mapping-la/neighborhoods/neighborhood/watts/>.
3. "2010 U.S. Census." U.S. Census Bureau. March 19, 2012 <2010.census.gov/2010census/>.
4. "Table 19. California – Race and Hispanic Origin: 1850 to 1990." U.S. Census Bureau. September 2002. March 16, 2012 <www.census.gov/population/www/documentation/twps0056/tab19.pdf>.
5. "2010 U.S. Census." U.S. Census Bureau. March 16, 2012 <2010.census.gov/2010census/>.
6. Kashef, Z. "Persistent Peril: Why African American babies have the highest infant mortality rate in the developed world." ColorLines RaceWire. February 2003. June 1, 2009 <www.arc.org/racewire/030210z_kashef.html>.
7. "Looking Forward: Immigrant Contributions to the Golden State." California Immigrant Policy Center. 2010. March 16, 2012 <caimmigrant.org/document.html?id=292>.
8. "How Health Reform Helps Communities of Color in California." Families USA. October 2010. March 19, 2012 <familiesusa2.org/assets/pdfs/health-reform/minority-health/helping-communities-of-color/California.pdf>.
9. "Vital Statistics Section, CD-Rom Public Use Birth Files." California Department of Health Services, Center for Health Statistics. KidsData.org. The Lucile Packard Foundation for Children's Health. March 19, 2012 <www.kidsdata.org/data/topic/table/prenatal_care-race.aspx>.
10. "American Community Survey, 2010." U.S. Census Bureau. March 19, 2012. <factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>.
11. "Medicaid and Children Overcoming Barriers to Enrollment: Findings from a National Survey." The Kaiser Commission on Medicaid and the Uninsured. The Henry J. Kaiser Family Foundation. January 2000. March 19, 2012 <www.kff.org/medicaid/2174-index.cfm>.
12. Collins, K., Hughes, D., Doty, M., Ives, B., Edwards, J., and Tenney, K. "Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans." The Commonwealth Fund. March 2002. May 7, 2009 <www.commonwealthfund.org/Publications/Fund-Reports/2002/Mar/Diverse-Communities--Common-Concerns--Assessing-Health-Care-Quality-for-Minority-Americans.aspx>.
13. Divi, C., Koss, R., Schmaltz, S., and Loeb, J. "Language Proficiency and Adverse Events in U.S. Hospitals: A Pilot Study." The Commonwealth Fund. April 2007. May 7, 2009 <www.commonwealthfund.org/Content/Publications/In-the-Literature/2007/Apr/Language-Proficiency-and-Adverse-Events-in-U-S-Hospitals--A-Pilot-Study.aspx>.
14. "American Community Survey, 2010." U.S. Census Bureau. March 19, 2012. <factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>.
15. Wertheim S. "Asset Poverty Index for San Francisco." Center for Community Innovation. Fall 2004. March 19, 2012 <communityinnovation.berkeley.edu/publications/Wertheim-Asset-Poverty-Index.pdf>.
16. Ibid.
17. "Twenty-to-One: Wealth Gaps Rise to Record Highs Between Whites, Blacks, Hispanics." Pew Research Center. July 26, 2011. March 6, 2012 <www.pewsocialtrends.org/2011/07/26/wealth-gaps-rise-to-record-highs-between-whites-blacks-hispanics/>.
18. "Overlooked and Undercounted 2009: Struggling to Make Ends Meet in California." United Way, Insight Center for Community Economic Development, and Center for Women's Welfare. 2009. February 2012 <www.insightcced.org/uploads/cfes/CA%20Overlooked%20%20Undercounted%202009.pdf>.
19. "Alternative Measures of Labor Underutilization for States, Fourth Quarter of 2010 through Third Quarter of 2011 Averages." United States Department of Labor, Bureau of Labor Statistics. October 2011. March 7, 2012 <www.bls.gov/lau/stalt11q3.htm>.
20. "Race Matters, Unequal Opportunities for Neighborhood Vitality." Annie E. Casey Foundation. April 23, 2009 <www.aecf.org/KnowledgeCenter/Publications.aspx?pubguid={6D9135A8-8896-4C5A-BD8C-58EAC455DFBD}>.
21. Heller, J. and Bhatia, R. "A Health Impact Assessment of the California Healthy Families, Healthy Workplaces Act." Human Impact Partners. 2008. April 23, 2009 <www.healthimpactproject.org/resources/document/California-Paid-Sick-Days.pdf>.
22. Drago, R. and Lovell, V. "San Francisco's Paid Sick Leave Ordinance: Outcomes for Employers and Employees." Institute for Women's Policy Research. February 2011. March 7, 2012 <www.iwpr.org/publications/pubs/San-Fran-PSD>.
23. "Race Matters, Unequal Opportunities in Education." Annie E. Casey Foundation. February 2006. April 23, 2009 <www.aecf.org/upload/publicationfiles/fact_sheet3.pdf>.
24. "Reporting on Race, Education, & No Child Left Behind." Applied Research Center. April 24, 2009 <www.arc.org/pdf/199c.pdf>.
25. "Standardized Testing and Reporting (STAR) Results." California Department of Education. 2010. KidsData.org. The Lucile Packard Foundation for Children's Health. February 17, 2012 <www.kidsdata.org/data/topic/table/reading_proficiency-race.aspx>.
26. "A Portrait of California: California Human Development Report 2011." American Human Development Project. May 17, 2011. February 17, 2012 <www.measureofamerica.org/docs/APortraitOfCA.pdf>.

27. Orfield, G., Losen, D., Wald, J., and Swanson, C. "Losing Our Future: How Minority Youth are Being Left Behind by the Graduation Rate Crisis." The Civil Rights Project at Harvard University. 2004. April 23, 2009 <www.urban.org/UploadedPDF/410936_LosingOurFuture.pdf>.
28. Swanson, C. "Cities in Crisis 2009: Closing the Graduation Gap." Editorial Projects in Education. 2009. April 24, 2009 <www.edweek.org/media/cities_in_crisis_2009.pdf>.
29. "A Decade of Disinvestment: California Education Spending Nears the Bottom." California Budget Project. October 2011. March 16, 2012 <www.cbp.org/pdfs/2011/111012_Decade_of_Disinvestment_%20SFF.pdf>.
30. "Community Colleges Hit by February Surprise of Unexpected Additional \$149 Million Budget Cut." Budget Advocacy Action Center. Community College League of California. February 2012. March 16, 2012 <www.ccleague.net/2012/02/599>.
31. Perez, E. "Despite Diversity Efforts, UC Minority Enrollment Down Since Prop. 209." California Watch. February 2012. March 21, 2012 <californiawatch.org/dailyreport/despite-diversity-efforts-uc-minority-enrollment-down-prop-209-15031>.
32. "Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement." Institute of Medicine. August 2009. April 23, 2012 <www.iom.edu/Reports/2009/RaceEthnicityData.aspx>.
33. "How Can California Spur Job Creation?" Public Policy Institute. February 2011. March 19, 2012 <www.ppic.org/main/publication.asp?i=939>.
34. "An economy that works: Job creation and America's Future." McKinsey & Company. McKinsey Global Institute. June 2011. March 19, 2012. <www.mckinsey.com/Insights/MGI/Research/Labor_Markets/An_economy_that_works_for_US_job_creation>.
35. Mordechay, K. "Fragmented Economy, Stratified Society, and the Shattered Dream." The Civil Rights Project, UCLA. December 2011. March 19, 2012 <civilrightsproject.ucla.edu/research/metro-and-regional-inequalities/lasanti-project-los-angeles-san-diego-tijuana/fragmented-economy-stratified-society-and-the-shattered-dream/labormkt-report-12-20-11-final-corrected.pdf>.
36. "California's Two-Step Minimum Wage Increase Provides an Important Boost to Low-Wage Workers' Earnings." California Budget Project. December 2007. April 9, 2012 <www.cbp.org/pdfs/2007/071211_MinimumWage_000.pdf>.
37. "Why Place Matters: Building a Movement for Healthy Communities." Policy Link and the California Endowment. April 23, 2009 <www.policylink.org/site/apps/nlnet/content2.aspx?c=lkIXLbMNjrE&b=5136581&ct=6997411>.
38. "Recent Research Findings: Health Effects of Particulate Matter and Ozone Air Pollution." California Air Resource Board. November 2007. May 27, 2009 <www.arb.ca.gov/research/health/healthres.htm>.
39. "Environmental Risks and Pregnancy." The March of Dimes. May 27, 2009 <www.marchofdimes.com/pregnancy/stayingsafe_indepth.html>.
40. "State of the Air: 2012." American Lung Association. May 18, 2012 <www.stateoftheair.org/2012/assets/state-of-the-air2012.pdf>.
41. "SB 375: Impact Analysis Report." Urban Land Institute. June 2010. April 23, 2012 <www.uli.org/ResearchAndPublications/~//media/Documents/ResearchAndPublications/Reports/Sustainable%20Development/SB375ImpactAnalysisReport.ashx>.
42. Adams, T., Eaken, A., and Notthoff, A. "Communities Tackle Global Warming: A Guide to California's SB 375." Natural Resources Defense Council and the California League of Conservation Voters. June 2009. April 23, 2012 <www.nrdc.org/globalwarming/sb375/files/sb375.pdf>.
43. Rose, E., Bernstein, A., and Cohen, S. "San Diego and SB 375: Lessons from California's First Sustainable Communities Strategy." December 2011. March 16, 2012 <www.climateplan.org/wp-content/uploads/2011/12/SD_and_sb375-final-Dec5.pdf>.
44. "State Snapshots California: Focus on Disparities 2010." Agency for Healthcare Quality and Research. May 2011. March 6, 2012 <statesnapshots.ahrq.gov/snaps10/dashboard.jsp?menuId=4&state=CA&level=0>.
45. "Childhood Asthma." L.A. Health. Los Angeles County Department of Health Services. October 2004. March 19, 2012 <publichealth.lacounty.gov/wwwfiles/ph/hae/ha/ChildAsthma02.pdf>.
46. "California Health Interview Survey." UCLA Center for Health Policy Research. March 19, 2012 <www.chis.ucla.edu/main/default.asp>.
47. "How Does Air Pollution Affect Agriculture?" Central Valley Air Quality Coalition. May 9, 2009 <www.calcleanair.org/ag-impact.html>.
48. "2009 California Health Interview Survey." UCLA Center for Health Policy Research. March 19, 2012 <www.chis.ucla.edu/main/default.asp>.
49. Meng, Y., Babey, S., Hastert, T., Brown, R. "California's Racial and Ethnic Minorities More Adversely Affected by Asthma." UCLA Center for Health Policy Research. February 2007. April 6, 2009 <www.healthpolicy.ucla.edu/pubs/files/Minorities_Asthma_PB_022707.pdf>.
50. "Food Miles: How Far Your Food Travels Has Serious Consequences for Your Health and the Climate." Natural Resources Defense Council, November 2007. March 19, 2012 <food-hub.org/files/resources/Food%20Miles.pdf>.
51. "Air Pollution and Children's Health" Cal/EPA's Office of Environmental Health Hazard Assessment and the American Lung Association of California. November 2003. June 5, 2009 <www.oehha.ca.gov/public_info/facts/pdf/kidsair4-02.pdf>.
52. "Where We Live Matters for Our Health: The Links Between Housing and Health." Robert Wood Johnson Foundation Commission to Build a Healthier America, September 2008. May 9, 2009 <www.rwjf.org/files/research/commissionhousing102008.pdf>.
53. "American Community Survey, 2010." U.S. Census Bureau. March 19, 2012 <factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>.



54. "Where We Live Matters for Our Health: The Links Between Housing and Health." Robert Wood Johnson Foundation Commission to Build a Healthier America, September 2008. May 9, 2009 <www.rwjf.org/files/research/commissionhousing102008.pdf>.
55. Hood, E. "Dwelling Disparities: How Poor Housing Leads to Poor Health." *Environmental Health Perspectives*. May 2005. March 19, 2012 <www.ncbi.nlm.nih.gov/pmc/articles/PMC1257572/>.
56. "2009 California Health Interview Survey." UCLA Center for Health Policy Research. March 19, 2012 <www.chis.ucla.edu/main/default.asp>.
57. "Dreams Deferred: Impacts and Characteristics of the California Foreclosure Crisis." Center for Responsible Lending. August 2010. February 29, 2012 <www.responsiblelending.org/california/ca-mortgage/research-analysis/california-foreclosure-crisis.html>.
58. "Behind Closed Doors: The Hidden Health Impacts of Being Behind on Rent." Children's HealthWatch. January 2011. February 17, 2012 <www.childrenshealthwatch.org/upload/resource/behindcloseddoors_report_jan11.pdf>.
59. "The Positive Impacts of Affordable Housing on Health: A Research Summary." The Center for Housing Policy. April 23, 2009 <www.nhc.org/pdf/chp_int_summary_hsglth0707.pdf>.
60. "What are the Benefits of Complete Streets?" National Complete Streets Coalition. 2005. April 24, 2009 <www.completestreets.org/benefits.html>.
61. "Roadblocks to Health: Transportation Barriers to Healthy Communities." Center for Third World Organizing, People United for a Better Oakland, and the Transportation and Land Use Coalition (now known as TransForm). 2002. April 8, 2009 <www.transformca.org/files/reports/roadblocks-to-health.pdf>.
62. "2007 California Health Interview Survey." UCLA Center for Health Policy Research. May 7, 2009 <www.chis.ucla.edu/>.
63. Cohen, S. "Healthy Transportation, Healthy Communities." TransForm. March 19, 2012. <www.cpehn.org/pdfs/Healthy%20Transportation%20Healthy%20Communities%20-%20Cohen%20-%20TransForm%204-11.pdf>
64. "Dangerous By Design 2011 California: Solving the Epidemic of Preventable Pedestrian Deaths (And Making Great Neighborhoods)." Transportation for America. 2011. December 29, 2011 <t4america.org/docs/dbd2011/ca-dangerous-by-design.pdf>.
65. Ibid.
66. "What is Safe Routes to School?" Safe Routes National Partnership. April 9, 2012 <www.saferoutespartnership.org/local/what-is-safe-routes-to-school>.
67. "CDC Recommendations for Improving Health through Transportation Policy." Centers for Disease Control and Prevention. April 2010. April 9, 2012 <www.cdc.gov/transportation/docs/FINAL%20CDC%20Transportation%20Recommendations-4-28-2010.pdf>.
68. Rose, E, Bernstein, A, and Cohen, S. "San Diego and SB 375: Lessons from California's First Sustainable Communities Strategy." December 1, 2011. March 16, 2012 <www.climateplan.org/wp-content/uploads/2011/12/SD_and_sb375-final-Dec5.pdf>.
69. Beyers, M., Brown, J., Cho, S., Desautels, A., Gaska, K., Horsley, K., Iton, T., Lee, T., Maker, L., Martin, J., Murgai, N., Schaff, K., Witt, S., and Anderson, S. "Life and Death from Unnatural Causes." Alameda County Public Health Department. August 2008. April 9, 2012 <www.barhii.org/press/download/unnatural_causes_report.pdf>.
70. "Health in All Policies Task Force Report to the Strategic Growth Council." Health in All Policies Task Force. December 3, 2010. April 9, 2012 <sgc.ca.gov/hiap/docs/publications/HiAP_Task_Force_Report.pdf>.
71. Ibid.
72. Beyers, M., Brown, J., Cho, S., Desautels, A., Gaska, K., Horsley, K., Iton, T., Lee, T., Maker, L., Martin, J., Murgai, N., Schaff, K., Witt, S., and Anderson, S. "Life and Death from Unnatural Causes." Alameda County Public Health Department. August 2008. April 9, 2012 <www.barhii.org/press/download/unnatural_causes_report.pdf>.
73. "Backgrounders from the Unnatural Causes Health Equity Database" California Newsreel. April 10, 2009 <www.unnaturalcauses.org/assets/uploads/file/primers.pdf>.
74. Beyers, M., Brown, J., Cho, S., Desautels, A., Gaska, K., Horsley, K., Iton, T., Lee, T., Maker, L., Martin, J., Murgai, N., Schaff, K., Witt, S., and Anderson, S. "Life and Death from Unnatural Causes." Alameda County Public Health Department. August 2008. April 9, 2012 <www.barhii.org/press/download/unnatural_causes_report.pdf>.
75. Echeverria S, Diez-Roux A, Shea S, Borrell L, Jackson S. "Associations of neighborhood problems and neighborhood social cohesion with mental health and health behaviors: The multi-ethnic study of atherosclerosis." *Health and Place* 14 (2008) 853-865. May 7, 2009 <hdl.handle.net/2027.42/60951>.
76. Beyers, M., Brown, J., Cho, S., Desautels, A., Gaska, K., Horsley, K., Iton, T., Lee, T., Maker, L., Martin, J., Murgai, N., Schaff, K., Witt, S., and Anderson, S. "Life and Death from Unnatural Causes." Alameda County Public Health Department. August 2008. April 9, 2012 <www.barhii.org/press/download/unnatural_causes_report.pdf>.
77. "African American Health Statistics." California Department of Public Health. July 2009. March 14, 2012 <publichealth.lacounty.gov/nut/Network/Docs/A.%20A.Health%20Statistics.pdf>.

78. "Adult Mental Health Needs in California: Findings from the 2007 California Health Interview Survey." The UCLA Center for Health Policy Research. November 2011. February 17, 2012. <www.healthpolicy.ucla.edu/pubs/files/MentalHealthreportnov2011.pdf>.
79. Bennet, G, McNeill, L, Woolin, K, Duncan, D, Puleo, E, and Emmons, K. "Safe to Walk? Neighborhood Safety and Physical Activity Among Public Housing Residents." *PLoS Med* 4(10): e306. October 2007. April 1, 2009 <www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2039759>.
80. "2003 California Health Interview Survey." UCLA Center for Health Policy Research. March 19, 2012. <www.chis.ucla.edu/main/default.asp>.
81. Ibid.
82. Ibid.
83. "Tipping Point: Maryland's Overuse of Incarceration and the Impact on Public Safety." Justice Policy Institute. March 2005. April 9, 2012 <www.justicepolicy.org/images/upload/05-03_REP_MD_TippingPoint_AC-MD.pdf>.
84. "Creating Safe Environments: Violence Prevention Strategies and Programs." Prevention Institute. June 2006. May 9, 2009 <www.preventioninstitute.org/documents/CreatingSafeEnvironmentsfinal62206.pdf>.
85. Cohen, L. and Swift, S. "A Public Health Approach to the Violence Epidemic in the United States." *Environment and Urbanization*. October 1993. May 9, 2009 <www.preventioninstitute.org/component/jlibrary/article/id-34/127.html>.
86. Beyers, M., Brown, J., Cho, S., Desautels, A., Gaska, K., Horsley, K., Iton, T., Lee, T., Maker, L., Martin, J., Murgai, N., Schaff, K., Witt, S., and Anderson, S. "Life and Death from Unnatural Causes." Alameda County Public Health Department. August 2008. April 9, 2012 <www.barhii.org/press/download/unnatural_causes_report.pdf>.
87. "Death Statistical Data Tables 2009." California Department of Public Health. March 6, 2012 <www.cdph.ca.gov/data/statistics/Pages/DeathStatisticalDataTables.aspx>.
88. California's Criminal Justice System: A Primer. California Legislative Analyst's Office, January 31, 2007. May 9, 2009 <www.lao.ca.gov/2007/cj_primer/cj_primer_013107.pdf>.
89. "Just the Facts: California's Changing Prison Population." Public Policy Institute of California. July 2011. December 29, 2011 <www.ppic.org/content/pubs/jtf/JTF_Prison/TF.pdf>.
90. "Prison and Jail Inmates at Midyear 2005." Bureau of Justice Statistics. May 2006. May 7, 2009 <bjs.ojp.usdoj.gov/content/pub/pdf/pjim05.pdf>.
91. "Who's in Prison? The Changing Demographics of Incarceration." California Counts: Population Trends and Profiles. Public Policy Institute of California. Volume 8, Number 1, August 2006. December 29, 2011 <www.ppic.org/content/pubs/cacounts/CC_806ABCC.pdf>.
92. "Justices, 5-4, Tell California to Cut Prisoner Population." *The New York Times*. May 2011. December 29, 2011 <www.nytimes.com/2011/05/24/us/24scotus.html?pagewanted=all>.
93. "California Department of Corrections And Rehabilitation: 2010 Adult Institutions Outcome Evaluation Report." California Department of Corrections and Rehabilitation. October 2010. March 14, 2012 <www.cdcr.ca.gov/Adult_Research_Branch/Research_Documents/ARB_FY0506_Outcome_Evaluation_Report.pdf>.
94. "Fact Sheet: Three Strikes." Center on Juvenile and Criminal Justice. March 14, 2012 <www.prisonpolicy.org/scans/cjcj/3strikes_facts.pdf>.
95. "Understanding the Public Health Implications of Prisoner Reentry in California: State-of-the-State Report." The RAND Corporation. 2011. March 7, 2012 <www.rand.org/pubs/monographs/2011/RAND_MG1165.pdf>.
96. Beyers, M., Brown, J., Cho, S., Desautels, A., Gaska, K., Horsley, K., Iton, T., Lee, T., Maker, L., Martin, J., Murgai, N., Schaff, K., Witt, S., and Anderson, S. "Life and Death from Unnatural Causes." Alameda County Public Health Department. August 2008. April 9, 2012 <www.barhii.org/press/download/unnatural_causes_report.pdf>.
97. "Understanding the Public Health Implications of Prisoner Reentry in California: State-of-the-State Report." The RAND Corporation. 2011. March 7, 2012 <www.rand.org/pubs/monographs/2011/RAND_MG1165.pdf>.
98. "Our Health is California's Health: Setting the Health Agenda for 2010 & Beyond." Prevention Institute. October 2010. April 9, 2012 <www.preventioninstitute.org/component/jlibrary/article/id-284/127.html>.
99. Ibid.
100. "Criminal Justice: Preventing Violence: A Primer." Prevention Institute. October 2009. March 19, 2012 <www.preventioninstitute.org/component/jlibrary/article/id-144/127.html>.
101. "Reducing Racial Disparity in the Criminal Justice System: A Manual for Practitioners and Policymakers." The Sentencing Project. September 2008. March 19, 2012 <www.sentencingproject.org/doc/publications/rd_reducingracialdisparity.pdf>.
102. Ibid.
103. Ibid.



104. Yañez, E. and Muzzy, W. "Healthy Parks, Healthy Communities: Addressing Health Disparities and Park Inequities through Public Financing of Parks, Playgrounds, and Other Physical Activity Settings." The Trust for Public Land. November 2005. April 23, 2009 <www.healthjusticect.org/wp-content/uploads/2011/07/HPHC_Policy_Brief.pdf>.
105. "Physical Activity and Health: A Report of the Surgeon General." National Center for Disease Control and Prevention. November 1999. April 24, 2009 <www.cdc.gov/nccdphp/sgr/sgr.htm>.
106. Gies, E. "The Health Benefits of Parks." The Trust for Public Land. 2006. April 23, 2009 <www.tpl.org/publications/books-reports/park-benefits/the-health-benefits-of-parks.html>.
107. "Physical Education Is A Right: The Los Angeles Unified School District Case Study." The City Project and Samuels & Associates. 2011. December 30, 2011 <www.cityprojectca.org/blog/wp-content/uploads/2011/10/PEisaRightTCPA2011.pdf>.
108. Ibid.
109. "Cause of High Blood Pressure." WebMD. March 6, 2009. April 6, 2009 <www.webmd.com/hypertension-high-blood-pressure/guide/blood-pressure-causes>.
110. Bolen, E. and Hecht, K. "Neighborhood Groceries: New Access to Healthy Food in Low-Income Communities." California Food Policy Advocates. January 2003. April 8, 2009 <healthycornerstores.org/wp-content/uploads/resources/CFPAreport-NeighborhoodGroceries.pdf>.
111. "Designed for Disease: The Link Between Local Food Environments and Obesity and Diabetes." California Center for Public Health Advocacy, PolicyLink, and the UCLA Center for Health Policy Research. April 2008. May 7, 2009 <www.healthpolicy.ucla.edu/pubs/publication.asp?pubID=250>.
112. Ibid.
113. Ibid.
114. "USDA Unveils Historic Improvements to Meals Served in America's Schools." U.S. Department of Agriculture. January 2012. March 19, 2012 <www.fns.usda.gov/cga/PressReleases/2012/0023.htm>.
115. "Statewide School Meal Statistics (2009 - 10)." California Food Policy Advocates. March 2011. March 19, 2012 <cfpa.net/ChildNutrition/ChildNutrition_CFPAPublications/StatewideSchoolMealStatistics-2009-10.pdf>.
116. Stokols, D., Pelletier, K.R., and Fielding, J.E. "The ecology of work and health: research and policy direction for the promotion of employee health." *Health Education Quarterly*. 1996; 23:137-158
117. "Table A-1: Time spent in primary activities and percent of the civilian population engaging in each activity, averages per day by sex, 2007 Annual Averages." U.S. Department of Labor, Bureau of Labor Statistics. 2007. July 20, 2010 <www.bls.gov/tus/tables/a1_2007.pdf>.
118. "PLACE Program: Policies for Livable, Active Communities and Environments." Los Angeles County Department of Public Health. May 18, 2012 <publichealth.lacounty.gov/index.htm>.
119. "Health in All Policies Task Force Report to the Strategic Growth Council." Health in All Policies Task Force. December 3, 2010. April 9, 2012 <sgc.ca.gov/hiap/docs/publications/HiAP_Task_Force_Report.pdf>.
120. Beyers, M., Brown, J., Cho, S., Desautels, A., Gaska, K., Horsley, K., Iton, T., Lee, T., Maker, L., Martin, J., Murgai, N., Schaff, K., Witt, S., and Anderson, S. "Life and Death from Unnatural Causes." Alameda County Public Health Department. August 2008. April 9, 2012 <www.barhii.org/press/download/unnatural_causes_report.pdf>.
121. "Health in All Policies Task Force Report to the Strategic Growth Council." Health in All Policies Task Force. December 3, 2010. April 9, 2012 <sgc.ca.gov/hiap/docs/publications/HiAP_Task_Force_Report.pdf>.
122. "Achieving Equity by Building a Bridge from Eligible to Enrolled." California Pan-Ethnic Health Network, UCLA Center for Health Policy Research, and the UC Berkeley Center for Labor Research and Education. February 2012. March 7, 2012 <www.cpehn.org/pdfs/EligibletoEnrolledBrief.pdf>.
123. Hadley, J. "Sicker & Poorer: The Consequences of Being Uninsured." Kaiser Commission on Medicaid & the Uninsured. 2002. April 17, 2009 <www.kff.org/uninsured/upload/Full-Report.pdf>.
124. "National Healthcare Disparities Report, 2005." Agency for Healthcare Research and Quality. December 2005. May 7, 2009 <www.ahrq.gov/qual/nhdr05/nhdr05.htm>.
125. "2009 California Health Interview Survey." UCLA Center for Health Policy Research. March 19, 2012. <www.chis.ucla.edu/main/default.asp>
126. CalSIM 1.5 Projections. UCLA Center for Health Policy Research, and the UC Berkeley Center for Labor Research and Education. 2012.
127. Enrollment data from the California Department of Health Care Services. April 23, 2012.
128. Brown, E.R., Lavarreda, S.A., Ponce, N., Yoon, J., Commings, J., and Rice, T. "The State of Health Insurance in California: Findings from the 2005 California Health Interview Survey." UCLA Center for Health Policy Research. July 2007. May 7, 2009 <www.healthpolicy.ucla.edu/pubs/publication.asp?pubID=226>.
129. Ibid.

130. "Achieving Equity by Building a Bridge from Eligible to Enrolled." California Pan-Ethnic Health Network, UCLA Center for Health Policy Research, and the UC Berkeley Center for Labor Research and Education. February 2012. March 7, 2012 <www.cpehn.org/pdfs/EligibletoEnrolledBrief.pdf>.
131. "California Physician Facts and Figures." California HealthCare Foundation. July 2010. April 23, 2012 <www.chcf.org/publications/2010/07/california-physician-facts-and-figures>.
132. "Realizing Health Reform's Potential: How the Affordable Care Act Will Strengthen Primary Care and Benefit Patients, Providers, and Payers." The Commonwealth Fund. January 2011. April 23, 2012. <www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/Jan/1466_Abrams_how_ACA_will_strengthen_primary_care_reform_brief_v3.pdf>.
133. "Representing the New Majority Part 3: A Status Report on the Diversity of the University of California Medical Student Body." The Greenlining Institute. Spring 2008. May 10, 2009 <www.greenlining.org/resources/pdfs/REPRESENTINGTHENEWMAJORITYPartIII.pdf>.
134. Ibid.
135. Bau I. "Opportunities to Advance Diversity in Our Workforce through the New Health Law." California Pan-Ethnic Health Network. February 2011. March 19, 2012 <org2.democracynaction.org/o/5261/p/salsa/web/common/public/content?content_item_KEY=5178>.
136. "Majorities of Californians Support the Nation's New Health Care Law, But Think More Health Care System Changes are Needed. Just One in Three Believes the Law Should be Reversed." The Field Poll. Field Research Corporation. June 3, 2010. April 9, 2012 <field.com/fieldpollonline/subscribers/Rls2336.pdf>.

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