LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140, Los Angeles, CA 90010 · TEL. (213) 7382816 · FAX (213) 637-4748
Website: http://hiv.lacounty.gov Email: hivcomm@lachiv.org

COMMISSION ON HIV ANNUAL MEETING

Thursday, November 9, 2017
9:00 AM - 4:00 PM

Dorothy Chandler Pavilion
5th Floor, Salons A&B
135 N. Grand Avenue
Los Angeles CA, 90012

Los Angeles County Commission on HIV

VISION

A comprehensive, sustainable, accessible system of prevention and care that empowers people at risk, living with or affected by HIV to make decisions and to maximize their lifespans and quality of life.

MISSION

The Los Angeles County Commission on HIV focuses on the local HIV/AIDS epidemic and responds to the changing needs of People Living With HIV/AIDS (PLWHA) within the communities of Los Angeles County.

The Commission on HIV provides an effective continuum of care that addresses consumer needs in a sensitive prevention and care/treatment model that is culturally and linguistically competent and is inclusive of all Service Planning Areas (SPAs).

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GUIDELINES FOR CONDUCT

The Los Angeles County Commission on HIV has played an active role in shaping HIV services in this County and in the State for over a decade. The dedication to providing quality services to people with and at risk of HIV/AIDS by people who are members of this body, both past and present, is unparalleled.

In order to encourage the active participation of all members and to address the concerns of many Commissioners, consumers and other interested members of the community, it is important that meetings take place in a “safe” environment. A “safe” environment is one that recognizes differences, while striving for consensus and is characterized by consistent professional and respectful behavior. As a result, the Commission has adopted and is consistently committed to implementing the following Guidelines for Conduct for Commission, committee and associated meetings.

Similar meeting ground rules have been developed and successfully used in large group processes to tackle difficult issues. Their intent is not to discourage meaningful dialogue, but to recognize that differences and even conflict can result in highly creative solutions to problems when approached in a respectful and professional manner.

The following should be adhered to by all participants and stakeholders:

1) Be on Time for Meetings
2) Stay for the Entire Meeting
3) Show Respect to Invited Guests, Speakers and Presenters
4) Listen
5) Don’t Interrupt
6) Focus on Issues, Not People
7) Don’t just Disagree, Offer Alternatives
8) Give Respectful, Constructive Feedback
9) Don’t Judge
10) Respect Others’ Opinions
11) Keep an Open Mind to Others’ Opinions
12) Allow Others to Speak
13) Respect Others’ Time
14) Begin and End on Time
15) Have All the Issues on the Table and No “Hidden Agendas”
16) Minimize Side Conversations
17) Don’t Monopolize the Discussion
18) Don’t Repeat What Has Already Been Said
19) If Beepers or Cell Phones Must Be On, Keep Them on Silent or Vibrate

Approved (11/12/1998); Revised (2/10/2005; 9/6/2005)

[REVISED] AGENDA FOR THE REGULAR MEETING OF THE
LOS ANGELES COUNTY COMMISSION ON HIV
(213) 738-2816 / FAX (213) 637-4748
hivcomm@lachiv.org   http://hiv.lacounty.gov

Understanding HIV from Intergenerational Perspectives: Exploring Partnerships, Innovations, and Solidarity

THURSDAY, November 9, 2017, 9:00 AM – 4:00 PM
(Registration begins at 8:30 AM)

Dorothy Chandler Pavilion
5th Floor, Salons A&B
135 N. Grand Avenue, Los Angeles CA, 90012

AGENDA POSTED: November 1, 2017

ATTENTION: Any person who seeks support or endorsement from the Commission on any official action may be subject to the provisions of Los Angeles County Code, Chapter 2.160 relating to lobbyists. Violation of the lobbyist ordinance may result in a fine and other penalties. For information, call (213) 974-1093.

ACCOMMODATIONS: Interpretation services for the hearing impaired and translation services for languages other than English are available free of charge with at least 5 business days' notice before the meeting date. To arrange for these services, please contact Dina Jauregui at (213) 738-2816 or via email at djauregui@lachiv.org.

Servicios de interpretación para personas con impedimento auditivo y traducción para personas que no hablan Inglés están disponibles sin costo. Para pedir estos servicios, póngase en contacto con Dina Jauregui al (213) 738-2816 (teléfono), o por correo electrónico á djauregui@lachiv.org, por lo menos cinco días antes de la junta.

SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. The Commission Offices are located in Metroplex Wilshire, one building west of the southwest corner of Wilshire and Normandie. Validated parking is available in the parking lot behind Metroplex, just south of Wilshire, on the west side of Normandie.

NOTES on AGENDA SCHEDULING, TIMING, POSTED and ACTUAL TIMES, TIME ALLOTMENTS, and AGENDA ORDER: Because time allotments for discussions and decision-making regarding business before the Commission's standing committees cannot always be predicted precisely, posted times for items on the meeting agenda may vary significantly from either the actual time devoted to the item or the actual, ultimate order in which it was addressed on the agenda. Likewise, stakeholders may propose adjusting the order of various items at the commencement of the committee meeting (Approval of the Agenda), or times may be adjusted and/or modified, at the co-chairs' discretion, during the course of the meeting.

If a stakeholder is interested in joining the meeting to keep abreast of or participate in consideration of a specific agenda item, the Commission suggests that the stakeholder plan on attending the full meeting in case the agenda order is modified or timing of the items is altered. All Commission committees make every effort to place items that they are aware involve external stakeholders at the top of the agenda in order to address and resolve those issues more quickly and release visiting participants from the obligation of staying for the full meeting.

External stakeholders who would like to participate in the deliberation of discussion of an a posted agenda item, but who may only be able to attend for a short time during a limited window of opportunity, may call the Commission's Executive Director in advance of the meeting to see if the scheduled agenda order can be adjusted accordingly. Commission leadership and staff will make every effort to accommodate reasonable scheduling and timing requests—from members or other stakeholders—within the limitations and requirements of other possible constraints.

REGISTRATION **8:30 AM – 9:00 AM**

Call to Order and Roll Call 9:00 AM – 9:03 AM

I. ADMINISTRATIVE MATTERS

1. Approval of Agenda MOTION #1 9:03 AM – 9:04 AM

2. Approval of Meeting Minutes MOTION #2 9:04 AM – 9:06 AM

3. Consent Calendar MOTION #3 9:06 AM – 9:07 AM

4. Approve recommendation to endorse the Undetectable = Untransmittable Consensus Statement and forward recommendation to the Board of Supervisors. MOTION #4 9:07 AM – 9:10 AM

5. Welcome and Oath of Office (Lorayne Lingat, Assistant Executive Officer, Executive Office, Board of Supervisors) 9:10 AM – 9:20 AM

II. REPORTS & PRESENTATIONS

6. Report: Acute Communicable Disease Control (ACDC) Program Department of Public Health (Sharon Balter, MD, Chief, ACDC Program) 9:20 AM – 9:45 AM

7. Goals and Objectives for the Day (Cheryl Barrit, Executive Director) 9:45 AM – 10:00 AM

8. Hopes and Aspirations for an Inclusive Conversation (Commissioner G. Wilson) 10:00 AM – 10:10 AM

9. Health Equity Across Generations and Places (Jahmal Miller, Deputy Director, Office of Health Equity, California Department of Public Health) 10:10 AM – 10:40 AM

10. **BREAK** 10:40 AM – 10:50 AM

11. Purposeful Aging: A Model for Age-Friendly Initiative (James Don, Assistant General Manager, City of Los Angeles, Department of Aging) 10:50 AM – 11:20 AM

12. Using Innovative Technology to Prevent HIV among Young MSM (Lynn Miller, Ph.D, USC Annenberg School for Communication & Journalism) — 11:20 AM – 11:50 AM

13. Lunch and Recognitions — 11:50 AM – 1:00 PM

14. Leading the Way: How can the Commission on HIV Sharpen our Intergenerational Lenses for Impactful Leadership - A Panel Discussion (Commissioners F. Darling Palacios, L. Spencer, R.Pena, A.Ballesteros) — 1:00 PM – 1:45 PM

15. Mixer Activity — 1:45 PM – 2:00 PM

16. Learning in Motion: Interactive Activity — 2:00 PM – 2:40 PM

III. PUBLIC COMMENT — 2:40 PM – 2:50 PM

17. Opportunity for members of the public to address the Commission on items of interest that are within the jurisdiction of the Commission.

IV. COMMISSION COMMENT — 2:50 PM – 3:00 PM

18. Non-Agendized or Follow-up

19. Los Angeles County Health Agency: Center for Health Equity (Dr. Barbara Ferrer, Director, Department of Public Health) — 3:00 PM – 3:30 PM

20. 2017 Highlights and Expectations for 2018 — 3:30 PM – 3:45 PM

21. Announcements and Evaluation — 3:45 PM – 3:55 PM

22. Closing Remarks and Adjournment — 3:55 PM – 4:00 PM

PROPOSED MOTION(s)/ACTION(s): **PROCEDURAL MOTION(S):**	
MOTION #1:	Approve the Agenda Order, as presented or revised.
MOTION #2:	Approve the Commission meeting minutes, as presented or revised.
MOTION #3:	Approve the Consent Calendar.

CONSENT CALENDAR:	
MOTION #4:	Approve recommendation to endorse the Undetectable = Untransmittable Consensus Statement and forward recommendation to the Board of Supervisors.

All Commission meetings will begin at their appointed times. Participants should make every effort to be prompt and ready. All agenda items are subject to action. Public comment will be invited for each item. All "action" (non-procedural) motions are included on the consent calendar and are approved when the consent calendar is approved. A motion can be "pulled" from the consent calendar if there are objections to it, or if it is to be presented or discussed later in the meeting.

Commission on HIV Members:			
Bradley Land, Co-Chair	Ricky Rosales, Co-Chair	Majel Arnold, MA-HSA	Traci Bivens-Davis
Al Ballesteros, MBA	Jason Brown	Joseph Cadden, MD	Danielle Campbell, MPH
Raquel Cataldo	Deborah Owens Collins, PA, MSPAS, AAHIVS	David Cunningham (Alternate)	Michele Daniels
Kevin Donnelly	Susan Forrest (Alternate)	Aaron Fox, MPM	Marcos Garcilazo (Alternate)
Jerry D. Gates, PhD	Joseph Green	Terry Goddard II, MA	Bridget Gordon
Grissel Granados, MSW	Lee Kochems, MA	David P. Lee, MPH, LCSW (Alternate)	Eric Paul Leue
Abad Lopez	Andrew Lopez (Alternate)	Eduardo Martinez (Alternate)	Miguel Martinez, MSW, MPH
Anthony Mills, MD	José Munoz	Derek Murray	Diana Oliva, MSW
Frankie Darling-Palacios	John Palomo	Raphael Péna	Mario Pérez MPH
Juan Preciado	Thomas Puckett, Jr.	Ace Robinson, MPH	Rebecca Ronquillo
Martin Sattah, MD	LaShonda Spencer, MD	Kevin Stalter	Yolanda Sumpter
Greg Wilson	Russell Ybarra		
MEMBERS:	**45**		
QUORUM:	**23**		

2. MEETING MINUTES

A. October 12, 2017 Commission Meeting Minutes

LOS ANGELES COUNTY COMMISSION ON HIV

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4. Approve recommendation to endorse the Undetectable = Untransmittable Consensus Statement (Motion #4)

Endorsements Updated: October 15, 2017
Issued: July 21, 2016

RISK OF SEXUAL TRANSMISSION OF HIV FROM A PERSON LIVING WITH HIV WHO HAS AN UNDETECTABLE VIRAL LOAD
Messaging Primer & Consensus Statement

There is now evidence-based confirmation that the risk of HIV transmission from a person living with HIV (PLHIV), who is on Antiretroviral Therapy (ART) and has achieved an undetectable viral load in their blood for at least 6 months is negligible to non-existent. (Negligible is defined as: *so small or unimportant as to be not worth considering; insignificant*.) While HIV is not always transmitted even with a detectable viral load, when the partner with HIV has an undetectable viral load this both protects their own health and prevents new HIV infections.[i]

However, the majority of PLHIV, medical providers and those potentially at risk of acquiring HIV are not aware of the extent to which successful treatment prevents HIV transmission.[ii] Much of the messaging about HIV transmission risk is based on outdated research and is influenced by agency or funding restraints and politics which perpetuate sex-negativity, HIV-related stigma and discrimination.

The consensus statement below, addressing HIV transmission risk from PLHIV who have an undetectable viral load, is endorsed by principal investigators from each of the leading studies that examined this issue. It is important that PLHIV, their intimate partners and their healthcare providers have accurate information about risks of sexual transmission of HIV from those successfully on ART.

At the same time, it is important to recognize that many PLHIV may not be in a position to reach an undetectable status because of factors limiting treatment access (e.g., inadequate health systems, poverty, racism, denial, stigma, discrimination, and criminalization), pre-existing ART treatment resulting in resistance or ART toxicities. Some may choose not to be treated or may not be ready to start treatment.

Understanding that successful ART prevents transmission can help reduce HIV-related stigma and encourage PLHIV to initiate and adhere to a successful treatment regimen.

The following statement has been endorsed by:

- Dr. Michael Brady – Medical Director of Terrence Higgins Trust and Consultant HIV Physician, London, UK
- Dr. Myron Cohen – Principal Investigator, HPTN 052; Chief, Division of Infectious Diseases, UNC School of Medicine, North Carolina, USA
- Dr. Demetre C. Daskalakis, MPH – Assistant Commissioner, Bureau of HIV/AIDS Prevention and Control New York City Department of Health and Mental Hygiene, New York, USA

- Dr. Andrew Grulich – Principal Investigator, Opposites Attract; Head of HIV Epidemiology and Prevention Program, Kirby Institute, University of New South Wales, Australia
- Dr. Jens Lundgren – Co-principal Investigator, PARTNER; Professor, Department of Infectious Diseases, Rigshospitalet, University of Copenhagen, Denmark
- Dr. Mona Loutfy, MPH – Lead author on Canadian consensus statement on HIV and its transmission in the context of the criminal law; Associate Professor, Division of Infectious Diseases, Women's College Hospital, University of Toronto, Toronto, ON, Canada
- Dr. Julio Montaner – Director of the British Columbia Centre for Excellence in HIV/AIDS; Director of IDC and Physician Program Director for HIV/AIDS PHC, Vancouver BC, Canada
- Dr. Pietro Vernazza – Executive Committee, PARTNER; Author, Swiss Statement 2008, Update 2016; Chief of the Infectious Disease Division, Cantonal Hospital in St. Gallen, Switzerland

The following statement has also been endorsed by over 400 organizations from 60 countries including:

- ACT - AIDS Committee of Toronto - Canada
- African and Black Diaspora Global Network on HIV/AIDS - ABDGN - Canada
- AIDES - France
- AIDS ACTION NOW - Canada
- AIDS Alabama - United States
- AIDS Foundation of Chicago - United States
- AIDS United - United States
- APLA Health - United States
- AIDS Solidarity Movement - Cyprus
- Australian Federation of AIDS Organizations - Australia
- Being Positive Foundation – India
- Black AIDS Institute - United States
- British Columbia Centre for Excellence in HIV/AIDS - Canada
- British HIV Association - United Kingdom
- Canadian AIDS Society - Canada
- Canadian HIV/AIDS Legal Network - Canada
- Canadian Positive People Network - Canada
- CATIE - Canadian AIDS Treatment Information Exchange - Canada
- Chicago Department of Health - United States
- Czech AIDS Help Society - Czech Republic
- Desmond Tutu HIV Foundation - South Africa
- District of Columbia Department of Health - United States
- GMHC - United States
- HIV Medicine Association – United States
- Housing Works - United States
- Human Rights Campaign - United States
- ICASO - International Council of AIDS Service Organizations - Canada
- INA - Māori, Indigenous & South Pacific HIV/AIDS Foundation - New Zealand

- International AIDS Society - Switzerland
- International Community of Women Living with HIV - Kenya
- Latino Commission on AIDS - United States
- Michigan Department of Health & Human Services - United States
- MSMGF (the Global Forum on MSM & HIV) - United States
- NAM aidsmap - United Kingdom
- National AIDS Trust - United Kingdom
- National Alliance of State and Territorial AIDS Directors (NASTAD) - United States
- National Black Justice Coalition - United States
- New York City Department of Health and Mental Hygiene - United States
- New York State Department of Health - United States
- Positive Women's Network - USA - United States
- San Francisco AIDS Foundation - United States
- Sensoa - Belgium
- Sidaction - France
- Southern AIDS Coalition - United States
- Terrence Higgins Trust - United Kingdom
- Whitman-Walker Health - United States
- YouthCO HIV & Hep C Society - Canada

(**The full list of organizational endorsements is here.**)

People living with HIV on ART with an undetectable viral load in their blood have a negligible risk of sexual transmission of HIV. Depending on the drugs employed it may take as long as six months for the viral load to become undetectable. Continued and reliable HIV suppression requires selection of appropriate agents and excellent adherence to treatment. HIV viral suppression should be monitored to assure both personal health and public health benefits.

NOTE: An undetectable HIV viral load only prevents HIV transmission to sexual partners. Condoms also help prevent HIV transmission as well as other STIs and pregnancy. The choice of HIV prevention method may be different depending upon a person’s sexual practices, circumstances and relationships. For instance, if someone is having sex with multiple partners or in a non-monogamous relationship, they might consider using condoms to prevent other STIs.

“NEGLIGIBLE” = so small or unimportant as to be not worth considering; insignificant.

ADDITIONAL EXPERT QUOTES, SOURCES, AND EXPLANATIONS [iii]

1. "When ART results in viral suppression, defined as less than 200 copies/ml or undetectable levels, it prevents sexual HIV transmission. Across three different studies, including thousands of couples and many thousand acts of sex without a condom or pre-exposure prophylaxis (PrEP), no HIV transmissions to an HIV-negative partner were observed when the HIV-positive person was virally suppressed. This means that people who take ART daily as prescribed and achieve and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner." U.S. Centers for Disease Control & Prevention (CDC), Dear Colleague Letter (September, 2017)

2. "The science really does verify and validate U=U." Anthony S. Fauci, M.D., Director, NIAID, NIH, Speech at the United States Conference on AIDS (September, 2017)

3. "Last month, the global medical and scientific community at the forefront of HIV research and care came together in Paris for the ninth International AIDS Society Conference, where they announced – unequivocally – that an undetectable HIV viral load means HIV is untransmittable." Dr. Julio Montaner, UBC-Killam Professor of Medicine; UBC-St. Paul’s Hospital Foundation chair in AIDS Research, Editorial (August, 2017)

4. "In addition to the positive impact upon the health of people living with HIV, there is increasing consensus among scientists that people with undetectable HIV in their blood do not transmit HIV sexually. This knowledge can be empowering for people living with HIV. The awareness that they are no longer transmitting HIV sexually can provide people living with HIV with a stronger sense of being agents of prevention in their approach to new or existing relationships." UNAIDS Explainer (July, 2017)

5. “If you diligently take your medicine and keep your viral load to below detectable levels, you will not be dangerous to your partner. We now have the scientific data to say you may be “infected” but you are not “infectious”. That goes a long way toward eliminating the stigma associated with HIV.” Anthony S. Fauci, M.D., Director, NIAID, NIH Video interview (July, 2017)

6. “Scientists never like to use the word 'Never' of a possible risk. But I think in this case we can say that the risk of transmission from an HIV-positive person who takes treatment and has an undetectable viral load may be so low as to be unmeasurable, and that’s equivalent to saying they are uninfectious. It’s an unusual situation when the overwhelming evidence base in science allows us to be confident that what we are saying is fact.” Anthony S. Fauci, M.D., Director, NIAID, NIH NAM aidsmap (July, 2017)

7. "People who take their ART effectively and in whom the virus is suppressed to undetectable levels are no longer infectious. A massive public health and social justice response has led to unprecedented scale up of this miraculous treatment." UNAIDS Science Report, Issue #6 (July, 2017)

8. "As the UK's leading voice for HIV health professionals, our backing for U=U is unequivocal. There should be no doubt about the clear and simple message that a person with sustained, undetectable levels of HIV virus in their blood cannot transmit HIV to their sexual partners. This fact is a testament to the preventive impact of effective HIV treatment and highlights the need to maximise access to treatment in order to minimise and ultimately eradicate HIV transmission. Spreading the U=U message is also an important way to help reduce the stigma experienced by people living with HIV, whose sexual partners may fear infection unnecessarily." British HIV Association Chair, Professor Chloe Orkin, statement from BHIVA (July, 2017)

9. "This is a landmark development in the response to HIV and too many people are not hearing this message and receiving its full benefit. A person living with HIV with a sustained suppressed viral load poses no risk of transmitting HIV. This development puts each one of us living with HIV at the forefront of stopping new infections, and gives everyone strong, clear and direct language to stop the stigma and move all communities faster towards ending the epidemic." Jesse Milan, Jr., President & CEO, statement from AIDS United (March, 2017)

10. "Research demonstrating that people living with HIV who are virally suppressed cannot transmit HIV to others is one of the most important developments in HIV prevention in the last decade. It is now more important than ever that we ensure universal access to antiretroviral therapy and educate our communities about the public health benefits of effective HIV treatment." Craig E. Thompson, Chief Executive Officer, statement from APLA Health (March, 2017)

11. "Desmond Tutu HIV Foundation strongly endorses the Prevention Access Campaign core message: Undetectable HIV is Untransmittable HIV (U=U). An HIV-positive person who maintains an undetectable viral load with the aid of regular, successful treatment cannot transmit HIV sexually. This knowledge has the potential to alter negative perceptions around the disease, yet the message still hasn't reached everyone." Statement from Desmond Tutu HIV Foundation (March, 2017)

12. "NAM aidsmap, one of the foremost sources of HIV information in the world, strongly endorses the 'Undetectable Equals Untransmittable' (U=U) Consensus Statement issued by the Prevention Access Campaign. The scientific evidence is clear. Someone who has undetectable levels of virus in their blood does not pose an infection risk to their sexual partners. This understanding transforms the way that HIV is considered with enormous implications for what

it now means to live with HIV and the best ways to prevent it." Statement from NAM aidsmap (February, 2017)

13. "NASTAD joins public health experts and leaders in affirming that there is now conclusive scientific evidence that a person living with HIV who is on antiretroviral therapy (ART) and is durably virally suppressed (defined as having a consistent viral load of less than <200 copies/ml) does not sexually transmit HIV." Statement from NASTAD (February, 2017)

14. "All of us here at CATIE, and indeed around the world, are celebrating the most significant development in the HIV world since the advent of effective combination therapy 20 years ago – people living with HIV with sustained undetectable viral loads can confidently declare to their sexual partners "I'm not infectious!" This is an absolute game-changer and those who live with HIV can proudly share this information. At the same time, service providers working in HIV must get up to speed fast and share this far and wide with their communities." Laurie Edmiston, Executive Director, Statement from CATIE - Canadian AIDS Treatment Information Exchange (January, 2017)

15. "The scientific evidence is clear and unequivocal: effective treatment reduces HIV transmission risk to zero. The Consensus Statement highlights unprecedented scientific consensus that early diagnosis and treatment with antiretroviral therapy (ART) not only restores people living with HIV to a normal life expectancy, but it also has far-reaching public health impacts." Joint statement from ICASO (International Council of AIDS Service Organizations) and INA (Māori, Indigenous & South Pacific) HIV/AIDS Foundation (January, 2017)

16. "...studies have proven that when an individual living with HIV is on antiretroviral therapy and the virus is durably suppressed, the risk that he or she will sexually transmit the virus is negligible." Anthony S. Fauci, M.D., Director, National Institute of Allergy and Infectious Diseases; Carl W. Dieffenbach, Ph.D., Director, Division of AIDS, NIAID. NIH Statement on World AIDS Day 2016 (December, 2016)

17. "If you are durably virologically suppressed you will not transmit to your partner... I'll say this again, for somebody who is in a discordant couple, if the person [with HIV] is virologically suppressed, 'durably' --there is no virus in their system, hasn't been for several months -- your chance of acquiring HIV from that person is ZERO. Let's be clear about that: ZERO. If that person the next day stops therapy for two weeks and rebounds, your chance goes up. That's why we talk about 'durable' viral suppression...You're as durably virologically suppressed as good as your adherence." Carl W. Dieffenbach, Ph.D., Director, Division of AIDS, NIAID, NIH. NIH Video interview (November, 2016)

18. "When an HIV positive person first starts on treatment, it takes a few months before viral growth is completely suppressed. During that short window of time, the couple should use

condoms. Alternatively, the HIV negative partner might use antiretroviral agents as pre-exposure prophylaxis [PrEP].” Dr. Myron Cohen Chief, Division of Infectious Diseases, UNC School of Medicine, North Carolina, USA; Principal Investigator, HPTN 052. POZ magazine (September, 2016)

19. Suppressing the viral load of a person living with HIV to undetectable levels "not only saves their lives but prevents them from infecting others. So the higher percentage of people who are on treatment, in care and get their viral loads to undetectable, the closer you get to literally ending the epidemic.” Anthony S. Fauci, M.D., Director, NIAID, NIH. NIH Video Interview (August, 2016)

20. “Once you begin therapy, you stay on therapy, with full virologic suppression you not only have protection from your own HIV…but you also are not capable of transmitting HIV to a sexual partner. With successful antiretroviral treatment, that individual is no longer infectious.” Carl W. Dieffenbach, Ph.D., Director, Division of AIDS, NIAID, NIH. NIH Video interview (August, 2016)

21. “We can now say with confidence that if you are taking HIV medication as prescribed, and have had an undetectable viral load for over six months, you cannot pass on HIV with or without a condom." Dr. Michael Brady, Medical Director, Terrence Higgins Trust, London, England (July, 2016)

22. "The force of evidence in both real world and clinical trial experience confirms that individuals with suppressed viral loads have a negligible risk of transmitting HIV. Treatment as prevention, pre-exposure prophylaxis, and traditional prevention measures, like condoms, make up an HIV prevention toolkit based in harm-reduction that allows individuals to make personalized and enlightened decisions to both maintain their health and prevent HIV and STI transmission.” Dr. Demetre C Daskalakis, MPH - Assistant Commissioner, Bureau of HIV/AIDS Prevention and Control New York City Department of Health and Mental Hygiene (July, 2016)

23. “Does this work over a long period of time for people who are anxious to be suppressed? The answer is absolutely yes, we now have 10,000 person years (of follow-up) with zero transmissions from people who are suppressed." Dr. Myron Cohen. Medpage; NEJM. (July, 2016)

24. “Among serodifferent heterosexual and MSM couples in which the HIV-positive partner was using suppressive ART and who reported condomless sex…there were no documented cases of within-couple HIV transmission” among 58,000 condomless sex acts. Reporting on PARTNER study, Dr. Alison Rodger, et al. JAMA. (July, 2016)

25. “These results are simple to understand – zero transmissions from over 58,000 individual times that people had sex without condoms…[PARTNER study] provides the strongest estimate of actual risk of HIV transmission when an HIV positive person has undetectable viral load – and that this risk is effectively zero.“ Simon Collins, Steering Committee, PARTNER, i-BASE (July, 2016)

26. "The [Swiss] statement [was the first position statement that] addressed the infectiousness of an HIV-positive person once the virus was stably suppressed for at least 6 months with ART. [T]he [Swiss Federal Commission for AIDS-related Issues] felt, based on an expert evaluation of HIV transmission risk under therapy, that the risk of HIV transmission in such a situation was negligible.” Dr. Pietro Vernazza, chief of the Infectious Disease Division, Cantonal Hospital in St. Gallen, Switzerland; Executive Committee, PARTNER Swiss Medical Weekly (Jan., 2016, confirming the original 2008 Swiss statement)'

27. “[T]he HPTN 052 study saw only cases of transmission during ART that occurred shortly (days) after the initiation of therapy. If only transmissions after the first six months of ART are considered (as stipulated in the Swiss statement) the efficacy would have been 100% with a transmission risk of zero.” Dr. Pietro Vernazza, Swiss Medical Weekly (Jan., 2016)

28. "Achieving viral suppression protects the body’s immune system, helps people living with HIV stay healthy and prevents transmission of HIV to other people." UNAIDS - Joint United Nations Programme on HIV/AIDS (2016)

29. “We have…rigorous confirmation that treatment prevents the spread of HIV and improves the health of infected people.” Dr. Thomas R. Frieden, Center for Disease Control Director, USA New England Journal of Medicine sourcing HPTN 052 & PARTNER studies (Dec., 2015)

30. "EATG calls for much better public information to be made available in Europe and globally about the prevention benefits of antiretroviral therapy (ART), and in particular (about) the fact that HIV-positive people with undetectable viral loads are not infectious. Widespread ignorance of this fact helps perpetuate stigma against and criminalisation of people living with HIV and it should be the subject of a funded public awareness campaign, possibly to run in conjunction with a PrEP awareness campaign." European AIDS Treatment Group (EATG) (October, 2015)

31. "If people are taking their pills reliably and they're taking them for some period of time, the probability of transmission in this study is actually zero." Dr. Myron Cohen, Chief, Division of Infectious Diseases, UNC School of Medicine, North Carolina, USA; Principal Investigator, HPTN 052 Interview with plus (August, 2015)

32. “[People with HIV] will not pass on the infection, if the virus is undetectable, to their partners...” Professor David Cooper - Director of the Kirby Institute for Infection and Immunity in Society. University of NSW, Australia; ABC AU interview (May, 2015)

33. When asked what the study tells us about the chance of someone with an undetectable viral load transmitting HIV, presenter Alison Rodger said: "Our best estimate is it's zero." Reporting on PARTNER study interim results. Dr. Alison Rodger, University College London, United Kingdom; Lead Author PARTNER, NAM -AIDSMap (March, 2014)

34. People living with HIV “are leading lives that are normal in quality and length. With effective treatment, they are not infectious.” Health care workers on effective HIV treatment are “totally safe.” Professor Dame Sally Davies, Chief Medical Officer, England. The Telegraph (Aug., 2013)

35. "Many people want to know their status, because they want to be rendered not contagious, because of confidence in living their lives normally. So I've heard dozens of stories of people who came in and said, 'I want to be tested, because if I'm infected I don't want to be transmissible.' Inspiring.” Dr. Myron Cohen, Chief, Division of Infectious Diseases, UNC School of Medicine, North Carolina, USA; Principal Investigator, HPTN 052; MEDPAGE Today (Jan., 2013)

36. “In reality, if you give the treatment the opportunity to get on with its work, you will have zero transmission.” Dr. Julio Montaner, Director of the British Columbia Centre for Excellence in HIV/AIDS; Director of IDC and Physician Program Director for HIV/AIDS PHC: TED Talk referring to HPTN 052 (Nov., 2011)

[i] Much of the current prevention messaging refers to this as Treatment as Prevention or TasP. As of the writing of this primer, there have been no confirmed cases of HIV transmission from a person with an undetectable viral load in any studies. The official cut-off point for an undetectable viral load as defined by the WHO ranges from <50 copies/ml in high-income countries to <1,000 copies/ml in low to middle-income countries. **For the purposes of this statement, an undetectable viral load is defined as under <200 copies/ml, which is also the measurement for viral suppression.**

[ii] Only a small proportion of people living with HIV in a large US treatment study regarded themselves as non-infectious after up to three years on antiretroviral therapy (ART), and a third of participants regarded their chance of transmitting HIV to a partner as still ‘high’, even though only 10% of participants actually had a detectable viral load.” NAM aidsmap (2016)

[iii] Acknowledgements: In addition to PAC’s Founding Task Force and Bruce Richman (PAC Executive Director), Professor Carrie Foote (Indiana University-Indianapolis; HIV Modernization Movement) and Edwin Bernard (HIV Justice Network) reviewed and provided valuable input on the Primer.

LOS ANGELES COUNTY COMMISSION ON HIV

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SPEAKERS' BIOGRAPHIES

LOS ANGELES COUNTY COMMISSION ON HIV ANNUAL MEETING

THURSDAY, NOVEMBER 9, 2017

"Understanding HIV from Intergenerational Perspectives: Exploring Partnerships, Innovations, and Solidarity"

SPEAKER BIOS

Jahmal Miller, MHA, BA, was appointed by Governor Jerry Brown as Deputy Director to the Office of Health Equity at the California Department of Public Health in October 2013. In August 2014, the California State Senate unanimously voted to confirm Mr. Miller.

Previously, he served as Communications Manager with Kaiser Permanente's National Offices - Community Benefit, Health Policy & Research Division. At Kaiser Permanente, he also served in the Central Valley Service Area, where he was the Manager for Community & Government Relations within the Public Affairs Division. Mr. Miller has provided overall management for Sutter Health's Sacramento Sierra Region as Manager for Strategic Marketing & Communications and oversight of growth, marketing and communications efforts with large-employer groups and brokers. Prior to that, he was the Program Manager for Sutter Children's Hospital at Sutter Medical Center, Sacramento. Mr. Miller was responsible for managing inpatient and outpatient operations by providing strategic direction for Sutter Children's Cancer Program and Outpatient Clinics. He has been a board member of the California Child Care Referral and Resource Network, one of the most respected systems of child care resources and referrals in the United States. The following are additional volunteer boards where he has served: American Heart Association's Western Region Health Equity Task Force, American Diabetes Association, Bloodsource Community Advisory & Ronald McDonald House Charities. Mr. Miller completed an Executive Fellowship with the Nehemiah Emerging Leaders Program in conjunction with the American Leadership Forum & CORO.

Mr. Miller is a proud graduate of Columbia University in New York City, receiving a Bachelor of Arts Degree in Psychology, and he holds a Master of Healthcare Administration from the University of Southern California.

James Don is the Assistant General Manager of the City of Los Angeles Department of Aging. The department is the designated Area Agency on Aging for the City of Los Angeles and provides Older Americans Act programs, Evidence Based Program Health and Wellness Centers, paratransit services, and pilot projects. He has recognized the numerous changes taking place within the senior community and as a result advocates for their needs. He has been administering senior and family caregiver services for 22 years for the City of Los Angeles. As the AGM, he is responsible for the department's management of services, new programs, budget and fiscal operations.

Lynn Carol Miller, PhD, is a Professor of Communication and Psychology at USC. She has over 80 publications and has been Principal Investigator on interdisciplinary HIV-prevention projects totaling over $13M (e.g., funded by the Centers for Disease Control and Prevention, National Institute of Mental Health (NIMH), National Institute of Allergy and Infectious Diseases (NIAID), National Institute for General Medical Sciences (NIGMS), California HIV/AIDS Research Program, and other agencies) and a Co-PI/senior scientist on other grants (National Institute for Drug Abuse (NIDA); Navy Personnel Research Studies and Technology/DoD; Office of Naval Research; AFOSR/DoD; United States Army, etc.) totaling an extra $5M.

Her research uses virtual interactive and gaming technologies to study, predict and reduce real-life risky decision-making for high-risk, diverse, community-based populations. The resulting game applications are designed to be both (1) scalable and capable of being rapidly diffused (e.g. through DVDs or the Internet) and (2) usable in neural (e.g., functional MRI) "test-beds" to better understand the complex dynamics of risky decision-making in challenging contexts for risky versus safe target populations.

At the center of this work is an approach called Socially Optimized Learning in Virtual Environments (SOLVE), which is a neuroscience-based approach to changing risky behaviors that are more automatic and contextual. In this approach MSM go on a "virtual date" that simulates real-life challenges and options, within which interventions to change decision-making are embedded.

Publishing in and reviewing for top outlets in many fields, Dr. Miller is a sought after speaker/consultant for academic and government sponsored conferences/meetings/panels (e.g., NIH, NSF). Dr. Miller has been the recipient of a variety of awards for research and teaching, including the Gerald R. Miller Early Career Award from the International Network on Interpersonal Relationships, the Provost Fellowship from the Center for Interdisciplinary Research at USC and the Phi Kappa Phi Mentorship Award.

Frankie Darling-Palacios, is from Los Angeles and uses gender neutral pronouns, "They/Them". Frankie is of Salvadoran descent and attended Cal State Northridge where they majored in Women's Studies with a focus on LGBTQ Studies. In their youth two things stood out that drove their desire to work in public health: a kindergarten teacher dying from AIDS and seeing the AIDS quilt when they were just 10 years old. These two events drove them to assure that those living with HIV/AIDS have access to wellness services and that those lives lost did not die in vain. They have worked in the field for more than four years conducting outreach and advocating for patients.

Currently, they serve as Co-Chair of the Transgender Service Provider Network and works at the Los Angeles LGBT Center. As an outreach and enrollment counselor for the LGBT Center some of their accomplishments consists of drafting a "No-Wrong Door" approach to enrollment services where LGBT patients can access health care enrollment through various events and locations during open enrollment, submitting 1,123 applications for consumers in ten months, conducting outreach in unique ways (ex: targeting specific populations such as individuals seeking PrEP, transgender people seeking gender reaffirming procedures, and lesbians seeking competent sexual health care), developing materials associated with health education and enrollment for transgender people, and reducing barriers to accessing healthcare by navigating clients through various state and federal programs.

Lashonda Spencer, MD, is an Assistant Professor of Clinical Pediatrics and Clinical Director of the MCA Clinic at LAC+USC Keck School of Medicine. Dr. Spencer provides primary HIV care to pediatric, adolescent and adult patients, including pregnant women. Her areas of research interest are HIV and prevention of Maternal to Child transmission, and HIV disease in Women and Adolescents. Her current research projects include Antiretroviral Concentrations in Breast Milk in HIV Infected Postpartum Women; Comparison of Immune Response in Blood and Breast Milk in HIV Infected Women, as well as several International Maternal Pediatric Adolescent AIDS Clinical Trials Group sponsored studies. Dr. Spencer has recently been selected for a grant award for AIDS United Dissemination of Evidence-Informed Interventions grantee for the Enhanced Patient Navigation for HIV-Positive Women of Color (Navigation WoC) intervention.

Raphael Pena, was born in Mexico and moved to Los Angeles approximately six years ago. He studied communication and tourism at the Universidad del Valle de Mexico and is also a choreographer. Raphael is bilingual in Spanish and English and considers himself a good communicator. As an effective communicator, he is able to educate and inform the public about HIV/AIDS. He is currently serving a second term as a commissioner for the Los Angeles County Commission on HIV.

Al Ballesteros, MBA, BA, is the President & Chief Executive Officer of JWCH Institute, Inc., a Los Angeles based non-profit, Federally Qualified Community Health Center, since October 2003. In this capacity, Mr. Ballesteros manages all aspects of the organizations functions, providing strategic direction and interacting with directors to implement community-based medical, social services, prevention and outreach programs for indigent men and women living in Los Angeles County. Previous to this appointment, Mr. Ballesteros was the Associate Vice President of HIV and Substance Services for AltaMed Health Services Corporation for the period of 1993 to 2003. In that capacity, he managed the growth of these services from $385,000 to over $8 million and was directly responsible for a wide-range of HIV programs from prevention to home health care for people living with or at-risk of acquiring HIV infection. Mr. Ballesteros managed a staff of more than 70 professionals and more than 30 grants from various public and private funding sources including Ryan White Title I, II, III and IV, the State of California, County of Los Angeles, Federal sources and the Centers for Disease Control and Prevention (CDC).

Currently, Mr. Ballesteros is Co-Chair of the Los Angeles County Commission on HIV Health Services and the Local Ryan White Title I and II Planning Council. He has been an active member of the Los Angeles County HIV Health Services Commission for more than ten years and has more than 13-years professional experience working in the HIV medical and social service system in Los Angeles County.

Mr. Ballesteros is one of the founding members and current publisher of ADELANTE Magazine, LA's most distinguished gay and lesbian bilingual publication. ADELANTE has become the voice of the gay and lesbian Latino community and is currently distributed across California. His community work includes participation as a member of the Los Angeles Police Department's Gay and Lesbian Community Task Force; as a past member of the Board of Directors of Being Alive: People with HIV / AIDS Action Coalition in Los Angeles; as a past member of the National Board of Directors of NAPA FASA (a national advocacy organization of substance mis-use agencies), and as a past Chair of the LA County HIV Health Services Commission's Fiscal Committee.

Barbara Ferrer, PhD, MPH, MEd, BA, Barbara Ferrer is a nationally-known public health leader with over 30 years of professional experience as a philanthropic strategist, public health director, educational leader, researcher, and community advocate. She has a proven track record of working collaboratively to improve population outcomes through efforts that build health and education equity. Most recently, Dr. Ferrer served as the Chief Strategy Officer for the W.K. Kellogg Foundation, where she was responsible for developing the strategic direction for critical program-related work and providing leadership to the foundation's key program areas: Education & Learning; Family Economic Security; Food, Health & Well-Being; Racial Equity; Community Engagement; and Leadership Development.

Prior to working at the W.K. Kellogg Foundation, Dr. Ferrer served as the Executive Director of the Boston Public Health Commission, where she led a range of public health programs and built innovative partnerships to address inequities in health outcomes and support for healthy communities and healthy families. During her time as Executive Director, Dr. Ferrer secured federal, state, and local funding for critical public health infrastructure and community-based programs. Under her leadership, the City of Boston saw significant improvements in health outcomes, including a decrease in the rates of childhood obesity, smoking, and infant mortality.

Dr. Ferrer has also served as Director of Health Promotion & Chronic Disease Prevention and Director of the Division of the Maternal & Child Health at the Massachusetts Department of Public Health. As a headmaster at a district high school in Boston, she led efforts to significantly improve high school graduation rates and ensure that every graduating senior was accepted to college. Dr. Ferrer received her Ph.D. in Social Welfare from Brandeis University, a Master of Arts in Public Health from Boston University, a Master of Arts in Education from the University of Massachusetts, Boston, and a Bachelor of Arts in Community Studies from the University of California, Santa Cruz.

riKu Matsuda, Senior Intergroup Relations Specialist, for the L.A. County Department of Workforce Development Aging and Community Services. His subject matter expertise is in hate crimes and violence affecting transgender and gender non-binary communities. riKu is a seasoned facilitator certified in community mediation.

AJ King, MPH, is an independent consultant with over 25 years of experience in the field of public health and nonprofit management. His work focuses on building the capacity of non-profit organizations, implementing community-based assessments, planning, facilitation and writing. A strong advocate for collaborative approaches, AJ has facilitated such processes for the Centers for Disease Control and Prevention, local coalitions and community based-organizations. He has also written successful grant proposals at the federal, state, and local level. As a seasoned trainer, AJ has developed numerous curricula and engaged a variety of audiences ranging from public health officials to community level providers. AJ served in leadership roles on the Los Angeles County Commission on HIV, HIV Prevention Planning Council, and is currently a member of the Annenberg Foundation's LA n Sync Grant Development Corps.

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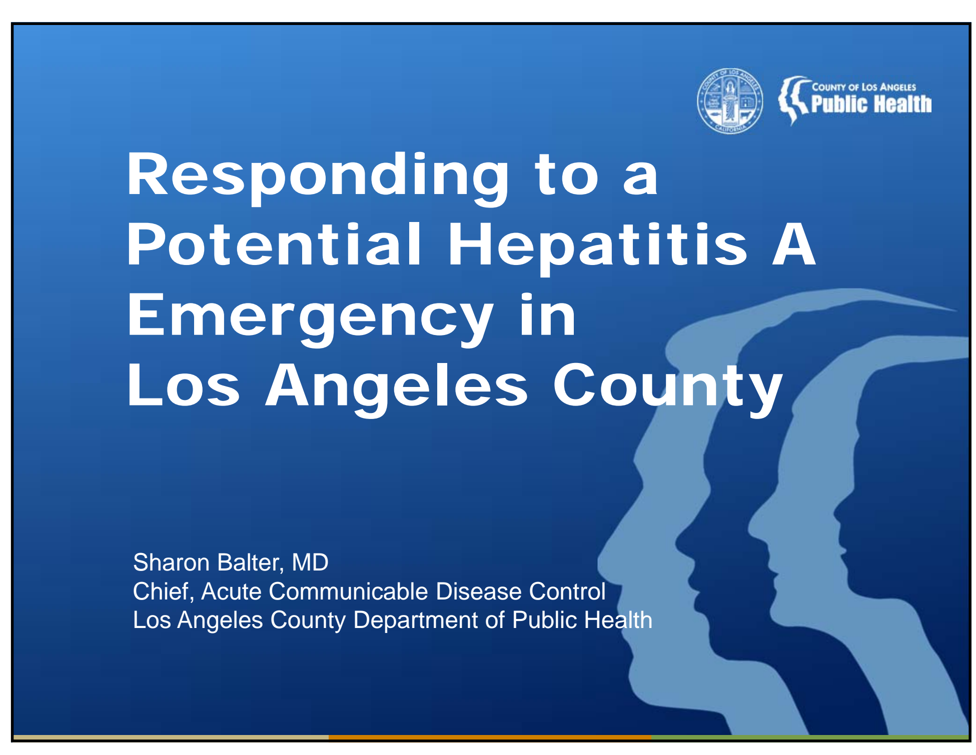
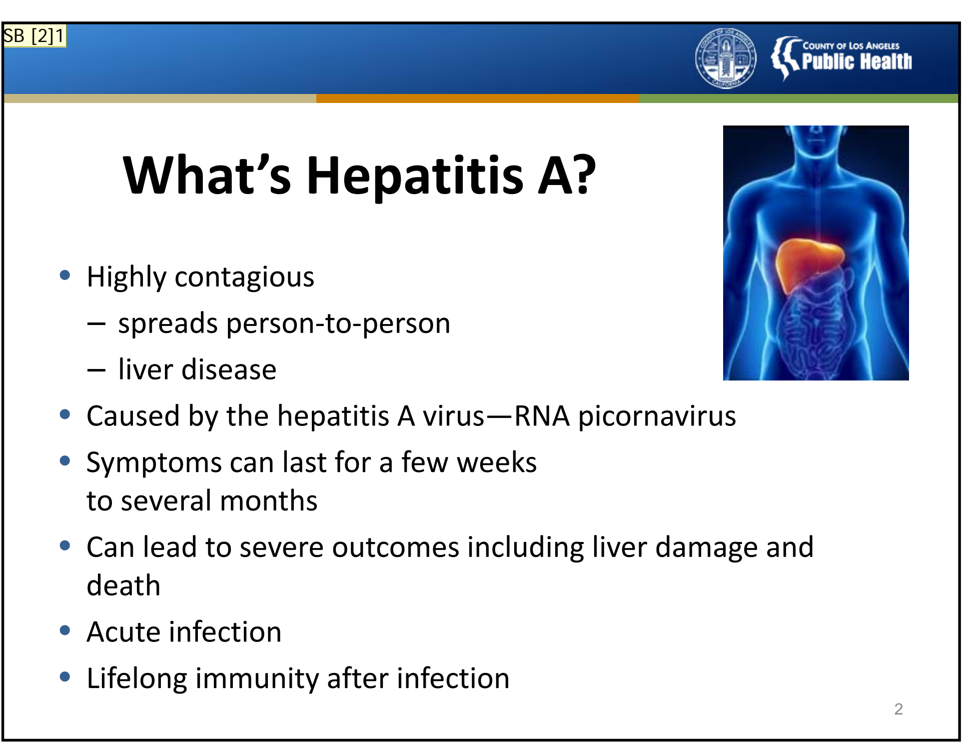
6. Report: Acute Communicable Disease Control (ACDC) Program, Department of Public Health


County of Los Angeles
Public Health
Responding to a Potential Hepatitis A Emergency in Los Angeles County
Sharon Balter, MD
Chief, Acute Communicable Disease Control
Los Angeles County Department of Public Health


SB [2]1
County of Los Angeles
Public Health
What's Hepatitis A?
• Highly contagious
– spreads person-to-person
– liver disease
• Caused by the hepatitis A virus—RNA picornavirus
• Symptoms can last for a few weeks to several months
• Can lead to severe outcomes including liver damage and death
• Acute infection
• Lifelong immunity after infection
2

Slide 2

SB [2]1 remove A

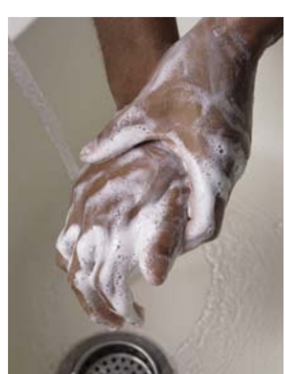
Sharon Balter, 9/16/2017

Epidemiology

- Reservoir is humans
- Primary mode of transmission is fecal-oral
  - Person-to-person, consumption of contaminated food or water
  - Bloodborne transmission can occur although rare
- Average incubation period is 28 days (15–50 days)
- Infectious period is 2 weeks prior to 1 week after onset of symptoms
  - Post-exposure prophylaxis (PEP) with vaccine or immune globulin is effective if given $\leq$ 2 weeks after exposure

How Can You Prevent Hepatitis A?

- Two doses of hepatitis A vaccine
  - Has been recommended for all children in Los Angeles County since 1999
  - Many adults are not protected and are vulnerable to infection
- Improved sanitation
- Handwashing
  - Before eating or preparing food
  - After changing diapers
  - After using the bathroom



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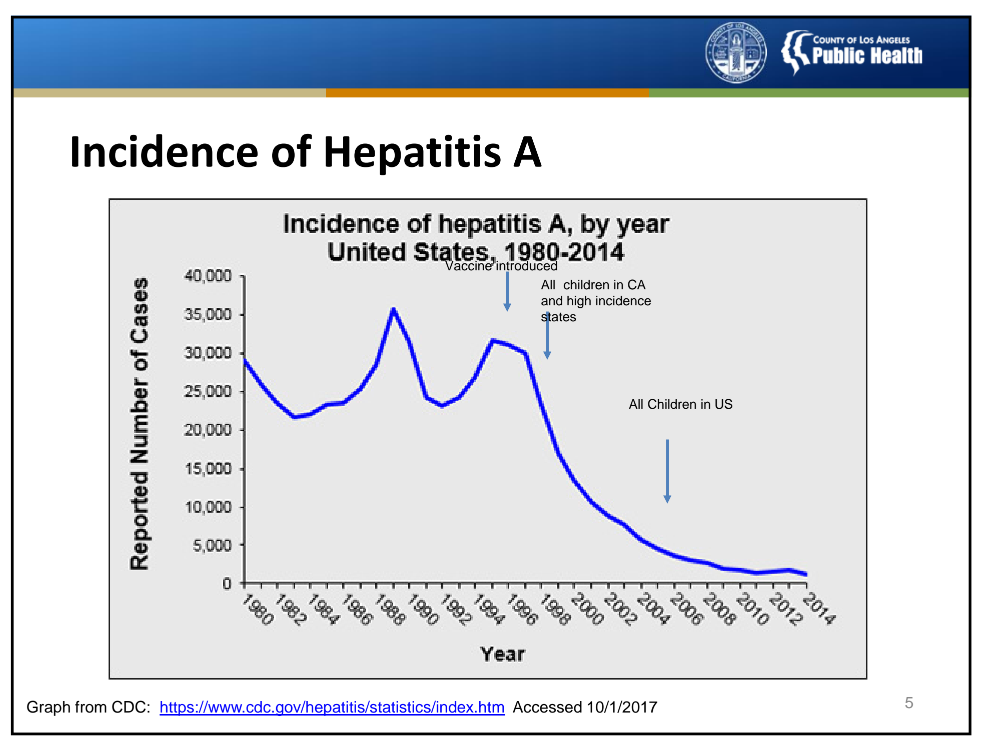
County of Los Angeles
Public Health
Incidence of Hepatitis A
Incidence of hepatitis A, by year
United States, 1980-2014
Reported Number of Cases
Vaccine introduced
All children in CA and high incidence states
All Children in US
Year
Graph from CDC: https://www.cdc.gov/hepatitis/statistics/index.htm Accessed 10/1/2017
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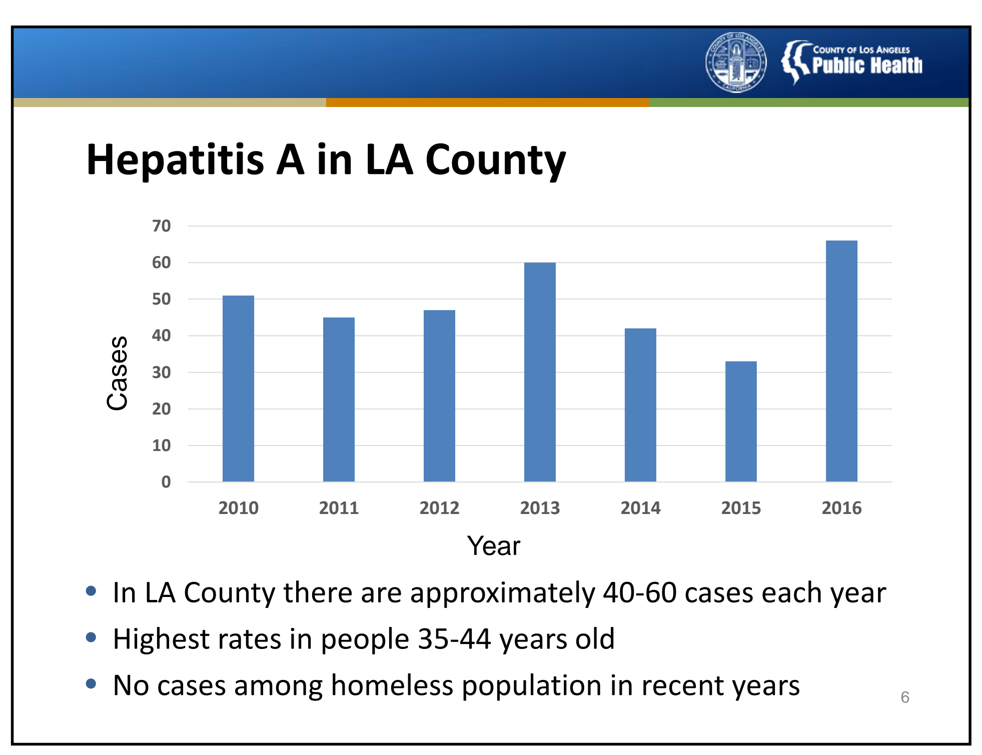
County of Los Angeles
Public Health
Hepatitis A in LA County
Cases
Year
In LA County there are approximately 40-60 cases each year
Highest rates in people 35-44 years old
No cases among homeless population in recent years
6

San Diego Hepatitis A Outbreak

- First case had onset on November 24, 2016
- Spread has been very rapid due to poor sanitary conditions
- As of October 26, 2017
  - 536 cases
  - 369 (68.8%) hospitalizations
  - 20 (3.7%) deaths
- 80% of outbreak patients are homeless and/or used illicit drugs.
- High fatality rate most likely reflects prior illness in the affected population.

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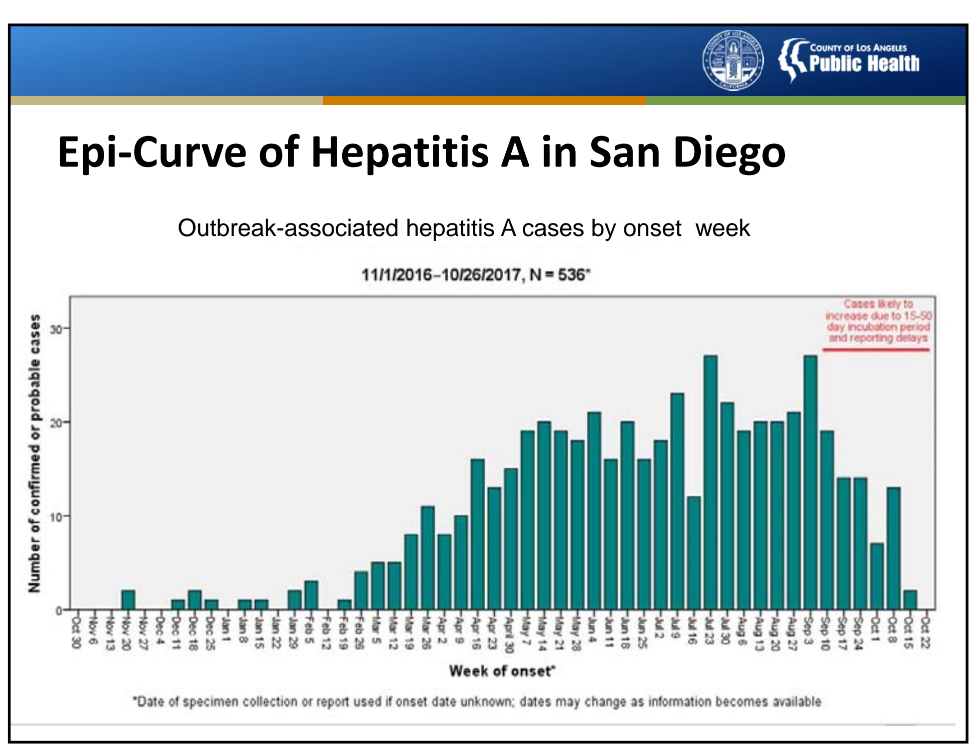

Symptoms of Hepatitis

- Fever/Chills/Headache
- Malaise/Fatigue
- Anorexia
- Nausea/Vomiting/Diarrhea
- Abdominal Pain
- Nothing at all! (20-30% of adults)

- Liver involvement
  - Jaundice
  - Dark urine
  - Light colored stools

Symptoms of Hepatitis A continued

- In children < 6, 70% of infections will be asymptomatic and if symptomatic will have no jaundice
- In adults 70% of infections will be symptomatic (though 30% still asymptomatic
- Patients can be infections for 2 weeks before jaundice and 1 week after jaundice
- Symptoms generally <20 months though 10-15% may have prolonged or relapsing illness
- 20% hospitalized
- < 1 % fatality rate

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Hepatitis A among Men who have Sex with Men (MSM)

- Included in ACIP Guidelines
  - Always at higher risk
- Outbreaks are occurring Internationally and nationally
  - Europe
  - Chile
  - Australia
  - New York City
  - Colorado
  - San Francisco

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Immunity in the population

- All infants 12-14 months of age in LA County since 1999
- This means that adults over 18 are not immune
- The generation between 20 and 40
  - probably had less exposure to hepatitis A in childhood
  - Are sexually active
  - Travel both domestically and internationally

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Hepatitis A among MSM

- Not surprisingly increase beginning among MSM
- 14 cases to date this year, 9 in all of last year
- Estimated 400,000 MSM in LA County
- Persons with HIV
  - May have longer course of illness
  - May see an increase in HIV viral load
  - May have to stop HIV medications that are hepatotoxic

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Infectious Period

- Two weeks before onset
- One week after jaundice (or symptom onset in the absence of jaundice)

Case Definition of Acute Hepatitis A

Clinical criteria

- An acute illness with discrete onset of symptoms (fever, headache, malaise, anorexia, nausea, vomiting, diarrhea and abdominal pain)

Evidence of liver injury

- Jaundice **or** elevated serum aminotransferase (ALT or AST) levels

AND

Positive IgM antibody to hepatitis A (IgM anti-HAV)

or

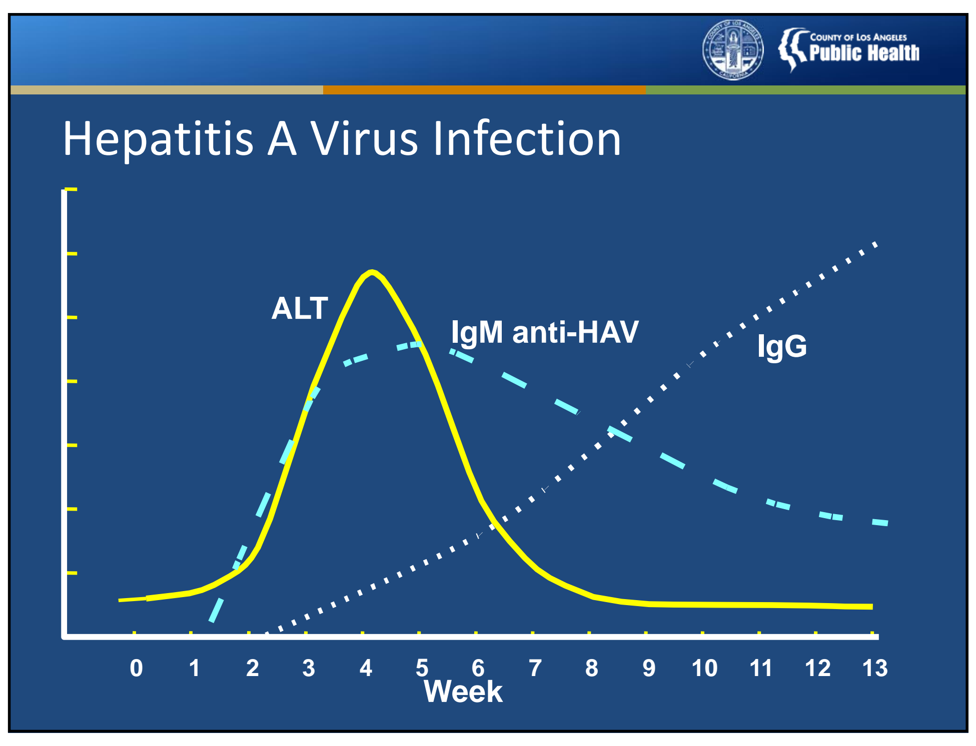
Epidemiologic link with person who has laboratory confirmed illness

Hepatitis A IgM

- Indicates acute disease
- Reportable
- Can last ~6 months after acute disease
- Can occur after vaccination
- Non-specific
  - Many false + cases
- Should **NOT** be used for routine screening order when
  - Patient is symptomatic or
  - Has elevated LFTs

Hepatitis A Total Antibody Test

- Anti-HAV total reflects the presence of both IgM and IgG
- Useful to show prior disease or immunity
- Must order IgM to determine if patient has acute disease
- Not Reportable



Reporting

- Suspect cases of HAV should be reported **immediately**
  - by phone,
  - while the patient is still at the clinical facility, in order to facilitate an on-site interview by a public health investigator and prophylaxis of contacts especially if the patient is homeless

Phone 888-397-3993.

After hours call: 213-974-1234

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Post Exposure Prophylaxis (PEP)

- **PEP** for contacts of cases
  - Provide PEP within 2 weeks of exposure
  - Vaccination recommended in all persons >1 year old
  - For persons at risk of severe infection add immune globulin
    - For older people and especially for those with serious immune compromise (HIV with low CD4, Chemotherapy, high dose steroids) can consider Gamma globulin
    - Also for person with serious underlying liver disease
    - **Note: increased dose for IM IG to 0.1 mL/kg**

Current ACIP Vaccine Recommendations

- All Children 12-23 months of age
- Persons traveling to countries with high or intermediate endemicity of Hepatitis A
- MSM
- Use of Injection and non-injection drugs
- Persons who have occupational risk factors such as working with HAV positive primates or work with the virus in a research laboratory workers
- Persons with clotting factor disorders
- Persons with chronic liver disease
- As recommended during outbreaks

HIV and Hepatitis A

- Hepatitis A may increase HIV viral load
- HIV may prolong Hepatitis A viremia
- Drugs for HIV can be hepatotoxic and may have to be stopped during hepatitis A infection

Vaccine Supply

- At-risk adults
  - homeless individuals
  - persons with direct contact with these individuals
    - Jail inmates, substance abuse treatment
  - those who meet other ACIP-identified risk factors
    - chronic liver disease
    - men who have sex with men
      - Especially those who are HIV
    - travel to an endemic country
- Due to limited vaccine supply, persons who desire immunity but do not fall within one of these priority groups should **not** be vaccinated at this time, but can be considered for vaccination when supplies increase.

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Vaccine Supply

- Hepatitis A/B vaccine (Twinrix)
  - Patients who are eligible for Hepatitis A and B vaccine should receive Twinrix
  - Twinrix is a 3 dose vaccine providing protection against both viruses.
  - Supplies are not known to be currently constrained.

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Prevention

- **Pre-exposure prophylaxis in LA County right now**
  - Vaccine recommendation is 2 doses 6 months apart
  - Even a single dose offers excellent protections
  - Vaccinate persons who are homeless or use drugs
    - First dose highly immunogenic (98% for single Ag vaccine)
    - Free vaccine available from Public Health for the uninsured (see website for time/location of clinics); also covered by Medi-Cal and ADAP
  - Consider vaccination for HCWs and persons who have ongoing close contact with the homeless and drug users
    - Especially those who prepare and serve food to the homeless

Prevention: Sanitation

- Emphasize handwashing with soap and water
  - Depending on alcohol concentration & exposure times, hand sanitizer may be less effective
- Environmental cleaning
  - Disinfect bathrooms and surfaces with bleach (1:10 dilution), formulation of quaternary ammonium and HCl (toilet bowl cleaner), or 2% glutaraldehyde

- Reduce risky behaviors
  - Don't share food, drink, eating utensils, smokes, towels, or toothbrushes with other peoples
  - Don't have sex with someone who has hepatitis A

What is DPH Doing to Respond to Hepatitis A?

- Investigating all hepatitis A cases
- Providing vaccinations for all case contacts, homeless people, new jail inmates, active drug-users, and some service providers, promoting vaccine among MSM
- Educating clinicians and service providers

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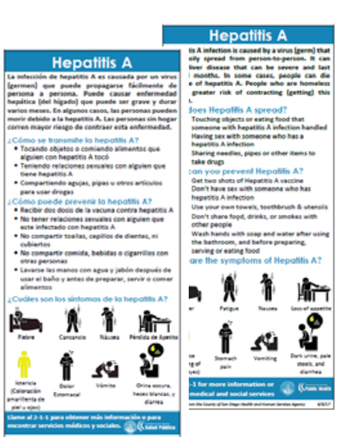
Steps to Prevent Increased Numbers of Hepatitis A Cases

- Promoting awareness and vaccination through media and social media
- Conducting health education and promoting vaccination



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Where Can People at Risk Get Vaccinated?

- Personal providers
- DPH Outreach events
- Pharmacies
- DHS and DPH Clinics

Dial 211 to locate a clinic.

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7. GOALS AND OBJECTIVES FOR THE DAY

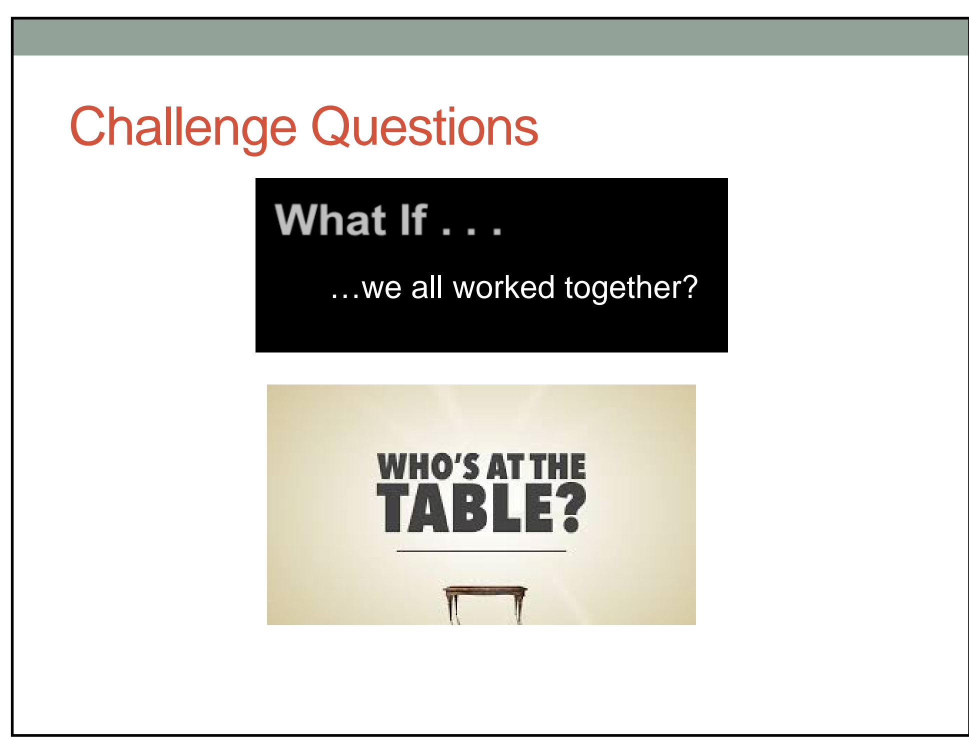
LOS ANGELES COUNTY COMMISSION ON HIV

Annual Meeting Goals and Objectives

November 9, 2017

Goals and Objectives

- Learn about initiatives that promote intergenerational perspectives around HIV/STD prevention and care
- Discuss ideas on assuring continued leadership and shared responsibility for an effective HIV/STD response
- Promote intergenerational understanding and enhance collaborations



Planning Council Reflectiveness

(Use HIV/AIDS Prevalence data as reported in your FY 2017 Application)

Race/Ethnicity	Living with HIV/AIDS in EMA/TGA		Total Members of the Planning Council		Non- Aligned Consumers on Planning Council	
	Number	Percentage (include % with #)	Number	Percentage (include % with #)	Number	Percentage (include % with #)
White, not Hispanic	15308	31.01%	11	26.83%	4	28.57%
Black, not Hispanic	10431	21.13%	8	19.51%	3	21.43%
Hispanic	20748	42.03%	12	29.27%	4	28.57%
Asian/Pacific Islander	1653	3.35%	1	2.44%	0	0.00%
American Indian/Alaska Native	274	0.56%	0	0.00%	0	0.00%
Multi-Race/Not Specified	951	1.93%	9	21.95%	3	21.43%
Total	49365	100%	41	100%	14	100%
Gender	Number	Percentage (include % with #)	Number	Percentage (include % with #)	Number	Percentage (include % with #)
Male	43008	87.12%	28	68.29%	11	78.57%
Female	5678	11.50%	11	26.83%	3	21.43%
Transgender	679	1.38%	1	2.44%	0	0.00%
Unknown	0	0.00%	1	2.44%	0	0.00%
Total	49365	100%	41	100%	14	100%
Age	Number	Percentage (include % with #)	Number	Percentage (include % with #)	Number	Percentage (include % with #)
13-19 years	171	0.35%	0	0.00%	0	0.00%
20-29 years	4553	9.22%	0	0.00%	0	0.00%
30-39 years	9164	18.56%	11	26.83%	1	7.14%
40-49 years	14553	29.48%	8	19.51%	3	21.43%
50-59 years	14662	29.70%	13	31.71%	7	50.00%
60+ years	6227	12.61%	5	12.20%	1	7.14%
Other/Unknown	35	0.07%	4	9.76%	2	14.29%
Total	49365	100%	41	100%	14	100%

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8. HOPES AND ASPIRATIONS FOR AN INCLUSIVE CONVERSATION

MORE THAN A SEAT AT THE TABLE: A RESOURCE FOR AUTHENTIC AND EQUITABLE YOUTH ENGAGEMENT

Author: Rebecca Reyes and Malana Rogers-Bursen

If you're working on creating change in your community, it's important to include all kinds of people in decision-making, including young people. The insight and talents of young people can bring value to any community change effort, yet community groups led by older adults sometimes find it hard to involve younger people, or keep them engaged.

We've led workshops on youth engagement to help people explore challenges they may face and think about possible solutions. People of all ages and from many sectors contributed their ideas for successfully engaging young people in their efforts. We've compiled a number of challenges that you may have encountered in your work or that may come up in the future, along with ways to address these challenges in your group.

There are many barriers young people can face that prevent them from getting involved. The barrier may be logistical, such as a meeting time or location. Even when we get young people to the table, they might not feel like they have an equal voice or decision making power.

Whenever we bring young people onto a planning team or steering committee, we need to make sure they're making a meaningful contribution. Think back to how you were involved as a young person. Would you have been satisfied if you were asked to join a sports team, but were never allowed to play? What about if you volunteered with a group, but weren't given any specific task to do? Or if you didn't see the impact you were making at your workplace, however small?

CIVIC AMBASSADOR PROGRAM LAUNCHES: ENGAGING STUDENTS AND RESIDENTS THROUGHOUT THE STATE

CT Civic Ambassadors will be the messengers of the importance of civic education and engagement by Connecticut residents and the catalysts for civic action that can lead to stronger civic health and...

TAKING ON THE CRIMINAL JUSTICE SYSTEM AFTER SPENDING 18 MONTHS IN JAIL FOR A CRIME HE DIDN'T COMMIT

Joshua Glenn was 16 years old when police officers arrested and charged him with aggravated assault with a weapon. “They tried to say I shot a guy,” said Glenn. After spending 18 months in jail for a...

All Updates...

Ultimately, the goal is to create intergenerational work with equitable relationships. This means that young people not only have a seat at the table and contribute in a meaningful way, but they are also a key part of decision-making. Engagement is just the first step.

Participants at Everyday Democracy's 2016 Convening, The Moment is Now: Democracy For All

Before you bring young people onto the team, it's good practice to have a conversation about *why* it's important to include young people and how you envision them contributing. Make sure everyone is on board and understands young people's value.

Another important step is setting ground rules. This can help make sure that people have equal voice in meetings and respect for each individual's opinion regardless of age.

The challenges and solutions you'll read about can come into play no matter which age range you're targeting, but you should define as a group what you mean by "youth" or "young people." We define "youth" as anyone who is middle school and high school age, typically between the ages of 12-18. We define "young adult" as anyone between the ages of 18-30, and "young people" as anyone under 30. It's also important to recognize that there are many different experiences people may have, even within these age ranges.

Note that young people aren't the only ones who might face some of the challenges listed below. When you address these barriers, you're being inclusive of many groups of people.

This is an in-depth list that is meant to be used as a reference whenever issues arise. Feel free to scroll through the list of scenarios and solutions, or click one of the links below to jump to a specific challenge:

- Understand how young people can contribute
- Making meetings and events appealing to young people
- Young people may not be aware of unspoken norms and practices
- Experience barriers
- The norms and practices are set and communicated by adults
- Young people have limited voice in meetings
- Allowing young people to try something that didn't work in the past
- One young person is asked to be the voice for their peers
- The same young people are always invited
- Microaggressions get in the way of building bridges between generations and cultural and racial identities
- Decisions made by planning teams don't reflect the diversity of the community

RESOURCES BY ISSUE

Racial Equity
Education
Neighborhoods
Early Childhood Development
Youth
Poverty
Diversity
Immigration
Community-Police Relations

JOIN OVER 13,000 CHANGEMAKERS IN RECEIVING MONTHLY E-MAILS WITH TIPS, TOOLS, AND STORIES TO CREATE CHANGE

Challenge: Understand how young people can contribute

Scenario:

Your planning team has been around for many years and most of the original members are still involved. The group is now almost entirely made up of people over 55. Your team discusses the fact that they need to bring younger people into the effort. When they mention new candidates who they consider to be younger, they're referring to people in their 40's. One team member suggests connecting with some local high school or college groups to recruit a younger demographic. Some of the decision-makers don't think the team should invite high school or college students to participate because they think people in those age groups won't have much to contribute. How can you overcome this challenge?

Strategies:

- Before bringing on young people, discuss why you want to go in this direction.
- Ask the adults in the group what their fears are with inviting young people to join the team. Validate their feelings and discuss strategies to overcome their fears.
- Take some time to talk about what kinds of activities the team members participated in as young adults and young people. Sometimes reconnecting with some of their experiences as a young person can help them be more open to bringing on younger people to their team.
- As a group, work to challenge assumptions. Implement a process you can use in your own group to identify when biases are clouding your decisions.
- Identify clear ways young people can contribute to the group.

Challenge: Making meetings and events appealing to young people

Scenario:

Your team always makes an effort to reach out to youth and young adults to be part of the planning process and to attend the events. Even though you put a significant amount of effort into recruiting young people, very few young people show up for the events and not many attend more than one or two of the planning meetings. You suspect that the meetings and events are missing some elements that would attract young people. How can you overcome this challenge?

Strategies:

- Examine any logistics of the meeting that may prevent young people from coming, and make necessary adjustments. For example: the time and place, transportation issues, and acknowledging that younger students are busy and often need parent permission.
- Take a look at how your team has been recruiting youth. Brainstorm some new recruitment tactics or groups to reach out to.
- Talk with some of the youth in your network. Ask them why they may or may not join the team. Try some of their ideas for recruiting more youth.
- Make sure the meetings themselves are a welcoming environment for youth.
- Make sure young people see and understand that they will be a valuable part of the team.
- Communicate the value for them. For example, they may be able to count their participation as service hours or work on a project that they can add to their resume.
- Provide incentives to join.
- If your recruitment efforts continue to fail, recognize that youth may simply not be interested in being involved in this part of the process. Make sure there are other meaningful ways youth can contribute.

Challenge: Young people may not be aware of unspoken norms and practices

Scenario:

People of all ages are part of a planning committee you're involved in. Older members have been part of the planning committee for many years. However, for the youngest members, this may be the first time participating in a team like this. There are many unspoken norms that the youngest and newest members are unaware of which make it difficult for them to participate fully. For example, older members often use a lot of jargon when mentioning organizations or describing certain ways of doing things, many of the older members come early or stay late to chat and end up making decisions without the entire team, and younger team members never offer to bring the snack because they aren't sure if or how to get reimbursed for the expense. How can you overcome this challenge?

Strategies:

- Make space in each meeting to answer any questions about language used or how the team is run.
- Celebrate questions and engagement in the group.
- Set up an orientation for all new members so they can learn how the process works.
- As a team, work to stop using acronyms and jargon during meetings and in your

communication materials.
- Recognize that new people may have different ideas and ways of working. Be open to hearing their ideas and implementing new ways of running meetings or doing projects.
- Create an anonymous space to ask questions about language – for example a white board. This way people can ask questions about what they don't know without feeling embarrassed.
- Give new members a glossary of terms.

Challenge: Experience barriers

Scenario:

The people on your planning team come from a wide range of ages and backgrounds. In one of the meetings, a young person suggests an idea for a flyer design. A more experienced group member suggests something different and adds, "I have 25 years of experience in publishing, so we should go with my idea." The young person shuts down and doesn't add anything else to the conversation that day. This kind of scenario happens at many of the meetings – when a young person suggests an idea, someone with more experience overshadows their idea. How can you overcome this challenge?

Strategies:

- Validate feelings from older adults that they may be threatened by young people or worried that their experience isn't valuable.
- As a group, work on recognizing the value of different perspectives, particularly those of young people.
- Establish ground rules as a group that includes respecting differences and refer to them during meetings as needed.
- Committee chairs should have a separate discussion with people who often shut down conversations. Ensure they make space for everyone's experiences, including those of young people.
- Evaluate who should do the project based on how well they've done similar projects in the past instead of how many years of experience they have. For example, you might have people who are interested in the project submit samples of their work and have the team choose the right person for the job based on the samples.
- Actively create meaningful opportunities for involvement for young people. Encourage young people to work on projects that make a wide impact and affect the whole community. Don't just have young people work on projects that affect other young people.
- Use this as an opportunity for an older and younger person to work together on a project. Make sure they both play an equal part in the project and that the older person isn't simply dictating what the younger person should do.
- Equip older adults to respond to these kinds of scenarios in the moment and advocate

for the younger people in the group if necessary.

Challenge: The norms and practices are set and communicated by adults

Scenario:

A number of youth are excited about joining your planning committee. They bring energy and unique perspective to the team. But, they also want to have fun. They suggest dance parties, community gatherings, and games. The adults respond that that’s not how they’ve done things in the past and they don’t have time or resources to incorporate these ideas. The youth start to lose interest in the meetings and in the work. How can you overcome this challenge?

Strategies:

- Revisit why the group decided to involve young people in the planning for the process.
- Add more youth to the planning team, or have youth create their own sub-committee. This can ensure that there are enough people to plan those kinds of events and that their voices are heard.
- Work as a group to be open to the ideas of young people before you invite them to join the committee.

Challenge: Young people have limited voice in meetings

Scenario:

Your steering committee has teamed up with a high school club to help design an upcoming community event. There are three high school students and ten adults that are part of this team. In the meetings you notice that people from the high school group rarely add their opinion or suggest ideas. How can you overcome this challenge?

Strategies:

Recognize the value young people will bring to your group:

- Before inviting young people, discuss ways to prepare adults to accept youth decision-making and ways to prepare youth to be decision-makers.
- Make sure bringing in younger people is a true collaboration and not simply an invitation to become a token "youth" member of the group. From the beginning, recognize the value they bring and make sure it's a mutually beneficial relationship.

- The adults could meet separately to explore how their behavior can shut down or exclude youth.

Intentionally listen to the experiences of younger people in the group:

- Have young people share their experiences with the group in a facilitated conversation so they have the space to discuss any challenges they're facing in contributing to the group.
- Plan a separate meeting to hear from youth stakeholders to ensure that their voice is heard.
- Have the adults reach out to the students one-on-one to begin establishing a relationship.

Create a welcoming meeting structure:

- As a group, explore how decisions are made and try new ways to run the meeting that may make it easier for young people to contribute.
- When the meeting organizer asks the group for suggestions or ideas, go around the room so everyone has a chance to share their opinion instead of the people who are the loudest.
- Examine the meeting structure - are the meetings long? Is it difficult for youth to access the meetings? Is the location and time accessible? Make sure the environment is youth-friendly.
- Rotate facilitation of the meeting so both adults and youth share this kind of role in the meeting equally.
- Instead of voicing opinions or ideas out loud, have people write ideas on a small piece of paper. That gives people time to formulate their ideas and is another way to make space for everyone to contribute.
- Integrate ways to evaluate and improve the meetings, anonymously if necessary.

Challenge: Allowing young people to try something that didn’t work in the past

Scenario:

People of all ages are part of the planning committee you’re involved in. You’re noticing a pattern in the meetings --whenever a younger person offers an idea, older adults quickly dismiss it because “we’ve tried that before.” Since the older adults hold positions with decision-making power, there isn’t further discussion about whether that idea could be tried again in a different way. Young people feel like their ideas and opinions don’t matter. They eventually stop offering ideas and coming to meetings. How can you overcome this challenge?

Strategies:

- Address the “elephant in the room” that young people have stopped attending – ask the committee why they think that is.
- Be clear about the purpose of young people being a part of the planning committee – the benefit for the planning committee and the benefit for the young people.
- Establish ground rules as a group and refer to them during meetings as needed.
- Be aware of knowledge gaps. Understand that young people may not know the history of different projects. Explain *why* a particular idea did not work. Also be open to hearing from young people about how their idea might be different.
- Have the young person who presented the idea and the older adult who was involved in a similar project partner to work on the idea together. That way, the younger person can learn from the mistakes that were made in the past while still having the opportunity to implement a new way of doing things.
- Use this as an opportunity for young people to develop skills to advocate for themselves. Older adults can mentor younger team members on how to get their ideas heard.

Challenge: One young person is asked to be the voice for their peers

Scenario:

Someone on the steering committee had the idea to bring a young person they know onto the committee. This young person is engaged, motivated and excited to take on new work. The adults on the committee turn to this young person for all advice about that age group. The group begins to think that all young people think like this person and like what they like. The young person also begins to feel burnt out and didn’t realize they signed up to be a liaison for other young people. How can you overcome this challenge?

Strategies:

- Be clear about why you want young people to join the team and what role they'll play. Truly listen to the ideas of the younger people in the group.
- Make sure you don't have just one young person on your team. It's helpful to have a group so they can support each other and don't feel outnumbered.
- Have everyone in the group contribute their ideas for recruiting more young people or designing a youth-focused event, not just the young people in the group.
- Assign one or more adults to check in with the young people in the group periodically to make sure they feel valued and to answer any questions they may have.

Challenge: The same young people are always invited

Scenario:

Your steering committee is striving to engage people of all ages in every aspect of the work. Many of the steering committee members have children who are teenagers or young adults who often participate. Your team also reaches out to the student government associations at the local high schools and colleges to recruit young people. Even though you've made these initial efforts to engage a younger demographic, the diversity of the steering committee doesn't necessarily reflect the diversity of the community. And, because everyone is from similar backgrounds, you don't have as many new ideas as you had expected. How can you overcome this challenge?

Strategies:

- Have the young people who are part of your network participate in reaching out to more diverse youth.
- Have youth plan a recruiting event.
- Make connections with organizations that serve young people in the areas you're trying to reach.
- Focus on increasing the diversity of the adults in the group to expand the networks you can reach.
- Partner with teachers so they can nominate students instead of having students self-select.
- Be clear in your communications that you value diversity in identities, experiences and opinions.

Challenge: Microaggressions get in the way of building bridges between generations and cultural and racial identities

Scenario:

You're part of a community that has become much more diverse in the last ten years. Many of the long-time residents are older, come from a white racial background, and are used to living and working with people who come from a similar background. Many of the new residents are younger and come from very diverse backgrounds. You're planning your yearly

neighborhood block party and have done a great job of getting people from different ages and diverse backgrounds to join the planning committee. However, sometimes during meetings the long-time residents make offensive comments: they refer to diverse neighborhoods as "the United Nations" or say they're "full of gangs," mistake new members of color for janitors, and repeatedly tell young people of color how "articulate" they are. These microaggressions, or subtle but offensive comments, further divide the team instead of building bridges. How can you overcome this challenge?

Strategies:

- Make space for a facilitated dialogue with all members of the group to address these issues.
- Educate the team about microagressions and come up with ways to hold each other accountable during meetings.
- Do trust-building activities to bring the group together and build common ground.
- Attend anti-racism trainings.

Challenge: Decisions made by planning teams don't reflect the diversity of the community

Scenario:

You're part of a community that has become much more diverse in the last ten years. Many of the long-time residents are older, come from a white racial background, and are used to living and working with people who come from a similar background. Many of the new residents are younger and come from very diverse backgrounds. You're planning your yearly neighborhood block party and have done a great job of getting people from different ages and diverse backgrounds to join the planning committee. Even though the planning team is diverse, the opinions of the long-time residents who are mostly white seem to dominate the conversation and the decision-making. The selection of food, music, games, vendors, and speakers don't reflect the diversity of your community. How can you overcome this challenge?

Strategies:

- As a group, discuss: Who is the block party for? Is it really for the neighborhood, or just for older residents?
- Revisit the purpose of the event. If the goal is truly to bring the neighborhood together, it has to reflect the diversity of the community.
- Discuss the assets these new residents bring. How can you welcome them and highlight some of their contributions?

- Make sure there's space in your meetings for team members to offer new ways of doing things.

Issues:
Youth

Phase:
Action Dialogue Evaluation Facilitation Organizing Sustaining Progress

Face 9 Twitt Print Emai Addt 13

HOW TALKING ABOUT MENTAL HEALTH CAN INSPIRE PEOPLE TO TAKE ACTION

Listen to how Text, Talk Act, is taking the pain we have experienced around mental health and turning it into a healing process. The talk around mental health is personal, powerful, and raw, and...

DIALOGUE TO CHANGE

Our ultimate goal is to create positive community change that includes everyone, and we believe that our tools, advice, and resources will help foster that kind of change. Whether you’re grappling with a divisive community issue, or simply want to include residents’ voices in city government, Everyday Democracy's Dialogue-to-Change process can help community members take action and make their voice heard.

EVERYDAY DEMOCRACY

Everyday Democracy works to strengthen democracy by making authentic engagement and public participation a permanent part of the way we work as a country. Since our founding in 1989, we have worked with hundreds of communities throughout the US, first by offering small, structured dialogues that led to positive and lasting change, and now

offering an array of flexible resources and discussion guides, technical assistance and coaching, and information about our Dialogue to Change process. Our process uses solid engagement principles and leads from personal connection to sustained action. We also work with Anchor Partners, and throughout the country, to expand our impact and create a democracy movement. Everyday Democracy is a project of the Paul J. Aicher Foundation.

EXPLORE OUR SITE

Dialogue to Change Program

Stories of Changemakers

Community Notes

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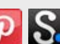

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LOS ANGELES COUNTY COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140, Los Angeles, CA 90010 · TEL. (213) 7382816 · FAX (213) 637-4748
Website: http://hiv.lacounty.gov Email: hivcomm@lachiv.org

9. HEALTHY EQUITY ACROSS GENERATIONS AND PLACES

Health Equity Across Generations and Places

Wm. Jahmal Miller, MHA, DHL
Deputy Director, Office of Health Equity
California Department of Public Health
Thursday, November 9, 2017

Office of Healthy Equity Mission

Promote equitable social, economic and environmental conditions to achieve optimal health, mental health and well-being for all.

Healthy Equity Defined

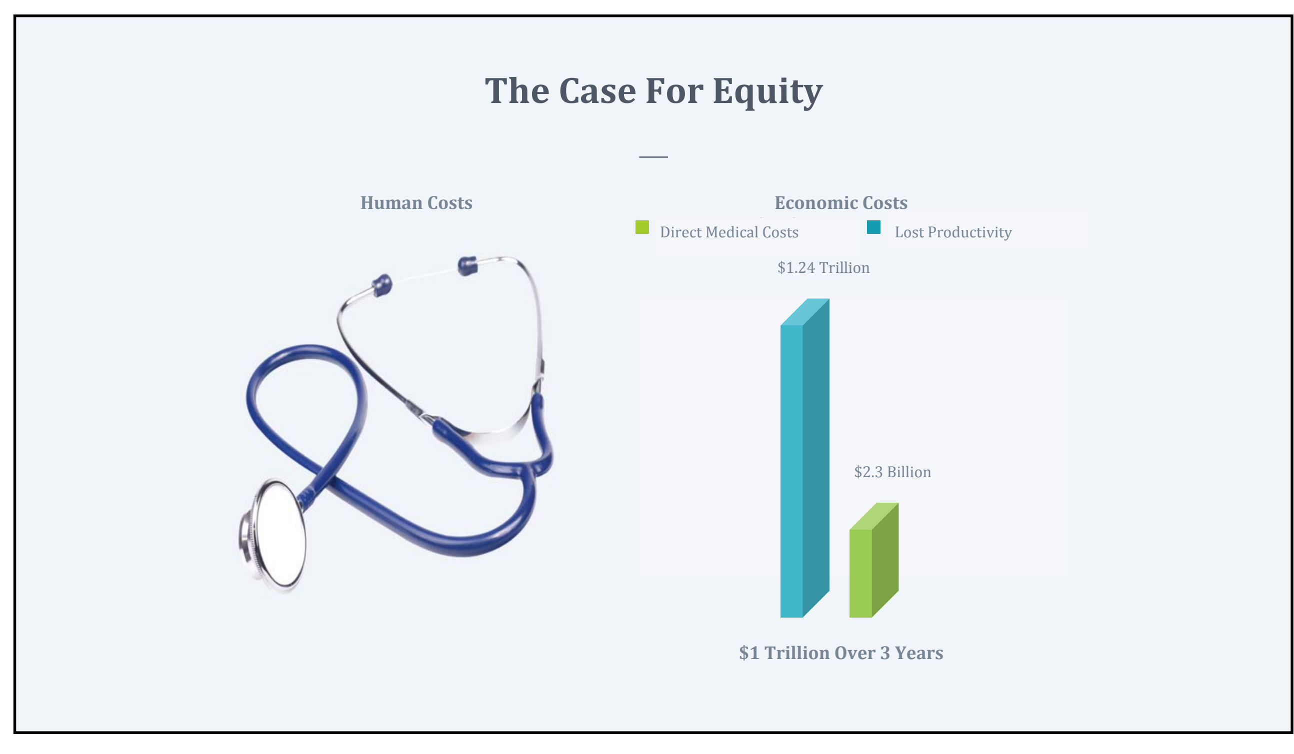
"Health equity" means effort to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

Source: California Health and Safety Code Selection 131019.5

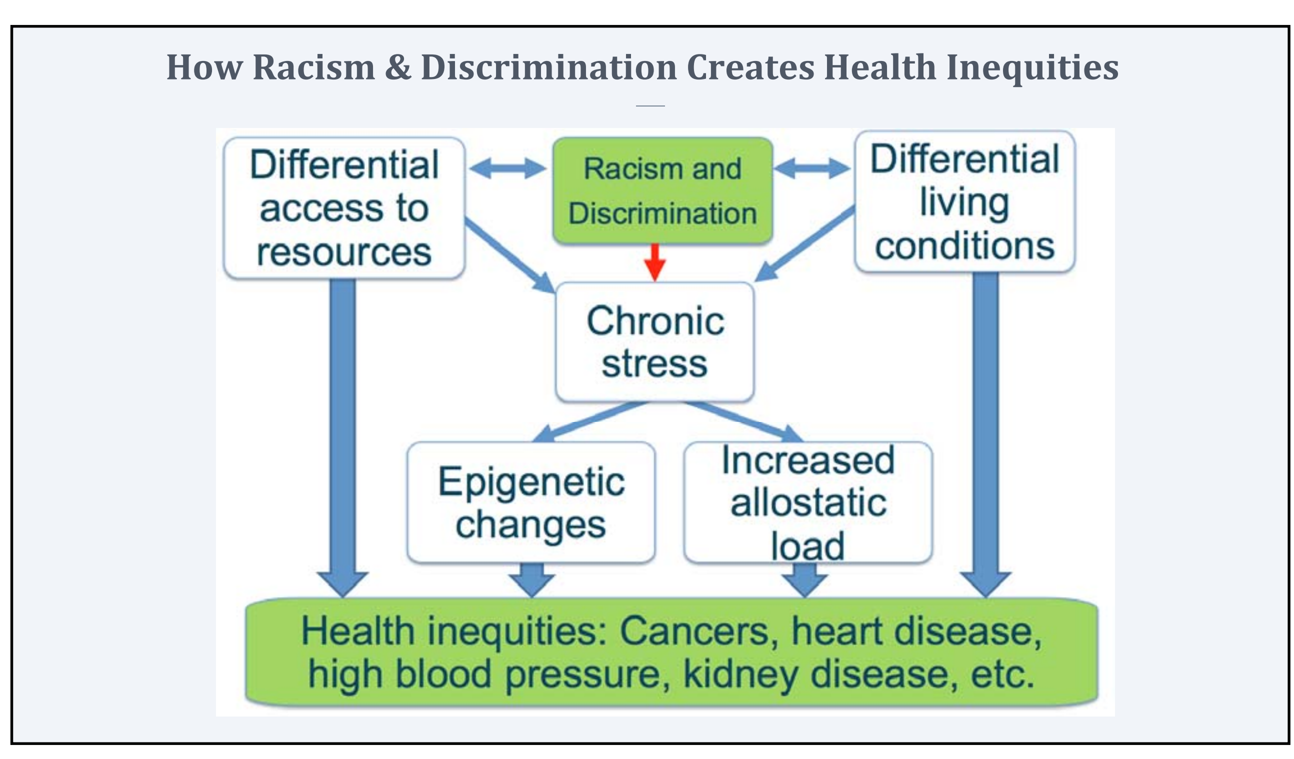
Improving the Health Status of All Populations

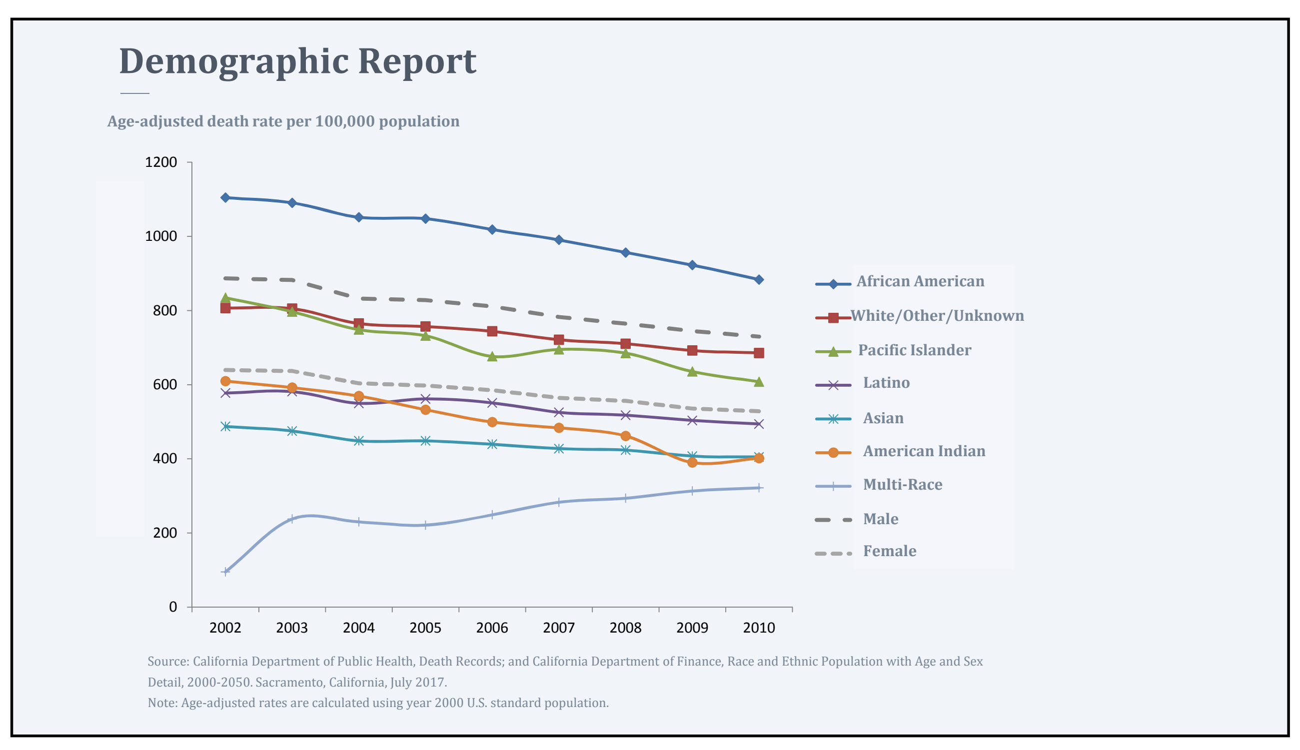
- Determinants of Equity: The social, economic, geographic, political, and physical environmental conditions that lead to the creation of a fair and just society.
- Health and Mental Health Disparities: Difference in health and mental health status among distinct segments of the population, including differences that occur by gender, age, race or ethnicity, sexual orientation, gender identity, education or income, disability or functional impairment, or geographic location, or the combination of any of these factors.
- Health and Mental Health Inequities: Disparities in health or mental health, or the factors that shape health, that are systemic and avoidable and, therefore, considered unjust or unfair.
- Vulnerable Communities: Vulnerable communities include, but are not limited to, women, racial or ethnic groups, low-income individuals and families, individuals with mental health conditions, children, youth and young adults, seniors, immigrants and refugees, individuals who are limited-English proficient (LEP), and Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQQ) communities, or combinations of these populations.
- Vulnerable Places: Places or communities with inequities in the social, economic, educational, or physical environment or environmental health and that have insufficient resources or capacity to protect and promote the health and well-being of their residents.

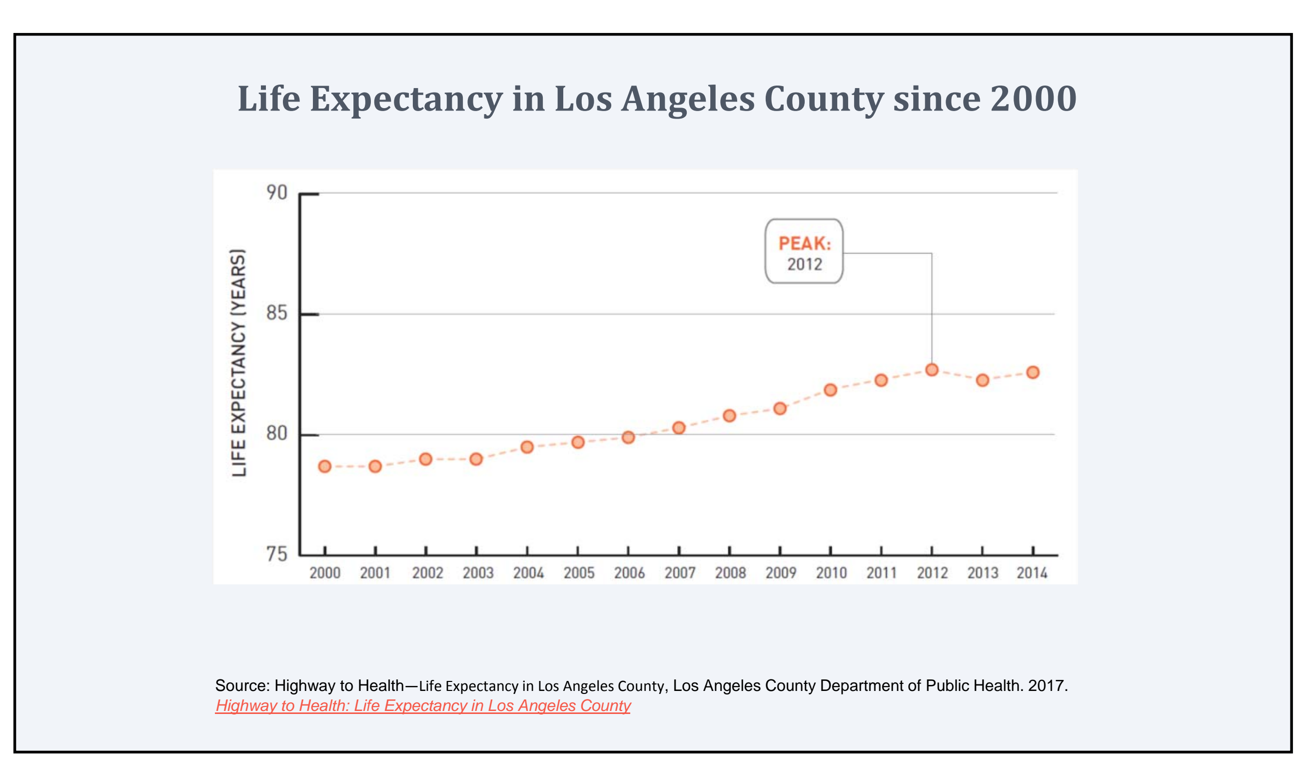
Source: California Health and Safety Code Section 131019.5

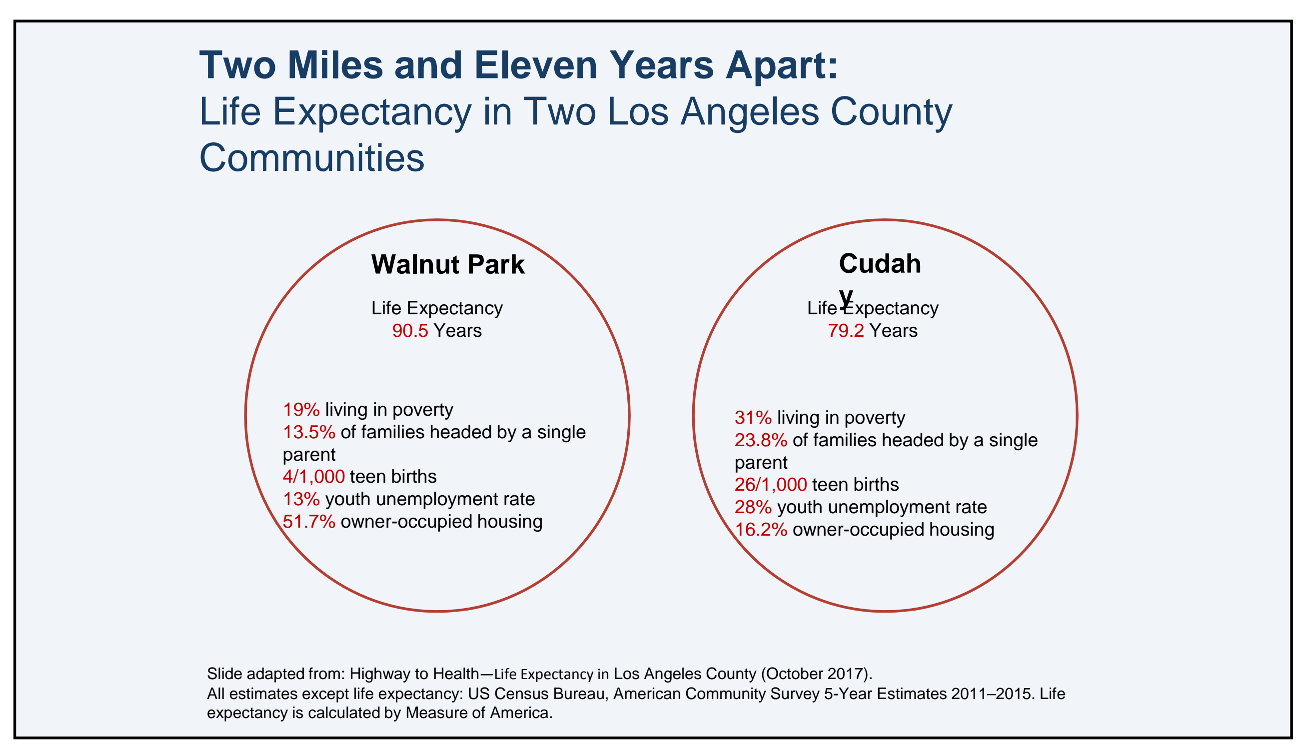


RACE
EQUITY


How Racism & Discrimination Creates Health Inequities
Differential access to resources
Racism and Discrimination
Differential living conditions
Chronic stress
Epigenetic changes
Increased allostatic load
Health inequities: Cancers, heart disease, high blood pressure, kidney disease, etc.


Demographic Report
Age-adjusted death rate per 100,000 population
1200
1000
800
600
400
200
0
2002
2003
2004
2005
2006
2007
2008
2009
2010
African American
White/Other/Unknown
Pacific Islander
Latino
Asian
American Indian
Multi-Race
Male
Female
Source: California Department of Public Health, Death Records; and California Department of Finance, Race and Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2017.
Note: Age-adjusted rates are calculated using year 2000 U.S. standard population.

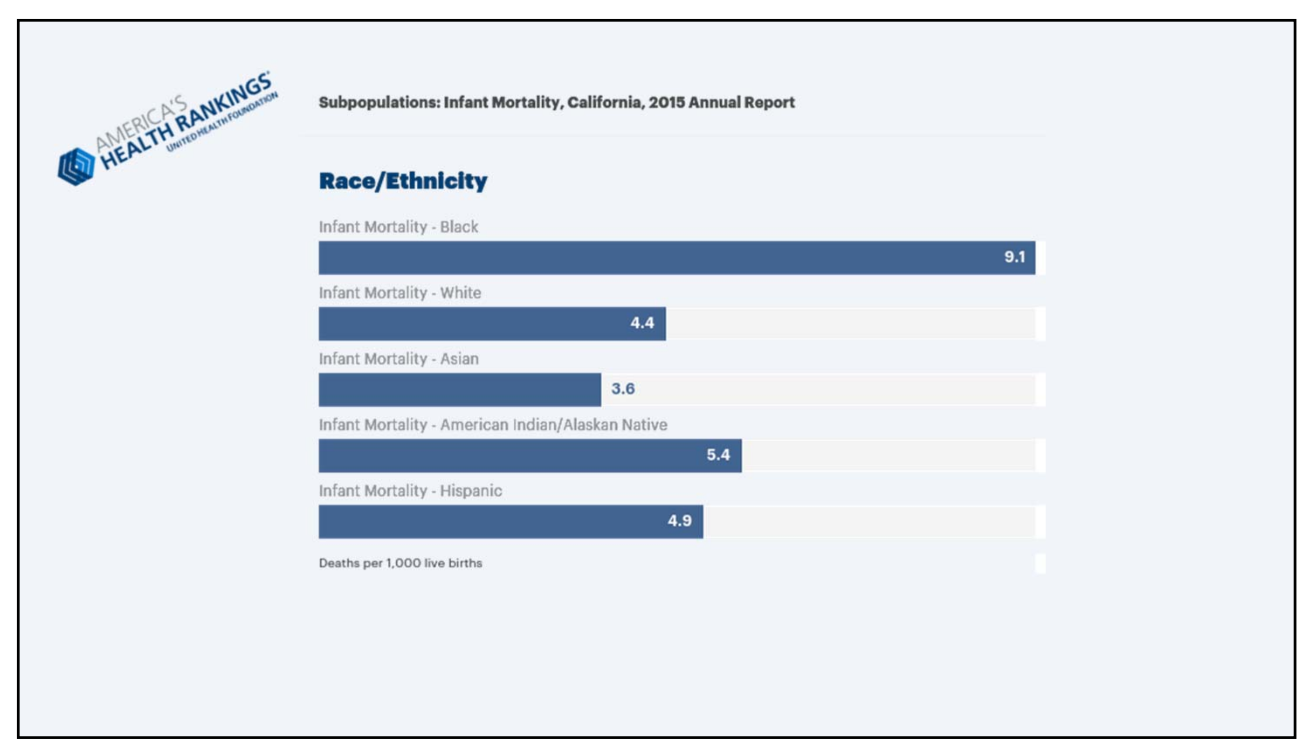

Life Expectancy in Los Angeles County since 2000
LIFE EXPECTANCY (YEARS)
90
85
80
75
PEAK:
2012
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
Source: Highway to Health—Life Expectancy in Los Angeles County, Los Angeles County Department of Public Health. 2017.
Highway to Health: Life Expectancy in Los Angeles County


Two Miles and Eleven Years Apart:
Life Expectancy in Two Los Angeles County Communities
Walnut Park
Life Expectancy
90.5 Years
19% living in poverty
13.5% of families headed by a single parent
4/1,000 teen births
13% youth unemployment rate
51.7% owner-occupied housing
Cudahy
Life Expectancy
79.2 Years
31% living in poverty
23.8% of families headed by a single parent
26/1,000 teen births
28% youth unemployment rate
16.2% owner-occupied housing
Slide adapted from: Highway to Health—Life Expectancy in Los Angeles County (October 2017).
All estimates except life expectancy: US Census Bureau, American Community Survey 5-Year Estimates 2011–2015. Life expectancy is calculated by Measure of America.

Achieving Equity at Every Level
Transforming the conditions in which people are
BORN, GROW, LIVE, WORK and AGE
for optimal health, mental health & well-being.
Prevention
Mental Health Services
Culturally/Linguistically Appropriate and Competent Services
Income Security
Housing
Neighborhood Safety/Collective Efficacy
Environmental Quality
HEALTHY PEOPLE
HEALTHY COMMUNITY
HEALTHY ENVIROMENT
HEALTHY SOCIETY
Health Care
Child Development, Education, and Literacy Rates
Food Security/ Nutrition
Built Environments
Discrimination/ Minority Stressors
Source: California Department of Public Health, Office of Health Equity as inspired by World Health Organization, Robert Wood Johnson Foundation, and many others.

Economic Disparities Impact Infant Health, Experts Show

- According to a new research from the University of Colorado Denver, women who are poor experience higher cortisol levels in pregnancy and give birth to infants with elevated levels of the stress hormone.
- Heightens the risk of developing serious disease later in life.
- The study published online recently in the American Journal of Human Biology, is the first to measure cortisol in infants and relate it directly to the socioeconomic status of their mothers during pregnancy.



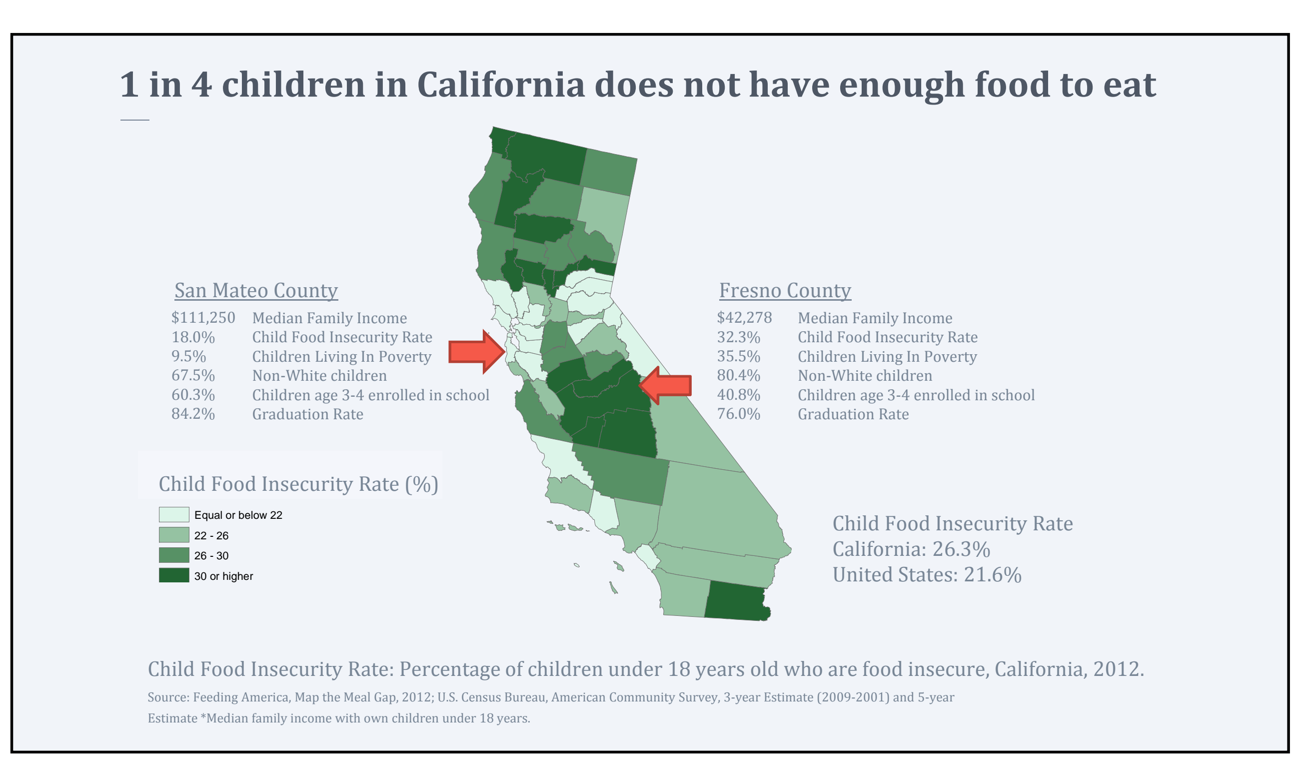
The Washington Post

My son has been suspended five times. He's 3.

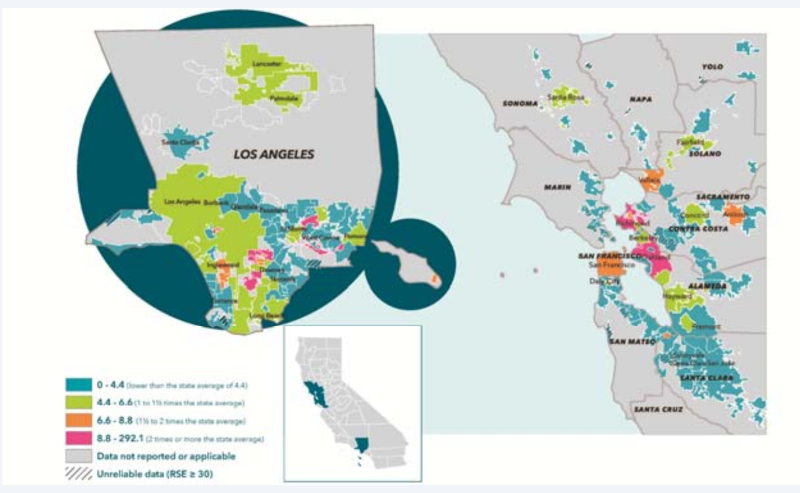
Black families fight entrenched prejudices to get fair discipline for their children in schools.

By Tunette Powell July 24, 2014 Follow @TunettePowell

Tunette Powell is a motivational speaker and author. She is co-founder of The Truth Heals, a nonprofit for individuals and families affected by fatherlessness.



The risk of crime can be highly disparate for neighboring California cities and towns

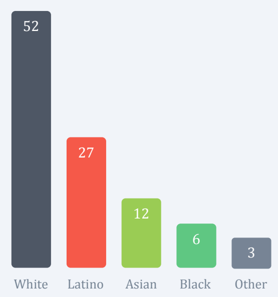


Number of violent crimes per 1,000 population, by cities and towns, Los Angeles County and Bay Area, California, 2010.

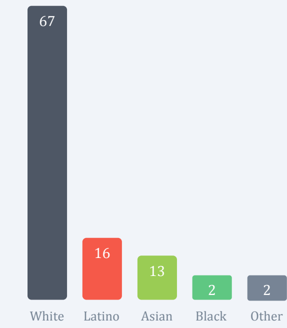
Source: Federal Bureau of Investigation, Uniform Crime Reports, 2010. Analysis by CDPH-Office of Health Equity and UCSF, Healthy Community Indicators Projectv

Uneven Distribution of Household Wealth Across Racial Ethnic Groups in California

Latino households represent 27% of California households, but hold about 16% of household wealth.



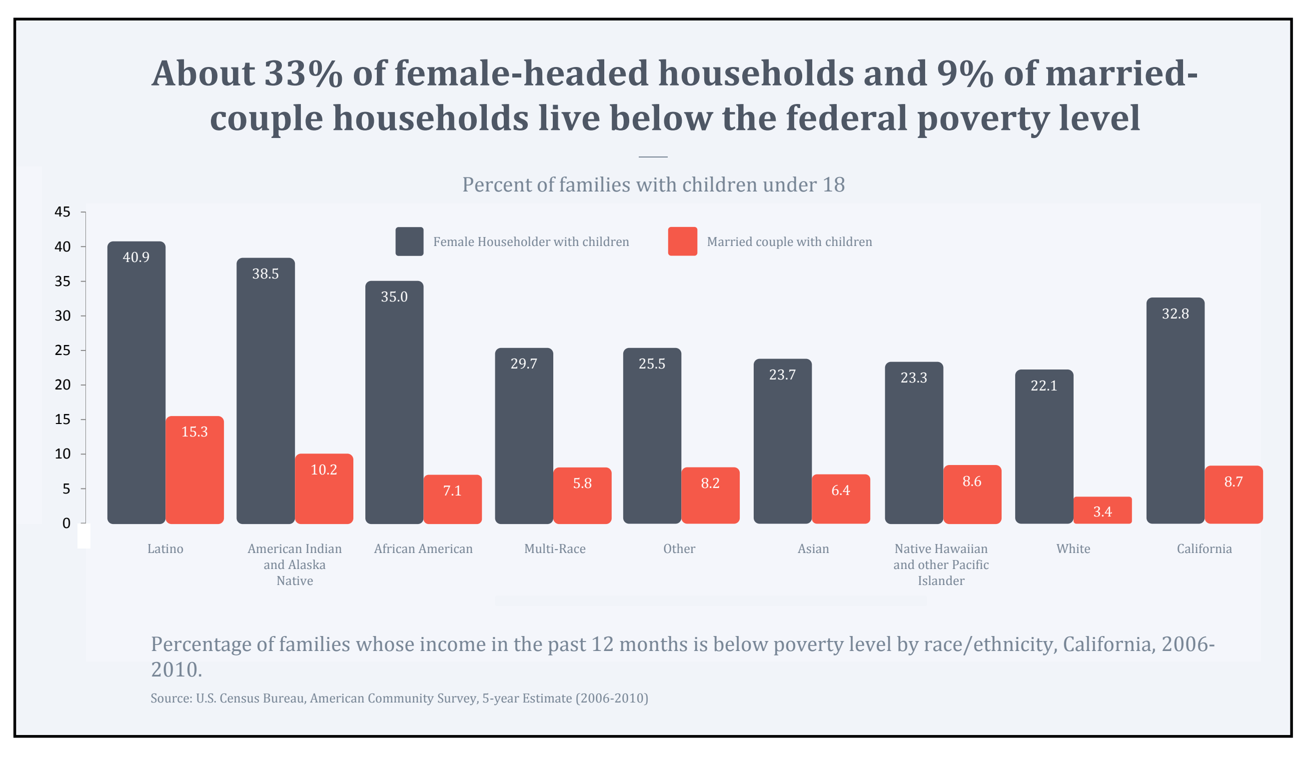
Households in California by Race/Ethnicity, 2010

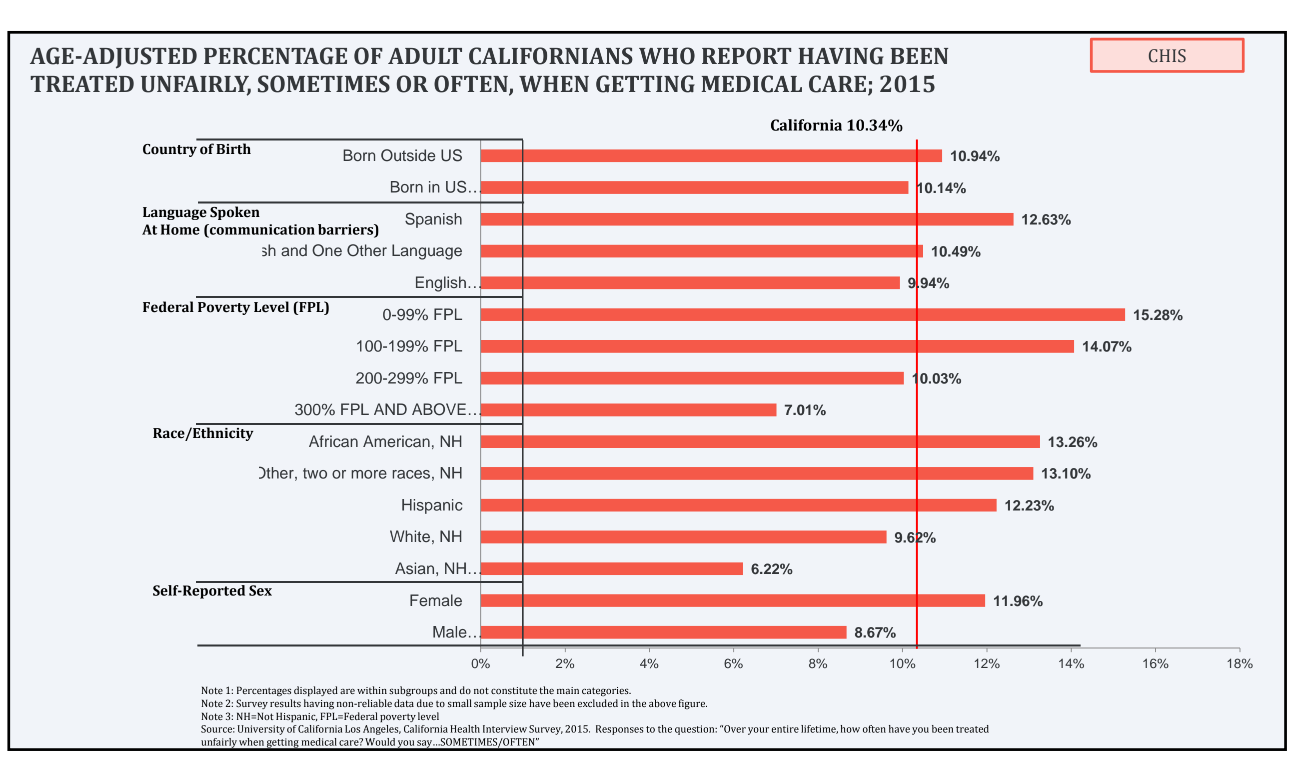


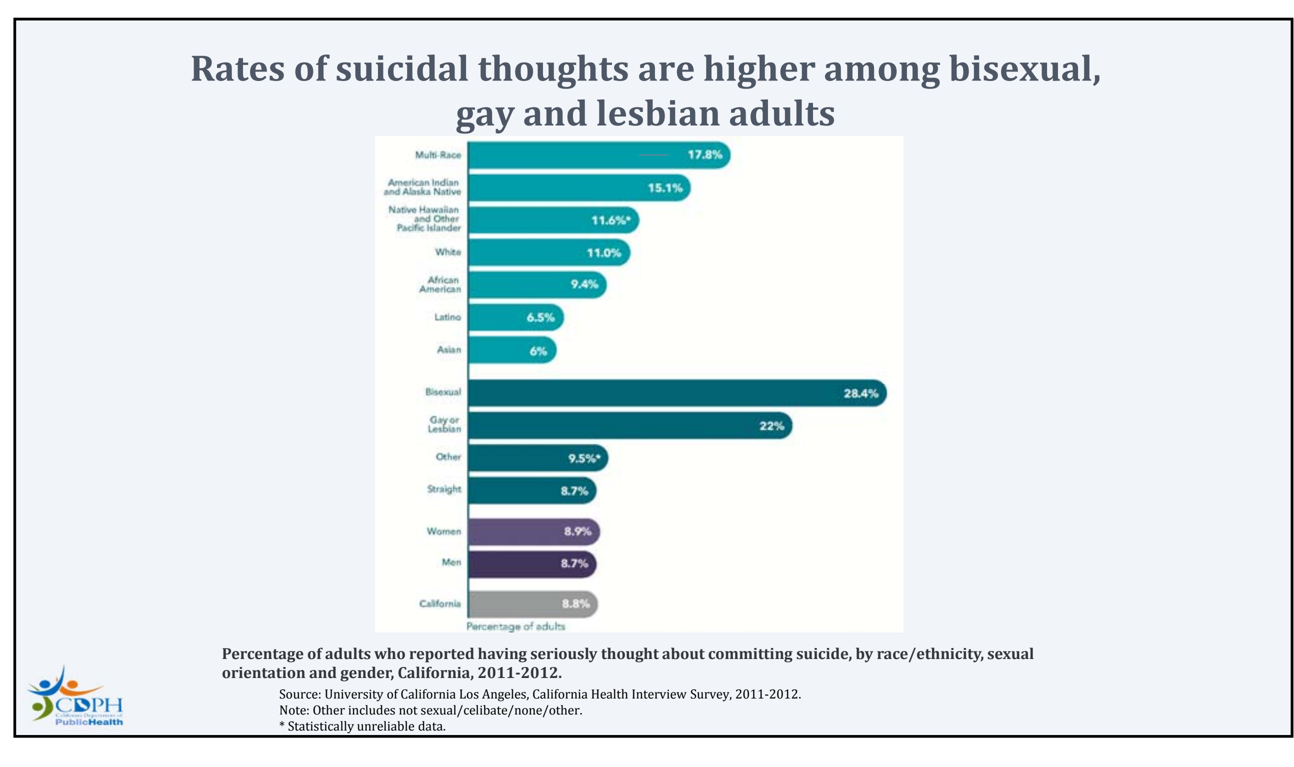
Households Wealth in California by Race/Ethnicity, 2010

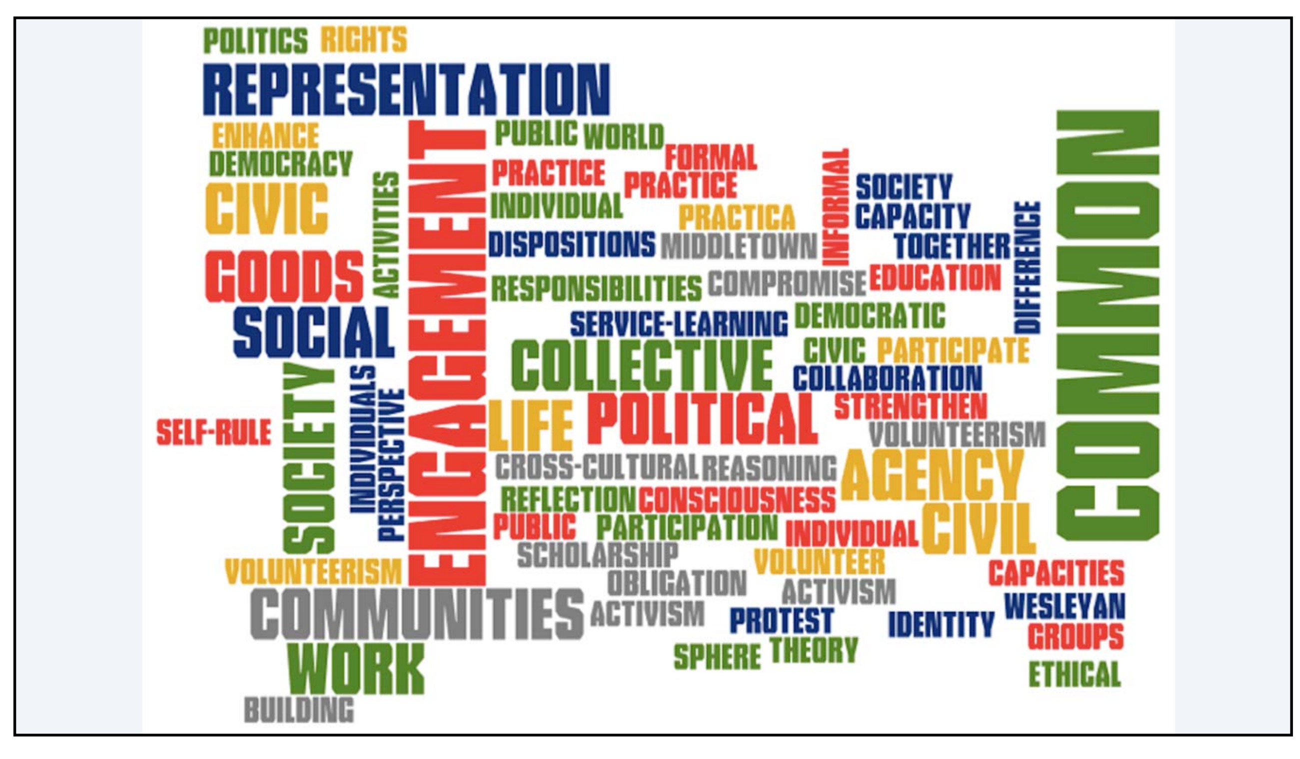
Net worth (wealth) is the sum of the market value of assets owned by every member of the household minus liabilities owed by household members. A household consists of all the people who occupy a housing unit.

Source: SIPP (Panel 2008, Wave 7), ACS (table QT-P11) 2010 Census


About 33% of female-headed households and 9% of married-couple households live below the federal poverty level
Percent of families with children under 18
Female Householder with children
Married couple with children
Latino 40.9 15.3
American Indian and Alaska Native 38.5 10.2
African American 35.0 7.1
Multi-Race 29.7 5.8
Other 25.5 8.2
Asian 23.7 6.4
Native Hawaiian and other Pacific Islander 23.3 8.6
White 22.1 3.4
California 32.8 8.7
Percentage of families whose income in the past 12 months is below poverty level by race/ethnicity, California, 2006-2010.
Source: U.S. Census Bureau, American Community Survey, 5-year Estimate (2006-2010)


AGE-ADJUSTED PERCENTAGE OF ADULT CALIFORNIANS WHO REPORT HAVING BEEN TREATED UNFAIRLY, SOMETIMES OR OFTEN, WHEN GETTING MEDICAL CARE; 2015
CHIS
California 10.34%
Country of Birth
Born Outside US 10.94%
Born in US 10.14%
Language Spoken At Home (communication barriers)
Spanish 12.63%
sh and One Other Language 10.49%
English 9.94%
Federal Poverty Level (FPL)
0-99% FPL 15.28%
100-199% FPL 14.07%
200-299% FPL 10.03%
300% FPL AND ABOVE 7.01%
Race/Ethnicity
African American, NH 13.26%
Other, two or more races, NH 13.10%
Hispanic 12.23%
White, NH 9.62%
Asian, NH 6.22%
Self-Reported Sex
Female 11.96%
Male 8.67%
Note 1: Percentages displayed are within subgroups and do not constitute the main categories.
Note 2: Survey results having non-reliable data due to small sample size have been excluded in the above figure.
Note 3: NH=Not Hispanic, FPL=Federal poverty level
Source: University of California Los Angeles, California Health Interview Survey, 2015. Responses to the question: "Over your entire lifetime, how often have you been treated unfairly when getting medical care? Would you say...SOMETIMES/OFTEN"


Rates of suicidal thoughts are higher among bisexual, gay and lesbian adults
Multi-Race 17.8%
American Indian and Alaska Native 15.1%
Native Hawaiian and Other Pacific Islander 11.6%*
White 11.0%
African American 9.4%
Latino 6.5%
Asian 6%
Bisexual 28.4%
Gay or Lesbian 22%
Other 9.5%*
Straight 8.7%
Women 8.9%
Men 8.7%
California 8.8%
Percentage of adults
Percentage of adults who reported having seriously thought about committing suicide, by race/ethnicity, sexual orientation and gender, California, 2011-2012.
Source: University of California Los Angeles, California Health Interview Survey, 2011-2012.
Note: Other includes not sexual/celibate/none/other.
* Statistically unreliable data.
CDPH
PublicHealth


POLITICS RIGHTS
REPRESENTATION
ENHANCE
DEMOCRACY
CIVIC
GOODS
SOCIAL
ACTIVITIES
ENGAGEMENT
PUBLIC WORLD
FORMAL
PRACTICE PRACTICE
INDIVIDUAL
PRACTICA
INFORMAL
SOCIETY
CAPACITY
TOGETHER
DIFFERENCE
COMMON
DISPOSITIONS MIDDLETOWN
RESPONSIBILITIES COMPROMISE EDUCATION
SERVICE-LEARNING DEMOCRATIC
COLLECTIVE
CIVIC PARTICIPATE
COLLABORATION
STRENGTHEN
VOLUNTEERISM
SELF-RULE
SOCIETY
INDIVIDUALS
PERSPECTIVE
LIFE POLITICAL
CROSS-CULTURAL REASONING
AGENCY
REFLECTION CONSCIOUSNESS
PUBLIC PARTICIPATION INDIVIDUAL CIVIL
SCHOLARSHIP
VOLUNTEERISM
VOLUNTEER
CAPACITIES
OBLIGATION
ACTIVISM
COMMUNITIES
ACTIVISM
PROTEST
IDENTITY
WESLEYAN
GROUPS
SPHERE THEORY
WORK
ETHICAL
BUILDING

Political Implications of Health Inequities

Key Findings:

- We estimate effects of black excess deaths on the composition of the US electorate.
- Excess mortality reduced the 2004 black voting age population by 1.7 million.
- In 2004, Kerry lost 900,000 votes and Bush lost 100,000 to black excess death.
- Outcomes of 7 senate and 11 gubernatorial races could have been reversed.
- Excess mortality among blacks in the United States dampens blacks' political voice.

Social Science & Medicine 136-137 (2015) 193–199

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journal homepage: www.elsevier.com/locate/socscimed

ELSEVIER

Black lives matter: Differential mortality and the racial composition of the U.S. electorate, 1970–2004

Javier M. Rodriguez [a,b], Arline T. Geronimus [c,b,d,*], John Bound [e,b,d], Danny Dorling [f]

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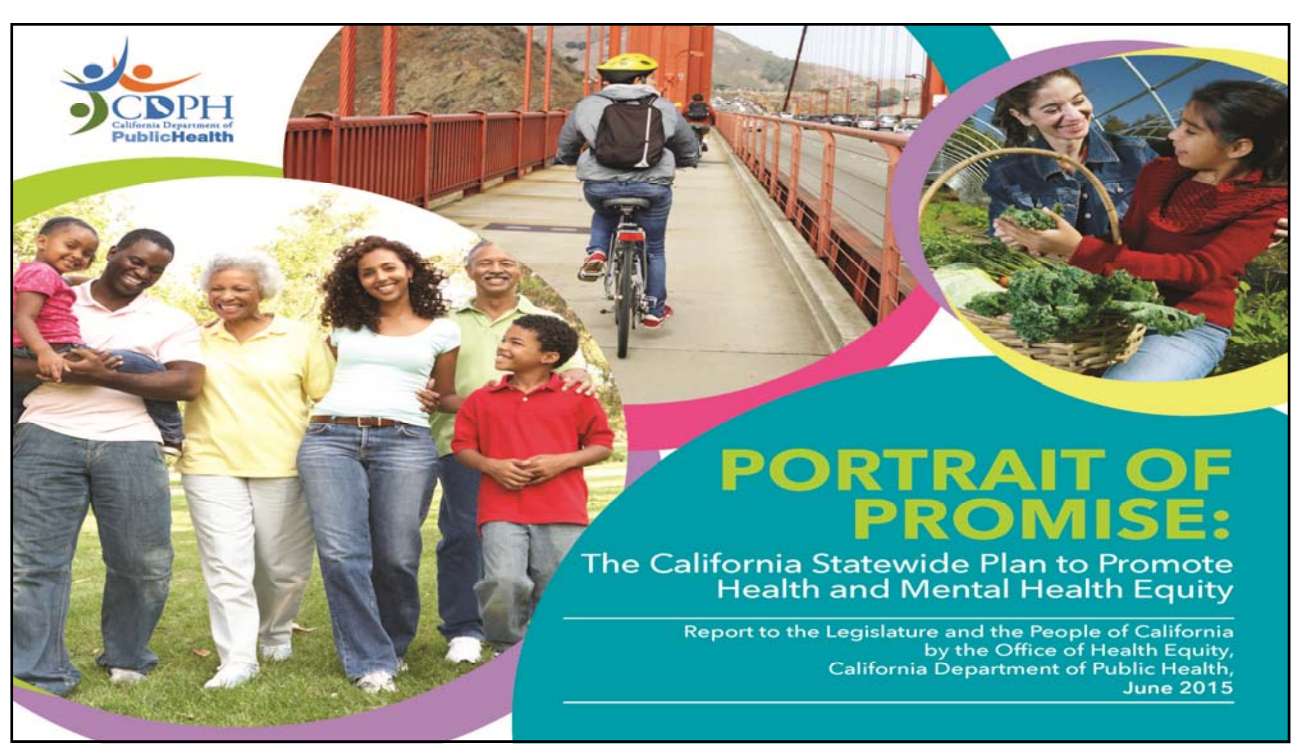
[b] Population Studies Center, Institute for Social Research, University of Michigan, USA
[c] Department of Health Behavior and Health Education, University of Michigan, USA
[d] Center for Advanced Study in the Behavioral Sciences, Stanford University, USA
[e] George E. Johnson Collegiate Professor, Department of Economics, University of Michigan, USA
[f] Halford Mackinder Professor of Geography, School of Geography and the Environment, Oxford University Centre for the Environment, Oxford University, UK



Laying a Foundation for Getting to Zero: California's Integrated Surveillance, Prevention, and Care Plan

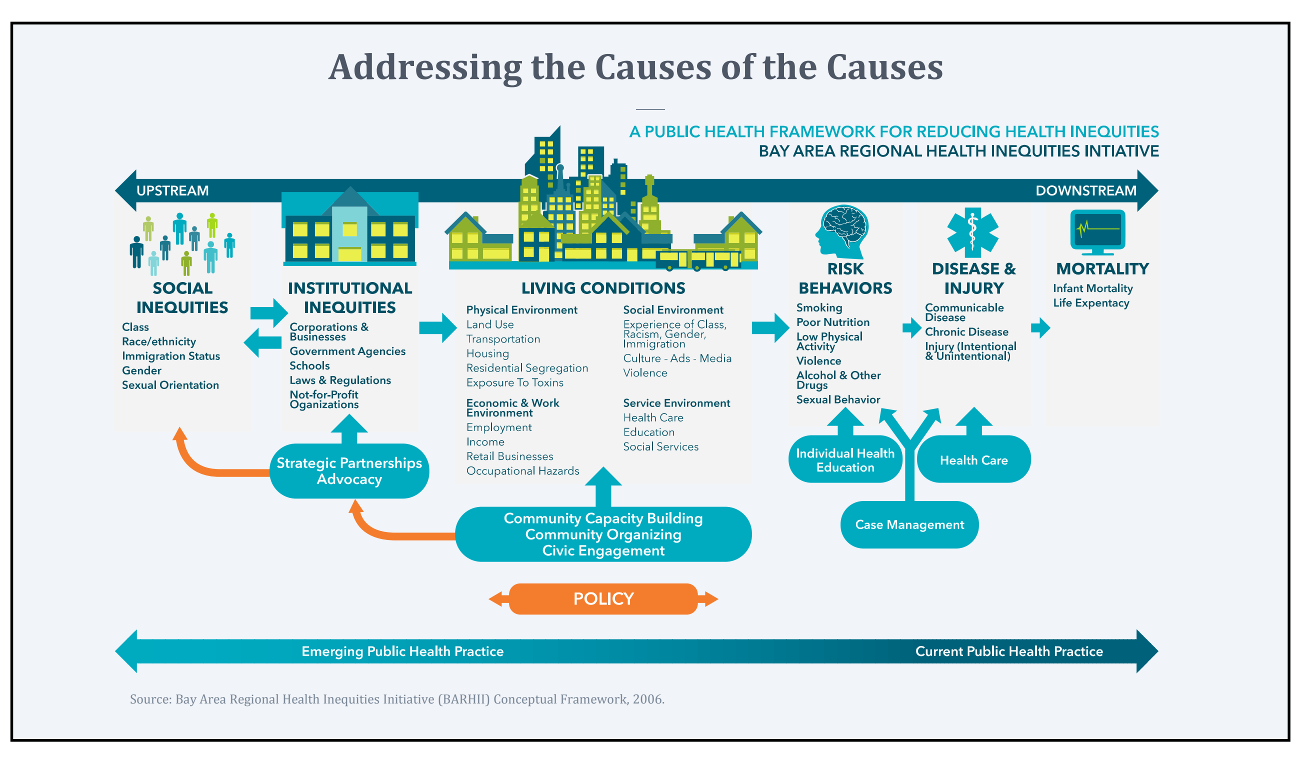
- Joint effort between state, local, and community partners
- Sets forth California's commitment to collaboration, efficiency, and innovation in order to meet or exceed National HIV/AIDS Strategy prevention, care, and treatment goals
- Provides a vision and foundation for eventually getting to zero new HIV infections in California
- *Covers calendar years 2017 — 2021*
- Co-authored with Sacramento, Riverside/ San Bernardino, Santa Clara Counties

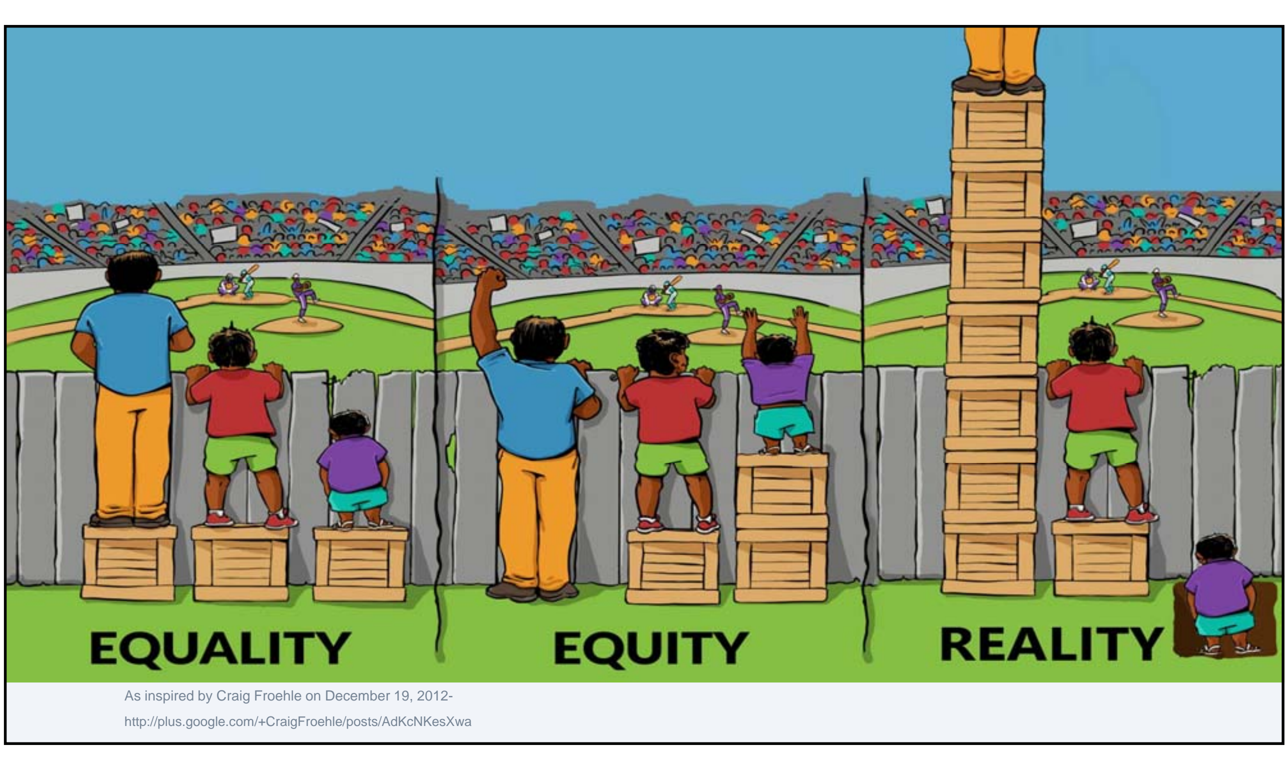
Four Goals

- Reduce New HIV Infections in California
- Increase Access to Care and Improve Health Outcomes
- Reduce HIV-Related Disparities and Health Inequities
- Achieve a More Coordinated Statewide Response to the HIV Epidemic

California Reducing Disparities Project (CRDP)

- Prop. 63-funded $60m initiative to identify promising practices and systems change recommendations to address persistent disparities in historically underserved populations.
- Priority Populations:
  - African American; Asian and Pacific Islander; Latino; Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning; and Native American communities
- In total, over 40 contractors and grantees will be funded over six years to implement Phase II of the CRDP.





As inspired by Craig Froehle on December 19, 2012-
http://plus.google.com/+CraigFroehle/posts/AdKcNKesXwa

Stay Connected to the Office of Health Equity

Questions?

Wm. Jahmal Miller, MHA

Deputy Director – Office of Health Equity

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OHE Website:

www.cdph.ca.gov/programs/pages/ohemain.aspx

PORTRAIT OF PROMISE:

The California Statewide Plan to Promote Health and Mental Health Equity

Report to the Legislature and the People of California
by the Office of Health Equity,
California Department of Public Health,
August 2015

Office of Health Equity
California Department of Public Health
P.O. Box 997377, MS 0022
Sacramento, CA 95899-7377
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Portrait of Promise: The California Statewide Plan to Promote Health and Mental Health Equity. A Report to the Legislature and the People of California by the Office of Health Equity. Sacramento, CA: California Department of Public Health, Office of Health Equity; August 2015.

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MESSAGE FROM THE CHAIR
OFFICE OF HEALTH EQUITY ADVISORY COMMITTEE

Widespread, systemic inequities take a toll on the mental and physical health of our state's residents. Those who suffer disproportionately from the stress of discrimination or the constraints of poverty also suffer disproportionately from heart disease, asthma, arthritis, and cancer.

As such, the health conditions of our most vulnerable populations will only improve as we address the source of those conditions. We have a responsibility and an obligation to understand the barriers that impede all of California's residents from achieving their greatest health potential – and to work together to remove those barriers.

It has taken hundreds of years of unjust social policies and practices to create the degree and magnitude of health inequities detailed in this report. Each resident, tribe, community, coalition, organization, institution, corporation, and philanthropy has inherited this legacy – and each has an important part to play as the tide is turned through a concerted, comprehensive, and sustained response. We welcome you to join us.

Sincerely,

Sandi Gálvez, MSW
Chair, Office of Health Equity Advisory Committee

ACKNOWLEDGMENTS

The California Statewide Plan to Promote Health and Mental Health Equity ("Plan") has been developed through a truly collaborative effort. Numerous individuals, agencies, and organizations have generously given of their time, knowledge, and expertise. The Office of Health Equity Advisory Committee (OHE-AC), the Health in All Policies Task Force, and the other state departments that participated in the development and review of this document ensured the process was a success.

Appreciation is extended to the following:

- Diana Dooley, Secretary of the California Health and Human Services Agency, and Dr. Ron Chapman, former State Health Officer and Director of the California Department of Public Health, for their leadership and steadfast support for the new Office of Health Equity (OHE) and this first report and strategic plan.

- Sandi Gálvez and Dr. Rocco Cheng, for serving as chair and vice chair, respectively, of the inaugural OHE Advisory Committee, and for providing leadership and guidance for the new OHE Advisory Committee (see the Office of Health Equity Advisory Committee page for a full list of Advisory Committee members).

- All the OHE staff, for their development and review of Plan documents, with special thanks to health research staff members Dr. Mallika Rajapaksa and Thi Mai for coalescing the data for the disparities report, as well as Senior Project Manager Dr. Tamu Nolfo, who helped manage the planning and collating of ideas into the strategic plan.

- Dr. Neil Kohatsu, California Department of Health Care Services (DHCS) Medical Director; Dr. Linette Scott, Chief Information Medical Officer at DHCS; and members of the DHCS-California Department of Public Health (CDPH)/ OHE data work group for their input and guidance on the disparities report.

- Jon Stewart, a technical writer who turned data into a story that everyone can understand, in the form of the disparities report.

- The Blanket Marketing Group, a design firm that had the graphic design magic necessary to make the words come alive, and TSI Consulting Partners, which facilitated the initial Advisory Committee deliberations.

- Sierra Health Foundation, California HealthCare Foundation, and Sutter Health, which provided financial and meeting support and which have been and continue to be dedicated to advancing health equity in California.

- Finally and most important, the public, for their input and contributions at OHE Advisory Committee meetings; during webinars; and through surveys, letters, and other discussions. The quality of authentic public engagement that shaped this document is to be commended.

Without the dedication and commitment of all those involved, this Plan would not have been possible. The collaboration and synergy from this diverse spectrum of talented individuals, agencies, and organizations provide great hope for what can be accomplished to achieve health and mental health equity.

OFFICE OF HEALTH EQUITY ADVISORY COMMITTEE

The Office of Health Equity Advisory Committee (OHE-AC) is integral to advancing the goals of the office and advises on the development and implementation of The California Statewide Plan to Promote Health and Mental Health Equity. The OHE-AC comprises representatives from applicable state agencies and departments, local health departments, community-based organizations, and service providers working to promote health and mental health equity for vulnerable communities.

The OHE-AC consists of a broad range of experts, advocates, health clinicians, public health professionals, and consumers who understand the importance of the health and mental health disparities and inequities of historically vulnerable, marginalized, underserved, and underrepresented communities.

The OHE-AC works to provide a forum to identify and address the complexities of health and mental health inequities and to identify interrelated and multisectoral strategies. Additionally, the OHE-AC consults regularly with the Office of Health Equity for input and updates on policy recommendations, strategic plans, and the status of cross-sectoral work.

Advisory Committee members are:

CHAIR

Sandi Gálvez, MSW, is Executive Director of the Bay Area Regional Health Inequities Initiative (BARHII).

VICE CHAIR

Rocco Cheng, PhD, is Corporate Director of Prevention and Early Intervention Services at Pacific Clinics.

MEMBERS

Sergio Aguilar-Gaxiola, MD, PhD, is Professor of Clinical Internal Medicine and Founding Director of the University of California (UC), Davis, Center for Reducing Health Disparities; Director of the Community Engagement Program of the UC Davis Clinical Translational Science Center; and Co-Director of the National Institute on Aging's Latino Aging Research and Resource Center.

Paula Braveman, MD, MPH, is Professor of Family and Community Medicine and Director of the Center on Social Disparities in Health at the University of California, San Francisco.

Delphine Brody formerly served as Program Director for the Mental Health Services Act (MHSA) at the California Network of Mental Health Clients and is currently a member of the National Association for Rights Protection and Advocacy and of the Mental Health Services Oversight and

Accountability Commission Cultural and Linguistic Competence Committee. She also serves on the California Behavioral Health Directors Association Cultural Competence, Equity and Social Justice Advisory Committee.

Jeremy Cantor, MPH, is a Senior Consultant with John Snow, Inc., in San Francisco, California.

Yvonna Cázares is Director of Next-Level Engagement at California State PTA.

Kathleen Derby is a peer and family advocate with over 25 years of lived experience in mental health.

Aaron Fox, MPM, is Director of State Health Equity and Policy at the Los Angeles LGBT Center.

Alvaro Garza, MD, MPH, is Health Officer at San Joaquin County Public Health Services.

Cynthia A. Gómez, PhD, is Founding Director of the Health Equity Institute at San Francisco State University.

Willie Graham, MS, MTh, is pastor of Christian Body Life Fellowship Church in Vacaville, California.

General Jeff is a community activist for the underserved and unserved residents in Skid Row in Downtown Los Angeles and founder of the organization Issues and Solutions.

Carrie Johnson, PhD, is a member of the Dakota Sioux tribe and is a licensed clinical psychologist and Director of the Seven Generations Child and Family Counseling Center at United American Indian Involvement in Los Angeles.

Neil Kohatsu, MD, MPH, was appointed in March 2011 as the first Medical Director for the California Department of Health Care Services.

Dexter Louie, MD, JD, MPA, is a founding member and Chair of the Board of the National Council of Asian Pacific Islander Physicians.

Francis G. Lu, MD, is Luke and Grace Kim Professor in Cultural Psychiatry, Emeritus, University of California, Davis.

Gail Newel, MD, MPH, is an obstetrician-gynecologist who serves the Fresno County Department of Public Health as Medical Director of Maternal, Child and Adolescent Health.

Teresa Ogan, MSW, is Supervising Care Manager for the California Health Collaborative Multipurpose Senior Service Program.

José Oseguera, MPA, is Chief of Plan Review and Committee Operations for the Mental Health Services Oversight and Accountability Commission.

Hermia Parks, MA, RN, PHN, is Director of Public Health Nursing/Maternal, Child, and Adolescent Health for Riverside County.

Diana E. Ramos, MD, MPH, is the Director for Reproductive Health, Los Angeles County Public Health Department, and a practicing obstetrician-gynecologist and adjunct Assistant Clinical Professor at the Keck University of Southern California School of Medicine.

Patricia Ryan, MPA, is serving as a consultant to the California Mental Health Directors Association, having recently retired after 12 years as its Executive Director.

Linda Wheaton is Assistant Director for Intergovernmental Affairs for the California Department of Housing and Community Development and a member of the California Health in All Policies Task Force.

Ellen Wu, MPH, is Executive Director of Urban Habitat.

EXECUTIVE SUMMARY

Almost one in four children in California lives in poverty,[1] which is often associated with factors that negatively affect their health, such as substandard housing, hunger, and poor air and water quality. In California, poverty is higher among women than men and highest among Latinas and single mothers.[2] Compare the salaries of women with those of men: Women go to work on average three months per year without pay,[3] resulting in lower incomes that severely limit health-related options like sleep, nutrition, and exercise. Exacerbating these hardships, one in five women in California has experienced physical or sexual violence by her partner.[4] Through our gender lens we are also now seeing a trend that boys and young men in California are less likely to both read at grade level early on and enroll in undergraduate education through the University of California and California State Universities than are girls and young women,[5,6] and they are disproportionately impacted by school discipline, arrest, and unemployment.[7,8] Additional data demonstrates different health and mental health outcomes among people of different races, ethnicities, and sexual orientations. For example, African American families are twice as likely as their White counterparts to suffer the grievous loss of an infant,[9] due in part to the pervasive and detrimental impacts of a lifetime of discrimination on the mother's physical and mental health.[10] Such racial discrimination appears to undercut the protective benefits of educational attainment, mother's age, and marital status.[11] Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQQ) youths experience suicidal ideation, suicide attempts, and suicide completion more often than do their straight peers.[12]

Health and mental health *disparities* are the differences in health and mental health status among distinct segments of the population, including differences that occur by gender, age, race or ethnicity, sexual orientation, gender identity, education or income, disability or functional impairment, or geographic location, or the combination of any of these factors.[7]

Are the disparities described above inevitable—or preventable?

Disparities in health or mental health, or in the factors that shape health, that are systemic and avoidable and, therefore, considered unjust or unfair are defined as **health and mental health *inequities***.[7]

In this document, the California Statewide Plan to Promote Health and Mental Health Equity ("Plan"), we present background and evidence on the root causes and consequences of health inequities in California. We explore and illustrate how a broad range of socioeconomic forces, including income security, education and child development, housing, transportation, health care access, environmental quality, and other factors, shape the health of entire communities—especially vulnerable and underserved communities—resulting in preventable health inequities for specific populations. With a better, data-based understanding of the causes and consequences of health inequities, Californians will be better prepared to take the steps necessary for promoting health across California's diverse communities and building on the great strengths that our diverse population brings.

In 2012, as authorized by Section 131019.5 of the California Health and Safety Code, the Office of Health Equity (OHE) was established within the California Department of Public Health. One of the key duties of the OHE outlined in the code is the development of a report with

demographic analyses on health and mental health disparities and inequities, highlighting the underlying conditions that contribute to health and well-being, accompanied by a comprehensive, cross-sectoral strategic plan to eliminate health and mental health disparities.

The timely creation of the Office of Health Equity (OHE) within the California Department of Public Health (CDPH) represents an opportunity, via the Plan presented here, to lessen inequities and pursue a path that leads to health, wellness, and well-being for every member of the great and diverse family of California residents.

The Plan is intended to illuminate the scope of the health equity challenge with compelling data and narrative. It makes the case that health is a basic human right, that health inequity is a moral and financial issue, and that health equity is in everyone's best interest. It also provides a brief summary of the most pervasive social determinants of health, and it offers examples of programs, policies, and practices that have begun to make a difference in the state's most vulnerable communities.

The Plan points to what California can do to capitalize on current windows of opportunity and minimize foreseeable threats. Momentum for health and mental health equity has been building in recent years, setting the stage for this important work. For example, the U.S. Department of Health and Human Services' Action Plan to Reduce Racial and Ethnic Health Disparities: *A Nation Free of Disparities in Health and Health Care*, was released in April 2011; the state's *Let's Get Healthy California Task Force Final Report* appeared in December 2012; and the state's California Wellness Plan was launched in February 2014 – each providing intersections and synergistic opportunities for moving forward with determination and focus. In addition to state and federal plans that address health and mental health inequities, nonprofit organizations have also published reports that reflect the views of stakeholders, such as *The Landscape of Opportunity: Cultivating Health Equity in California*, authored by the California Pan-Ethnic Health Network and released in June 2012.

While the OHE facilitated the process for creating this document, the outcome reflects the thoughtful participation of hundreds of stakeholders. Those who invested the most time were the 25 members of the OHE Advisory Committee, who worked alongside the public and OHE staff over the course of

three two-day meetings and for countless hours before and between those meetings. These members were chosen from 112 applications received by CDPH, a sign of both the enthusiasm and the expertise brought to bear on this endeavor.

The Advisory Committee members have been strong advocates for paying due attention to mental health in the Plan. Mental health is one aspect of overall health and, as such, should be assumed within all references to "health." However, because mental health has historically been excluded – and in many circumstances continues to be excluded – from our society's overall approach to health, it is called out explicitly throughout this document.

The Office of Health Equity staff, working with the Advisory Committee and other stakeholders, have established a vision, a mission, and a central challenge to guide the development of strategies.

Vision: Everyone in California has equal opportunities for optimal health, mental health, and well-being.

Mission: Promote equitable social, economic, and environmental conditions to achieve optimal health, mental health, and well-being for all.

Central Challenge: Mobilize understanding and sustained commitment to eliminate health inequity and improve the health, mental health, and well-being of all.

The following are the Plan's five-year strategic priorities:

Through **assessment**, yield knowledge of the problems and the possibilities.

Through **communication**, foster shared understanding.

Through **infrastructure** development, empower residents and their institutions to act effectively.

Goals for each of the strategic priorities were crafted for California overall as well as within the health field, among potential health partners, and within local communities for Stage 1 (2015-2018) and Stage 2 (2018-2020) of the Plan. In this inaugural effort, the OHE also recognized the critical need to create goals aimed at building capacity for implementation of the strategic priorities.

We have the honor of introducing the inaugural California Statewide Plan to Promote Health and Mental Health Equity, which provides both a context for why this work is of utmost importance (the report) and a road map for how to achieve it (the strategic plan). This planning process has been a truly collaborative effort. We are grateful for the insightful and broad thinking of the OHE Advisory Committee, stakeholders, and staff. Their dedication, thoughtfulness, and contributions were crucial components in the creation of this Plan.

Sincerely,

Karen L. Smith, MD, MPH
Director & State Health Officer
California Department of Public Health

Wm. Jahmal Miller, MHA
Deputy Director, Office of Health Equity
California Department of Public Health

INTRODUCTION AND BACKGROUND

This report on the California Statewide Plan to Promote Health and Mental Health Equity is the first biennial report of the new Office of Health Equity (OHE), established in 2012 under the California Health and Safety Code Section 131019.5 ("Code"). The OHE, operating within the California Department of Public Health (CDPH), is tasked, first and foremost, with aligning state resources, decision making, and programs to achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantages and historical injustice. The overriding objective of the Plan, included in this report, is to improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and inequities.

The Code instructed the OHE to seek input from the public on the Plan through an inclusive public stakeholder process and to develop the Plan in collaboration with the Health in All Policies Task Force. This was accomplished through several means, including meetings, webinars, surveys, and other correspondence. The Advisory Committee was established with a membership of 25 health experts, advocates, clinicians, and consumers representing diverse vulnerable communities and vulnerable places

across multiple fields and sectors. The Health in All Policies Task Force was represented on the committee as well. The Advisory Committee held its first meeting in September 2013. All meetings have adhered to the Bagley-Keene Open Meeting Act ("Act"), set forth in Government Code Sections 11120-111321, which covers all state boards and commissions. Generally, it requires these bodies to publicly notice their meetings, prepare agendas, accept public testimony, and conduct their meetings in public unless specifically authorized by the Act to meet in closed session.

The Advisory Committee meetings held in January, March, and May 2014 were largely dedicated to providing input into the development of the Plan. At these meetings there were presentations; full committee discussions; small group discussions involving Advisory Committee members, OHE staff, and the public; and formal public comments. Members of the public who were not able to participate on-site were able to participate via conference call.

In April and May 2014, statewide webinars were held to introduce initial drafts of the Plan, answer questions, receive comments, and allow for polling to establish priorities and partnership interests. A 61-item survey was also made available during that time for more in-depth feedback opportunities. The input from over 120 surveys and several letters was considered in the further development of the Plan.

Engagement with the public consisted of hundreds of meet-and-greets in person and occurred by phone with OHE staff, primarily with the Deputy Director, Jahmal Miller. These meetings additionally informed the Plan.

Definition of Terms

Determinants of Equity: The social, economic, geographic, political, and physical environmental conditions that lead to the creation of a fair and just society.

Health Equity: Efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

Health and Mental Health Disparities: Differences in health and mental health status among distinct segments of the population, including differences that occur by gender, age, race or ethnicity, sexual orientation, gender identity, education or income, disability or functional impairment, or geographic location, or the combination of any of these factors.

Health and Mental Health Inequities: Disparities in health or mental health, or the factors that shape health, that are systemic and avoidable and, therefore, considered unjust or unfair.

Vulnerable Communities: Vulnerable communities include, but are not limited to, women, racial or ethnic groups, low-income individuals and families, individuals who are incarcerated and those who have been incarcerated, individuals with disabilities, individuals with mental health conditions, children, youth and young adults, seniors, immigrants and refugees, individuals who are limited-English proficient (LEP), and Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQQ) communities, or combinations of these populations.

Vulnerable Places: Places or communities with inequities in the social, economic, educational, or physical environment or environmental health and that have insufficient resources or capacity to protect and promote the health and well-being of their residents.

Source: Health and Safety Code Section 131019.5.

California's Human Diversity: **Opportunities**

California's population is the most diverse in the continental United States[1] and one of the most diverse in the entire world. The Latino population is the state's largest ethnic plurality, at about 38 percent of the population, and is predicted to approach majority status by 2060 *(see Figure 1)*. That makes California only the second state in the nation, behind New Mexico, in which Whites are not the majority and where Latinos are the plurality. The state's non-Hispanic White population in mid-2014 is estimated to be a fraction of a percent smaller than the Latino population, at 38.8 percent, down from 57.4 percent in 1990. Whites are trailed by the Asian/Pacific Islander population, at 13 percent (up from 9.2 percent in 1990); African Americans, at 5.8 percent (down from 7.1 in 1990); and Native Americans, at less than 1 percent.[2]

California's human diversity goes beyond race and ethnicity. It also includes large shares of other subpopulations relative to other states, including the Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQQ) community; persons with disabilities; undocumented immigrants; and many others. For instance, according to the 2010 census, California has one of the highest percentages in the nation of married couples of mixed race or ethnicity and is among the leading states in the number of same-sex households.[3] More than 42 percent of the state's population over the age of five speaks one of several hundred languages other than English at home, with more than two-thirds of those also speaking English well or very well, while about 10 percent do not speak English at all.[4]

Diversity's Many Benefits...

California's diversity has been a source of great strength for the state's economy and cultural life, enriching California's schools, universities, communities, and industries with a kaleidoscope of skills and knowledge and with a determination to succeed. Approximately one in three small business owners in California is an immigrant,[5] and according to the Small Business Association, close to half of all small businesses in Los Angeles are owned by immigrants, who make up about 34 percent of the city's population. Statewide, almost one-third of the state's 3.4 million small businesses are owned by people of color.[6] At the national level, Latinos alone accounted for an estimated $1.2 trillion in consumer purchasing power in 2012, a market larger than the entire economies of all but 13 countries.[7]

Foreign-born individuals also make up 38.3 percent of all science, technology, engineering, and math graduates at the state's most research-intensive universities and account for 56.5 percent of the state's engineering PhDs.[8] A recent study from the University of California,

LATINOS ARE PROJECTED TO BECOME THE LARGEST RACIAL/ETHNIC GROUP AND WILL ACCOUNT FOR NEARLY HALF OF ALL CALIFORNIANS BY 2060

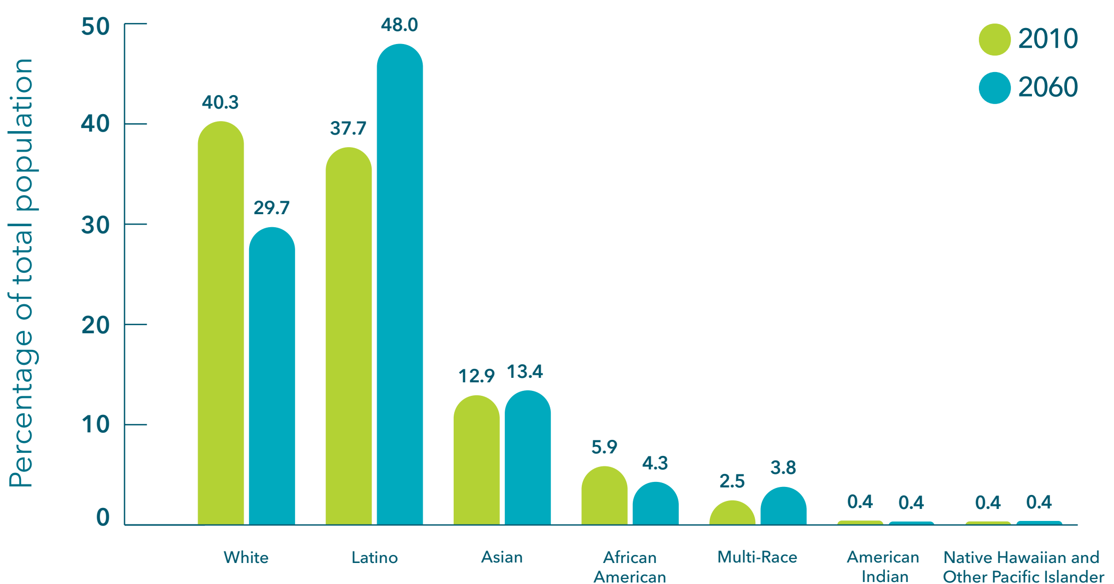

FIGURE 1: Percentage of California's population and projected population, by race/ethnicity, 2010 and projected 2060.

Source: California Department of Finance, Report P-1 (Race): State and County Population Projections by Race/Ethnicity, 2010-2060. Sacramento, California, January 2013.

Irvine, of Orange, Los Angeles, Riverside, San Bernardino, and Ventura counties looked at interrelationships among changing community factors such as racial and ethnic demographics, employment and economic welfare, housing density, crime and public safety, and land use. It found positive signs of change along all dimensions, especially rising property values in formerly homogeneous neighborhoods that have become ethnically mixed due to recent Latino and Asian immigration, reversing the trend of declining property values in the 1980s and 1990s.[9]

While immigration has already brought about powerful impacts in California, the future holds the promise of even greater change. The state's baby boomer population, which numbered 10 million in 1990, is aging into retirement over the next two decades, resulting in a steadily decreasing White share of the working age population and a rising share of workers who are Latino or Asian. The potential for the future growth of the labor force and the state's economy will increasingly depend on these younger, more diverse cohorts. The California Department of Finance projects that by 2030, the state's over-65 White population will be significantly larger than the under-25 White population, which will be only about half the size of the under-25 Latino population. Adding working-age Asians and other minority populations to the mix further illustrates the potential impact of people of color on the state's future labor force.[10]

...And Many Challenges

Despite these strengths, the great advantages of California's demographic diversity continue to be undermined by persistent, unjustifiable inequities in various social, economic, and environmental conditions that result in gaping disparities in the health of vulnerable populations, especially low-income (below 200 percent of the federal poverty level) families and neighborhoods; communities of color; the very young and the very old; and those who have experienced discriminatory practices based on gender, race/ethnicity, or sexual orientation.

These disparities in health status are a matter of life and death, shown by differences in death rates and life expectancy among the state's major racial and ethnic groups. Although the state's death rates have been steadily declining for almost all racial and ethnic groups, major gaps persist for African Americans relative to Asians and other populations as of 2010 (see Figure 2). Similarly, the state's average life expectancy of 80.8 years in 2010 masked a more than 11-year gap between Asian Americans, at 86.3 years, and African Americans, at 75.1 years.[11]

Further, life expectancy is tied to the social and environmental conditions of place – where we live, work, learn, and play. For example, residents of high-income San Francisco outlive those in the lower-income Riverside-San Bernardino area by three years: 81 to 78, respectively.[12] These neighborhood differences are particularly striking when looking within communities. In Oakland, an African American child in the low-income flatlands will, on average, die 15 years earlier than a White child who lives in the affluent hills.[12]

Similar gaps among population groups exist for numerous chronic health conditions that drive the disparities in death rates. Although death rates from stroke have declined in almost all racial and ethnic groups, the rate among African Americans remains about 50 percent higher than among some other racial or ethnic groups, mirroring similar disparities in related risks for high blood pressure, high cholesterol, tobacco use, and obesity.[12] Prevalence of diabetes is two and a half times as high among Hawaiian/Pacific Islanders as among Whites, and more than twice as high among those with a family income below 200 percent of the federal poverty level as among those with family incomes of at least 300 percent above the poverty level.[12]

While data showing the difference between aggregated populations can be useful, important disparities in health risks may be missed when looking only at this aggregated data for populations designated by large geographic areas of origin, such as Latinos and Asian/Pacific Islanders. For instance, significant gaps in rates of colorectal cancer exist among Japanese, Korean, Vietnamese, Chinese, Filipino, and South Asian Californians,[12] and so looking at only rates of colorectal cancer for Asians can be misleading and can result in missed opportunities for prevention. *(See Appendix D for information on data limitations.)*

ALTHOUGH DEATH RATES IN CALIFORNIA HAVE DECLINED, DISPARITIES PERSIST, WITH AFRICAN AMERICANS HAVING HIGHER DEATH RATES THAN OTHER RACIAL/ETHNIC GROUPS

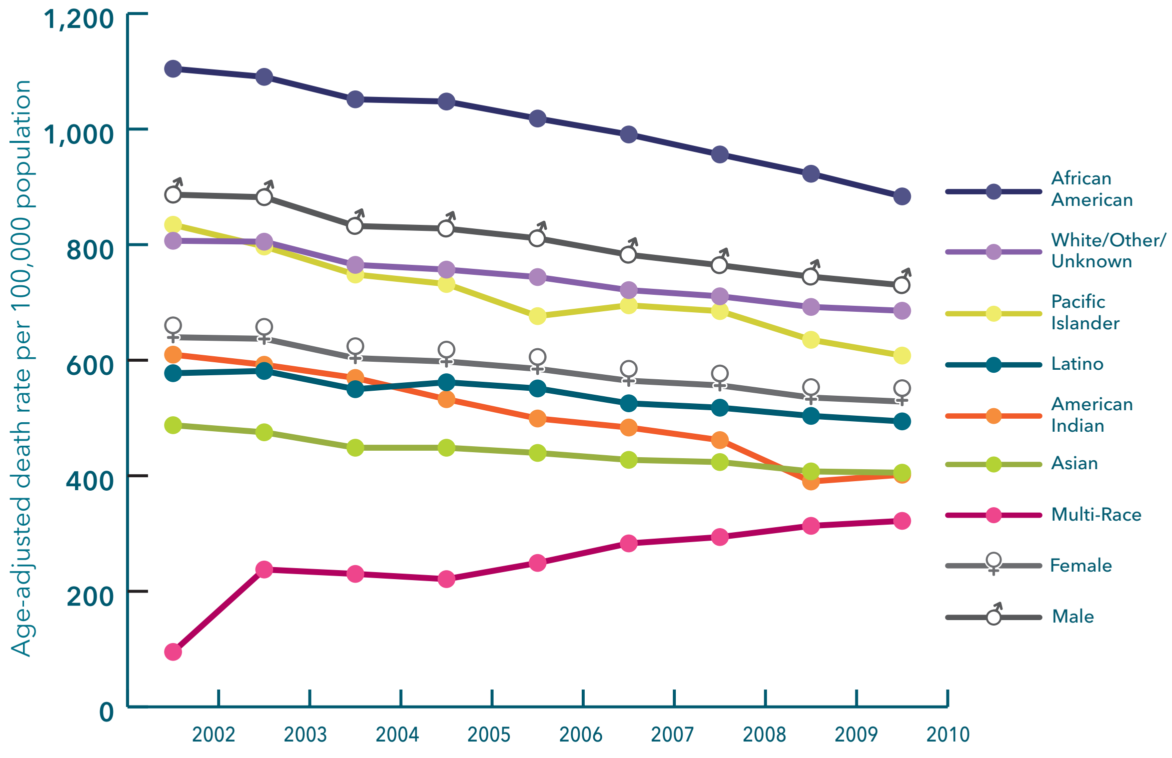

FIGURE 2: Death rates, by race/ethnicity and gender, California, 2002 to 2010.

Sources: California Department of Public Health, Death Records; and California Department of Finance, Race and Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.
Note: Age-adjusted rates are calculated using year 2000 U.S. standard population.

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What Drives Health Disparities?

One way of identifying the causes of health disparities is to examine the factors that produce and maintain healthy individuals, communities, and places. Many people assume that health is mostly a function of individuals' seeing the doctor regularly for good medical care and avoiding unhealthy behaviors, such as smoking and inactivity. However, most public health experts have adopted an upstream/downstream model of the causal factors that produce health, illness, and health disparities. In this model, factors such as medical care to maintain health or treat an illness or injury are viewed as the immediate, or "downstream," determinants of health outcomes. These downstream factors are causally related to "midstream" health determinants, such as people's genetic and biological makeup, and individual health behaviors, such as smoking, unhealthy eating, or lack of physical exercise. Further "upstream" are a host of environmental, social, and economic factors that even more powerfully influence health outcomes for entire populations. The World Health Organization (WHO) has defined these upstream factors as "the conditions in which people are born, grow, live, work, and age. These circumstances," declared WHO, "are shaped by the distribution of money, power and resources" within every level of society,[13] resulting in significant upstream health inequities and downstream health disparities that disproportionately impact low-income populations, communities of color, and other groups that are subject to racism and discrimination.

While public health researchers have differed on the relative importance of these various upstream and downstream health determinants, it is estimated that medical care, healthy behaviors, and genes and biology altogether account for only about half of a society's overall health outcomes,[14] even though downstream determinants attract the majority of health funding and expenditures.

The Social Determinants of Health

What constitutes the other 50 percent of the determinants of health and well-being is a complex interplay of environmental conditions, such as air and water quality, the quality of the built environment (e.g., housing quality; land use; transportation access and availability; street, park, and playground safety; workplace safety; etc.), and a whole host of socioeconomic factors. These latter factors include opportunities for employment, income, early childhood development and education, access to healthy foods, health insurance coverage and access to health care services, safety from crime and violence, culturally and linguistically

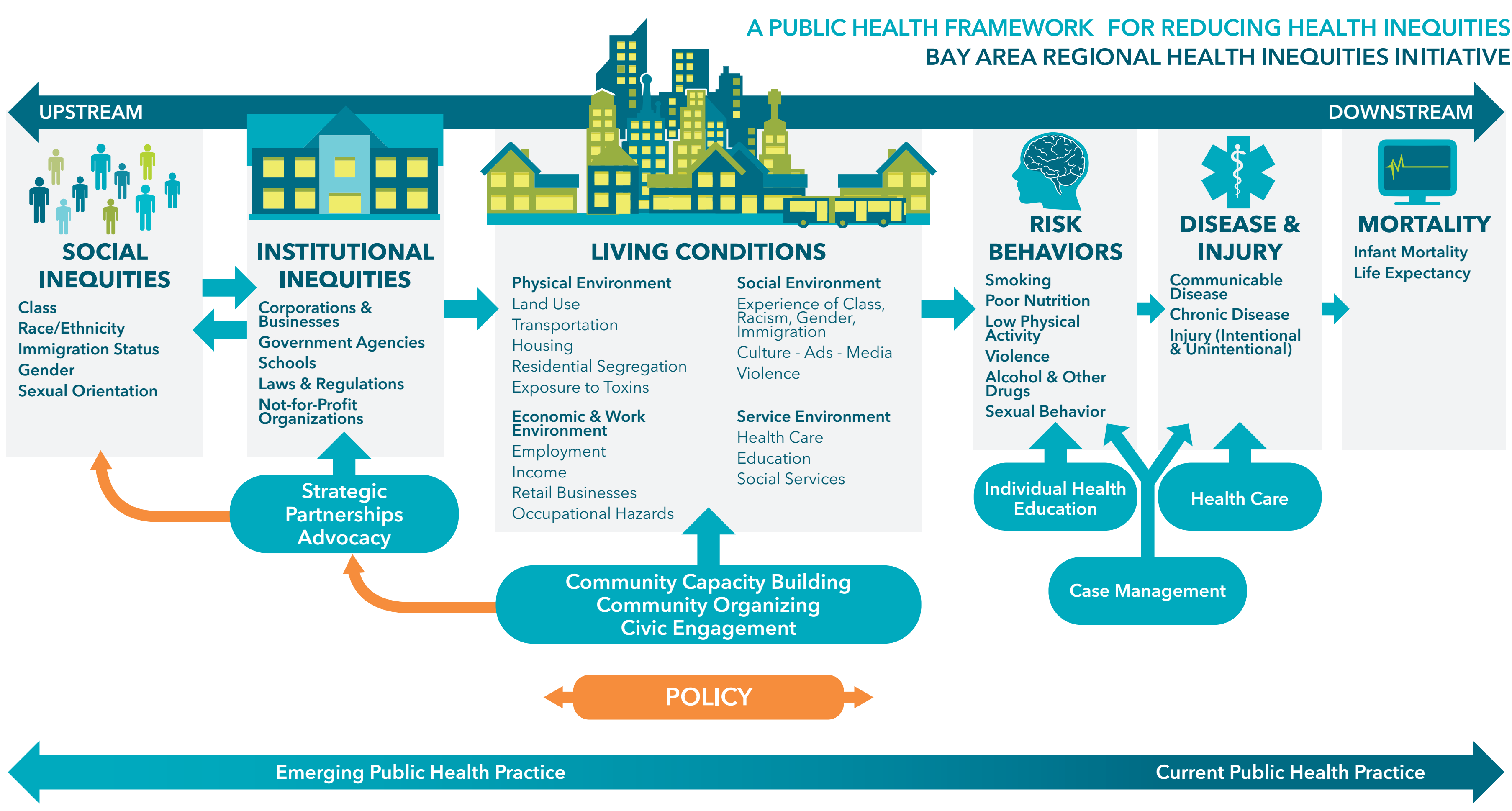

FIGURE 3: Bay Area Regional Health Inequities Initiative (BARHII) Conceptual Framework, 2006.

appropriate services in all sectors, protection against institutionalized forms of racism and discrimination, and public and private policies and programs that prioritize individual and community health in all actions.

Significantly, in contrast to the individual-level downstream determinants, these environmental and socioeconomic determinants have population-level impacts. Understanding this is vital when designing and implementing health interventions, such as economic development programs in low-income communities, which can be targeted to specific subpopulations, communities, and neighborhoods, thus affecting thousands or tens of thousands of people rather than one individual at a time.

When a society's principles and policies work to optimize these interrelated social determinants of health on the basis of justice and equity for everyone, health is created at the levels of the individual, the community, the environment, and society at large *(see Figure 4)*. When any combination of these drivers is lacking, the

engine that powers total health can break down, resulting in significant health inequities and disparities in health outcomes. Understanding what creates or limits the opportunity for health is essential to understanding what creates disparate health outcomes and what needs to be done to prevent them. Among other things, the solutions need to involve changes at the policy level by a broad set of public and private partners representing sectors that impact public health but may not have health at the center of their decision making, such as transportation, economic development, chambers of commerce, city planning, and others.

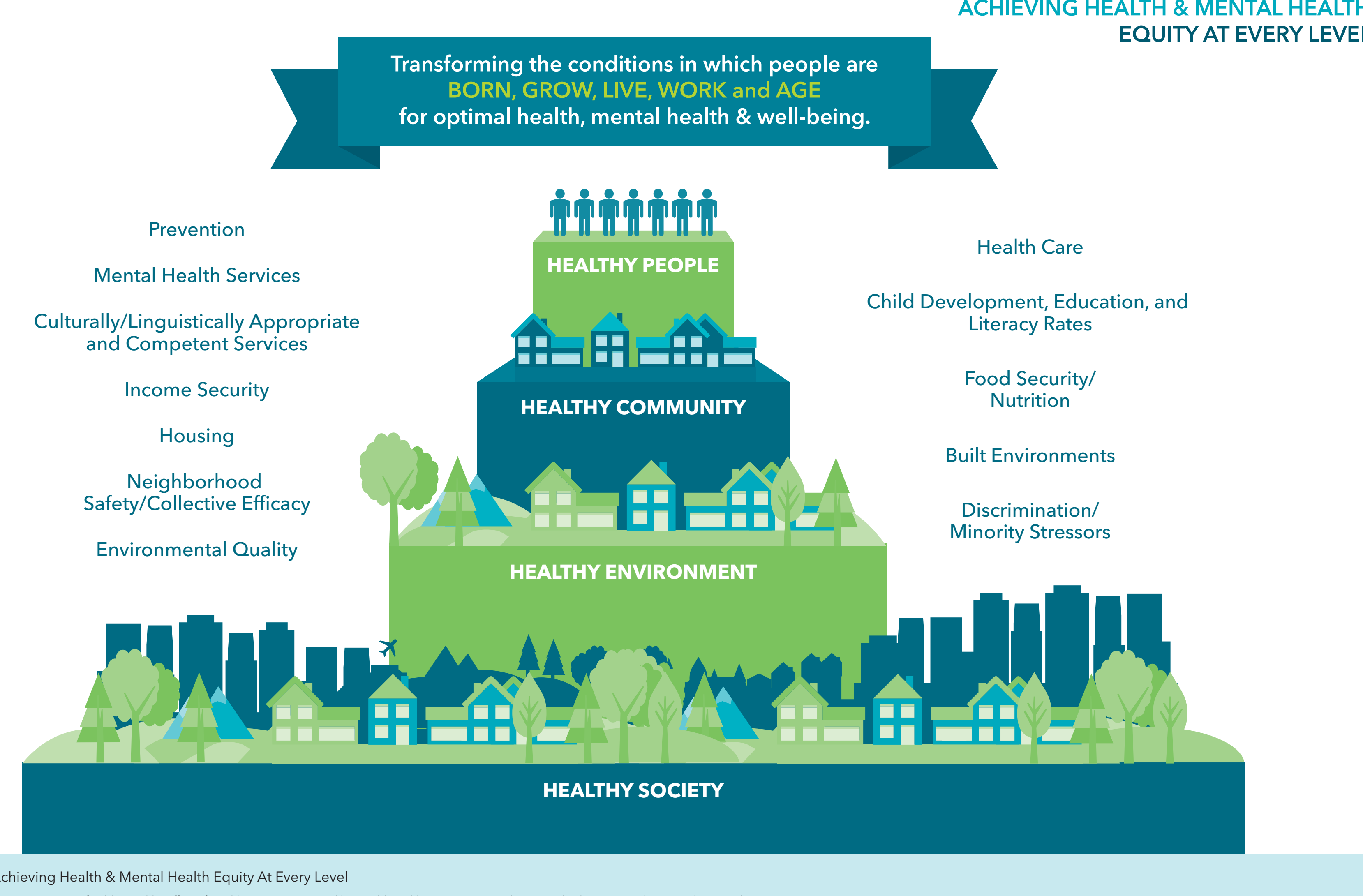

FIGURE 4: Achieving Health & Mental Health Equity At Every Level

Source: California Department of Public Health, Office of Health Equity, as inspired by World Health Organization, Robert Wood Johnson Foundation, and many others.

The Deep Roots **of Health Inequities**

While there are many indicators of health, income and wealth play especially important roles in determining health outcomes. Income and wealth are discussed in depth in this section because of their tremendous impact on health, and the inequities in how they are distributed among California's population.

While America's constitutional principles emphasize the importance of justice and equity, its policies and practices have historically allowed some population groups disproportionately greater opportunities for building household wealth. As the poet Ralph Waldo Emerson wrote, "The first wealth is health." That saying has recently been revised to make the point that "wealth equals health," a point forcefully driven home in the *2006 Handbook for Action: Tackling Health Inequities Through Public Health Practice*. This handbook closely examined how U.S. household wealth (meaning the value of all financial and nonfinancial assets, such as real estate owned by a household, minus any debts) serves as the major determinant of health and health inequities, influencing and influenced by virtually all other upstream environmental and socioeconomic factors, including income, education, employment, housing, bank lending policies, child care, recreational opportunities, food supply, health care access, neighborhood safety, and environmental quality.[15]

If health is wealth, it follows that efforts to understand and reverse the drivers of health inequities need to begin by looking at how the policies and actions of private institutions and governments have contributed to the large gaps in wealth that mirror the gaps between the healthy and the unhealthy.

Behind the Gaps in Wealth and Health

Historically, the United States' long eras of slavery and discriminatory policies in housing, education, transportation, and economic development largely excluded people of color and other minorities from the formal economy, up until the latter half of the 20th century and the passage of major civil rights legislation. Although many of those policies, such as lending institution redlining, have been prohibited by law in recent decades, their harmful legacies persist in numerous, less obvious ways, both officially and unofficially.

For instance, it is widely recognized today that private and public bank lending policies that enabled the subprime mortgage practices during the housing boom contributed significantly to the 2007-2009 housing bust, which wiped out vast shares of homeowners' household wealth. The bust affected all but the richest few percent of the population, having much greater negative impacts on low-income households, especially communities of color. This is the result of the fact that wealth accumulation among African American and

Latino families, among other disadvantaged groups, is more recent and more concentrated in home values than for most White families, whose much greater wealth is more broadly distributed over many kinds of assets other than housing, such as stocks and bonds.[16]

A recent analysis of national annual income surveys by the U.S. Census Bureau revealed that in 2011 – two years into the so-called recovery period from the Great Recession – average African American and Latino households owned only six and seven cents, respectively, for every dollar in wealth held by the average White family. In 2011, the median net worth of households of color had fallen from 2005 levels – before the recession – by 58 percent for Latinos, 48 percent for Asians, and 45 percent for African Americans, but by only 21 percent for Whites. The same study found that the average liquid wealth – meaning cash on hand or assets easily converted to cash – of White families was 100 times that of African Americans and more than 65 times that held by Latinos.[17] This type of wealth is key to maintaining a sense of security and stability when unexpected crises occur, such as serious illness or loss of a job, as well as to being able to act on unexpected opportunities, such as building or expanding a business in response to changed circumstances. Wealth serves as both a cushion against hard times and a potential launching pad for economic growth.

The study, from Brandeis University, also examined the significant growth of the wealth gap for African American families over a 25-year period (1984-2009) and concluded that it could be largely explained by five factors: years of homeownership, household income, unemployment, education, and inheritance, all of which are deeply influenced by local, state, and federal policies that create either opportunities or barriers to wealth and health.[16]

California's wealth gaps are shown in Figure 5. White families, which accounted for just over half of total households in 2010, held two-thirds of total wealth. African American families, with 6 percent of total households, held just 2 percent of total wealth, and Latinos, with 27 percent of households, held just 16 percent of total wealth.

Public policies and private practices affecting the economy, housing, the environment, education, and other sectors are a major factor in the persistence and growth of a widening American wealth gap, which is a key driver of health inequities among low-income families, communities of color, women, children, and other vulnerable populations. Fortunately, policies are not carved in stone. They can be reshaped to address inequities and promote greater access for all people to both wealth and health. Through policy choices, government can play an important role in slowing and even reducing the growing wealth gap, thereby helping slow and ideally reduce California's growing health inequities.

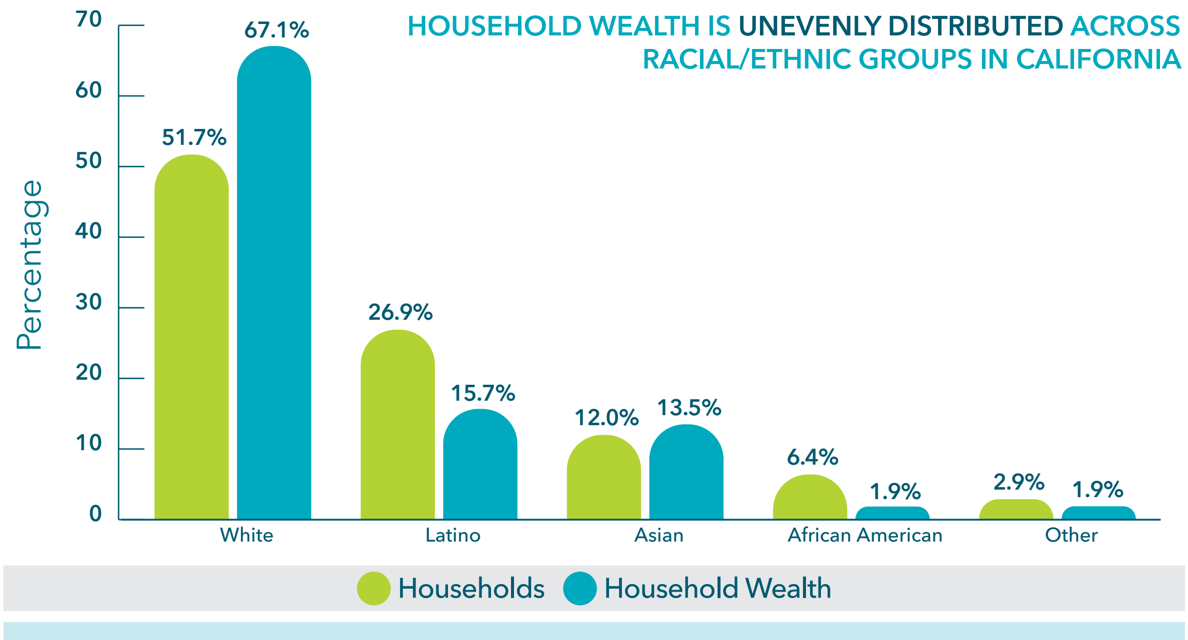

FIGURE 5: Percentage of California's households and household wealth (net worth), by race/ethnicity, California, 2010.

Sources: U.S. Census Bureau, Census 2010, Summary File 2; and Survey of Income and Program Participation (Panel 2008, Wave 7).

Health in **All Policies**

Health in All Policies is a cutting-edge approach to shaping effective public and private policies for the promotion of health and health equity. The American Public Health Association describes Health in All Policies as "a collaborative approach to improving the health of all people by incorporating health considerations into decision making across sectors and policy areas."[18]

Health in All Policies is based on the recognition that the greatest health challenges – including the health inequities described in this report – are highly complex and often interrelated. Because public health and health care institutions do not have authority over many of the policy and program areas that impact health, solutions to these complex and urgent problems require working collaboratively across many sectors to address the social determinants of health, such as transportation, housing, and economic policy.

Health in All Policies builds on public health's long and successful tradition of collaboration among government sectors, as demonstrated in such initiatives as implementing fluoridated tap water policies, reducing occupational and residential lead exposure, restricting tobacco use in workplaces and public spaces, improving sanitation, and requiring use of seatbelts and child car seats. Health in All Policies takes the idea of cross-sector collaboration further by formalizing ways to systematically incorporate a health, equity, and sustainability lens across the entire government apparatus. A Health in All Policies approach also supports collaboration across multiple sectors, ensures that policy decisions benefit multiple partners, engages stakeholders, and works to create positive structural and process change.[19]

For these reasons, a Health in All Policies approach has been embraced by the World Health Organization, the American Public Health Association, the Association of State and Territorial Health Officers, the National Association of County and City Health Officers, and other professional public health organizations. It is being implemented in a variety of ways across the United States, including by California's state government through the Health in All Policies Task Force *(see below and Appendix B for more information).*

The Case for Addressing **Health Inequities**

Almost 70 years ago, both the then-new World Health Organization (WHO) and the United Nations (UN) broadly defined health as a basic human right. The WHO Constitution defines the right to health as "the enjoyment of the highest attainable standard of health," including the right to healthy child development; equitable dissemination of medical knowledge and its benefits; and government-provided social measures to ensure adequate health.[20] The UN's Universal Declaration of Human Rights in 1948 declared in Article 25 that "*[e]veryone has the right to a standard of living adequate for the health and well-being of himself [sic] and of his family, including food, clothing, housing, and medical care and necessary social services.*"[21] More recently, the focus on health disparities received a boost in 1998 when the federal government launched the Racial and Ethnic Health Disparities Initiative.[22] Subsequently, the Healthy People 2010 and 2020 initiatives moved beyond the traditional research paradigm of merely documenting the health inequities of vulnerable populations, by incorporating a commitment to actually "achieve health equity, eliminate disparities, and improve the health of all groups" as one of its four overarching goals.[23]

The case for viewing health and mental health equity as an issue of basic social justice has grown ever stronger as researchers and policy experts have learned more about the social and economic impacts of historic and continuing health disparities on the nation's large and growing vulnerable populations.

The Costs of Health Inequities

The moral case for addressing health inequities is buttressed by a strong economic argument, as reducing health inequities will yield savings in health care costs. Health spending accounted for 17.7 percent of gross domestic product (GDP) in the United States in 2011, by far the highest share in comparison with the 34 developed nations of the Organization for Economic Cooperation and Development (OECD) and more than 8 percentage points higher than the OECD average of 9.3 percent. The United States spent $8,508 per capita on health in 2011, two and a half times more than the OECD average of $3,339, while lagging most developed nations in key measures of health outcomes.[24]

What share of that excess U.S. spending is attributable to the cost of health disparities is a complex issue, but one widely reported study in 2011 estimated that more than 30 percent of direct medical costs faced by African Americans, Hispanics, and Asian Americans were excess costs due to health inequities – more than $230 billion over a three-year period, plus indirect costs of $1 trillion in lower workplace productivity due

to associated illness and premature death.[25] That three-year total of "excess costs" due to health disparities is equal to approximately half the total of all U.S. health care spending in 2012. Meanwhile, total spending in 2012 on public health and health prevention accounts for only 2.7 percent of total health care spending.[26]

These numbers, dramatic as they may be, fail to convey the actual human costs of health disparities – lives lost prematurely and lives stunted and scarred by debilitating ill health, both physical and mental. It may be impossible to objectively assess the full dimensions of the human tragedy of health inequities and disparities, but the cost in mortalities alone is revealing. According to a National Institutes of Health 2011 study in the *American Journal of Public Health*,[27] nearly three-quarters of a million U.S. adult deaths in 2000 were attributable to just five of the leading social determinants of health:

Low education accounted for 245,000 deaths,

Racial segregation accounted for 176,000,

Low social supports accounted for 162,000,

Income inequality accounted for 119,000,

and Area-level poverty accounted for 39,000.

In addition to moral arguments that health inequities are unjust, there are strong economic and social arguments that these health inequities impose avoidable costs.On an individual level, these inequities negatively impact the health and well-being of the populations that constitute the majority of Californians and that will increasingly represent over half of the nation's workforce and its taxpayers. In short, the elimination of health disparities and the creation of health security for all are vital to creating the kind of future we all want for our children and grandchildren.

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Creating Health Equity in California: The Office of Health Equity

The Office of Health Equity (OHE), operating within the California Department of Public Health (CDPH), was created in 2012. The office continues California's multifaceted efforts to reduce or eliminate health and mental health disparities among California's vulnerable communities.

The OHE was created both to build upon the existing network of public and private sector partnerships in all economic, social, and environmental sectors that influence health and mental health and to align all state resources, decision making, and programs to accomplish the following objectives:

- Achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantage and historical injustice;
- Work collaboratively with the Health in All Policies Task Force to promote work to prevent injury and illness through improved social and environmental factors that promote health and mental health;
- Advise and assist other state departments in their mission to increase access to, and the quality of, culturally and linguistically competent health and mental health care and services; and
- Improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and achieving health equity.[28]

To carry out its work, the OHE has been organized into three operational units:

- Community Development and Engagement Unit
- Policy Unit
- Health Research and Statistics Unit

Community Development and Engagement Unit

The Community Development and Engagement Unit's (CDEU's) current focus is to strengthen the CDPH's ability to advise and assist other state departments in their work to increase access to, and the quality of, culturally and linguistically competent mental health care and services.

The primary responsibility of the CDEU is to carry on the ambitious work of the **California Reducing Disparities Project (CRDP)**, launched in 2009 to improve and increase access to care, quality of care, and positive mental health outcomes for racial, ethnic, and cultural communities. Since its creation, CRDP has provided funding for the development of

five population-specific reports for identifying and reducing mental health disparities among five target populations: African Americans; Asian/Pacific Islanders; Latinos; Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning individuals; and Native Americans.

The implementation and evaluation of local-level interventions recommended in these population reports is serving in the development of a single comprehensive strategic plan, authored by stakeholders, that brings together the community-identified lessons and successful strategies of each of the population-specific plans, identifying any similarities among them. This multiyear project aims to provide the state's mental health system with community-identified strategies and interventions that will result in meaningful culturally and linguistically competent services and programs that meet the unique needs of the five target populations.

Also part of the CRDP is the **California Mental Health Services Act Multicultural Coalition (CMMC)**, whose primary goal is to integrate cultural and linguistic competence throughout the public mental health system. The CMMC is a CRDP contractor and provides a new platform for racial, ethnic, cultural, and LGBTQQ communities to come together to address historical system and community barriers and collaboratively seek solutions that will eliminate barriers and mental health disparities. The coalition, launched in 2010, is made up of 30 members representing diverse multicultural perspectives on mental health, including those that have not been adequately represented in other efforts. CMMC members have provided extensive input into the comprehensive CRDP strategic plan.

Finally, CDEU also supports ongoing implementation of the Bilingual Services Act of 1973, which requires state agencies to provide translated materials in "threshold languages" or those languages identified by Medi-Cal as the primary language of 3,000 beneficiaries or 5 percent of the beneficiary population, whichever is less, in an identified geographic area.

Policy Unit

The work of the Policy Unit includes staff facilitation for the California **Health in All Policies (HiAP) Task Force**, which is made up of 22 state agencies, departments, and offices and is charged with identifying priority programs, policies, and strategies to improve the health of Californians while advancing the goals of the Strategic Growth Council (SGC). Executive Order S-04-10 created the HiAP Task Force in 2010, placed it under the auspices of the SGC, and called for the California Department of Public Health (CDPH) to provide facilitation. CDPH facilitates the HiAP Task Force through a private/public partnership with the Public Health Institute and several nongovernment funders. While CDPH facilitates the HiAP Task Force, the member agencies and departments contribute staff time for meetings and ongoing collaborative projects. CDPH engages HiAP Task Force members in an intensely collaborative and creative process to promote innovative strategies to improve health, equity, and sustainability. Because local governments play a major role in shaping communities and community health, the HiAP Task Force has focused on the unique role that state agencies play in supporting local action. The successes of the HiAP Task Force include incorporating health and equity principles in state guidance documents, increasing public input into key state processes, and growing collaboration across government sectors and among communities and decision-makers throughout California. *For more detailed information about the work of the HiAP Task Force, see Appendix B.*

The **Healthy Places Team** in the Policy Unit is building the Healthy Communities Data and Indicators Project (HCI). The goal of the HCI is to enhance public health by providing data, a standardized set of statistical measures, and tools that a broad array of sectors can use for planning healthy communities and by evaluating the impact of plans, projects, policies, and environmental changes on community health. With funding from the Strategic Growth Council, the HCI is a two-year collaboration of the California Department of Public Health and the University of California, San Francisco (UCSF), to pilot the creation and dissemination of indicators linked to the HiAP Task Force's Healthy Communities Framework.

The Policy Unit's Climate and Health Team leads CDPH's efforts to address the health aspects of the state's efforts to reduce California's greenhouse gas emissions by 80 percent by 2050, prepare for the climate change impacts that are already occurring and plan for future impacts. The staff participate in the state's Climate Action Team (CAT), a cross-sector group of 20 agencies and departments working to develop and coordinate overall state climate change efforts. The Climate and Health team leads the CAT's Public Health Workgroup, where public health, state agency partners and diverse stakeholder groups meet to review critical climate and public health issues and work to ensure that public health and health equity are recognized and incorporated in state climate change planning efforts.

Health Research and Statistics Unit

The Health Research and Statistics Unit (HRSU) is the technical backbone of the OHE, providing and sharing research and data for OHE reports as well as baseline information for programs aimed at eliminating health and mental health inequities in California.

The unit inventories and organizes the abundant information regularly collected by other CDPH programs, state agencies, research organizations, and community-based organizations on the demographics and geography of vulnerable populations and on inequities in health and mental health outcomes, health services, and social determinants of health. It also collects existing information on interventions to reduce health and mental health inequities, allowing stakeholders to rapidly access such information.

The unit is also responsible for synthesizing and analyzing data to provide this report and subsequent biennial statistical profiles of health and mental health inequity in California, thereby providing a baseline against which progress can be measured. In addition, the unit analyzes and tracks Healthy People 2020 targets in order to monitor the state's progress toward eliminating health and mental health disparities and achieving health equity for all Californians.

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DEMOGRAPHIC REPORT ON HEALTH AND MENTAL HEALTH EQUITY IN CALIFORNIA

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The Social Determinants
Shaping the Health of California's People and Places

As noted in the introduction to this report, the physical and mental health of individuals and entire communities is shaped, to a great extent, by the social, economic, and environmental circumstances in which people live, work, play, and learn. As explained by the World Health Organization, these same circumstances, or social determinants of health, are also "mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries."[1]

In preparing the California Statewide Plan to Promote Health and Mental Health Equity, the Office of Health Equity, working in close collaboration with other public and private agencies and advocacy organizations, has collected and analyzed a wealth of primary and secondary demographic and health data concerning the major underlying social, economic, and environmental conditions that contribute to the health and health inequities of the state's residents and their communities. This data and analysis represent an initial benchmark to inform the current plan for addressing health inequities and disparities, as well as for measuring future progress toward the goal of reducing and eliminating these inequities and disparities.

In the following pages, we present highlights of the data and analysis relative to each of these key social determinants of health.

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Income Security: The High Cost of Low Incomes

For many years, the relationship between socioeconomic status (SES), usually measured by income, education, or occupation, and health and mental health has been known. As individuals move up the SES ladder, their health improves, they live longer lives, and they have fewer health problems. Socioeconomic status is important because it provides access to needed resources that help people avoid risks, promote healthy behaviors, and protect health, such as "money, knowledge, power, prestige, and beneficial social connections."[1]

Several recent studies of the economic impact of poverty in the United States reveal that the nation as a whole pays the equivalent of $500 billion a year, or roughly 4 percent of U.S. gross domestic product (GDP), for the lost productivity and excess costs of health and other services associated with child poverty.[2] These studies confirm that children growing up in poverty receive less and lower-quality education, earn less as adults, are more likely to receive public assistance, and have lower-quality health and higher health costs over their lifetimes.

California Wealth and Income Disparities

Although the Great Recession of 2007-2009 hit the pocketbooks of families across the entire socioeconomic spectrum, the hardest hit included those who were already on the lower ranks of the income ladder. California families at the lowest income level (10th percentile) saw incomes fall more than 21 percent, while those at the 25th and 50th percentiles saw theirs fall about 10 percent. On the other hand, individuals in the 90th percentile experienced only a 5 percent decline, resulting in a new record level of income inequality in the state.[3]

Under the official federal poverty measure, California ranks 14th among the 50 states. However, California has the highest poverty rate in the nation when calculated according to an alternate (although unofficial) measure, known as the Supplemental Poverty Measure (SPM), which was developed by an Interagency Technical Working Group commissioned by the Office of Management and Budget's Chief Statistician to better reflect contemporary social and economic realities and government policy. The SPM factors in the cost of housing; taxes; noncash benefits; and day-to-day costs such as childcare, work-related expenses, utilities, clothing, and medical costs. This alternate method adds nearly 3 million more people to the official poverty rate, meaning that nearly one in four Californians would be considered poor.[4]

Single-Mother Households and Children Bear the Brunt of Poverty

Extreme income inequality is especially acute among California families headed by a single mother, one in three of which has an income below the poverty level. The disparity is even higher for families led by Latino, American Indian/Alaska Native, and African American single mothers *(see Figure 6)*. This suggests that the persistent (if improving) inequity in wages between men and women, with women being paid 75 percent of comparable wages paid to men,[5] is not simply a women's issue but also a serious family issue that contributes to additional inequities in quality of life for children. Almost half of the state's 2 million children age 3 or under live in low-income families.[6]

The Health Impact of Poverty

One of the highest costs of poverty is paid in the high rates of poorer health and lower life expectancy among vulnerable populations.[7] Evidence has shown a strong correlation between poverty-level income and cardiovascular disease, low birth weight, hypertension, arthritis, and diabetes.[8] One-third of deaths in the United States can be linked to income inequality, and it is estimated from data from 2007 that 883,914 deaths could have been prevented that year had the level of income inequality been lowered.[9] In addition, income-based inequities emerge in cognitive development among infants as young as 9 months and widen as they age, leading to educational achievement gaps between higher- and lower-income peers in later years.[10] The prevalence of psychiatric disorders, including neurotic disorders, functional psychoses, and alcohol and drug dependence, is consistently more common among lower-income people.[11]

In short, one of the most beneficial prescriptions for improving people's health and closing the gaping disparities in health outcomes is to

Incubating Latino-Owned Startups In San Francisco's Mission District

In San Francisco, business incubators are normally associated with financial and technical assistance for high-tech startups looking to become the next Google. But since 2010, at a SparkPoint Center sponsored by United Way of the Bay Area, El Mercadito has helped nurture nine new microenterprises for Latino entrepreneurs impacted by economic circumstances. The center provides technical assistance, retail space, and financing opportunities from the Mission Economic Development Agency's Business Development Program and the Mission Asset Fund's Lending Circle program. Once the startups achieve sustainability, they can move into their own storefronts. El Mercadito merchants have also formed a small community of their own through a merchants association, assisting and relying on each other to achieve business success. Current businesses include Simmi's Boutique, Express Beauty and Warehouse, the Peruvian restaurant Cholo Soy, and Gallardo's Printing and Engraving, among others.

Recommended further reading from the Health Atlas for the City of Los Angeles: http://cityplanning.lacity.org/Cwd/framwk/healthwellness/text/HealthAtlas.pdf.

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ABOUT 33% OF FEMALE-HEADED HOUSEHOLDS AND 9% OF MARRIED-COUPLE HOUSEHOLDS LIVE BELOW THE FEDERAL POVERTY LEVEL

Percentage of families with children below the federal poverty level

	Female householder with children	Married couple with children
Latino	40.9%	15.3%
American Indian and Alaska Native	38.5%	10.2%
African American	35.0%	7.1%
Multi-Race	29.7%	5.8%
Other	25.5%	8.2%
Asian	23.7%	6.4%
Native Hawaiian and Other Pacific Islander	23.3%	8.6%
White	22.1%	3.4%
California	32.8%	8.7%

FIGURE 6: Percentage of families whose income in the past 12 months was below poverty level, by race/ethnicity, California, 2006-2010.

Source: U.S. Census Bureau, American Community Survey, 5-Year Estimates (2006-2010).

Food Security and Nutrition

Food security, defined as stable access to affordable, sufficient food for an active, healthy life, is a basic human right.[1] Yet here in California, the nation's food-rich "breadbasket," many people experience periods when they cannot afford to put sufficient food on the table or they have to forgo other basic needs to do so. The food insecurity of California households with children ages 0 to 17 increased from 11.7 percent in 2000-2002 to 15.6 percent in 2010-2012.[2]

Chronic Food Insecurity Means More Than a Missed Meal

Adults who are food insecure have poorer health and are at risk of major depression as well as chronic diseases such as heart disease, diabetes, and hypertension:[3]

- Food-insecure expectant mothers may experience long-term physical health problems,[4] experience birth complications,[5] and be at greater risk of depression[6] and other mental health problems.[7]
- Food-insecure children have increased rates of developmental and mental health problems. They may also have problems with cognitive development and stunted growth, leading to detrimental impacts on their behavioral, social, and educational development.[6,8-14]
- Women living in food-insecure households are more likely to be overweight or obese. One possible explanation for this paradoxical correlation is that these women tend to overcompensate for periods when food is scarce by overeating when food is available.[15]

Communities of Color and Children Bear the Brunt

The pain of hunger and food insecurity impacts virtually all racial and ethnic groups and geographic regions of the state. However, low-income Latinos, African Americans, and American Indians/Alaska Natives have been disproportionately impacted by hunger and food insecurity *(see Figure 7)*. More than 40 percent of these individuals experience food insecurity, as do more than 26 percent of all California children. Ironically, many of California's most food-insecure communities are located in the very heart of the state's agriculturally rich – and increasingly Latino – San Joaquin Valley. For example, the percentage of children in Fresno County who are food insecure is almost double that of food-insecure children in San Mateo County *(see Figure 8)*.

Food Deserts in a Fertile Landscape

Marginalized, vulnerable communities experiencing high rates of food insecurity are not limited to the state's agricultural regions;

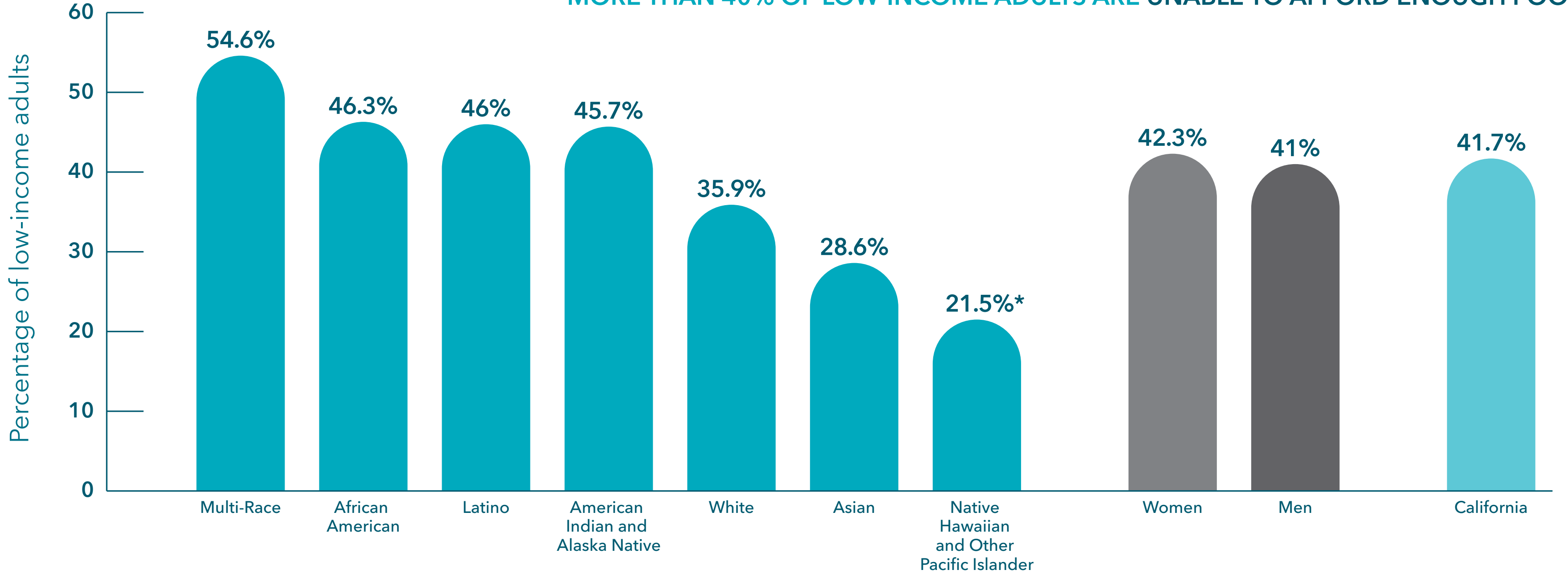

FIGURE 7: Percentage of adults whose income is less than 200% of the federal poverty level and who reported having food insecurity, by race/ethnicity and gender, California, 2011-2012.

Source: University of California, Los Angeles, California Health Interview Survey, 2011-2012.

** Statistically unreliable data.*

they are also common throughout California's cities and suburban areas. Nationally, in 2010, nearly 30 million Americans (9.7 percent of the population) lived in low-income areas more than a mile from a supermarket.[16] These areas are often defined as virtual "food deserts," where fewer than 12 percent of local food retailers offer healthier food options, such as fresh fruits and vegetables, and where residents have limited means of travel to more distant full-service grocery stores.

One study found that residents with no supermarkets near their homes were 25 to 46 percent less likely to have a healthy diet.[17]

Summer Food Service Program for Low-Income Kids

The Summer Food Service Program is a federally funded program that reimburses public and private schools, nonprofit agencies, and local governments for providing free, nutritious meals to children (18 and younger) in low-income communities through the summer months when school is not in session. Participating organizations, which are reimbursed for their costs, can serve two meals or a meal and a snack each day, or up to three meals in residential camps and migrant farm worker sites. The U.S. Department of Agriculture, which sponsors the program, is working with California Department of Education officials to expand the program in California to at least 600 sites throughout the state. Nationally, about 7.5 million meals were served on a typical summer day in 2013.

Learn more at http://www.cde.ca.gov/fg/aa/nt/sfsp.asp.

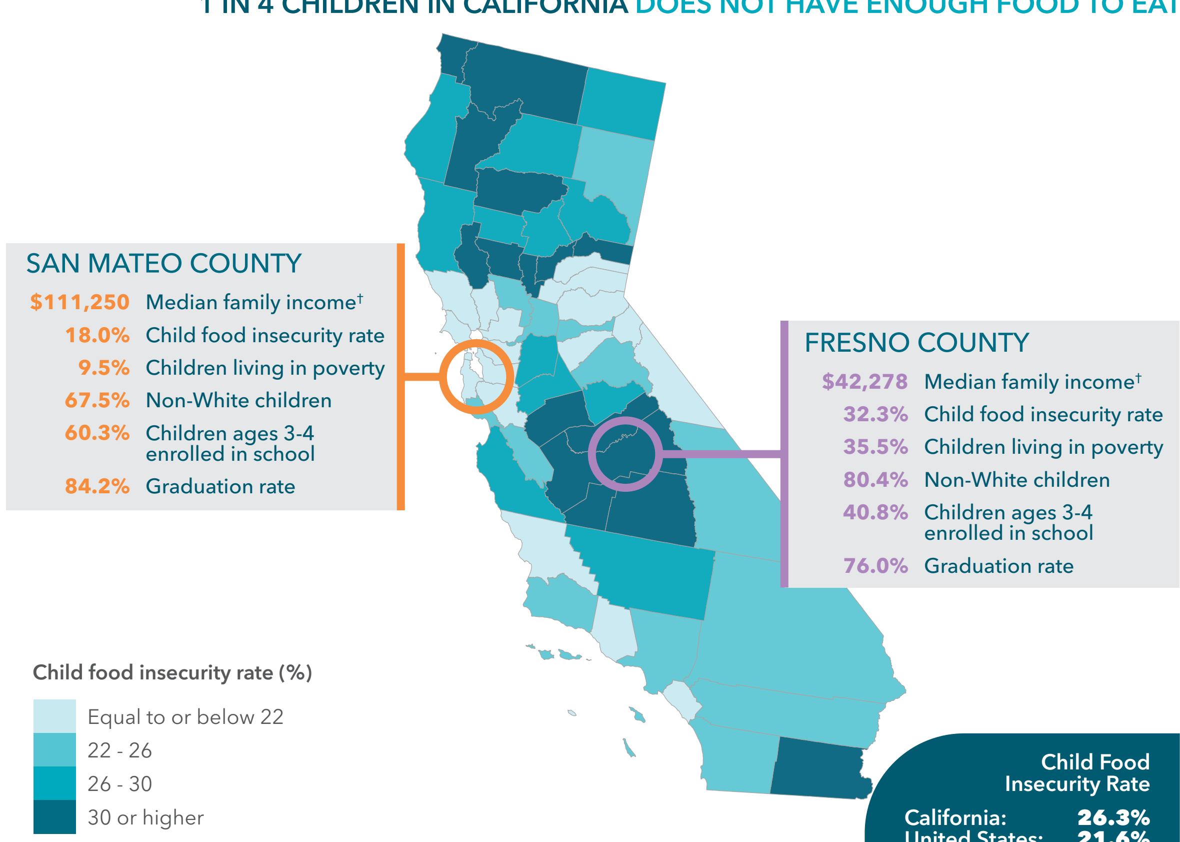

FIGURE 8: Child food insecurity rate: percentage of children under 18 years old who are food insecure, California, 2012.

Sources: Feeding America, Map the Meal Gap, 2012; U.S. Census Bureau, American Community Survey, 3-Year Estimates (2009-2011) and 5-Year Estimates (2008-2012); and California Department of Education, Graduation Data, 2011-2012.
†Median family income with own children under 18 years.

A 2005 study focused on California found that for the state as a whole there were more than four times as many fast-food restaurants and convenience stores as supermarkets and produce vendors. This ratio of unhealthy to healthy food options varied substantially among counties and cities, with two counties (San Bernardino and Sacramento) and two cities (Bakersfield and Fresno) having nearly six times as many fast-food restaurants and convenience stores as supermarkets and produce vendors.[18] The communities with high concentrations of fast-food outlets and relatively high-priced convenience stores have been shown to be characterized by disproportionately high rates of obesity and diabetes, which are precursors of other chronic diseases, such as cardiovascular disease, stroke, and arthritis.

Food Councils Tackle Food Insecurity

Food councils and local, food-centered community groups have emerged as leaders of a movement to solve food insecurity and food quality concerns across California. They do this by promoting policies and education at the state and local levels that encourage and support sustainable urban and regional foodsheds, including community and home-scale gardening efforts, farmers markets, and urban agriculture. The California Food Policy Council is bringing together the food councils from the smallest counties, such as Plumas County and Sierra County, with the largest, Los Angeles County, to ensure that California's food system reflects the needs of all its communities.

Food councils address food security through policy changes that increase access to subsidized foods, like CalFresh, WIC, senior nutrition programs, and food banks. They also promote home- and community-grown food efforts; encourage economic development; and advocate for sustainable farming and fair labor practices by large-scale food producers, retailers, and the food-service industry.

Food councils are changing the foodscape of California through local ingenuity combined with community resourcefulness and resilience.

Learn more at http://www.rootsofchange.org/content/activities-2/california-food-policy-council.

Child Development and Education:
Addressing Lifelong Disparities in Early Childhood

Many of the basic foundations for lifelong health, prosperity, and well-being are formed in early and middle childhood. That observation, increasingly recognized in policy, research, and clinical practice,[1] means that, as a society, we can minimize many of the health inequities featured in this report by focusing attention and resources on ensuring that our children – all our children – are provided with the strongest possible foundations for future success.

Getting a Head Start

In purely financial terms, early investment in childhood education is a winner. The rate of return on a $1 investment is 7 to 10 percent annually "through better outcomes in education, health, sociability, [and] economic productivity and [through] reduced crime," according to University of Chicago economist and Nobel laureate James Heckman. Over a lifetime, the return on that $1 adds up to $60

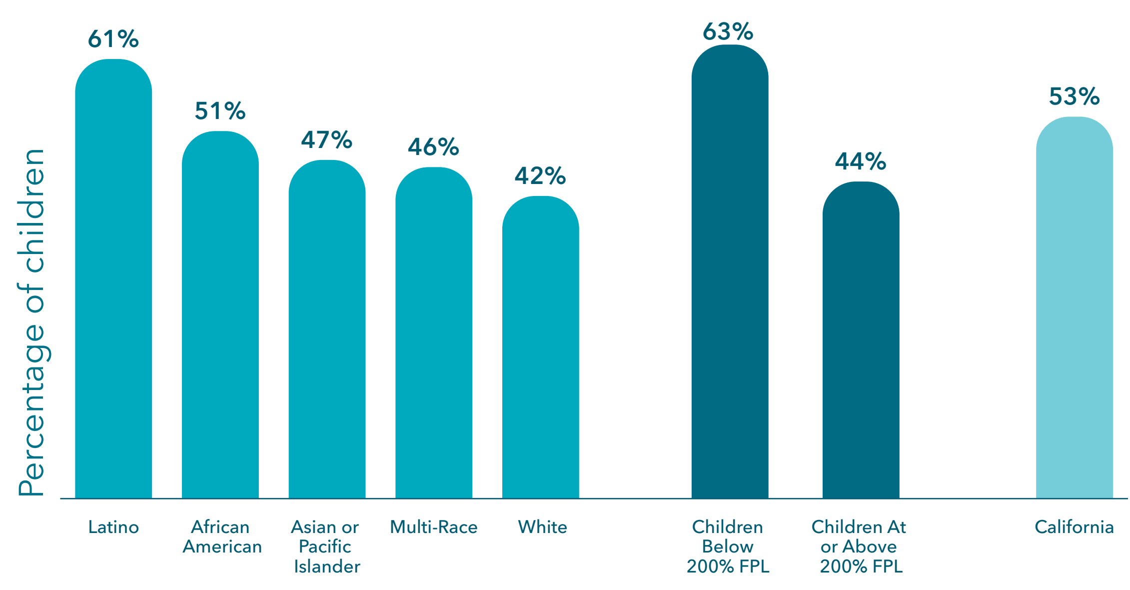

FIGURE 9: Percentage of children in California ages 3 to 4 who are not attending preschool, by race/ethnicity and federal poverty level (FPL), 2009-2011.
Source: U.S. Census Bureau, American Community Survey, 3-Year Estimates (2009-2011). Analysis by the Annie E. Casey Foundation, KIDS COUNT Data Center.

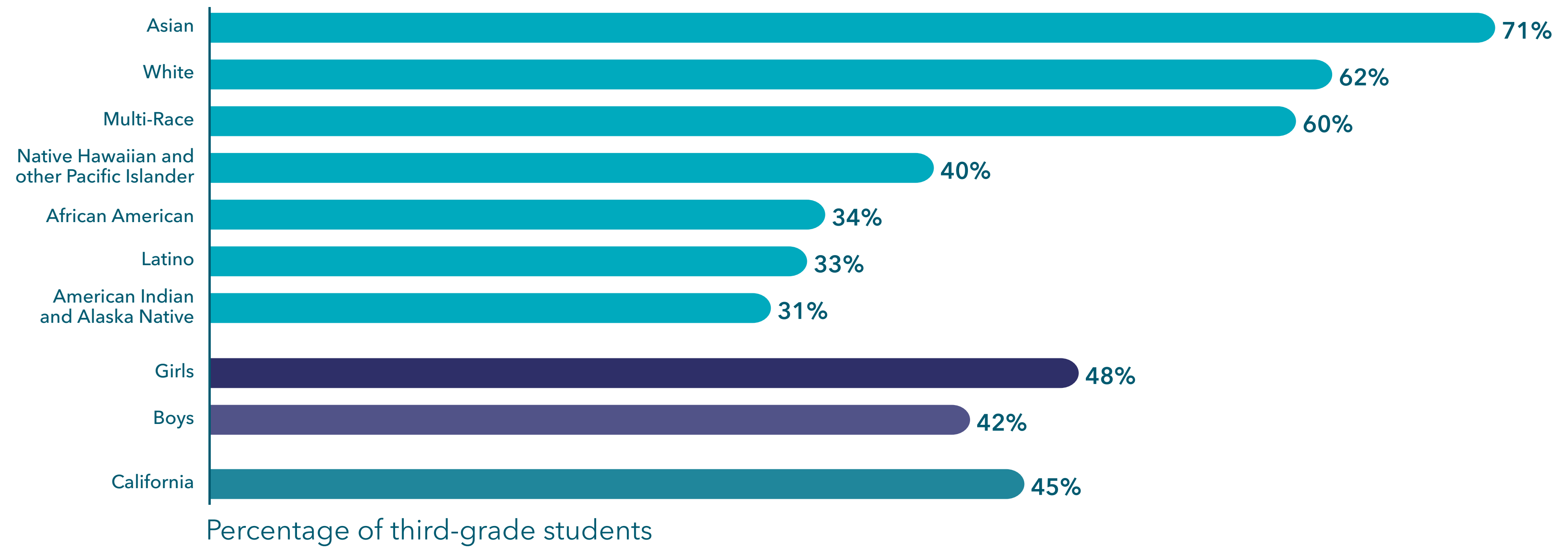

FIGURE 10: Percentage of third-grade students scoring proficient or higher on English Language Arts California Standards Test (CST), by race/ethnicity and gender, California, 2013.

Source: California Department of Education, Standardized Testing and Reporting (STAR) Results, 2013. Analysis by www.kidsdata.org, a program of the Lucile Packard Foundation for Children's Health.

to $300.[2]

One of the most successful ways of supporting healthy early childhood development is through high-quality infant and toddler care, whether provided by parent(s) who feel prepared and supported, or by family or outside day care providers, Head Start, or preschool programs.[3] Getting ready to learn is especially important for the nearly half of all California children who live in low-income families (less than 200 percent of the federal poverty level),[4] a disproportionately large share of whom are non-White. Despite the evidence demonstrating the importance of early childhood care and enrichment, only 6 percent of income-eligible children under age 3 are served by any publicly supported program.[5] Some reasons proposed for this are transportation barriers, especially for rural areas; cultural, language, or literacy barriers; lack of awareness; and staffing or facilities issues. As shown in Figure 9, about three in five low-income children ages 3 to 4 are not attending preschool, including three out of five Latinos and more than half of African Americans.

Third-Grade Reading Proficiency as a Predictor of Future Performance

When children do not participate in early developmental and educational opportunities, the impact is seen in later educational performance. In a hopeful trend, the latest data shows that the percentage of reading-proficient California third-graders increased between 2003 and 2013 for all subgroups. However, despite this overall improvement, significant gaps remain between English learners; economically disadvantaged children (those eligible for reduced-price lunch programs); boys and girls; and some of the largest racial or ethnic subgroups, including American Indians/Alaska Natives, Latinos, and African

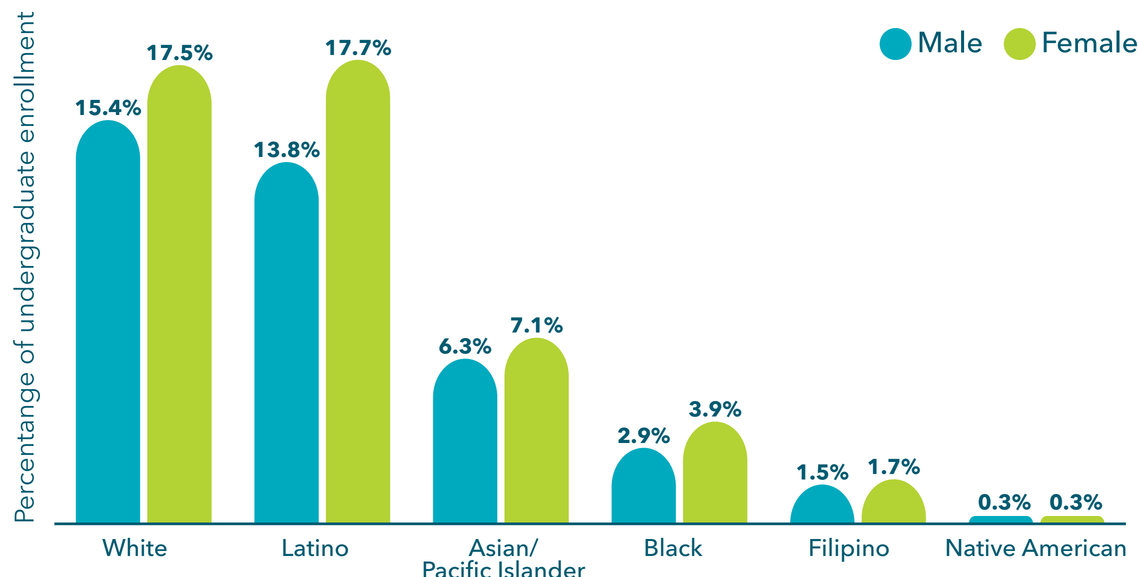

FIGURE 11: Percentage of undergraduate enrollment, by race/ethnicity and gender, California Public Higher Education, 2010.

Source: California Postsecondary Education Commission.
Note: Unknown percentage is not included in the table.

A Green Education for a Green Economy

The East Bay Green Corridor's Energy and Technology (GET) Academies were founded in 2008 to create high-quality jobs in green manufacturing and clean energy research among East Bay communities. The GET Academies, with support from the Institute for Sustainable Economic, Educational and Environmental Design, are located in nine East Bay high schools, where they are pioneering an educational curriculum in green science, technology, engineering, and math to help students graduate with the 21st-century skills and knowledge they will need to succeed in the clean energy economy. The program is designed to support the development of multiple pathways by which California's students can graduate high school, complete postsecondary education, attain industry-recognized credentials, and embark on a long and lasting career in a fulfilling, high-paying job.

Learn more at http://iseeed.org/programs/east-bay-green-corridor/.

Strong Public Support for Universal Preschool

Reflecting a growing public focus on preschool since President Obama proposed universal access to high-quality preschool for all low- and middle-income 4-year-olds, an April 2014 survey by the California Field Poll, a nonpartisan public opinion news service, registered strong voter support for extending California's transitional kindergarten to include all 4-year-olds at an estimated cost of $1.4 billion. The poll found that 56 percent of those without young children, and 57 percent of people overall, support the idea. Latinos registered the greatest support (75 percent), followed by African Americans, at 72 percent. The 2014-15 Budget Act allocates funding to support the expansion of California State Preschool Program for 3- and 4-year old children from low income families.

Sources: The President's 2015 Budget Proposal for Education. U.S. Department of Education Website. http://www.ed.gov/budget15. Accessed July 2014.

DiCamillo M, Field M. Majority of California Voters supports expanding pre-school to all four-year-olds despite its additional costs and regardless of parents' incomes. San Francisco, CA: The Field Poll; April 2014.

California State Budget 2014-2015. California State Budget Website. http://www.ebudget.ca.gov/2014-15/pdf/Enacted/BudgetSummary/FullBudgetSummary.pdf. Accessed November 2014.

Americans, compared with higher-income, White, and Asian students *(see Figure 10)*. For example, only 33 percent of economically disadvantaged third-graders in 2013 were reading at proficiency levels, compared with 67 percent of higher-income students.[6] These educational inequities start early and have long-lasting implications *(see Figure 11)*.

Similar disparities exist in terms of high school dropout and graduation rates, although here, too, there has been notable improvement in recent years. In 2012, more than 65,000 California students who started high school in 2008 dropped out – about one of every eight students. However, dropout rates vary widely by school district and among racial/ethnic groups. Generally, African American, American Indian/Alaska Native, Latino, and Native Hawaiian/Pacific Islander students have significantly higher dropout rates than Asian American and White students.[7] Research has shown that young people who do not complete high school are more likely than those with higher education levels to be unemployed, live in poverty, be dependent on welfare benefits, have poor physical and mental health, and engage in more criminal activity.[8] One national study estimated that if those who dropped out of high school in 2011 had graduated instead, the nation's economy would benefit by about $154 billion over their lifetimes.[9]

Implications for Lifelong Health

More than any other developmental period, early childhood development sets the stage for acquiring skills that directly affect children's physical and mental health – health literacy, self-discipline, the ability to make good decisions about risky situations, eating habits, and conflict negotiation.[1] These same skills influence children's health and mental health throughout adolescence, contributing to important public health and social problems, including increases in school violence, teen sexuality, and eating disorders, as well as the onset of many psychological disorders.[10]

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The Mission Neighborhood Promise of Cradle-to-Career Education

Despite high and rapidly rising housing costs, San Francisco's Mission District remains one of the poorest in the city, with a high teen birthrate, a high dropout rate, and more than three out of four of its 12,000 mostly Latino children living in low-income housing, according to the Mission Economic Development Agency (MEDA). But big changes are coming to the neighborhood, thanks to a five-year, $30 million U.S. Department of Education grant recently awarded to MEDA to implement the Mission Promise Neighborhood (MPN). The MPN is a citywide partnership of local agencies, the school district, colleges and universities, and 26 nonprofit service providers to integrate a host of cradle-to-college-to-career services that improve academic achievement and build family wealth for the families of children at four participating Mission District schools. The MPN integrated service model builds on the success of the Harlem Children's Zone, which provides children and families with high-quality, coordinated educational, health, social, and community supports from cradle to career.

Learn more at www.missionpromise.org.

Housing:
A Leading Social Determinant of Public Health

Housing plays a fundamental role impacting public health, from locational attributes to housing quality and affordability.[1] Stable housing (adequate, safe, and affordable) is a foundation for healthy family growth and for thriving communities.

An Unaffordable House Is Not a Healthy Home

Healthy and stable housing is one of the most basic requirements for a sense of personal security, sustainable communities, family stability, and the health of every individual. It is essential for meeting our physical needs for shelter against environmental hazards, our psychological and emotional needs for personal space and privacy, and our social needs for a gathering place for family and friends.

When Housing Becomes Unaffordable...

Cost of shelter is the largest non-negotiable expense for most families. When the cost is excessive, families fall behind on rent or mortgage payments and have little or no disposable income, often going without food, utilities, or health care.[2] For a growing share of lower- and even middle-income Californians, lack of affordable and adequate housing has made this issue a contributor to mental stress and physical illness rather than a source of health and well-being. The rising cost of housing over several decades (a trend that reversed temporarily during the Great Recession) has put even the lowest-priced 25 percent of homes in any given area out of reach for approximately half of all American families, up from 40 percent in the mid-1980s.[3] In California, the housing "affordability index" – the percentage of households that can afford to purchase a median-priced home without exceeding 30 percent of the household income, as recommended by lending institutions – has fallen rapidly, as housing prices have rebounded since 2012. For example, in 2014, only 33 percent of California households could afford to purchase a median-priced single-family home, while 44 percent could afford to purchase a condominium or a town house. Nationally, 59 percent of households could afford to purchase a home of either type.[4] Rents are rising rapidly and rental vacancy rates are in decline, impacting lower-income households in particular, of which a third are households headed by an elderly person or a person with disabilities, and a third are families with children. The latest American Community Survey shows that almost 60 percent of all renters and 78 percent of the lower-income renters (earning 80 percent or less than the median income)

AFRICAN AMERICANS AND LATINOS ARE MORE LIKELY TO SPEND MORE THAN 30% OF THEIR INCOME ON HOUSING THAN OTHER RACIAL/ETHNIC GROUPS

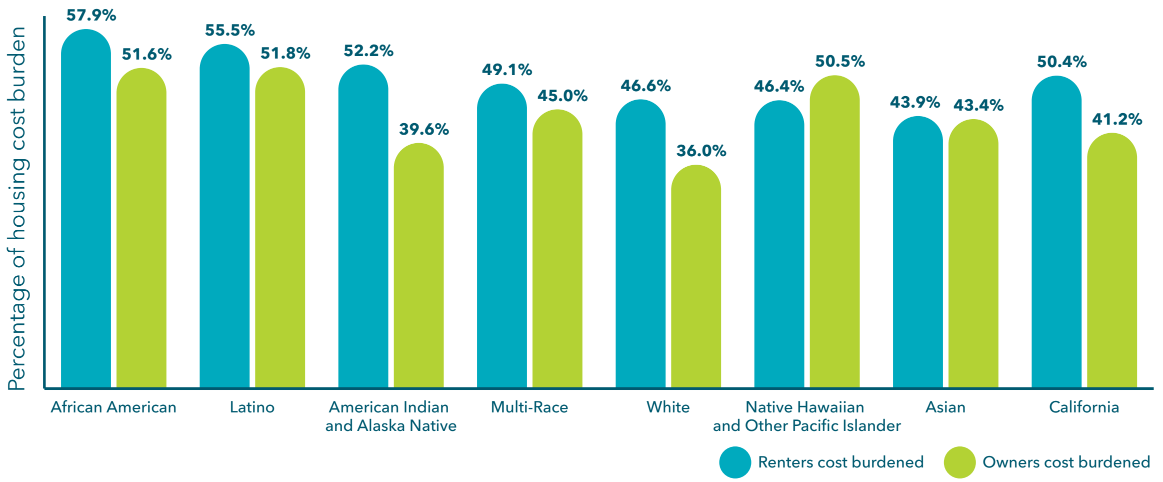


FIGURE 12: Percentage of housing cost burden, by tenure and race/ethnicity, California, 2006-2010.

Source: U.S. Department of Housing and Urban Development, Comprehensive Housing Affordability Strategy, 2006-2010. Analysis by CDPH-Office of Health Equity and UCSF, Healthy Communities and Data and Indicators Project.
Cost burdened is defined as households spending more than 30% of monthly household income on housing costs.
Housing costs include monthly, gross rent (rent and utilities) or selected, housing costs (mortgage, utilities, property tax, insurance and, if applicable, home association fees).

pay in excess of 30 percent of their income for rent.[5] Households with high housing cost burdens (over 30 percent of annual income) are often referred to as "shelter poor" because they have less to spend on other essentials, such as food, clothing, and health care, and are more likely to report that their children have only fair or poor health.[6] In California, African American and Latino households are shouldering a slightly heavier burden of housing cost, with more than 50 percent of these renters and owners spending more than 30 percent of their monthly household income on housing *(see Figure 12)*.

The Color of the Housing Crisis

The affordability crisis is particularly acute in California, and it has disproportionately affected low-income and other vulnerable populations throughout the state. Home ownership rates among Latinos and African Americans are significantly below the state average and about 31 to 43 percent lower than the rate of White families *(see Figure 13)*. In addition, African American and Latino families who were recent borrowers experienced foreclosure rates during the recession that were double the rate of White families.[7] Foreclosures and rapidly rising rents have also contributed to high rates of housing disruption for economically disadvantaged families and communities of color: African Americans and American Indians/Alaska Natives are roughly one-third more likely than the California average to experience a disruptive change of residence during a given year *(see Figure 14)*. Such unplanned changes are a source of harmful stress and disruption in families' access to health care services, education, social networks, and employment opportunities. These families will be more likely to also feel the delayed "spin-off" effects of recession, such as poor credit affecting employment and renting, or declining neighborhoods with increased crime and poverty.[8]

The barriers to healthy, stable, and affordable housing resulted in the ultimate plight of the housing crisis: homelessness.[9] With 12 percent of the U.S. population, California was home to more than 22 percent of the nation's homeless in 2013, an increase of 5,928 people from the previous year. On a single night in January 2013, 136,826 Californians were homeless. Almost seven in 10 homeless individuals in California live unsheltered (meaning they do not use shelters and are typically found on the streets, in abandoned buildings, or in other places not meant for human habitation) on any given night – the highest rate for unsheltered homeless in the nation.

Beyond Affordable Housing: Healthy Communities

A healthy home is more than an affordable house. Ultimately it must also meet at least minimum community safety and

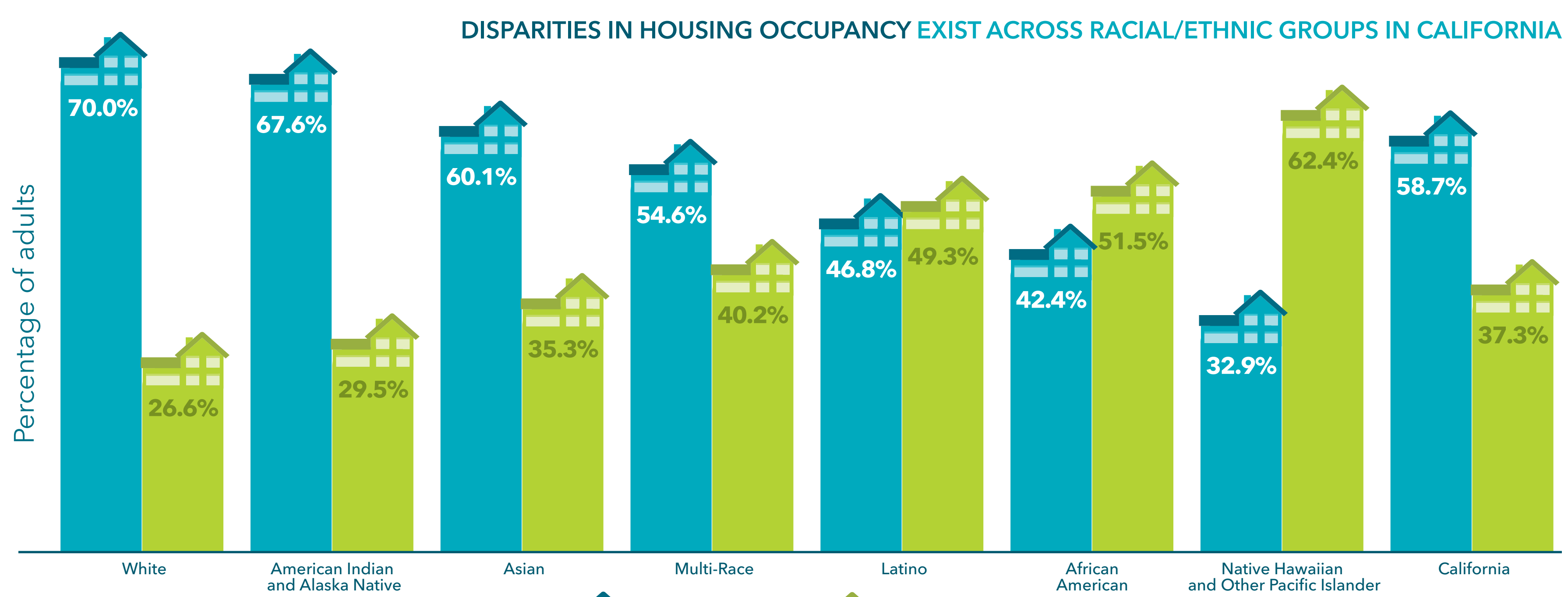


FIGURE 13: Percentage of adults who own or rent their homes, by race/ethnicity, California, 2011-2012.

Source: University of California Los Angeles, California Health Interview Survey, 2011-2012.
Note: Within each race/ethnic group, variable "have other arrangement" is not included, and the percentages may not add up to 100.

Building Housing and Wealth in East L.A.

The East L.A. Community Corporation (ELACC) is focused on developing housing and providing financial education for the low-income and mostly Latino residents of Boyle Heights and unincorporated East Los Angeles. ELACC's approach has four components: increasing the supply of quality, affordable housing; providing financial education for first-time home-buying and foreclosure prevention; providing related tenant services, including affordable childcare and English language tutoring; and community organizing for neighborhood cohesion and empowerment.

ELACC serves more than 2,000 residents every year and has leveraged more than $135 million of investment to the Eastside while completing more than 550 housing units serving more than 1,000 residents, with more than 300 units in various stages of development. It has mobilized a community organizing base of over 1,300 members annually and has helped over 3,000 families purchase their first homes, avoid foreclosure, establish savings, and build and sustain wealth.

Learn more at http://www.elacc.org/.

AFRICAN AMERICANS AND AMERICAN INDIANS/ALASKA NATIVES ARE MORE LIKELY TO EXPERIENCE THE DISRUPTION OF A RESIDENTIAL MOVE THAN ARE OTHER RACE/ETHNICITIES

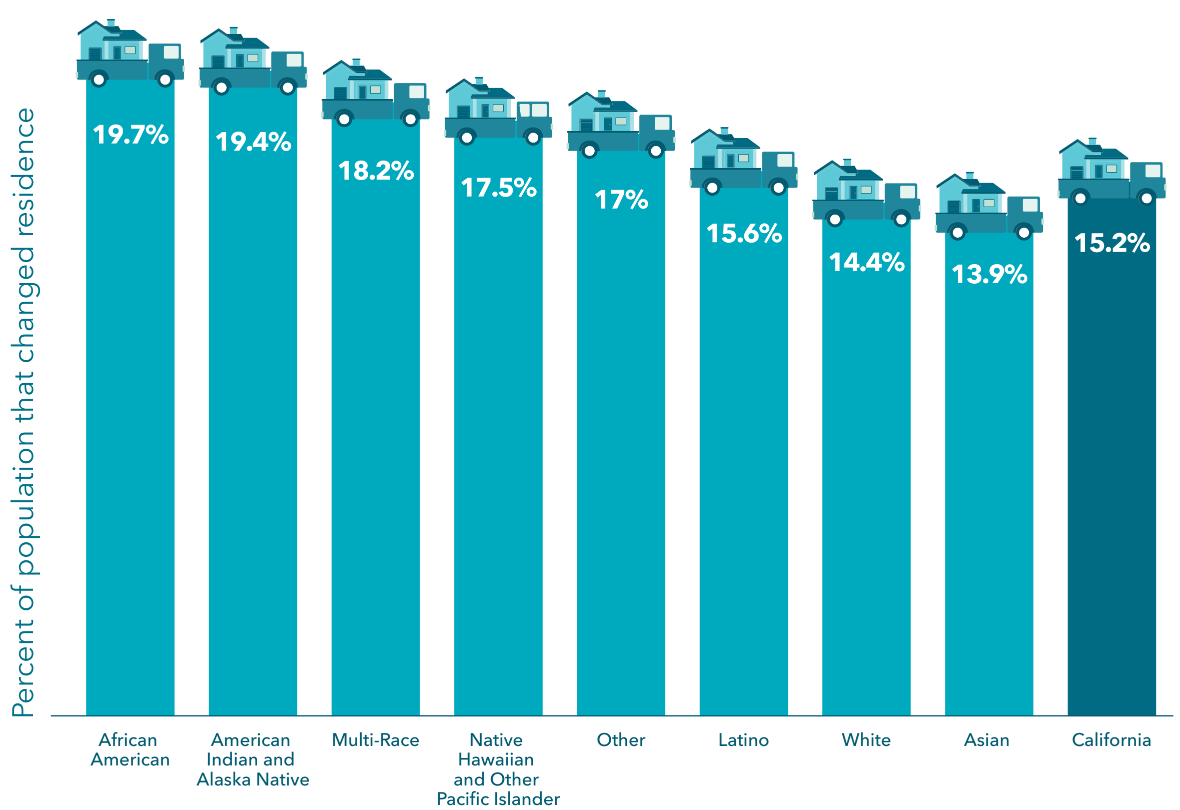


FIGURE 13: Percentage of population age 1 year and over who changed their residence (different house in the U.S.) from last year to current year, by race/ethnicity, California, 2006-2010.

Source: U.S. Census Bureau, American Community Survey, 5-year Estimate (2006-2010).

health standards and be part of a healthy neighborhood. That means being part of a community with parks and sidewalks and bike paths; with clean air and clean soil and clean water; with full-service grocery stores that stock affordable, healthy, fresh fruits and produce; with high-quality childcare, preschools, and K-12 schools that graduate all children; with reliable, affordable public transit for getting to work; and with decent-paying local jobs at healthy workplaces. That's the kind of healthy home we all deserve.

New Resource on Low-Income Housing from the California Housing Partnership Corporation

The California Housing Partnership Corporation (CHPC), a nonprofit organization created by the state legislature to monitor, protect, and augment the supply of affordable homes to lower-income Californians, has assisted more than 200 nonprofit and local government housing organizations in leveraging more than $5 billion in private and public financing to create and preserve 20,000 affordable homes. In February 2014, CHPC published *California's Housing Market Is Failing to Meet the Needs of Low-Income Families.* The comprehensive report includes an analysis of the enormous shortfall of homes affordable to low-income families in California, the impact of state and federal disinvestment in affordable housing, and recommendations for policy makers.

Learn more at http://www.chpc.net/policy/index.html.

Environmental Quality: The Inequities of an Unhealthy Environment

The environment – the air we breathe; the water we consume; the soil that nourishes the food we eat; and all the natural and human-made conditions of the places we live, work, learn, and play – has a profound impact on the health of every one of us. Yet low-income families, communities of color, and certain other vulnerable populations, especially children, are disproportionately subjected to environmental perils that have been causally linked to epidemic rates of various respiratory problems, including bronchitis, emphysema, asthma, and other diseases, disabilities, and chronic health conditions.[1] Figure 14 illustrates that the pollution burden tends to be high in California's Central Valley, where Latinos and non-Whites make up a large proportion of the population.

Despite having achieved impressive improvements in overall air pollution quality in recent decades, California is still home to the top five cities in the nation for both ozone pollution and year-round and short-term particle pollution, the two sources of the most negative health effects of polluted air.[2] The state's smoggiest cities are also the cities with the highest densities of people of color and low-income residents who lack health insurance.[3]

Climate Change Threatens Even Greater Disparities

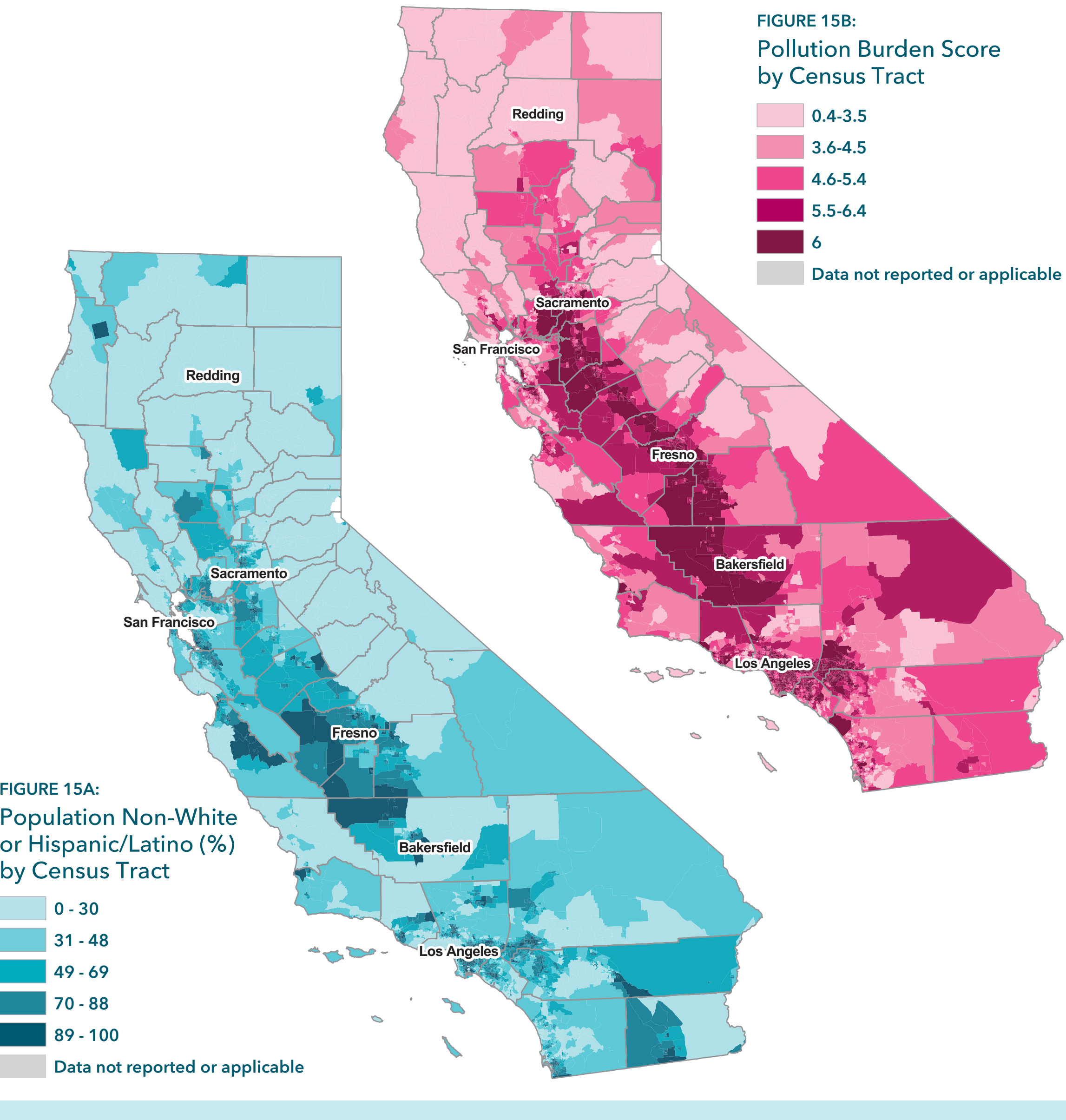
Climate change poses significant risks to the health and well-being of all Californians today and for generations to come, according to *The Third National Climate Assessment*, released in May 2014.[4] A 2009 report from the California Climate Change Center warned that current and anticipated impacts of climate change will likely create especially heavy burdens on low-income and other vulnerable populations: "Without proactive policies to address these equity concerns, climate change will likely reinforce and amplify current as well as future socioeconomic disparities, leaving low-income, minority, and politically marginalized groups with fewer economic opportunities and more environmental and health burdens." The report emphasized that some of the greatest economic impacts of climate change are expected to hit the state's agricultural sector, whose half million workers are predominantly Latino, and tourism-related industries, in which people of color make up a majority of the workforce.[3]

Responding to climate change through public health prevention and preparedness measures can help reduce existing health disparities and create opportunities to improve health and well-being across multiple sectors, including agriculture, transportation, and energy.[3]

Low-Income Children Are Uniquely Vulnerable

It is well established that children are more susceptible to environmental pollutants than are adults because their nervous, immune, digestive, and other bodily systems are still developing. Moreover, children eat more food, drink more fluids, and breathe more air in relation to their body weights compared with adults.[5] Exposure to high levels of air pollutants, including indoor air pollutants and secondhand smoke, increases the risk of premature death, respiratory infections, heart disease, and asthma.[6] Children living in low-income neighborhoods near heavy, energy-intensive industry; rail yards; and heavily trafficked freeways and streets in urban areas are at special risk of chronic respiratory conditions. African American children are four times more likely to be hospitalized for asthma compared with White children, and urban African American and Latino children are two to six times more likely to die from asthma than are White children.[7] Of the more than 600,000 Californians who experience frequent symptoms of uncontrolled asthma, nearly 240,000 cases are in families earning less than 200 percent of the federal poverty level, compared with 120,000 cases from families with income of 400 percent of the federal poverty level or higher.[8]

LATINO OR NON-WHITE POPULATIONS ARE MORE LIKELY TO LIVE IN AREAS WITH A HIGH BURDEN OF POLLUTION



Source: California Environmental Protection Agency (Cal/EPA) and the Office of Environmental Health Hazard Assessment (OEHHA), California Communities Environmental Health Screening Tool, Version 2.0 (CalEnviroScreen 2.0), 2014.

Built Environment:
Healthy Neighborhoods, Healthy People

The built environment refers to human-designed and constructed surroundings, including everything from transportation networks (e.g., streets, freeways, sidewalks) to buildings (e.g., stores, hospitals, factories, houses, schools, office buildings) to various recreational amenities (e.g., parks, playgrounds). How we design the built environment profoundly impacts every aspect of our quality of life, especially as it relates to our physical, mental, and social health.

Influence on Access to Healthy Foods and Physical Activity

The built environment influences many aspects of a community, such as whether healthy food can be accessed and where children can safely play. An analysis of data from the California Health Interview Survey has shown that people in neighborhoods with a low number of full-service grocery stores have higher rates of obesity, and neighborhoods with fewer grocery stores tend to have more poor non-White residents than do neighborhoods with easy access to fresh fruits and vegetables.[1] The dietary link to obesity is further exacerbated because many of these same neighborhoods that lack healthy food outlets also lack safe places to be active, including walkable streets, bike paths, parks, and other recreational amenities.

Land Use, Transportation, and Health

Transportation systems and land use policies can support health and equity by influencing an individual's social connections, physical activity, and level of access to jobs, medical care, healthy food, educational opportunities, parks, and other necessities. In addition, promoting safe, active transportation (e.g., walking, biking, rolling, or public transportation) is an important strategy for promoting health and equity while also reducing greenhouse gas emissions. California's state leadership has identified healthy, sustainable transportation as a priority, and in 2014 the California Department of Transportation adopted a new goal to "promote health through active transportation and reduced pollution in communities."[2]

In California and throughout the nation, the health consequences of traffic-intensive development and transport patterns include higher rates of air pollutants, which are associated with higher incidence and severity of respiratory symptoms, and stress-related health problems and other physical ailments (e.g., back pain) associated with commuting.[3] In a car-based transportation region, people are less likely to bike, walk, or skate to school or the grocery store, thus contributing to higher rates of cardiovascular disease, diabetes, and obesity. For example, school siting and transportation planning significantly impact

how children get to school; despite the health and environmental benefits of walking and biking, the percentage of children walking or biking to school in the U.S. has dropped from 40 percent in 1969 to just 5 to 13 percent in 2009.[4] Additionally, families living in these car-based transportation regions tend to spend a higher proportion of their income on transportation costs *(see Figure 16)*, and the high burden of transportation costs can put a strain on other essential expenses such as health care, education, and food.

THE BURDEN OF TRANSPORTATION COST RELATIVE TO INCOME IS HIGHER IN RURAL REGIONS AND COUNTIES OF CALIFORNIA

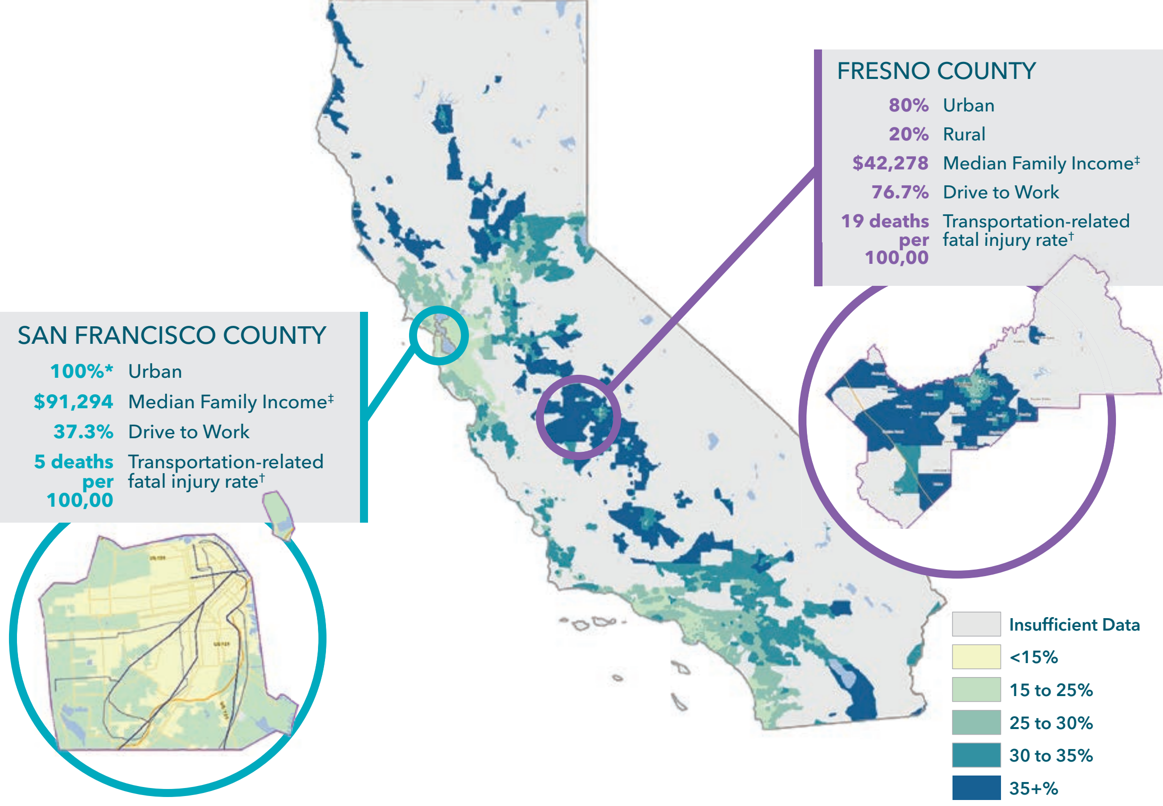


FIGURE 16: Transportation costs as a percentage of income, California, 2009.

Sources: Center for Neighborhood Technology, Housing and Transportation (H+T) Affordability Index, 2009; U.S. Census Bureau, American Community Survey, 5-Year Estimate (2008-2012); Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control, Web-Based Injury Statistics Query and Reporting System (WISQARS), 2004-2010; and University of California Los Angeles, California Health Interview Survey, 2011-2012.

†Age-adjusted death rate.

**Statistically unreliable data.*

‡Median family income with own children under 18 years.

Clean Trucks, Healthier Neighborhoods

The ports of Los Angeles and Long Beach handle 70 percent of U.S. Pacific Coast cargo, and thousands of trucks spewing diesel fuel exhaust routinely passed through the low-income, immigrant neighborhoods of southwest Los Angeles each day from the port, raising cancer and asthma risks and causing injuries and traffic problems. Thanks to campaigns by a coalition of environmental, public health, and environmental justice groups, the Air Resources Board adopted a statewide regulation in 2007 and the ports adopted a Clean Truck Program in 2008; both set more stringent emission standards for port trucks. Nearly $200 million in state and local incentives aided the transition to cleaner trucks. In less than three years, these programs were responsible for cleaning up the nation's busiest drayage truck fleet and cut related air pollution in local communities by 90 percent.

Sources: Clean trucks. Port of Long Beach Website. http://www.polb.com/environment/cleantrucks/default.asp. Posted January 11, 2011. Fighting the cycle of poverty and pollution at the ports of Los Angeles and Long Beach. Coalition for Clean and Safe Ports Website. http://cleanandsafeports.org/los-angeleslong-beach/#sthash.kfSBbdib.dpuf. Accessed May 2014.

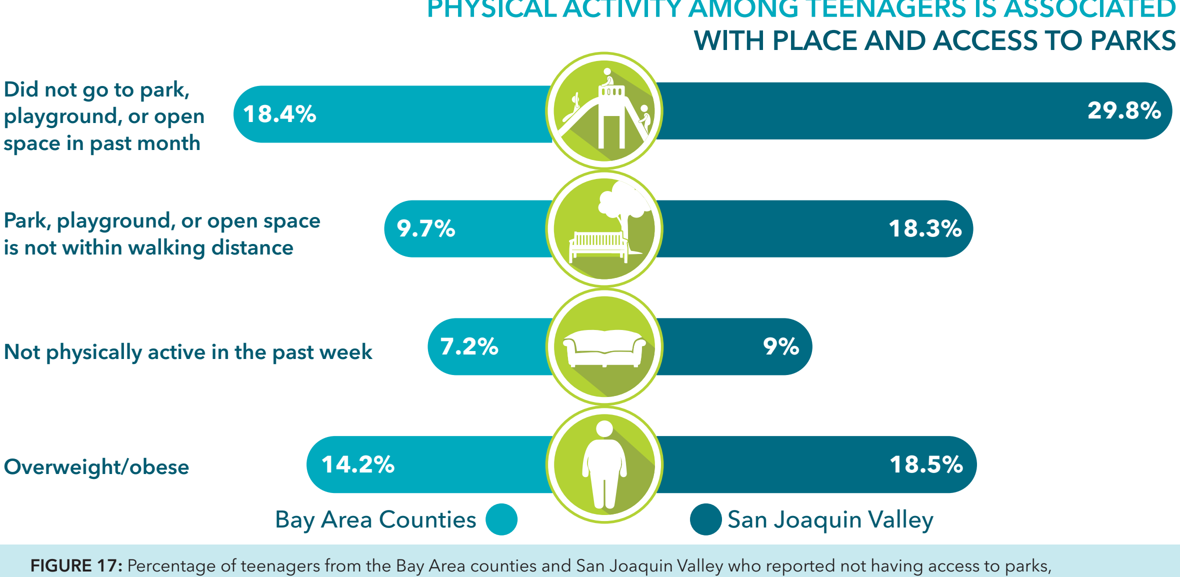


FIGURE 17: Percentage of teenagers from the Bay Area counties and San Joaquin Valley who reported not having access to parks, playgrounds, or open spaces; not being physically active; and being overweight or obese, California, 2011-2012.

Source: University of California Los Angeles, California Health Interview Survey, 2011-2012.

In addition to reducing transportation costs and the associated inequities, a focus on California's land use and transit systems can address important health inequities. People who live in highly walkable, safe, mixed-use communities with easy access to green space and public transit options have higher levels of physical activity and lower body mass indices[5,6], contributing to greater overall health *(see Figure 17)*. Strong evidence suggests that active transportation is positively associated with better cardiovascular health, lower risk of diabetes, and lower risk of hypertension. For example, the Integrated Transport and Health Impacts Model (I-THIM), developed by the California Department of Public Health, found that in the San Francisco Bay Area an increase in daily walking and biking per capita from four to 22 minutes would reduce cardiovascular disease and diabetes by 14 percent, and would decrease greenhouse gas emissions by 14 percent. The downside of this increased activity, however, would be a 39 percent increase in traffic injuries.[7] Traffic-related injuries and deaths disproportionately impact vulnerable populations such as older adults, children, communities of color, and low-income communities.[8] Investing in a range of land use and safety improvements that support active transportation could help reduce these inequities. Well-designed, well-built, safe neighborhoods and streets are essential to people's well-being, and are important strategies for promoting health and mental health throughout California.

Jobs and Healthy Food for South Los Angeles

For the 455,000 residents of South Los Angeles, the April 2014 opening of the Northgate Gonzales Market was a cause for celebration. The market, the latest addition of a local, Mexican American-owned grocery chain, gives local area residents unaccustomed access to healthy food options that have eluded this fast-food-dense area for years. It also provides 130 "living wage," permanent jobs for local people in a region with high unemployment and a large share of Mexican and Central American immigrants.

The grocery chain worked with Homeboy Industries to source and train applicants for supermarket jobs. More than 70 percent of initial hires are local residents, and more than 20 percent are African American. Eight employees were direct referrals from incarcerated youth reentry programs at either Homeboy Industries or Los Angeles County Probation.

The market's lead investor was the California FreshWorks Fund, backed by The California Endowment and other partners to finance new and upgraded grocery stores and other healthy food distribution and retail outlets in California's underserved communities.

Source: Alejandrez L. FreshWorks funded Northgate Gonzalez Marketplace brings healthy foods to South Los Angeles. The California Endowment Website. http://tcenews.calendow.org/blog/freshworks-funded-northgate-gonzalez-marketplace-brings-healthy-foods-to-south-los-angeles. Published April 15, 2014.

Health Care Access and Quality of Care: **Narrowing the Gaps**

Access to high-quality health care services ranks as one of the most important overall health indicators of the federal government's Healthy People 2020 initiative. However, as late as 2011, nearly 23 percent of Americans did not have a regular primary care provider (a doctor or health center) whom they could visit when they were sick or needed preventive care or advice. As of 2012, about 17 percent of Americans under age 65 did not have any form of health insurance, a rate virtually unchanged since 2008.[1] For both measures, the national rates were higher for various ethnic or racial groups, especially Latinos.[2] In California, the uninsured rate among Latinos in 2011-2012, 28 percent, was almost double that among the White population *(see Figure 18)*. From year to year, the largest disparities in access to care and quality of care nationally are for Spanish-speaking Latinos,[3] a fact that points to the critical importance of access to health insurance and linguistically and culturally appropriate care.

LATINOS HAVE THE HIGHEST RATES OF **BEING UNINSURED FOR HEALTH INSURANCE** OF ANY RACIAL/ETHNIC GROUP IN CALIFORNIA

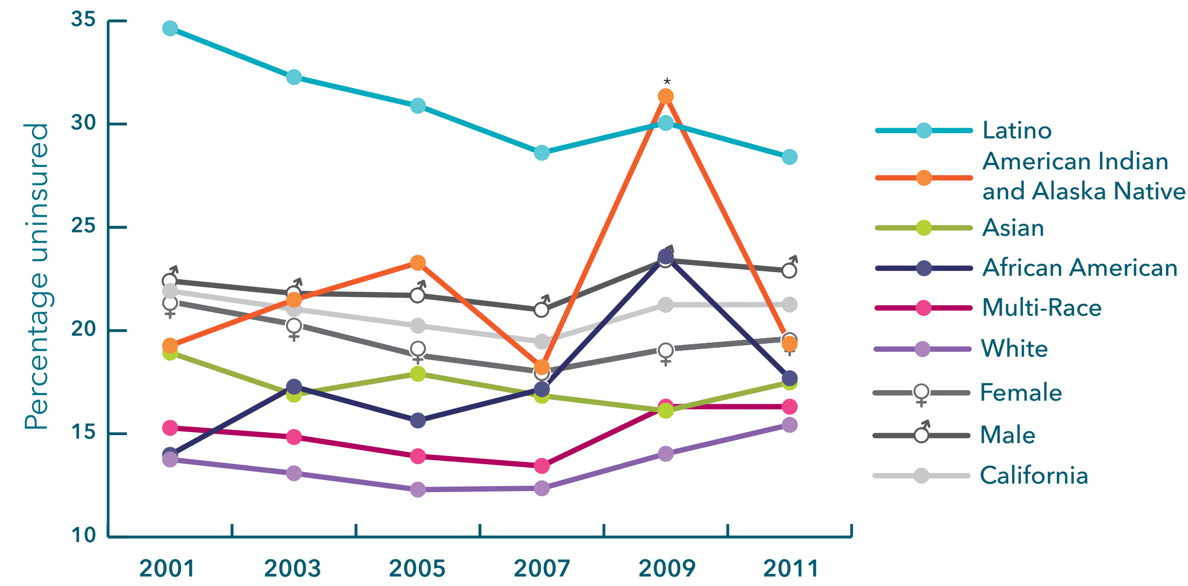


FIGURE 18: Percentage of people ages 0-64 without health insurance† during the past 12 months, by race/ethnicity, California, 2001 to 2011.

Source: University of California Los Angeles, California Health Interview Survey, 2001-2011.
Note: "Asian" includes Native Hawaiian and other Pacific Islander.
† Had no insurance the entire year or had insurance only part of the past year.
** Statistically unreliable data*

Implementation of the federal Affordable Care Act (ACA) is providing expanded access to health insurance for most people. Undocumented residents are an exception to this access, aside from those who qualify for some emergency services. In California, of the 1.4 million covered California enrollees as of February 2015, Latinos accounted for 37 percent of new enrollees, up from 31 percent during the last open enrollment period.[4] This level of enrollment represents important progress, because data on the national level has shown that having insurance coverage positively affects people's ability to obtain a usual source of care and thus increases their use of preventive, urgent, or chronic health care services.[5] However, significant racial and ethnic disparities in insurance coverage in California are likely to persist, though at lower levels, due in part to observed cultural and linguistic barriers to expanded access to insurance, and in part to ineligibility under federal law (an estimated 1.1 million uninsured, undocumented California residents are ineligible).[6]

The ACA provides a number of avenues to address the health disparities linked to cultural and linguistic barriers. For example, the ACA has expanded research on health and health care disparities and created the Patient-Centered Outcomes Research Institute to oversee studies that examine differences in patient outcomes among racial and ethnic minorities. The ACA also expands grant programs to attract and retain health professionals from diverse backgrounds and directs funding to encourage service in underserved areas. The ACA provides support for the development and dissemination of curricula to promote cultural competency and supports a variety of culturally appropriate prevention and education initiatives.

Equal Access Is One Piece of Health Equity

Although insurance provides access to care, it does not ensure that everyone receives appropriate or high-quality care at the right time; nor does it fully address the remaining financial barriers to access for low-income people with insurance.[6,7] An examination over an eight-year period of 16 "prevention quality indicators" – conditions such as pediatric asthma, hypertension, and low birth weight, for which quality outpatient care, as in a doctor's office, can often prevent the need for hospitalization – concluded that African Americans consistently had the highest hospitalization rates for 14 measures. In some cases, the rates were two to three times higher than for Whites. For example, the average hospitalization rate for short-term complications of diabetes was 134 per 100,000 for African Americans, compared with 44 for Latinos, 42 for Whites, and just 14 for Asian/Pacific Islanders.[8]

California's Wide Dental Gap

Oral health, a critical though often neglected aspect of overall health, is believed to be the single greatest unmet need for health services among children. In California, the disparity in oral health between low-income and affluent children is the second worst in the nation, exceeded only in Nevada, according to a 2014 study by the Lucile Packard Foundation for Children's Health.

The report cites data from a 2011-2012 National Survey of Children's Health based on parent reports that found that 69.7 percent of California children ages 1-17 with public insurance had a preventive dental care visit during the previous year. In comparison, 83.4 percent of children with private insurance and 46.4 percent of uninsured children had a preventive visit during that time frame.

The disparity in access to dental care should narrow somewhat beginning in 2015, when dental insurance will become available as part of health insurance plans purchased through the state's new health insurance marketplace.

This survey is based on parent responses, not on claims data. These types of surveys tend to over-report utilization, partly because of faulty recall of events that may have happened a year ago.

Source: Schor E. Dental Care Access for Children in California: Institutionalized Inequality (Issue Brief). Palo Alto, CA: Lucile Packard Foundation for Children's Health; 2014.

Major disparities in quality of care also exist across the nation among cities, regions, and states. A 2013 study of quality of care received by low-income Americans found that if every state could have achieved the high-quality levels achieved by the top-performing states, an estimated 86,000 premature deaths would have been avoided, 750,000 low-income Medicare beneficiaries would not have been unnecessarily prescribed high-risk medication, and tens of millions of adults and children would have received timely preventive care.[7] California ranked 20th among all states for overall quality of care for low-income patients but was among the lower third quartile of states for prevention and treatment.

School-Based Health Centers Boost Access to Care for Underserved Families

School-based health centers (SBHCs), which bring vital primary care services into the heart of low-income neighborhoods, have more than doubled in California over the past decade, numbering more than 226 as of 2013. Serving nearly a quarter million K-12 students and their families, the clinics, financed by a variety of public and private sources, have sprung up in schools from Del Norte County to San Diego County, with large concentrations in Los Angeles and the Bay Area.

Most SBHCs are located in schools with low-income Latino and African American students–ethnic groups that are more likely to suffer health disparities due to higher rates of violent injury, poor nutrition, physical inactivity, substance abuse, and sexually risky behavior. They also have lower rates of health insurance and less access to health and mental health services.

California schools received $30 million, almost a third of the $95 million provided under the health care reform law, for creation of school-based health clinics in 2011 to 2013.

Learn more at http://www.schoolhealthcenters.org.

Clinical and Community Prevention Strategies: **The Power of Prevention**

Prevention in health is a broad concept. It can occur in health care in a range of settings and in various ways, including public health strategies to prevent the occurrence of a disease (such as antismoking campaigns), clinical strategies or treatments to detect the early stages of a disease (such as cancer screening), or clinical interventions to prevent complications of an existing disease (such as care management plans for diabetes). Prevention also includes public health activities, such as health education about risky or positive personal behavior, and changes to the larger environmental or social conditions that have an impact on health. In all these ways, prevention has long been recognized as an essential public health strategy for creating better health and promoting health and mental health equity throughout society.

Unfortunately, prevention strategies are not fully utilized in California or elsewhere in the United States. The result has been the avoidable loss of thousands of lives annually in the United States, unnecessarily high levels of poor mental and physical health, the persistence of health disparities among vulnerable populations, and inefficient use of health care dollars. For instance, a national study from the Partnership for Prevention states that a 90 percent utilization rate for just five widely recommended and cost-effective preventive services – daily aspirin use to prevent heart attacks, antismoking advice by health professionals, periodic colorectal cancer screening, annual influenza immunization for adults over age 50, and biennial breast cancer screening for women over age 40 – would save more than 100,000 lives each year in the United States. Among the 12 preventive services examined in the Partnership for Prevention study, seven are being used by about half or less of the people who should be using them. Racial and ethnic minorities are getting even less preventive care than the general U.S. population. Latinos, for instance, have lower utilization of 10 preventive services than do non-Hispanic Whites and African Americans, and Asian adults age 50 and older are 40 percent less likely to be up to date on colorectal screening than are White adults.[1] In a number of important areas, use of preventive mental and physical health strategies among disadvantaged populations significantly lags behind use among more advantaged population groups.[2]

Disparities in Clinical Prevention: Mammograms and Childhood Immunization

In California, very low-income women are more than twice as likely as high-income women in the same age bracket to not receive timely mammograms, and almost twice as likely to not receive timely Pap tests *(see Figure 19)*.

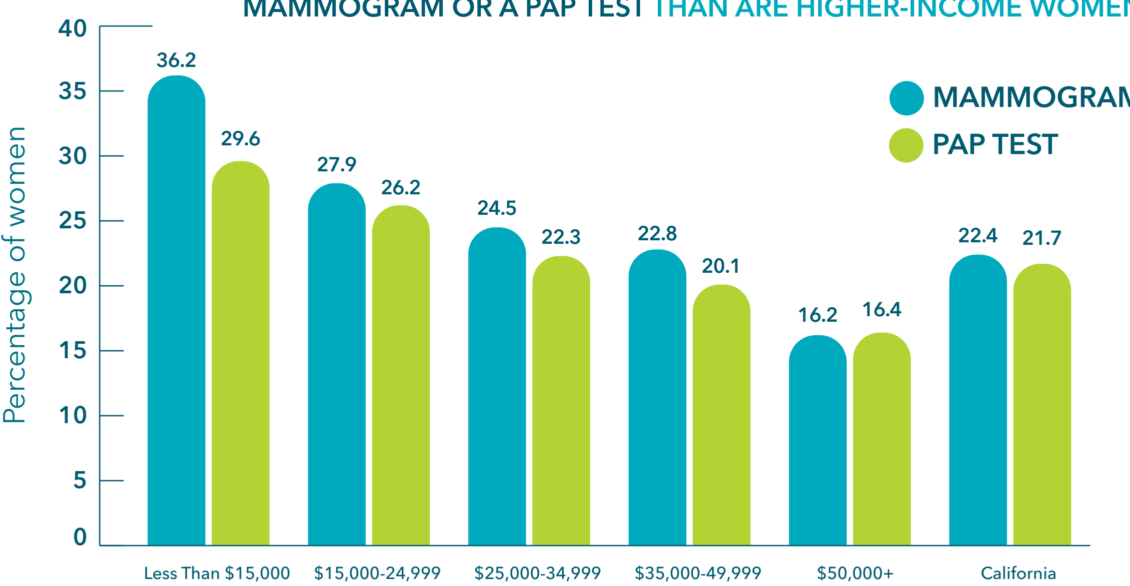


FIGURE 19: Percentage of women who have not had a mammogram or a Pap test, by annual income level, California, 2012.

Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2012.

Note: Mammogram screening among women age 40 years or over within the past two years, and Pap smear screening among women age 18 years or over within the past three years.

This is especially important for African American women, who in 2010 had the highest breast cancer death rates of all racial and ethnic groups, at 33 per 100,000, compared with 24 per 100,000 for White women, though White women are actually more likely to be diagnosed with breast cancer.[3]

Another core component of preventive medicine is the recommended childhood immunization regimen. Immunizations are estimated to save, for every United States birth cohort, 33,000 lives; prevent 14 million cases of disease; and avoid more than $43 billion in direct and indirect costs. Despite progress in immunization rates, however, approximately 42,000 adults and 300 children in the United States die each year from vaccine-preventable diseases.[4] In California, students entering kindergarten must show proof of immunizations for DTaP, polio, MMR, Hep B, and varicella.[5] The dosages required for these vaccines can be taken within the first 24 months of life.[6] As shown in Figure 20, African American kindergarteners continue to significantly lag all other racial or ethnic groups in immunization rates.

Behavior-Level Prevention: Breastfeeding

Like immunization, breastfeeding has multiple health benefits for infants and children as well

AFRICAN AMERICAN KINDERGARTNERS ARE REPORTED TO HAVE THE LOWEST IMMUNIZATION RATE AT EACH AGE CHECKPOINT FOR RECOMMENDED VACCINATION

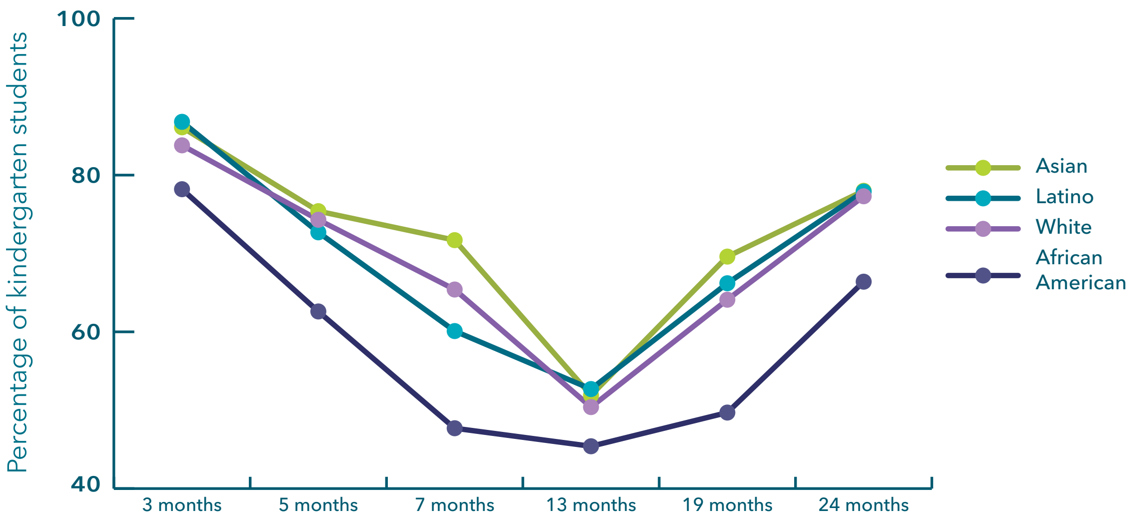


FIGURE 20: Percentage of immunization coverage among kindergarten students, by age checkpoint and race/ethnicity, California, 2010-2011.
Source: California Department of Public Health, Immunization Branch, Kindergarten Retrospective Survey Results, 2010-2011.

as mothers. It reduces the likelihood of many common infections and is associated with reduced risk of atopic dermatitis (eczema).[7] Studies estimate that 27 percent of monthly pediatric hospitalizations for lower respiratory tract infections and 53 percent of monthly pediatric hospitalizations for diarrhea could be prevented by exclusive breastfeeding.[8] Yet rates of breastfeeding beyond the first week following birth fall off sharply among California women at the lowest levels of family income, partly because low-income women are more likely than their higher-income counterparts to return to work earlier and to be engaged in jobs that make it challenging for them to continue breastfeeding.[9,10] There is a range of policy and health education strategies that can be taken to improve the rates of breastfeeding among new mothers.

Preventing Upstream Health Inequities

As this report indicates throughout, a growing body of evidence shows that many of the downstream health disparities that occur among vulnerable populations can be effectively reduced or eliminated by addressing the related upstream socioeconomic and environmental inequities.[11] Clean air and safe playgrounds, for instance, may be as effective for reducing levels of childhood asthma in low-income communities as a shot in the arm is for preventing measles. As another example, transportation systems, which are generally not thought of as part of the health care system, can indirectly impact health by influencing physical activity opportunities. Active transportation (walking, biking, and wheeling to destinations) can help prevent obesity and improve both mental and physical health.[12,13]

Improving Childhood Immunization Rates

A 2004 study involving more than 200 randomly selected English- and Spanish-speaking families with young children in Bakersfield identified the following key barriers facing any program to improve childhood immunization rates in ethnically diverse rural communities: lack of transportation, child illness, parental forgetfulness, and fear of side effects. Among providers, the key barriers were lack of an opening for an appointment, limited clinic hours, and long lines at clinics. The report concluded that effective strategies must include reminder calls, increased transportation options, weekend clinics, and improved communication with parents.

Source: Thomas M, Kohli V, King D. Barriers to childhood immunization: findings from a needs assessment study. Home Health Care Serv Q; 2004;23(2):19-39.

Experiences of Discrimination and Health

The United States has made progress in creating a more tolerant society, yet discrimination and inequality persist today. Discrimination, whether experienced as individual acts or at an institutional level, makes people sick.[1] Although many of the most blatant forms of discrimination have been greatly reduced since passage of the Civil Rights Act of 1964 and subsequent civil rights laws, which prohibit discrimination in workplaces, schools, public facilities, and state and local government, many groups continue to be vulnerable to both subtle and overt forms of discrimination in other social and economic sectors.[2] Numerous studies have documented the harmful mental and physical health effects of discrimination, including depression, stress, anxiety, hypertension, self-reported poor health, breast cancer, obesity, high blood pressure, and substance abuse.[3,4]

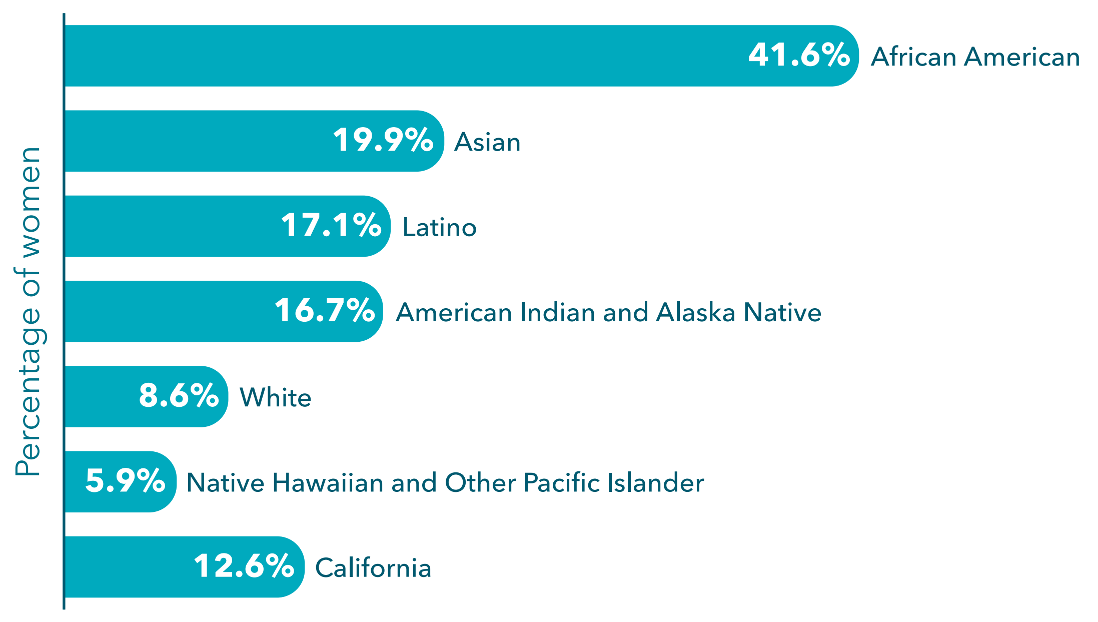


FIGURE 21: Percentage of women who reported experiencing discrimination because of their race/ethnicity, California, 2012.

Source: California Department of Public Health, California Women's Health Survey, 2012.

Prejudice and acts of discrimination are experienced by members of racial and ethnic groups, and Figure 21 details how California women experience discrimination across these groups. In addition, discrimination is experienced by individuals and groups defined by age, gender, gender identification, sexual orientation, religion, and other social or personal characteristics. Individuals who are members of two or more disadvantaged groups (such as a member of a racial minority who is also disabled) are the most likely to report acts of discrimination and to experience stress and poor mental or physical health as a result.[5]

Discrimination is complex, rooted in historical racist and sexist social policy, and compounds the disproportionate burden of poor health outcomes that marginalized groups experience directly and indirectly. Therefore, efforts to

ARRESTS FOR MARIJUANA POSSESSION DISPROPORTIONATELY AFFECT AFRICAN AMERICAN TEENAGERS

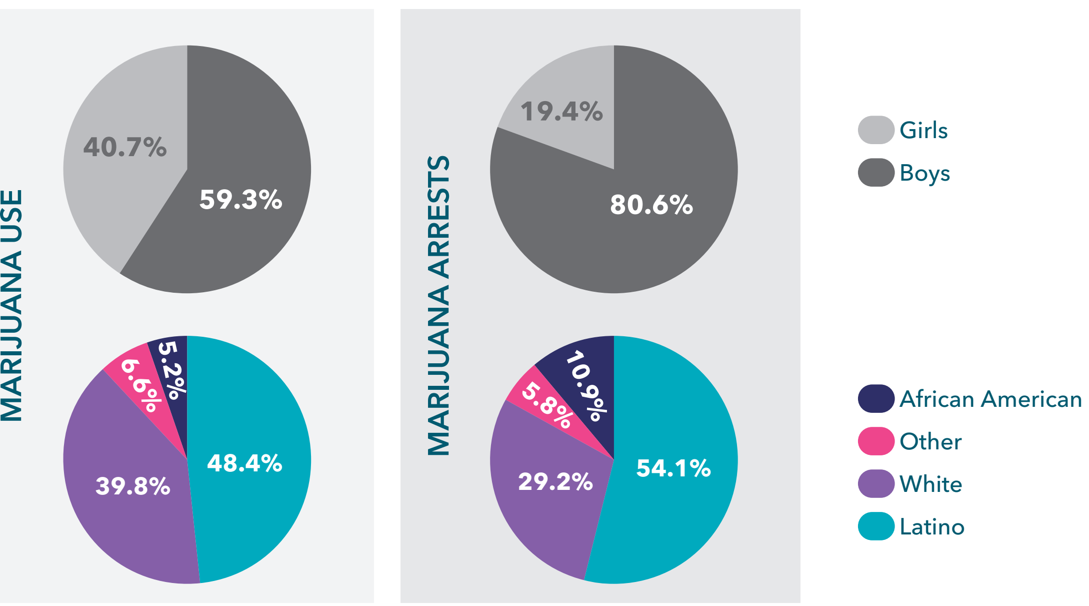


FIGURE 22: Percentage of marijuana use and misdemeanor arrests among teenagers ages 10 to 17, by race/ethnicity and gender, California, 2011-2012.

Sources: University of California Los Angeles, California Health Interview Survey, 2011-2012; and California Department of Justice, Criminal Justice Statistics Center, 2011-2012.
Note: Under California Health and Safety Code 11357b, possession of one ounce or less of marijuana for personal use is considered a misdemeanor.

Let Her Work Campaign Scores a Win

The Let Her Work campaign by Equal Rights Advocates (ERA), a statewide organization working for legal protection and policy change on behalf of the civil rights of women and girls, is focused on enabling the rising number of California's incarcerated women (most of whom are mothers) to resume their caregiving responsibilities following release. However, like men, these women face tremendous obstacles in seeking employment following their release. Many employers refuse outright to consider the application of a person with even a minor criminal record.

In partnership with the National Center for Lesbian Rights, ERA launched the Breaking Barriers: Let Her Work project to train women with criminal histories about their employment rights and promote policy changes to remove barriers to their employment. An early win for the campaign was the passage in 2013 of AB 218, which prohibits government agency employers from asking a potential new hire to disclose his or her previous criminal convictions on a preliminary employment application.

Learn more at http://www.equalrights.org/legislative-update-ban-the-box-and-let-her-work/.

Expanding Rights of Transgender Students

California became the first state in the nation in 2013 to pass groundbreaking legislation expanding antidiscrimination protections for transgender students in public elementary and secondary schools. Education Code Section 221.5 mandates that schools respect the gender identity of transgender students by allowing them equal access to the sports teams, programs, and facilities associated with their gender.

Learn more at http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB1266.

achieve health equity must also include efforts to identify and correct the discrimination that persists.

How Discrimination Gets Under Our Skin

Discrimination is not just something that we cognitively or emotionally feel. Discrimination gets under our skin and causes negative physiological changes in the body. Researchers are able to measure the body's stress response to discrimination by assessing changes in blood pressure,[6,7] stress hormone levels,[8] protein markers associated with heart disease,[9,10] and more. Over time, the resulting physiological and psychological effects of discrimination start to wear down

MORE THAN HALF OF ALL HATE CRIMES ARE MOTIVATED BY RACE/ETHNICITY, FOLLOWED BY THOSE MOTIVATED BY SEXUAL ORIENTATION AND BY RELIGION OF THE VICTIM

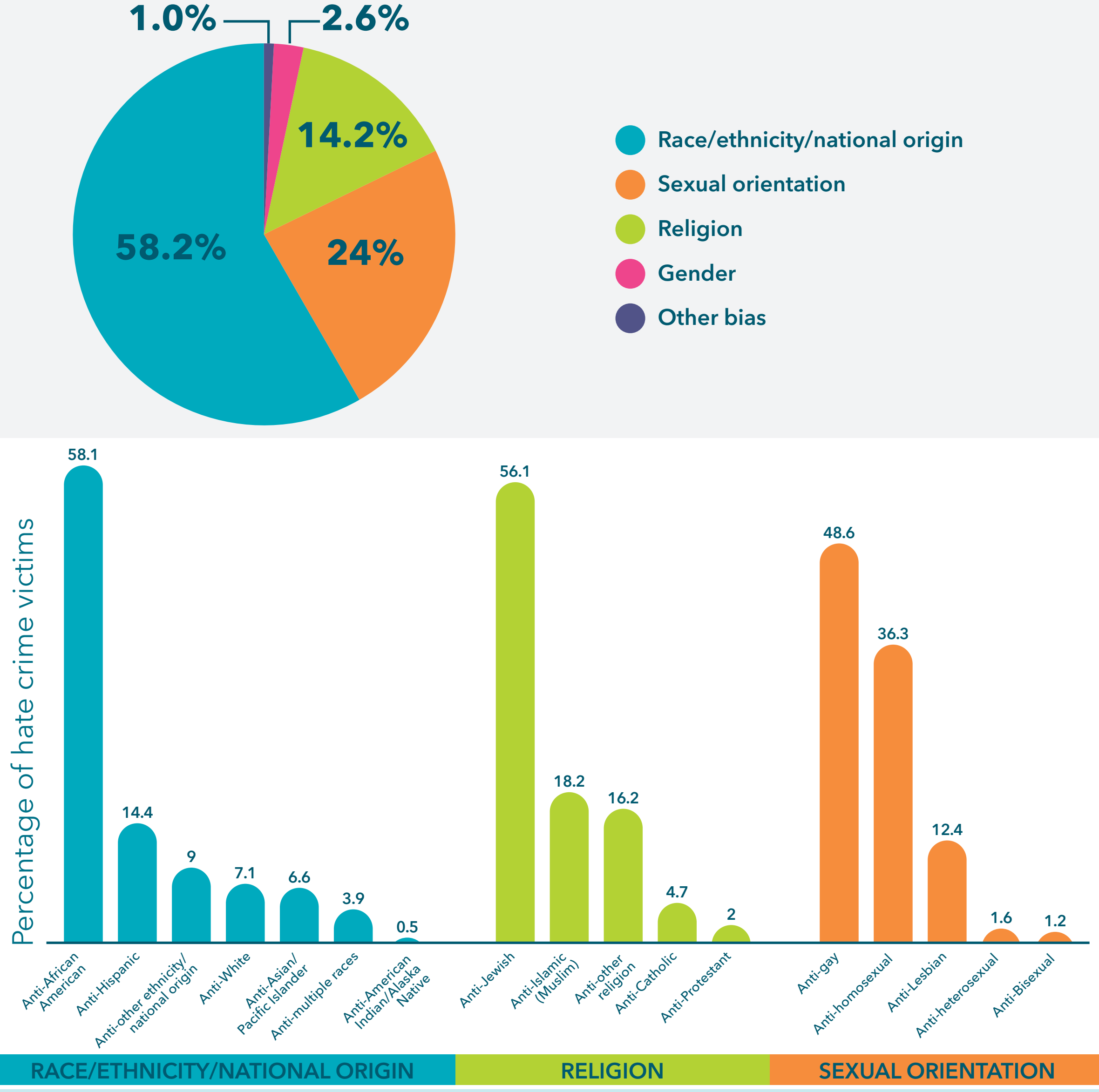


FIGURE 23: Percentage of hate crimes victims motivated by the victim's race/ethnicity/national origin, religion, and sexual orientation, California, 2012.

Source: California Department of Justice, Hate Crime in California Report, 2013.

the body. This wearing, or "weathering," effect from repeated exposure to discrimination contributes to a number of health disparities, such as the disproportionate prevalence of cardiovascular disease and low-weight births in African Americans compared with Whites.[11,13,14] Studies have shown that when comparing women with the same levels of income and education, job status, and health insurance status, African American mothers in the U.S. have lower-weight babies compared with their African-born and White counterparts, suggesting that genetic ancestry is not a strong determinant of birth weight.[12] Although this is a complex area of research, the lower-weight babies born to African American mothers can be explained in part by the stress caused by the mothers' lifelong experiences of discrimination.[13,14] This is particularly problematic because low birth weight is a strong indicator of long-term health consequences. Furthermore, according to the Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, non-White patients tend to experience discrimination at the patient-provider level and to receive a quality of care inferior to that received by their White counterparts, even when controlling for access-related factors such as income and insurance status.[15] Given the impact of discrimination, it must be addressed as rigorously as the other social determinants of health.

The Indirect Health Effects of Discrimination

Beyond the direct health effects of discrimination, complex social and political sources of discrimination have serious health consequences. These discriminatory practices include pay inequality between women and men, bank redlining practices targeted toward lower-income individuals, disproportionate arrest rates for boys and men of color *(see Figure 22)*, and lack of job opportunities and protection for those with physical and mental disabilities, among many others. In limiting an individual's or a group of individuals' ability to make a fair and decent wage, buy a home, access high-quality education at all levels, and marry and support the person of their choice, society is directly or indirectly impacting their health and overall quality of life.

Hate Crimes Declining but Still Pervasive

One way of discussing different groups' experience of discrimination is the number of hate crimes inflicted on individuals that are motivated by the victim's race, ethnicity, or other personal characteristics *(see Figure 23)*. In California, the number of victims who experience hate crimes overall has decreased 42.4 percent in recent years, from 1,815 in 2003 to 1,045 in 2013.[16,17] In 2013, hate crimes involving race, ethnicity, or national origin were the most frequent in absolute (but not population-adjusted) terms, accounting for 609 victims (mostly anti-Black, 354 victims). Sexual orientation bias accounted for 251 victims (mostly for anti-gay bias, 122 victims), and religious bias accounted for 148 victims (mostly anti-Jewish bias, 83 victims).[17]

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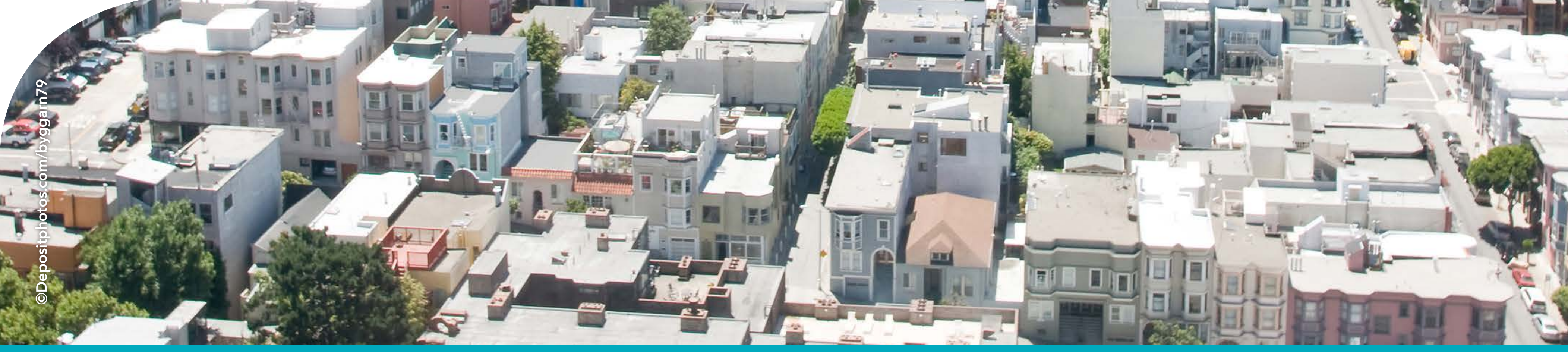


Neighborhood Safety and Collective Efficacy

Across the country, when you ask people what they want their neighborhood to look like, the answers are fairly consistent. People want neighbors who care enough about the neighborhood to work together to create and maintain a healthy and safe environment, with convenient access to cultural and economic opportunities, and where their children can play, learn, and thrive in an atmosphere of trust and security.[1] In other words, they want neighborhoods that ensure access to basic goods, that are socially cohesive, that are designed to promote good physical and psychological well-being, and that are protective of the natural environment. Such characteristics are essential to community mental and physical health and health equity.[2]

Trust as a Foundation for Health

An analysis of the literature on neighborhood-level social determinants of health shows that, among other factors, the collective health of neighborhoods is highly subject to the social relationships among residents, including the degree of mutual trust and feelings of connectedness among neighbors. For instance, residents of close-knit neighborhoods work together to create and maintain clean and safe playgrounds, parks, and schools. They exchange information on childcare, employment, and health access, and they cooperate to discourage crime and other negative behaviors, such as domestic violence, child abuse, substance abuse, and gang involvement, which can directly or indirectly influence health. Conversely, less close-knit neighborhoods and greater degrees of social disorder have been related to anxiety and depression.[3]

Unfortunately, California has many low-income neighborhoods, both rural and urban, where the opportunities or traditions for engagement in community service are lacking. While opportunities for social engagement benefit people across the socioeconomic spectrum, lower-income adults in California are less likely to have participated in a board, council, or organization or to have worked informally to address a community problem, when compared with higher-income California adults *(see Figure 24)*.

Unsafe Neighborhoods Produce Sick Children

Low levels of neighborhood trust and cohesion may also be related to higher rates of criminal activity in disadvantaged neighborhoods. A 2010 study from the U.S. Department of Justice found a high correlation between low household income levels and rates of property crime, such as burglary.[5] A similar relationship holds true for violent crime, as seen in Figure 25, where low-income, disadvantaged neighborhoods in the Bay Area and in South

Partying for Safe Neighborhoods

When neighbors are organized, their neighborhoods are safer. That's the concept of National Night Out (NNO). In 2013, Oakland residents hosted 670 block parties on August 6 – one of the largest NNO events in the country. When the event started about nine years ago, Oakland had only 35 parties. Each year, Oakland's mayor's office seeks to grow the number of neighborhood events and to encourage residents to take the next step and become a neighborhood watch group. The first step is simply for neighbors to get to know one another.

Central Los Angeles have the highest crime rates. The combination of high crime rates and other social factors associated with low-income neighborhoods creates barriers to healthful behaviors, such as walking and playground use; puts children at risk for poor educational, emotional, and health outcomes; and makes children more likely to become victims or perpetrators of violent crime.[5,6] Community-level crime interventions, such as well-lit, secure playgrounds; neighborhood watch organizations; and development of well-resourced teen centers to reduce neighborhood gang activity, are important components in many community-based neighborhood improvement initiatives.[7]

LOWER-INCOME ADULTS ARE LESS LIKELY TO ENGAGE IN VOLUNTEER WORK OR GET TOGETHER WITH OTHERS TO DEAL WITH COMMUNITY PROBLEMS

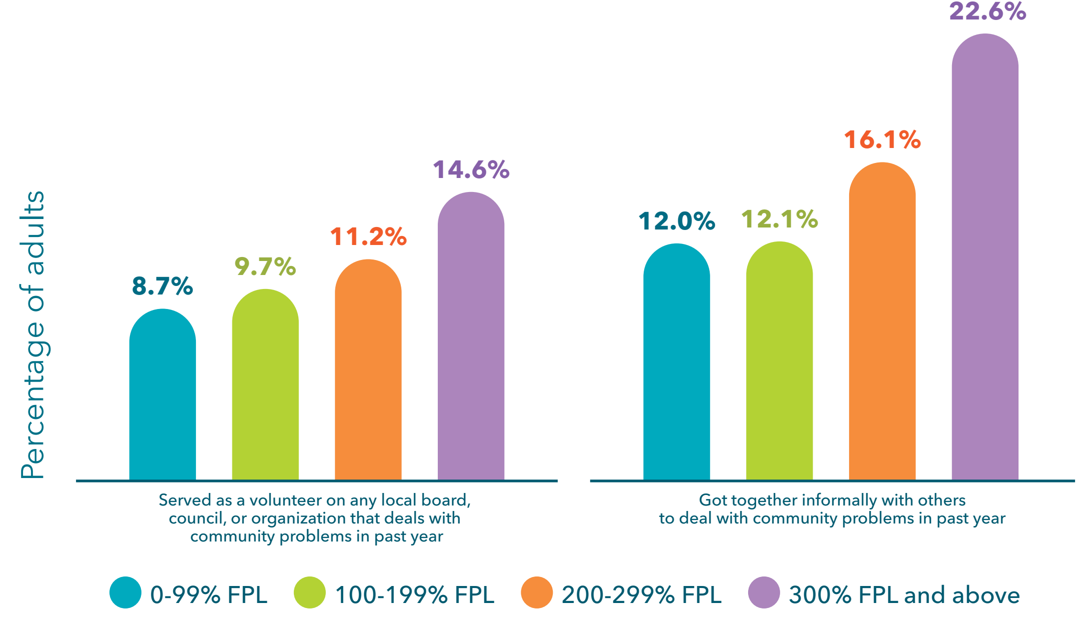


FIGURE 24: Percentage of adults who participated in community service, by federal poverty level (FPL), California, 2011-2012.

Source: University of California Los Angeles, California Health Interview Survey, 2011-2012.

Operation Ceasefire/Safe Community Partnership

Operation Ceasefire is an evidence-based strategy designed to reduce gang- and group-related homicides and nonfatal shootings. Localized versions of the Operation Ceasefire model of neighborhood gang and gun violence suppression are making headlines in 10 California cities that have seen rising rates of gun violence in recent years. In Stockton, the initiative, which operates under the name Safe Community Partnership, has been credited with helping reduce the number of homicides from 71 in 2012 to 32 in 2013. In Richmond, the city's homicide rate in 2013 was the lowest in 33 years and total crimes were more than 40 percent lower than the 2003 total. Other cities that have implemented the model in select neighborhoods include Los Angeles, Modesto, Oakland, Salinas, Oxnard, Union City, East Palo Alto, and Sacramento.

Learn more at http://www.nnscommunities.org/index.php.

THE RISK OF CRIME CAN BE HIGHLY DISPARATE FOR NEIGHBORING CALIFORNIA CITIES AND TOWNS

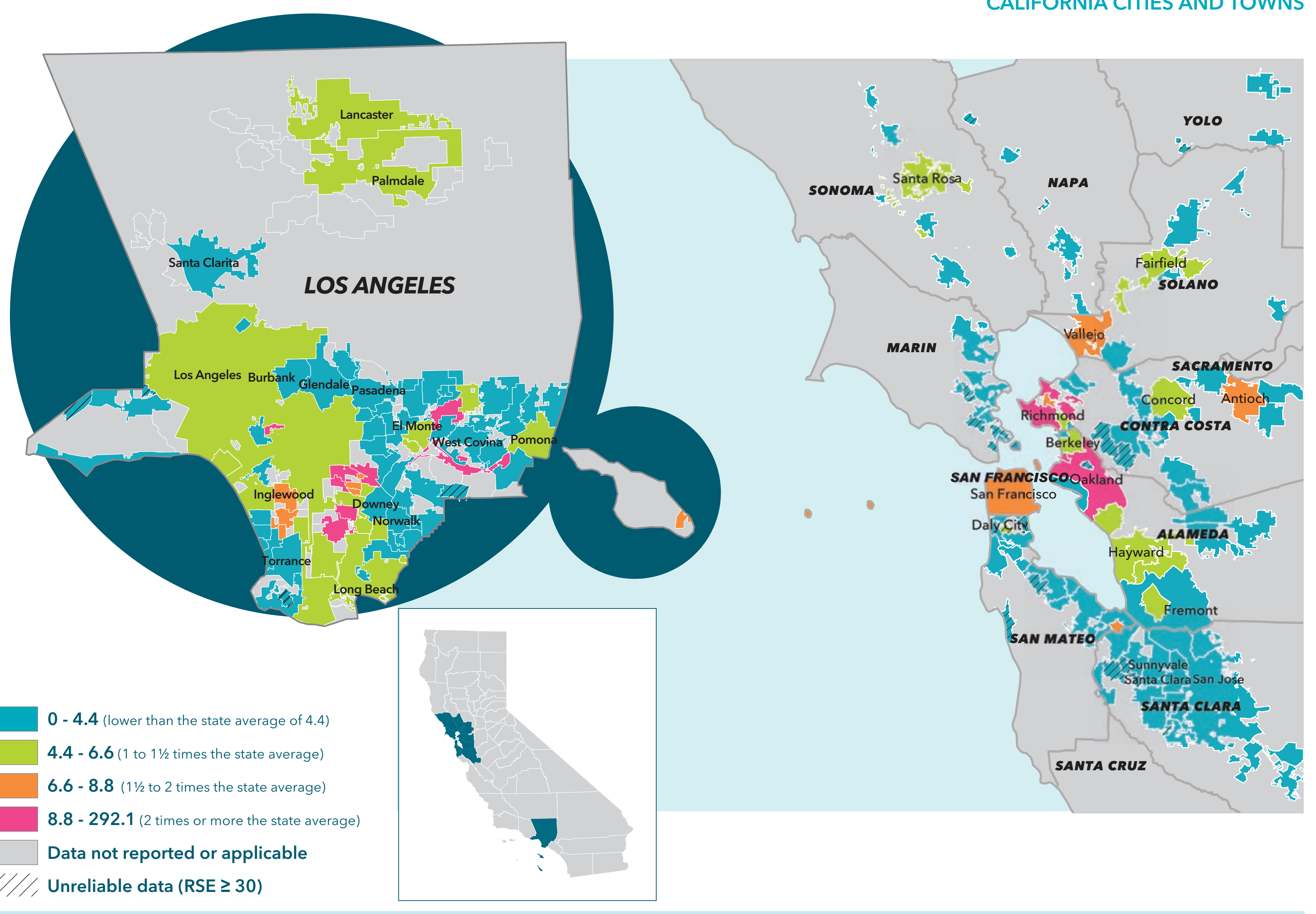


FIGURE 25: Number of violent crimes per 1,000 population, by cities and towns, Los Angeles County and Bay Area, California, 2010.

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

Cultural and Linguistic Competence: **Why It Matters**

The ability of health and mental health care providers to effectively communicate with service recipients and to understand and respond to their cultural beliefs and values regarding health, illness, and wellness is essential for providing high-quality care to every person and for reducing health disparities among all social groups.[1,2,3]

California's vast and growing population diversity represents a special challenge for the state's primary and behavioral health care providers and organizations. The state is home to more than 200 languages, with more than 40 percent of the population speaking languages other than English at home, and 20 percent, or almost 7 million Californians, considered limited English proficient (LEP) – meaning they do not speak English "very well."[4,5]

The state's physician workforce in 2012 was disproportionately White and Asian.

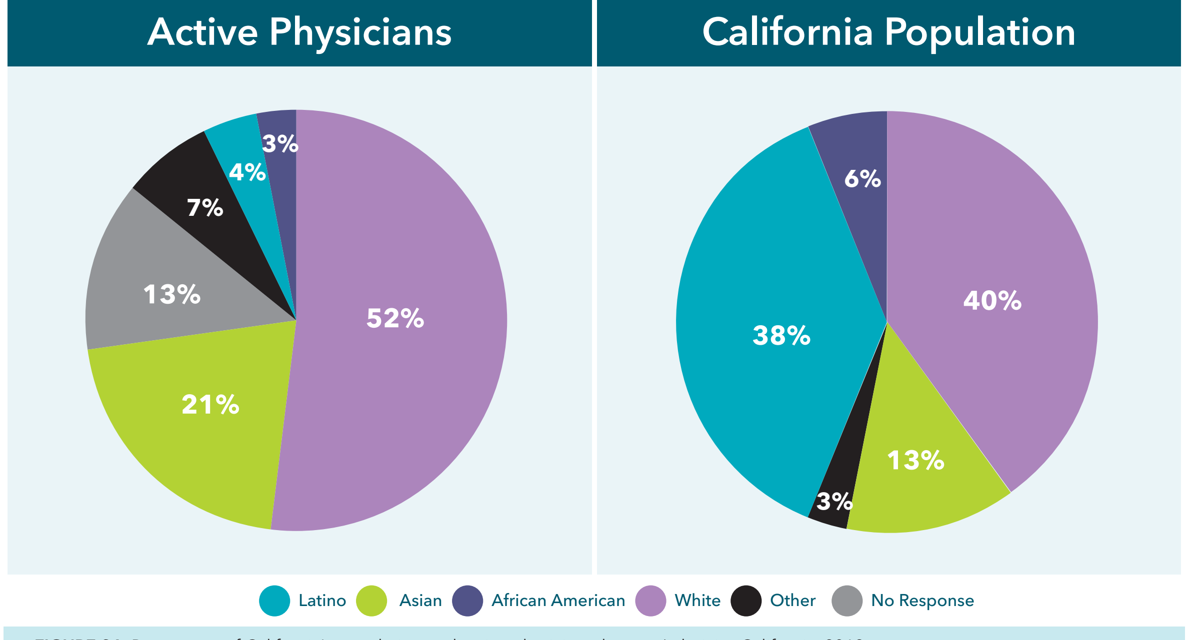


FIGURE 26: Percentage of California's population and active physicians, by race/ethnicity, California, 2012.

Sources: Medical Board of California, Cultural Background Survey Statistics, 2012; and U.S. Census Bureau, Population Division, Annual Estimates of the Resident Population by Sex, Age, Race, and Hispanic Origin for the United States: 2010-2012. Analysis by California HealthCare Foundation, California Health Care Almanac, California Physicians: Surplus or Scarcity, 2014.
Note: Data includes active medical doctors (MDs).

ALTHOUGH MEDICAL SCHOOL GRADUATES OF BOTH GENDERS WERE ABOUT EVEN, WOMEN ARE UNDERREPRESENTED IN MEDICAL PRACTICE

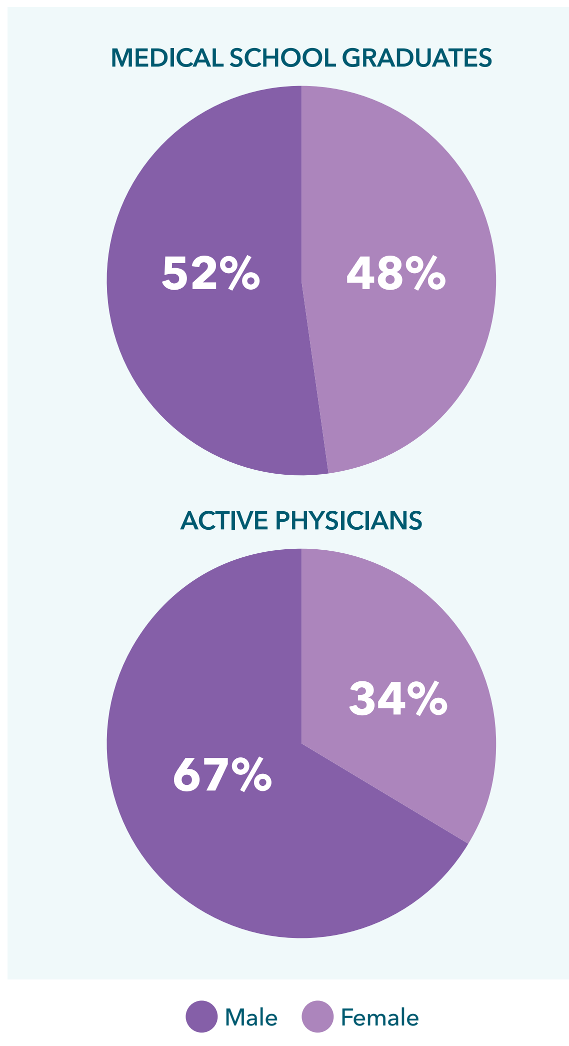


FIGURE 27: Percentage of California's medical school graduates and active physicians, by gender, California, 2012.

Source: Association of American Medical College, State Physician Workforce Data Book, 2013. Analysis by California HealthCare Foundation, California Health Care Almanac, California Physicians: Surplus or Scarcity, 2014.

Note: Data includes active medical doctors (MDs) and doctors of osteopathic medicine (DOs).

While White and Asian people made up 53 percent of the population in California, they accounted for 73 percent of the active physicians. Latinos, African Americans, and other ethnicities made up 47 percent of the California population but only 14 percent of active physicians *(see Figure 26)*; women are also underrepresented *(see Figure 27)*. While Latinos constituted 38 percent of the population (and close to 50 percent in many regions), Latino physicians made up only 4 percent of the physician workforce, including those in Los Angeles and the San Joaquin Valley, where Latinos are a near majority. African Americans, who make up about 6 percent of the state's population, account for just 3 percent of physicians. It is estimated that roughly nine out of 10 physicians, dentists, and pharmacists in California are either White or Asian.[6]

Impacts on Quality of Care

Although as many as 20 percent of the state's non-Hispanic White physicians are relatively fluent in Spanish,[7] significant cultural and linguistic barriers remain for many patients,

ADULTS WITH LIMITED ENGLISH PROFICIENCY (LEP) GENERALLY HAVE POORER HEALTH COMPARED WITH THOSE WHO SPEAK FLUENT ENGLISH

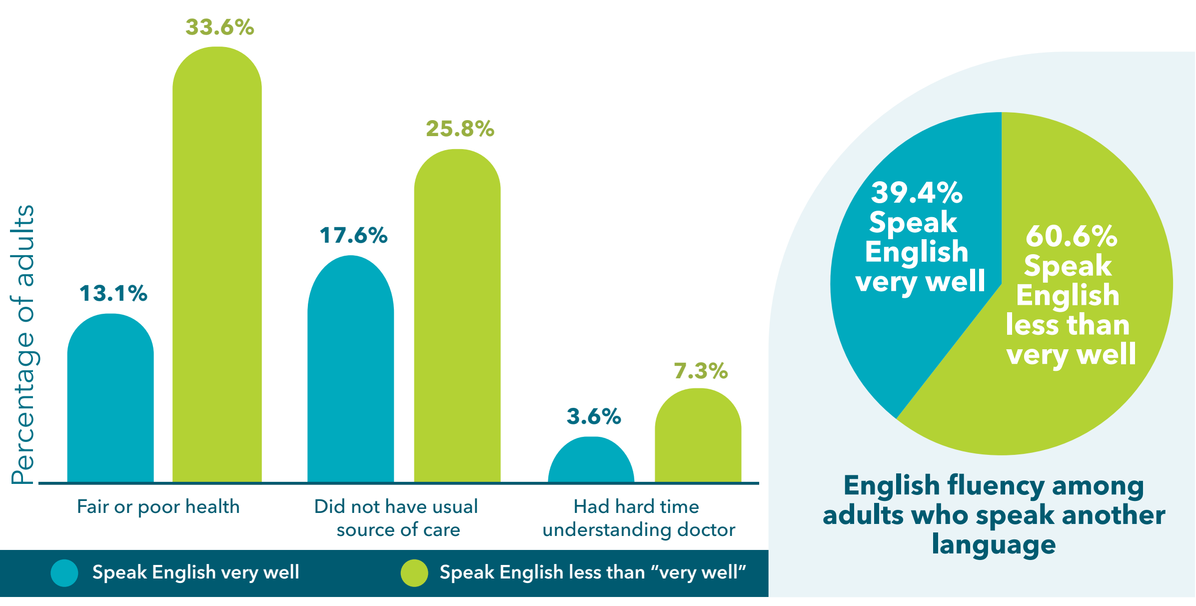


FIGURE 28: Percentage of English fluency levels among adults ages 18 years and older who speak a language other than English at home, by selected characteristics, California, 2011-2012.

Source: University of California Los Angeles, California Health Interview Survey, 2011-2012.

Note: Adults who reported speaking English less than "very well" includes those who reported speaking English well, not well, or not at all.

and these barriers are associated with multiple forms of reduced quality of care and decreased access to primary and preventive care.[8,9,10] The Institute of Medicine report *Unequal Treatment* indicates that U.S. racial and ethnic minorities are less likely to receive routine medical procedures and more likely to experience a lower quality of health services.[11] Racial/ethnic minorities and individuals with low household incomes are more likely than their non-Hispanic White and higher-income counterparts to experience culturally insensitive health care and dissatisfaction with health care – health care experiences that have been linked to poorer health outcomes.[12]

The persistent racial, cultural, and linguistic gaps in the health care workforce are reflected in significant health disparities between population groups with limited English proficiency and those that speak English very well *(see Figure 28)*. In order to achieve cultural and linguistic competency in California's public and private health care institutions, we must look beyond the issue of language alone and grapple with a larger challenge – that of developing a primary and behavioral health care workforce capable of providing services that are responsive to the health beliefs, health practices, and cultural and linguistic needs of California's diverse population.

Priming the Medical School Pipeline

The University of California, Riverside, School of Medicine obtained $3 million in private grant funding in 2013 to expand its existing medical school pipeline programs, aimed at broadening and diversifying the pool of students in inland Southern California applying to medical school. The program, Imagining Your Future in Medicine, will link students as young as the middle school level with pipeline initiatives at the high school, community college, and university levels. For middle school students it includes a one-week residential summer camp called Medical Leaders of Tomorrow, in which 40 to 50 educationally and socioeconomically disadvantaged students in the Inland Empire have access to presentations on science and health care topics; study skills, workshops, and training; leadership and team-building activities; laboratory and clinic tours; and college admissions information. Once students enter the pipeline, they are provided a continuous path for academic preparation and enrichment, hopefully leading to entry into medical training, particularly in primary care and short-supply specialties.

Source: UC Riverside Today, April 3, 2013.

Sharing Trained Health Care Interpreters

The Health Care Interpreter Network (HCIN), funded in 2005, by California HealthCare Foundation and others, is a national network of more than 40 hospitals and provider organizations that share more than 100 trained health care interpreters in 16 languages through an automated video/voice call center. Videoconferencing devices and all forms of telephones throughout each hospital and clinic connect within seconds to an interpreter on the HCIN system, either at their own hospital and clinic or at another participating hospital and clinic.

In California HCIN membership is offered to:

- Public, district, or University of California hospitals
- Community hospitals that are not members of hospital systems larger than three distinct acute care facilities
- Community clinics that serve the Medi-Cal population
- Health plans that serve the Medi-Cal population

Learn more at http://www.hcin.org/.

Mental Health Services: 'No Health Without Mental Health'

The World Health Organization (WHO) defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." WHO adds, "Mental health is an integral part of health; indeed, there is no health without mental health,"[1] since physical health impacts mental health and vice versa.

Mental disorders, characterized by alterations in thinking, mood, and/or behaviors that are associated with distress and/or impaired functioning, contribute to a host of physical and emotional problems, including disability, pain, or death. In fact, mental health disorders are the leading cause of disability in the United States, accounting for 25 percent of all years of life lost to disability and premature mortality.[2] In California, suicide, which is a direct outcome of mental distress, is the third leading cause of death among individuals ages 15 to 34.[3]

Unequal Burdens

The prevalence of mental illness and problems of availability, affordability, and access to mental health treatment and preventive services are areas of striking disparities on the basis of race, ethnicity, gender, income, age, and sexual preference. Various racial, ethnic, and other minority groups and low-income individuals of all races experience higher rates of mental illness than do Whites and more affluent individuals. Further compounding the problem, these individuals are less likely to access mental health care services, and when they do, these services are more likely to be of poor quality.[4] In California, almost one in six adults has a mental health need, and about one in 20 (and one in 13 children) suffers from a serious mental illness (SMI), according to a recent study by California HealthCare Foundation.[5] The study found that nearly half of adults and two-thirds of adolescents with mental health needs did not get recommended treatment. Other findings included significant racial and ethnic disparities for incidence of SMI, with Native Americans, multiracial individuals, African Americans, and Latinos all experiencing rates above the state average.

A notable exception to the link between race/ethnicity and mental illness is the suicide rate, which is highest among White men.[5] This is an area that could benefit from additional understanding, as White men do not report having seriously thought about committing suicide any more than their multiracial and American Indian and Alaska Native counterparts do (the data on

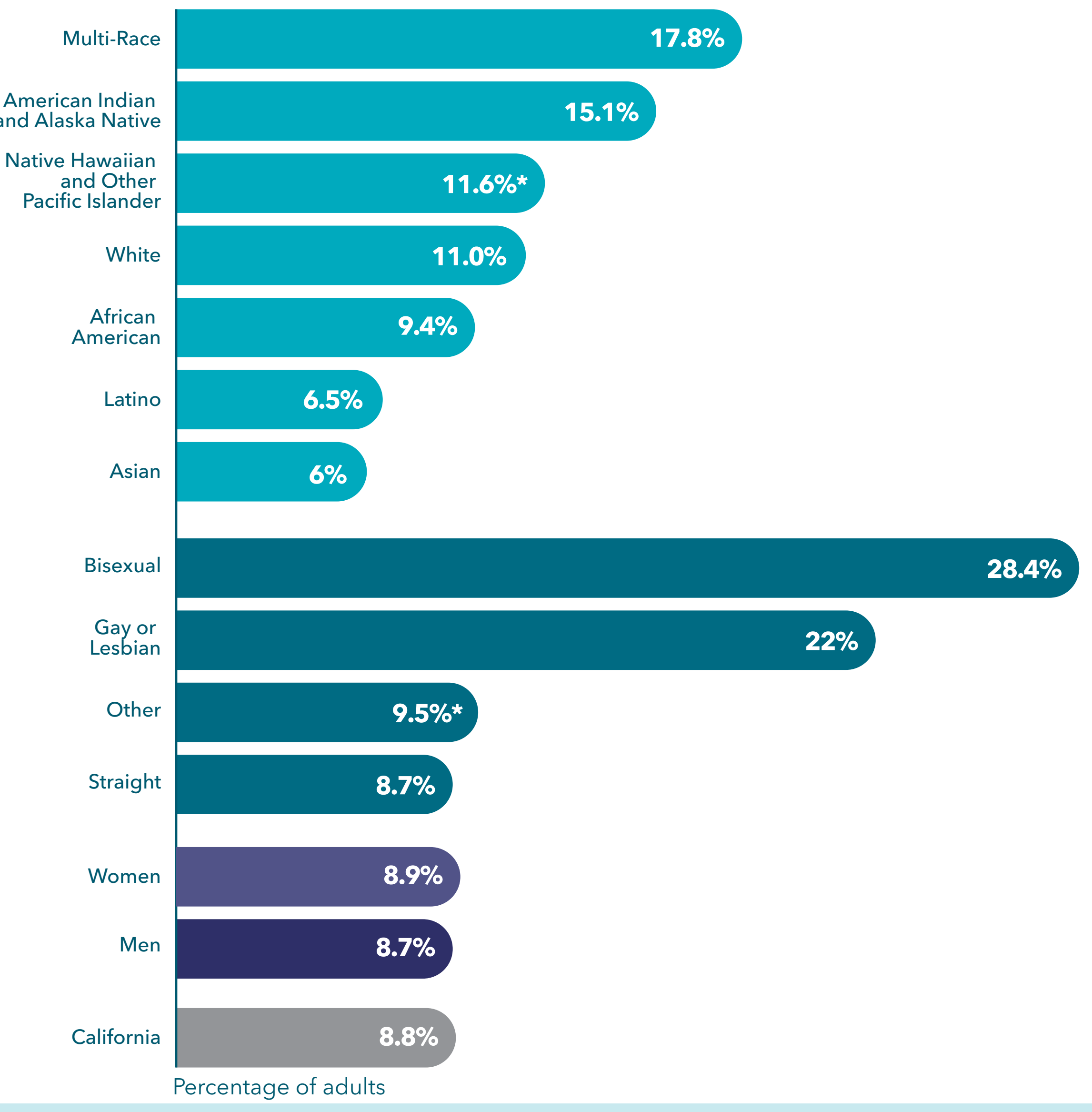


FIGURE 29: Percentage of adults who reported having seriously thought about committing suicide, by race/ethnicity and sexual orientation, California, 2011-2012.

Source: University of California Los Angeles, California Health Interview Survey, 2011-2012.
Note: "Other" includes not sexual/celibate/none.
**Statistically unreliable data*

Integrating Mental and Physical Health in New Minority Physicians

The Combined Internal Medicine/ Psychiatry Residency Training (IMP) Program at UC Davis Health System combines psychiatry with either family practice or internal medicine training, as well as board certification. The program, launched in 2007, is a response to the growing need to address mental and physical health needs in primary care settings, where most low-income minorities, especially Mexican Americans, first seek help for emotional problems. Most of the program's physicians-in-training come from underrepresented or culturally diverse backgrounds and plan to work in underserved settings and be future residency directors, policy makers, and thought leaders. Research shows that underrepresented minority physicians are more likely to work in health workforce shortage areas and to care for medically underserved populations, patients of their own ethnic group, and Medicaid recipients.

Source: The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand. U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, 2008.

Native Hawaiians and other Pacific Islanders is statistically unreliable). When the data is examined by sexual orientation, rates of suicidal thoughts are highest among Bisexual individuals, followed by those who identify as Gay or Lesbian *(see Figure 29)*.

Barriers to Care

Affordability of care and low rates of health insurance among vulnerable populations have been major barriers to care for certain underserved populations *(see Figure 30)*. African American, Latino, and Asian American teens who need help for emotional or mental problems are less likely to receive counseling than are White teens. About two-thirds of White teens who need counseling access it, compared with about half of African American, Latino, and Asian teens.[6] Studies show that rates of serious mental illness are more than four times as high among the lowest-income adults in California (less than 100 percent of the federal poverty level) than among those earning at least 300 percent of the poverty rate. Among children age 17 and under, serious emotional disturbance is more closely associated with family income than with race or ethnicity.[5]

Another key barrier to equity in mental health prevention and treatment is the wide cultural and linguistic gulf between underserved populations and health care and behavioral health professionals. For example, a recent University of California, Davis, study found that up to 75 percent of Latinos who seek mental health services opt not to return for a second appointment, due largely to cultural, social, and language barriers.[7] Although mental health services must be provided in native languages of major immigrant groups, the study found Spanish-speaking professionals few and far between within Latino communities.

On the positive side, changes in state and federal legislation on mental health, including mental health parity laws and the Affordable Care Act, are expected to increase access to mental health prevention and treatment for underinsured and uninsured Californians with mental health needs. In addition, funding for California's public mental health system is getting a boost from the expansion of Medi-Cal and increased revenue stemming from passage of the Mental Health Services Act in 2004 and the Mental Health Wellness Act of 2013.[7]

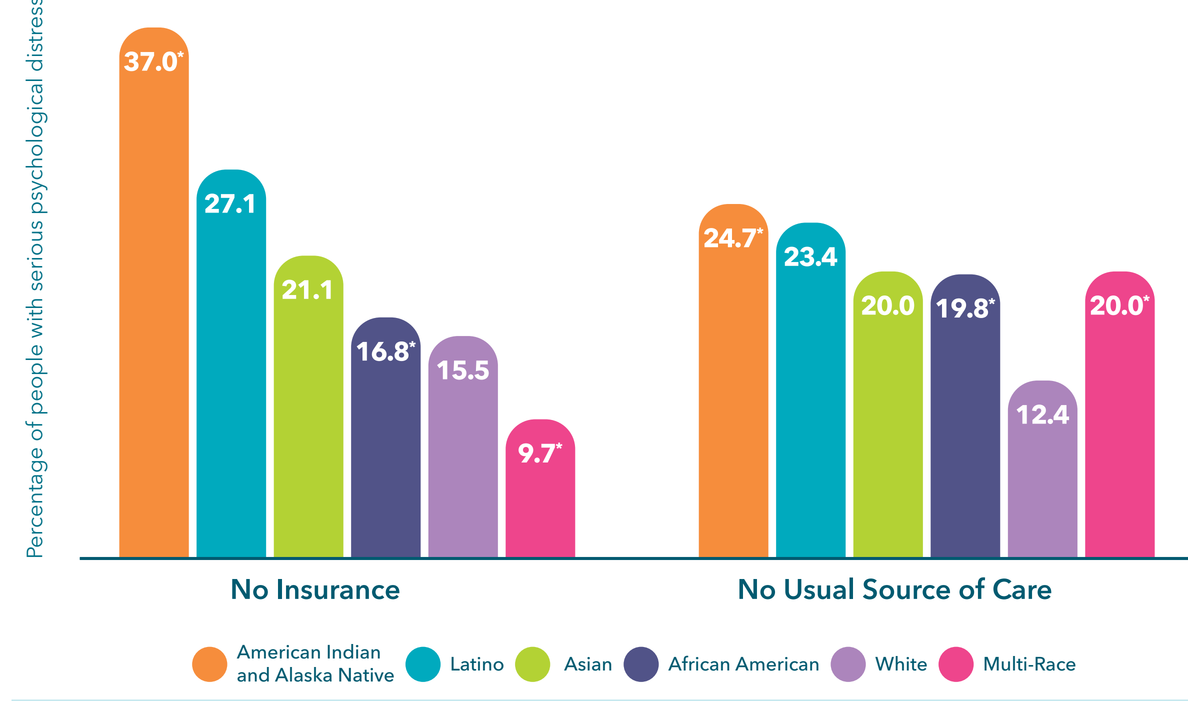


FIGURE 30: Percentage of people with serious psychological distress who reported not having health insurance or the usual source of care, by race/ethnicity, California, 2011-2012.

Source: University of California Los Angeles, California Health Interview Survey, 2011-2012.
Note: "Other" includes not sexual/celibate/none.
** Statistically unreliable data.*

THE CALIFORNIA STATEWIDE PLAN TO PROMOTE HEALTH AND MENTAL HEALTH EQUITY

VISION

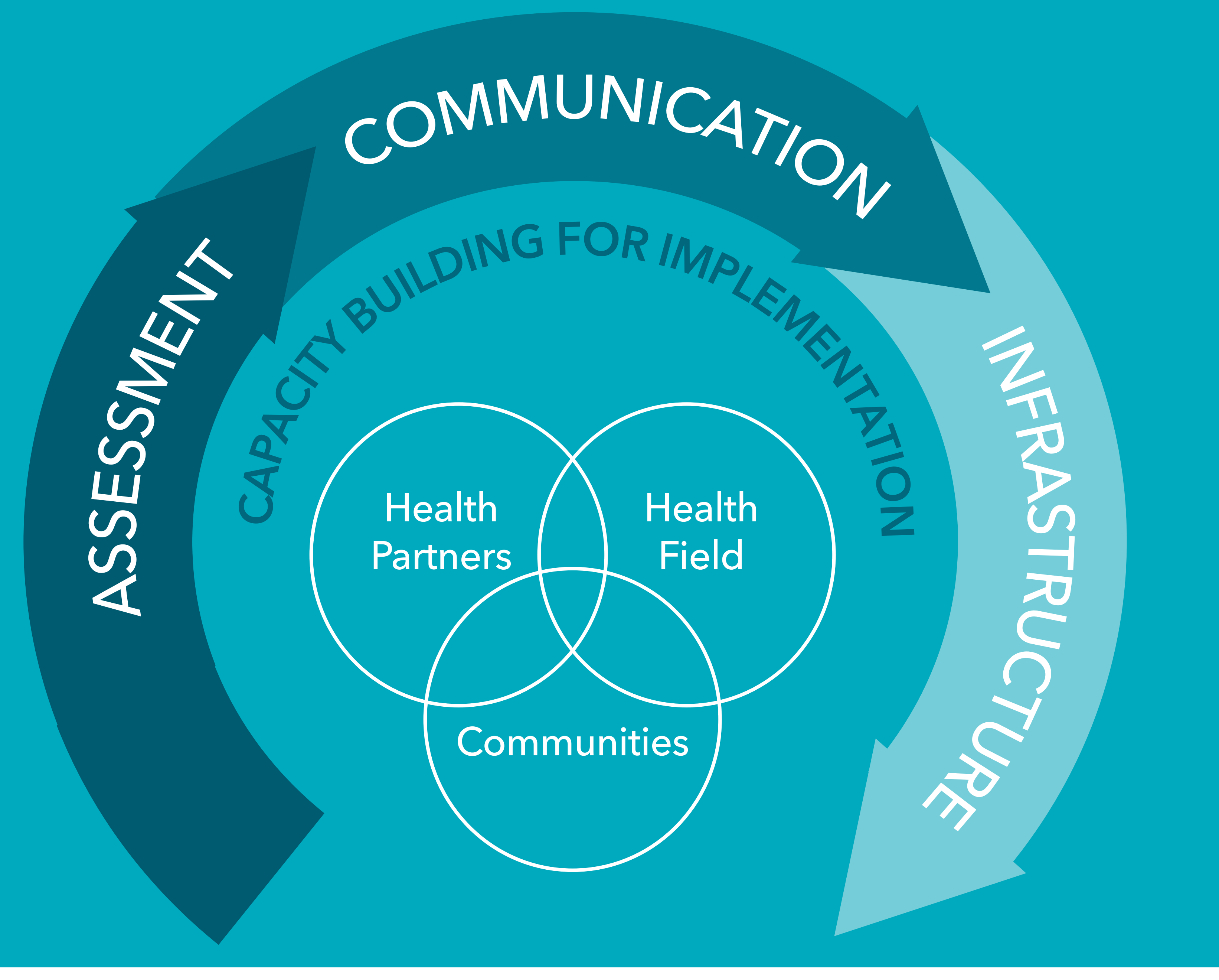
Everyone in California has equal opportunities for optimal health, mental health, and well-being.

MISSION

Promote equitable social, economic, and environmental conditions to achieve optimal health, mental health, and well-being for all.

CENTRAL CHALLENGE

Mobilize understanding and sustained commitment to eliminate health inequity and improve the health, mental health, and well-being of all.



Eliminate Health and Mental Health Inequities

PREFACE

We are grateful for the work of hundreds of stakeholders, as well as staff at other state departments, who have participated in the process of launching the first-ever Statewide Plan to Promote Health and Mental Health Equity. To move the Plan from a strategic conversation to a tactical one, we have embedded a set of goals to guide and support our implementation efforts.

Capacity Building for Implementation of the Strategic Priorities

As the facilitator of the planning and implementation processes, the Office of Health Equity (OHE) intends to build capacity for movement on its strategic priorities. First and foremost, we will be building mechanisms for ongoing public engagement and accountability. This will enable meaningful participation of stakeholders to engage in how the goals are prioritized, who will be involved in their implementation, and other important considerations that need to be made along the way. Mechanisms will likely include the use of both technology and personal interaction and will be designed for maximum participation and transparency.

The staff members at the OHE have had the honor and privilege of leading this planning process and will have the responsibility of maintaining accountability for its implementation. However, it should be acknowledged that the process has been highly inclusive and the content of the Plan is reflective of the hard work of the OHE Advisory Committee and hundreds of other stakeholders. This Plan belongs to all who participated in its creation and who will participate in and/or benefit from its implementation. Ultimately the OHE is the author and keeper of the Plan. As such, please note that the terminology "we" and "our" used in this Plan comes from the vantage point of the OHE, in consideration of the many contributions that have been offered in the Plan's development.

Strategic Priorities

Assessment, Communication, and Infrastructure

Health and mental health inequities have surfaced through a culmination of unjust policies and practices over multiple generations. As such, there is no one-to-one relationship in eliminating the inequities; it is a many-to-many relationship. The individuals who have been involved in developing this Plan have identified many intersecting, complementary interventions to turn the tide on the many inequities that are well documented in the accompanying report.

These interventions have as their basis; assessment, communication, and infrastructure development for California overall, as well as within the health field, among potential health partners, and within local communities. The next sections will detail our rationale for prioritizing these three intervention targets, but first we would like to describe the interventions themselves.

Assessment will yield knowledge of the problems and the possibilities. **Communication** will foster shared understanding. **Infrastructure** development will empower residents and their institutions to act effectively. This approach speaks to our intention to identify and disseminate actionable information on inequities and

disparities to develop and align sustainable multisectoral infrastructure and support.

There is growing interest in health and mental health equity, yet many do not know what this terminology means, how it impacts them and others, or why they should be involved in this work. We see an opportunity to build and strengthen the existing network of individuals, organizations, and institutions committed to promoting health and mental health equity—work that is also strongly linked to addressing the social determinants of health. Working to address the social determinants of health includes working to broadly improve the economic, service, and built environments in which people live, work, learn, and play. To expand this network, we must understand who is already engaged in this work and reach out to those who have a potential interest in engaging in it. In order to be both motivated and successful in reducing the inequities caused by the social determinants of health, partners need access to one another, models that work, and data that is relevant and user friendly. They also need as much support as they can get in building their capacity to effectively implement and sustain their interconnected, mutually advancing infrastructures.

Assessment

Readily available assessment data, including what interventions work under what circumstances, is vital to the implementation of this plan. Research and case studies on evidence-based, evidence-informed, and community-based practices for reducing health and mental health disparities and inequities, as well as issue briefs, should be used to guide our efforts. Data that allows us to see disparities at the level of social determinants of health, and that is disaggregated in ways that make our often-invisible communities visible, has been hard to obtain but is vitally important. Failing to account for a community in data means missing the opportunity to understand and address that community's unique challenges, needs, and assets. Although there are a number of major surveys conducted to help us understand our health challenges, such as the American Community Survey and the California Health Interview Survey, not all groups are covered by these surveys. There are particular data challenges for small communities and overlooked groups (e.g., LGBTQQ, people with disabilities, multiracial individuals), and our aim is to increase the availability of this disaggregated data.

In addition to collecting meaningful data, it is important to deliver data in a way that is accessible and understandable to multiple audiences, including various communities, policy makers, and health industry partners. Both qualitative and quantitative data are valuable, and we intend to capture and present both in order to best tell the story of the disparities and inequities that exist and how we are addressing them.

The Healthy Places Team in the Office of Health Equity will continue to build the Healthy Communities Data and Indicators Project (HCI). The goal of the HCI is to enhance public health by providing data, a standardized set of statistical measures, and tools that a broad array of sectors can use for planning healthy communities and by evaluating the impact of plans, projects, policies, and environmental changes on community health. With funding from the Strategic Growth Council (SGC), the HCI was initiated as a two-year collaboration of the California Department of Public Health (CDPH) and the University of California, San Francisco (UCSF), to pilot the creation and dissemination of indicators linked to the Healthy Communities Framework ("Framework"). The Framework was developed by the California Health in All Policies Task Force, with extensive public discussion and input from community stakeholders and public health organizations. The Framework identifies 20 key attributes of a healthy community (of 60 total), clustered in five broad categories: 1) basic needs of all (housing, transportation, nutrition, health care, livable communities, physical activity); 2) environmental quality and sustainability; 3) adequate levels of economic and social development; 4) health and social equity; and 5) social relationships that are supportive and respectful. Indicators are associated with each attribute, and the goal is to present the

data for each indicator for local assessment and planning down to the census tract or zip code wherever possible. CDPH will continue the work beyond the two-year collaboration as existing resources allow.

Communication

Health and mental health equity are new concepts for many – communicating what they are and what they are not to multiple sectors and fields will have major implications moving forward. The same will be true for communicating about the Office of Health Equity and the California Statewide Plan to Promote Health and Mental Health Equity. There has already been much discussion about how to communicate the strategies and for whom the Plan is intended. Ultimately a goal was added to create a comprehensive marketing and communications plan, which will address the many questions that have surfaced and inspired rich dialogue.

Communication plays a meaningful role overall and is particularly important in each of the three intervention targets – health partners, health field, and communities. While these goals are intended to stand alone, the proposed website and issue briefs will be important components of the marketing and communications plan. They will be successful when they reach their target audience with timely, accurate, actionable information. Actions may include utilizing data for decision making, replicating a promising practice, or joining others to move a particular issue forward.

So that these efforts are not taking place in isolation, we will seek to coordinate and convene those involved. We will capitalize on technology and on face-to-face interaction, utilizing the communication avenues that have already been established, such as summits and forums, and building new ones as necessary. California is a vast state, and we want everyone to be included in these efforts, so special attention will be paid to reaching the corners of the state and the individuals and communities that have historically been challenged to participate in statewide dialogue and action.

Infrastructure

We envision a robust, statewide community of people engaged in conducting their work and advocating for their needs through a health and mental health equity lens. Our vision is to have a workforce with the capacity to effectively dismantle health and mental health inequities. This will require education, training, guidance, support, and accountability at multiple levels throughout multiple sectors. It will also require strong partnerships to leverage the resources, tools, and incentives to facilitate such workforce development. We intend to bring together partners in the national, state, local, tribal, and private spheres to consider how we can capitalize on our expertise and resources to accomplish this common vision. We see opportunities for further embedding health and mental health equity outcomes into funding criteria and accompanying technical assistance.

We also see opportunities for California to benefit from the implementation efforts under way through the U.S. Department of Health and Human Services' Action Plan to Reduce Racial and Ethnic Health Disparities and other plans and entities that are addressing the needs of historically underserved communities. Many of these efforts have resources connected to the shared vision of workforce development; monitoring them and seeking a role for California and its communities will allow us to align with national and other efforts and to leverage resources when available.

Strategic Intervention Target: Health Partners

Embed Health and Mental Health Equity into Institutional Policies and Practices Across Fields with Potential Health Partners

In order to advance health and mental health equity, our work will extend beyond the traditional boundaries of public health and health care to address the other factors that contribute to overall health. These factors include educational attainment, income, housing, safe places, and clean environments. Fortunately, this work has begun with many willing partners, and many more will have the opportunity to engage. We will identify the equity practices currently being conducted across a spectrum of fields and work with both existing and new partners.

At the level of state government, exciting work is being done with the Health in All Policies (HiAP) Task Force created administratively in 2010 and accountable to the Strategic Growth Council. Pending available resources, the Office of Health Equity helps staff the HiAP Task Force in partnership with the Public Health Institute, with primary funding from The California Endowment. The HiAP Task Force is specifically identified in the statute that created the Office of Health Equity (California Health and Safety Code Section 131019.5), naming it as a partner in the creation of this statewide plan.

We will foster a HiAP approach to embed health equity criteria in decision making, grant programs, guidance documents, and strategic plans.

A key area for dialogue and action that will require the cooperation of interests across a spectrum of fields is climate change.[1] We anticipate that the most profound consequences of climate change will disproportionately impact the state's most vulnerable populations.[2] As such, we will engage in partnerships to enhance understanding of climate change and its impact on the health of Californians. There are opportunities through the Climate and Health Team in the Office of Health Equity to incorporate health equity into the state's Climate Action Team, share data and tools, and participate in cross-sector planning and consultation.

Strategic Intervention Target: Health Field

Embed Equity into Institutional Policies and Practices across the Health Field

Promoters of health and mental health equity abound throughout the health field, and they are among the first to identify the challenges in their own field. Equity policies and practices are not consistent, and learning still needs to take place around the social determinants of health and the National Culturally and Linguistically Appropriate Services (CLAS) Standards. We will take stock of the equity policies and practices in the field to determine how widespread they are, providing a basis for subsequent engagement.

California Health and Human Services (CHHS) oversees departments, boards, and offices that provide a wide range of health care services, social services, mental health services, alcohol and drug treatment services, public health services, income assistance, and services to people with disabilities. Initially, we will facilitate a common understanding of health and mental health equity and the social determinants of health between the departments, boards, and offices within CHHS and then extend that conversation to health, behavioral health, and social services departments

outside of the state system. Awareness may be raised through film or speaker series, online learning communities, in-person and online trainings, or other mechanisms. The OHE Climate and Health Team will be a natural resource to engage in this outreach.

There is also an opportunity to synchronize our efforts with the National CLAS Standards, which were enhanced in 2013 to move toward a health equity model inclusive of health and health care. We envision widespread assessment, technical assistance, and training to align California's practitioners with the National CLAS Standards. This attention to cultural and linguistic competence will strengthen the capacity of organizations, institutions, and systems to assess, plan, implement, evaluate, and communicate their efforts.

The health field is changing dramatically with the implementation of the Affordable Care Act (ACA), a historic health care reform law designed to improve health care coverage and access while putting in place new protections for people who already have health insurance. Under the law, health insurance coverage is becoming affordable and accessible for millions of California residents, a factor that will help reduce health disparities. The United States' foreign-born population is currently over 2.5 times more likely than native-born Americans to be uninsured. The ACA has expanded health care coverage to certain refugees and documented immigrants.[3] However, we anticipate that health coverage disparities will increase for California residents who are undocumented immigrants, and it is possible that the disparities will widen also for those residing in mixed-status households, who may fear triggering immigration investigations upon ACA enrollment. We intend to explore how to maximize coverage opportunities for California's residents while assisting those who will remain uninsured. There is great potential for partnering with health plans to pursue innovations in this area.

Strategic Intervention Target: Communities

Empower Communities in Inequity and Disparity Reduction Initiatives

Tremendous work in reducing formal and informal inequities and disparities is being conducted throughout the state, in organizations and communities large and small, rural and urban. We will gain a better understanding of this work so that it can be networked, spotlighted, elevated, and replicated. Communities that have identified effective ways to reduce inequities and disparities have much to share, and the entire state has much to learn from their successes–including how they are resourced, how they are building local capacity for sustainability, and how they are measuring their success. Our vision is to integrate these lessons statewide and to identify the partnerships and available resources that will allow that to happen.

One exciting possibility is the launch of local initiatives to increase health and mental health equity in all policies. These initiatives could build upon local, state, and national efforts to ensure that their local policies consider equity and the social determinants of health. This would be an opportunity to build alliances across local public health departments, county mental health or behavioral health departments, local social services, local mental health agencies, and other local agencies that address key health determinants, including but not limited to housing, transportation, planning, education, parks, and economic development. We have heard from stakeholders that these alliances have been difficult to forge because it is hard to make the case for common interests in a way that can be easily understood and appreciated. With this in mind, we intend to explore the feasibility of local initiatives inspired by HiAP approaches. Ideally, we will establish avenues for learning from the lessons of existing local efforts and enlist them in technical assistance for their colleagues statewide.

Such HiAP-inspired initiatives might draw from the experiences of place-based models established in other states. The Division of Community, Family Health, and Equity at the Rhode Island Department of Health has created a model for cross-program integration that includes pooled community investment grants in high-need communities called Health Equity Zones, each with a Center for Health Equity and Wellness. The model includes a statewide Healthy Places Learning Collaborative, with web-based resources, tools, and on-site technical assistance for communities; uniform contract language for all health contracts to communicate expectations for implementation of health equity work; a collaborative network of state/local stakeholders from multiple coalitions and interest groups doing cross-program, state-level strategic thinking; and an online relational mapping database of community assets and gaps to ensure that investments and partnerships result in the greatest reach and impact. We intend to further research Health Equity Zones and other place-based models to assess the feasibility of replicating them in high-need California communities.

To immediately mobilize resources to reduce health and mental health disparities, we will initially act through the California Reducing Disparities Project (CRDP) within the Office of Health Equity. CRDP Phase 2 provides $60 million dollars in Mental Health Services Act (MHSA) funding over five years to implement the practices and strategies identified in the CRDP Strategic Plan. Phase 2's focus is to demonstrate the effectiveness of community-defined practices in reducing mental health disparities. Through a multicomponent program, the California Department of Public Health plans to fund selected approaches across the five CRDP-targeted populations with strong evaluation, technical assistance, and infrastructure support components. These populations are African Americans; Asians and Pacific Islanders; Latinos; Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQQ) individuals; and Native Americans. After successful completion of this multiyear investment in community-defined evidence, California will be in a position to better serve these communities and to provide the state and the nation a model to replicate the new strategies, approaches, and knowledge. As partnerships become available, we will further seek to mobilize resources at the community level.

Two priority areas that relate to the CRDP Strategic Plan and have been identified by a range of stakeholders throughout the state are 1) the possible extension of the California MHSA Multicultural Coalition beyond 2015 and its utilization as a major advisor to the Office of Health Equity regarding the CRDP, in addition to its other purposes; and 2) the possible creation of new Strategic Planning Workgroups (SPWs) in order to continue the critical work of identifying promising practices for underserved communities not covered by the original SPWs.

REFERENCES

EXECUTIVE SUMMARY

[1] U.S. Census Bureau. Table S1701: Poverty status in the past 12 months, American Community Survey 1-Year Estimates, California, 2012. American Community Survey. http://factfinder2.census.gov. Accessed April 2014.

[2] University of California Los Angeles. Poverty level by race and ethnicity, gender and family type, 2011-2012. California Health Interview Survey. http://ask.chis.ucla.edu/main/default.asp. Accessed January 2015.

[3] U.S. Census Bureau. Table S2401: Occupation by sex and median earnings in the past 12 months (in 2011 inflation-adjusted dollars) for the civilian employed population 16 years and over, American Community Survey 5-Year Estimates, California, 2007-2011. American Community Survey. http://factfinder2.census.gov. Accessed April 2014.

[4] University of California Los Angeles. Physical or sexual violence by an intimate partner since age 18 among women aged 18 and over, by race and ethnicity and marital status, 2009. California Health Interview Survey. http://ask.chis.ucla.edu/main/default.asp. Accessed January 2015.

[5] The University of California Statistical Summary of Students and Staff. University of California, Office of the President, Department of Information Technology Services; fall 2013.

[6] California State University Statistical Reports 2013-14, Fall 2013. The California State University Website. http://www.calstate.edu/as/stat_reports/2013-2014/index.shtml. Accessed April 2015.

[7] University of California Los Angeles. Suspended Education in California. 2012. The Civil Rights Project. http://civilrightsproject.ucla.edu/resources/projects/center-for-civil-rights-remedies/school-to-prison-folder/summary-reports/suspended-education-in-california/SuspendedEd-final3.pdf. Accessed April 2015.

[8] My Brother's Keeper Task Force Report to the President. 2014. https://www.whitehouse.gov/sites/default/files/docs/053014_mbk_report.pdf. Accessed April 2015.

[9] California Birth and Death Statistical Master Files, 2000-2010. Prepared by the Epidemiology, Assessment and Program Development Branch, Maternal, Child and Adolescent Program, Center for Family Health. http://www.cdph.ca.gov/data/statistics/Documents/MO-MCAH-StatewideInfantMortalityData.pdf.

[10] Collins JW Jr., David RJ, Handler A, Wall S, Andes S. Very low birthweight in African American infants: the role of maternal exposure to interpersonal racial discrimination. Am J Public Health. 2004;94:2132-2138.

[11] Elder TE, Goddeeris JH, Haider SJ, Paneth N. The changing character of the black-white infant mortality gap, 1983-2004. Am J Public Health. 2014;104(S1):S105-S111.

[12] Mikalson P, Pardo S, Green J. First, Do No Harm: Reducing Disparities for Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Populations in California – The California LGBTQ Reducing Mental Health Disparities Population Report. California Department of Public Health, Office of Health Equity, Mental Health America of Northern California, and Equality California Institute; December 2012.

[13] California Health and Safety Code Section 131019.5.

INTRODUCTION AND BACKGROUND

[1] Mapping diversity in the United States. Beyond Diversity Resource Center website. http://www.beyonddiversity.org/. Accessed May 2014.2 Lopez MH. In 2014, Latinos will surpass whites as largest racial/ethnic group in California. Pew Research Center. http://www.pewresearch.org/fact-tank/2014/01/24/in-2014-latinos-will-surpass-whites-as-largest-racialethnic-group-in-california/. Published January 24, 2014.

[3] Lofquist D, Lugaila T, O'Connell M, Feliz S. Households and Families: 2010 Census Briefs. U.S. Census Bureau, U.S. Department of Commerce, Economics and Statistics Administration; 2012.

[4] Shin HB, Kominski RA. Language Use in the United States: 2007. American Community Survey Reports. U.S. Census Bureau, U.S. Department of Commerce, Economics and Statistics Administration; 2010.

[5] Kallick DD. Immigrant Small Business Owners: A Significant and Growing Part of the Economy. A Report From the Fiscal Policy Institute's Immigration Research Initiative. Latham, NY: Fiscal Policy Institute, Immigration Research Initiative; June, 2012.

[6] Small business profile: California. U.S. Small Business Administration, Office of Advocacy website. http://www.sba.gov/sites/default/files/files/ca10.pdf. Published February 2011.

[7] Waldman M. Hispanic consumer market in the U.S. is larger than the entire economies of all but 13 countries in the world, according to annual UGA Selig Center Multicultural Economy study. University of Georgia, Terry College of Business website. http://www.terry.uga.edu/news/releases/hispanic-consumer-market-in-the-u.s.-is-larger-than-the-entire-economies-of#. Published May 1, 2012.

[8] The economic benefits of fixing our broken immigration system: Impacts for California families. The White House Website. http://www.whitehouse.gov/sites/default/files/docs/state-reports/The%20Economic%20Benefits%20of%20Fixing%20Our%20Broken%20Immigration%20System_California.pdf. Accessed May 2014.

[9] Hipp JR, Basolo V, Boarnet M, Houston D. Southern California Regional Progress Report. Irvine, CA: University of California Irvine, School of Social Ecology, Metropolitan Futures Initiative; June, 2012.

[10] California Department of Finance. Report P-1: Summary population projections by race/ethnicity and by major age groups, 2010-2060 – Population projections press release. http://www.dof.ca.gov/research/demographic/reports/projections/. Published January 31, 2013.

[11] Social Science Research Council. Human Development (HD) Index and supplemental indicators by state, 2013-2014 dataset. Measure of America Website. http://www.measureofamerica.org/california/. Access April 2014.

[12] Peck C, Logan J, Maizlish N, Court JV. The California Burden of Chronic Disease and Injury Report. Sacramento, CA: California Department of Public Health, Center for Chronic Disease Prevention and Health Promotion; 2013.

[13] What are social determinants of health? World Health Organization Website. http://www.who.int/social_determinants/sdh_definition/en/. Updated May 7, 2013.

[14] Tarlov AR. Public policy frameworks for improving population health. *Ann N Y Acad Sci.* 1999;896:281-93.

[15] Iton A. Tackling the root causes of health disparities through community capacity building. In: Hofrichter R, ed. Tackling Health Inequities Through Public Health Practice: A Handbook for Action. Washington, DC, and Lansing, MI: National Association of County and City Health Officials and Ingham County Health Department; 2006:116-136.

[16] Shapiro T, Meschede T, Osoro S. The Roots of the Widening Racial Wealth Gap: Explaining the Black-White Economic Divide. Waltham, MA: Brandeis University, Institute on Assets and Social Policy; February 2013.

[17] Tippett R, Jones-DeWeever A, Rockeymoore M, Hamilton D, Darity W. Beyond Broke: Why Closing the Racial Wealth Gap Is a Priority for National Economic Security. Washington, DC, and Durham, NC: Center for Global Policy Solutions and Duke University, Research Network on Racial and Ethnic Inequality at the Social Science Research Institute; May 2014.

[18] Rudolph L, Caplan J, Ben-Moshe K, Dillon L. Health in All Policies: A Guide for State and Local Governments. Washington, DC, and Oakland, CA: American Public Health Association and Public Health Institute; 2013.

[19] Rudolph L, Caplan J, Mitchell C, Ben-Moshe K, Dillon L. *Health in All Policies: Improving Health Through Intersectoral Collaboration.* Paper presented at Institute of Medicine Roundtable on Population Health Improvement; September 2013.

[20] Constitution of the World Health Organization. New York, NY: World Health Organization; 1948.

[21] The Universal Declaration of Human Rights 1948. United Nations Website. http://www.un.org/en/documents/udhr/. Accessed May 2014.

[22] Satcher D. The Initiative to Eliminate Racial and Ethnic Health Disparities is moving forward. Public Health Rep. 1999;114(3):283-287.

[23] About Healthy People: Overarching goals. Healthy People 2020 Website. http://www.healthypeople.gov/2020/about/default.aspx. Updated June 6, 2014.

[24] OECD health data 2013: How does the United States compare? The Organization for Economic Co-operation and Development (OECD) Website. http://www.oecd.org/unitedstates/Briefing-Note-UNITED-STATES-2014.pdf. Updated October 2013.

[25] LaVeist TA, Gaskin D, Richard P. Estimating the economic burden of racial health inequalities in the United States. Int J Health Serv. 2011;41(2):231-238.

[26] National Health Expenditure Data. Baltimore, MD: U.S. Centers for Medicare and Medicaid Services. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf. Published January 2013.

[27] Galea S, Tracy M, Hoggatt KJ, Dimaggio C, Karpati A. Estimated deaths attributable to social factors in the United States. Am J Public Health. 2011;101(8):1456-1465.

[28] California Health and Safety Code Section 131019.5.

THE SOCIAL DETERMINANTS SHAPING THE HEALTH OF CALIFORNIA'S PEOPLE AND PLACES

[1] What are social determinants of health? World Health Organization Website. http://www.who.int/social_determinants/sdh_definition/en/. Updated May 7, 2013.

INCOME SECURITY

[1] Link BG, Phelan J. Social conditions as fundamental causes of disease. J Health Soc Behav. 1995;35(Extra Issue):80-94.

[2] Holzer HJ, Schanzenbach DW, Duncan GJ, Ludwig J. The economic costs of poverty in the United States. *J Child Poverty.* 2008;14(1):41-61.

[3] Bohn S, Schiff E. The Great Recession and Distribution of Income in California. San Francisco, CA: Public Policy Institute of California; 2011.

[4] Short K. *The Research Supplemental Poverty Measure: 2011.* U.S. Census Bureau, U.S. Department of Commerce, Economics and Statistics Administration; November 2012.

[5] U.S. Census Bureau. Table S2401: Occupation by sex and median earnings in the past 12 months (in 2011 inflation-adjusted dollars) for the civilian employed population 16 years and over, American Community Survey 5 Year Estimates, California, 2007-2011. American Community Survey. http://factfinder2.census.gov. Accessed April 2014.

[6] Population Reference Bureau (PRB) analysis of U.S. Census Bureau, American Community Survey (ACS) 2011, provided by PRB to Children Now August 2013.

[7] Kahn RS, Wise PH, Kennedy BP, Kawachi I. State income inequality, household income, and maternal mental and physical health: cross sectional national survey. BMJ. 2000;321(7272):1311-1315.

[8] Adler NE, Newman K. Socioeconomic disparities in health: pathways and policies. Health Affairs. 2002;21(2):60-76.

[9] Kondo N, Sembajwe G, Kawachi I, van Dam RM, Subramanian SV, Yamagata Z. Income inequality, mortality, and self rated health: meta-analysis of multilevel studies. *BMJ*. 2009;339:b4471.

[10] Hart B, Risley TR. The early catastrophe: the 30 million word gap by age 3. American Educator. Spring 2003.

[11] Murali V, Oyebode F. Poverty, social inequality and mental health. Adv Psychiatr Treat. 2004;10:216-224.

FOOD SECURITY AND NUTRITION

[1] De Schutter O (United Nations Special Rapporteur). Final Report: The Transformative Potential of the Right to Food. General Assembly, United Nations; January 2014.

[2] Coleman-Jensen A, Nord M, Singh A. *Household Food Security in the United States in 2012, ER-155.* U.S. Department of Agriculture, Economic Research Service; September 2013.

[3] Karpilow KA, Reed DF, Chamberlain PT, Shimada T. Primer module on food insecurity. In: Understanding Nutrition: A Primer on Programs and Policies in California. 2nd ed. Sacramento, CA: California Center for Research on Women and Families, Public Health Institute; October 2011.

[4] Tarasuk VS. Household food insecurity with hunger is associated with women's food intakes, health and household circumstances. *J Nutr.* 2001;131(10):2670-2676.

[5] Laraia BA, Siega-Riz AM, Gundersen C. Household food insecurity is associated with self-reported pregravid weight status, gestational weight gain, and pregnancy complications. *J Am Diet Assoc.* 2010;110(5):692-701.

[6] Whitaker RC, Phillips SM, Orzol SM. Food insecurity and the risks of depression and anxiety in mothers and behavior problems in their preschool-aged children. *Pediatrics.* 2006;118(3):e859-868.

[7] Heflin CM, Siefert K, Williams DR. Food insufficiency and women's mental health: findings from a 3-year panel of welfare recipients. *Soc Sci Med.* 2005;61(9):1971-1982.

[8] Weinreb L, Wehler C, Perloff J, et al. Hunger: its impact on children's health and mental health. *Pediatrics.* 2002;110(4):e41.

[9] Kursmark M, Weitzman M. Recent findings concerning childhood food insecurity. *Curr Opin Clin Nutr Metab Care.* 2009;12:310-316.

[10] Slack KS, Yoo J. Food hardship and child behavior problems among low-income children. *Soc Serv Rev.* 2005;79:511–536.

[11] Rose-Jacobs R, Black MM, Casey PH, et al. Household food insecurity: associations with at-risk infant and toddler development. *Pediatrics.* 2008;121:65-72.

[12] Heinig MJ, Dewey KG. Health advantages of breastfeeding for infants: a critical review. *Nutr Res Rev.* 1996;9:89-110.

[13] Winicki J, Jemison K. Food insecurity and hunger in the kindergarten classroom: its effect on learning and growth. *Contemp Econ Policy.* 2003;21(2):145-157.

[14] Alaimo K, Olson CM, Frongillo EA Jr. Food insufficiency and American school-aged children's cognitive, academic, and psychosocial development. *Pediatrics.* 2001;108(1):44-53.

[15] Harrison GG, Manalo-LeClair G, Ramirez A, et al. *More Than 2.9 Million Californians Now Food Insecure – One in Three Low-Income, An Increase in Just Two years.* Los Angeles, CA: UCLA Center for Health Policy Research; June 2005.

[16] Ploeg MV, Breneman V, Dutko P, et al. *Access to Affordable and Nutritious Food: Updated Estimates of Distance to Supermarkets Using 2010 Data, ERR-143.* Washington, DC: U.S. Department of Agriculture, Economic Research Service; November 2012.

[17] Moore LV, Diez Roux AV, Nettleton JA, Jacobs DR Jr. Associations of the local food environment with diet quality – A comparison of assessments based on surveys and geographic information systems: the multi-ethnic study of atherosclerosis. *Am J Epidemiol.* 2008;167(8):917-924.

[18] *Searching for Healthy Food: The Food Landscape in California Cities and Counties*. Davis, CA, and La Puente, CA: California Center for Public Health Advocacy; January 2007.

CHILD DEVELOPMENT AND EDUCATION

[1] 2020 topics and objectives: Early and middle childhood. Healthy People 2020 Website. http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=10. Updated May 18, 2014.

[2] Heckman JJ, Moon SH, Pinto R, Savelyev PA, Yavitz A. The rate of return to the High/Scope Perry Preschool Program. *J Public Econ.* 2010;94(1-2):114-128.

[3] Burchinal P, Kainz K, Cai K, et al. Early Care and Education Quality and Child Outcomes. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Child Trends from the Office of Planning, Research, and Evaluation; May 2009.

[4] University of California Los Angeles. Poverty level by age groups, 2011-2012. California Health Interview Survey. http://ask.chis.ucla.edu/main/default.asp. Accessed June 2014.

[5] Governor's State Advisory Council on Early Learning and Care. California Comprehensive Early Learning Plan. Sacramento, CA: California Department of Education, Child Development Division; 2013.

[6] California Department of Education. Standardized Testing and Reporting (STAR) results, 2013. Analysis by www.kidsdata.org, a program of the Lucile Packard Foundation for Children's Health. HYPERLINK "http://www.kidsdata.org/topic" \l "cat=18,25" http://www.kidsdata.org/topic#cat=18,25. Accessed May 2014.

[7] California Department of Education, Data Reporting Office. California Longitudinal Pupil Achievement Data System (CALPADS): Graduation data, cohort outcome summary report by race/ethnicity for the class of 2011-2012. http://dq.cde.ca.gov/dataquest/. Updated August 11, 2013. Accessed April 2014.

[8] High school dropout rates. Child Trends Data Bank Website. http://www.childtrends.org/?indicators=high-school-dropout-rates. Updated September 2013.

[9] Alliance for Excellent Education. The High Cost of High School Dropouts: What the Nation Pays for Inadequate High Schools. Washington, DC: Alliance for Excellent Education; November 2011.

[10] Stages of growth child development: Early childhood (birth to eight years), middle childhood (eight to twelve years). Education Encyclopedia Website. http://education.stateuniversity.com/pages/1826/Child-Development-Stages-Growth.html#ixzz0j0jMHgRB. Accessed April 2014.

HOUSING

[1] Housing and health. California Department of Housing and Community Development Website. http://www.hcd.ca.gov/hpd/docs/pb01housing_healthpp0214.pdf. Published September 2013.

[2] Housing and family economic well-being. California Department of Housing and Community Development Website. http://www.hcd.ca.gov/hpd/docs/pb02housing_economic_well_being0214.pdf. Published September 2013.

[3] Wilson E, Callis RR. *Who Could Afford to Buy a Home in 2009? Affordability of Buying a Home in the United States: Current Housing Reports*. U.S. Census Bureau, U.S. Department of Commerce, Economics and Statistics Administration; May 2013.

[4] Market data, Housing Affordability Index (HAI) – Traditional. California Association of Realtors Website. http://www.car.org/marketdata/data/haitraditional/. Accessed May 2014.

[5] The State of Housing in California 2014 update - Affordability worsens, supply problems remain. California Department of Housing and Community Development Website. http://www.hcd.ca.gov/hpd/shp/web_hcd_stateofhousing_april2014.pdf. Updated April 2014.

[6] Lipman BJ. Something's Gotta Give: Working Families and the Cost of Housing. New Century Housing (volume 5, issue 2). Washington, DC: Center for Housing Policy; April 2005.

[7] Bocian DG, Li W, Ernst KS. *Foreclosures by Race and Ethnicity: The Demographics of a Crisis.* Durham, NC, Oakland, CA, and Washington, DC: Center for Responsible Lending; June 2010.

[8] Ellen IG, Dastrup S. *Housing and the Great Recession.* Stanford, CA: Stanford Center on Poverty and Inequality; October 2012.

[9] Henry M, Cortes A, Morris S. *The 2013 Annual Homeless Assessment Report (AHAR) to Congress, Part 1, Point-in-Time Estimates of Homelessness.* U.S. Department of Housing and Urban Development, Office of Community Planning and Development; 2013.

ENVIRONMENTAL QUALITY

[1] Faust J, August LM, Alexeeff G, et al. *California Communities Environmental Health Screening Tool, Version 1.1 (CalEnviroScreen 1.1).* California Environmental Protection Agency, Office of Environmental Health Hazard Assessment; September 2013.

[2] American Lung Association. State of the Air 2014. Chicago, IL: American Lung Association; 2014.

[3] Shonkoff SB, Morello-Frosch R, Pastor M, Sadd J. Environmental Health and Equity Impacts From Climate Change and Mitigation Policies in California: A Review of the Literature. California Climate Change Center; August 2009.

[4] Melillo JM, Richmond TC, Yohe GW, eds. Climate Change Impacts in the United States: The Third National Climate Assessment. Washington, DC: U.S. Global Change Research Program; 2014.

[5] Blaisdell RJ. *Air Toxics Hot Spots Program Risk Assessment Guidelines. Technical Support Document for Exposure Assessment and Stochastic Analysis.* Oakland, CA: California Environmental Protection Agency, Office of Environmental Health Hazard Assessment; August 2012.

[6] Woodruff TJ, Axelrad DA, Kyle AD, Nweke O, Miller GG. America's Children and the Environment: Measures of Contaminants, Body Burdens, and Illness. 2nd ed. Washington, DC: United States Environmental Protection Agency; February 2003.

[7] Pacific Southwest, Region 9, children and asthma: California U.S. Environmental Protection Agency Website. http://www.epa.gov/region9/childhealth/asthma-california.html. Updated July 30, 2013.

[8] Wolstein J, Meng YY, Babey SH. Income Disparities in Asthma Burden and Care in California. Los Angeles, CA: UCLA Center for Health Policy Research; December 2010.

BUILT ENVIRONMENT

[1] Designed for Disease: The Link Between Local Food Environments and Obesity and Diabetes. UCLA Center for Health Policy Research, PolicyLink, and California Center for Public Health Advocacy; April 2008.

[2] Mission, Vision, Goals, Values. California Department of Transportation Website. http://www.dot.ca.gov/hq/paffairs/about/mission.htm. Accessed October 2014.

[3] Frumkin H. Urban sprawl and public health. Public Health Rep. 2002;117(3):201-217.

[4] Committee on Environmental Health. The built environment: designing communities to promote physical activity in children. Pediatrics. 2009; 123(6), 1591-1598.

[5] Doyle S, Kelly-Schwartz A, Schlossberg M, et al. Active community environments and health: the relationship of walkable and safe communities to individual health. *J Am Plann Assoc.* 2006;72:19-31.

[6] Saelens BE, Sallis JF, Frank LD. Environmental correlates of walking and cycling: findings from the transportation, urban design, and planning literatures. Ann Behav Med. 2003;25:80.

[7] Maizlish N, Woodcock J, Co S, Ostro B, Fanai A, Fairley D. Health cobenefits and transportation-related reductions in greenhouse gas emissions in the San Francisco Bay area. Am J Public Health. 2013;103(4):703-709.

[8] Frumkin H. Guest editorial: health, equity, and the built environment. Environ Health Perspect. 2005;113(5):A290–A291.

HEALTH CARE ACCESS AND QUALITY OF CARE

[1] Healthy People 2020 leading health indicators: Access to health services. Healthy People 2020 Website. http://healthypeople.gov/2020/lhi/HP2020_LHI_Acc_Hlth_Svcs.pdf. Updated May 2014.

[2] 2020 topics and objectives: Access to health services. Healthy People 2020 Website. http://www.healthypeople.gov/2020/LHI/accessCare.aspx?tab=data#AHS-1.1. Updated June 21, 2014.

[3] Escarce JJ. Racial and Ethnic Disparities in Access to and Quality of Health Care. Robert Wood Johnson Foundation, The Synthesis Project, Robert Wood Johnson Foundation; September 2007.

[4] Covered California's second open enrollment yields strong numbers; nearly 500,000 new consumers sign up for health plans. Covered California Daily News Website. http://news.coveredca.com/2015/03/covered-californias-second-open.html. Published March 5, 2015.

[5] Cordasco KM, Ponce NA, Gatchell MS, Traudt B, Escarce JJ. English language proficiency and geographical proximity to a safety net clinic as a predictor of health care access. *J Immigr Minor Health.* 2011;13(2):260-267.

[6] Lavarreda SA, Cabezas L, Jacobs K, Roby DH, Pourat N, Kominski GF. The State of Health Insurance in California: Findings from the 2009 California Health Interview Survey. Los Angeles, CA: UCLA Center for Health Policy Research; February 2012.

[7] Schoen C, Radley D, Riley P, et al. Health Care in the Two Americas (Executive Summary): Findings From the Scorecard on State Health System Performance for Low-Income Population. The Commonwealth Fund;September 2013.

[8] Racial and Ethnic Disparities in Healthcare in California: California Fact Book 2010. Sacramento, CA: California Office of Statewide Health Planning and Development; winter 2010.

CLINICAL AND COMMUNITY PREVENTION STRATEGIES

[1] Preventive Care: A National Profile on Use, Disparities, and Health Benefits. Washington, DC: National Commission on Prevention Priorities, Partnership for Prevention; August 2007.

[2] *National Prevention Council. National Prevention Strategy: Elimination of Health Disparities*. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General; June 2011.

[3] California Cancer Registry fact sheet: Breast cancer. California Department of Public Health Website. http://www.ccrcal.org/pdf/Factsheets/BreastFactSheet_130913.pdf. Accessed May 2014.

[4] 2020 topics and objectives: Immunization and infectious diseases. Healthy People 2020 Website. http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=23. Updated June 12, 2014.

[5] Immunization and health checkup – CalEDFacts. California Department of Education Website. http://www.cde.ca.gov/ls/he/hn/cefimmunization.asp. Updated September 16, 2013.

[6] 2014 recommended immunizations for children from birth through 6 years old. Centers for Disease Control and Prevention Website. http://www.cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf. Published January 2014.

[7] Ip S, Chung M, Raman G, et al. Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries. Evidence Report/Technology Assessment No. 153 (Prepared by Tufts-New England Medical Center Evidence-based Practice Center, under Contract No. 290-02-0022). AHRQ Publication No. 07-E007. Rockville, MD: Agency for Healthcare Research and Quality; April 2007.

[8] Quigley MA, Kelly YJ, Sacker A. Breastfeeding and hospitalization for diarrheal and respiratory infection in the United Kingdom Millennium Cohort Study. Pediatrics. 2007;119(4):837-842.

[9] *Maternal and Infant Health Assessment 2011*. Sacramento, CA: California Department of Public Health, Maternal, Child and Adolescent Health Program, Center for Family Health; 2014.

[10] Shealy KR, Li R, Benton-Davis S, Grummer-Strawn LM. The CDC Guide to breastfeeding interventions. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2005.

[11] Disparity Reducing Advances Project. The Imperative of Reducing Health Disparities Through Prevention: Challenges, Implications, and Opportunities. Oakland, CA: Prevention Institute; October 2006.

[12] Frank LD, Andresen MA, Schmid TL. Obesity relationships with community design, physical activity, and time spent in cars. Am J Prev Med. 2004;27(2):87-96.

[13] U.S. Department of Health and Human Services. Physical Activity and Health: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion; 1996.

EXPERIENCES OF DISCRIMINATION AND HEALTH

[1] Krieger N. Does racism harm health? Did child abuse exist before 1962? On explicit questions, critical science, and current controversies: an ecosocial perspective. *Am J Public Health.* 2003;93(2):194-199.

[2] Civil Rights Act (1964). Our Documents Website. http://www.ourdocuments.gov/doc.php?flash=true&doc=97. Accessed May 2014.

[3] Williams DR, Neighbors HW, Jackson JS. Racial/ethnic discrimination and health: findings from community studies. *Am J Public Health.* 2003;93(2):200-208.

[4] Pascoe EA, Richman LS. Perceived discrimination and health: a meta-analytic review. *Psychol Bull.* 2009;135(4):531-554.

[5] Grollman EA. Multiple disadvantaged statuses and health: the role of multiple forms of discrimination. *J Health Soc Behav.* 2014;55(1):3-19.

[6] Merritt MM, Bennett GG Jr., Williams RB, Edwards CL, Sollers JJ. Perceived racism and cardiovascular reactivity and recovery to personally relevant stress. Health Psycho. 2006;25(3):364-369.

[7] Smart Richman L, Pek J, Pascoe E, Bauer DJ. The effects of perceived discrimination on ambulatory blood pressure and affective responses to interpersonal stress modeled over 24 hours. Health Psychol. 2010;29(4):403-411.

[8] Cohen S, Schwartz JE, Epel E, Kirschbaum C, Sidney S, Seeman T. Socioeconomic status, race, and diurnal cortisol decline in the Coronary Artery Risk Development in Young Adults (CARDIA) study. Psychosom Med. 2006;68(1):41-50.

[9] Cooper DC, Mills PJ, Bardwell WA, Ziegler MG, Dimsdale JE. The effects of ethnic discrimination and socioeconomic status on endothelin-1 among blacks and whites. Am J Hypertens. 2009;22(7):698-704.

[10] Lewis TT, Aiello AE, Leurgans S, Kelly J, Barnes LL. Self-reported experiences of everyday discrimination are associated with elevated C-reactive protein levels in older African-American adults. Brain Behav Immun. 2010;24(3):438-443.

[11] Wyatt SB, Williams DR, Calvin R, Henderson FC, Walker ER, Winters K. Racism and cardiovascular disease in African Americans. *Am J Med Sci.* 2003;325(6):315-331.

[12] David RJ, Collins JW. Jr., Differing birth weight among infants of U.S.-born blacks, African-born blacks, and U.S.-born whites. New Engl J Med. 1997;337(17):1209-1214.

[13] Collins JW Jr., David RJ, Handler A, Wall S, Andes S. Very low birthweight in African American infants: the role of maternal exposure to interpersonal racial discrimination. *Am J Public Health.* 2004;94:2132-2138.

[14] Collins JW Jr., David RJ, Symons R, Handler A, Wall SN, Dwyer L. Low-income African American mother's perception of exposure to racial discrimination and infant birth weight. *Epidemiology.* 2000;11(3):337-339.

[15] National Research Council. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Full printed version. Washington, DC: The National Academies Press; 2003.

[16] Hate Crime in California 2003. Sacramento, CA: California Department of Justice, Division of California Justice Information Services, Bureau of Criminal Information and Analysis, Criminal Justice Statistics Center; 2003.

[17] Hate Crime in California 2013. Sacramento, CA: California Department of Justice, Division of California Justice Information Services, Bureau of Criminal Information and Analysis, Criminal Justice Statistics Center; 2013.

NEIGHBORHOOD SAFETY AND COLLECTIVE EFFICACY

[1] Rudolph L, Ca plan J, Ben-Moshe K, Dillon L. *Health in All Policies: A Guide for State and Local Governments.* Washington, DC, and Oakland, CA: American Public Health Association and Public Health Institute; 2013.

[2] Commission on Social Determinants of Health. Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health. Geneva, Switzerland: World Health Organization; 2008.

[3] Cubbin C, Pedregon V, Egerter S, Braveman P. Where We Live Matters for Our Health: Neighborhoods and Health. Robert Wood Johnson Foundation and Commission to Build a Healthier America; September 2008.

[4] Truman JL. *National Crime Victimization Survey: Criminal Victimization, 2010.* Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics; September 2011.

[5] Margolin G, Gordis EB. Children's exposure to violence in the family and community. *Curr Dir Psychol Sci.* 2004,13(4),152-155.

[6] Finkelhor D, Turner H, Ormrod R, Hamby S, Kracke K. *Children's Exposure to Violence: A Comprehensive National Survey.* Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention; October 2009.

[7] Anderson LM, Scrimshaw SC, Fullilove MT, Fielding JE, Task Force on Community Preventive Services. The Community Guide's model for linking the social environment to health. Am J Prev Med. 2003;24(3 Suppl):12-20.

CULTURAL AND LINGUISTIC COMPETENCE

[1] Clear communication: Cultural competency. National Institutes of Health Website. http://www.nih.gov/clearcommunication/culturalcompetency.htm. Updated June 3, 2014.

[2] Office of Minority Health Funding. U.S. Department of Health and Human Services Website. http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=34. Updated June 3, 2014

[3] The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice. U.S. Department of Health and Human Services, Office of Minority Health; 2013.

[4] *Providing Language Services for Limited English Proficient (LEP) Patients in California: Developing a Service System for the States.* The Medi-Cal Language Access Services (MCLAS) Taskforce; March 2009.

[5] U.S. Census Bureau. Table DP02: Selected social characteristics in California, 2008-2012, American Community Survey 5-Year Estimates. American Community Survey. http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml. Accessed April 2014.

[6] Healthcare Workforce Diversity Advisory Council. Diversifying California's Healthcare Workforce: An Opportunity to Address California's Health Workforce Shortages. Sacramento, CA: Office of Statewide Health Planning and Development; May 2008.

[7] Grumbach K, Odom K, Moreno G, Chen E, Vercammen-Grandjean C, Mertz E. Physician Diversity in California: New Findings from the California Medical Board Survey. San Francisco, CA: University of California San Francisco, Center for California Health Workforce Studies; March 2008.

[8] County of Los Angeles Department of Health Services Cultural and Linguistic Competency Standards Work Group. Cultural and Linguistic Competency Standards. Los Angeles, CA: Los Angeles County Department of Health Services, Office of Diversity Programs; 2003.

[9] Rodriguez F, Cohen A, Betancourt JR, Green AR. Evaluation of medical student self-rated preparedness to care for limited English proficiency patients. BMC Med Educ. 2011;11:26.

[10] Wilson E, Chen AH, Grumbach K, Wang F, Fernandez A. Effects of limited English proficiency and physician language on health care comprehension. J Gen Inten Med. 2005;20(9):800-806.

[11] National Research Council. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Full printed version. Washington, DC: The National Academies Press;

[12] Tucker CM, Marsiske M, Rice KG, Nielson JJ, Herman K. Patient-centered culturally sensitive health care: model testing and refinement. *Health Psychol.* 2011;30(3):342-350.

MENTAL HEALTH SERVICES

[1] Mental health: Strengthening our response fact sheet no. 220. World Health Organization Website. http://www.who.int/mediacentre/factsheets/fs220/en/. Updated April 2014.

[2] 2020 topics and objectives: Mental health and mental disorders. Healthy People 2020 Website. http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=28. Updated June 9, 2014.

[3] Peck C, Logan J, Maizlish N, Court JV. *The California Burden of Chronic Disease and Injury Report.* Sacramento, CA: California Department of Public Health, Center for Chronic Disease Prevention and Health Promotion; 2013.

[4] U.S. Department of Health and Human Services. Mental Health: Culture, Race, and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services; 2001.

[5] Holt W, Adams N. California Health Care Almanac. Mental Health Care in California: Painting a Picture. Oakland, CA: California HealthCare Foundation; July 2013.

[6] University of California Los Angeles. Teen needed help for emotional/mental health problems, and teen received psychological/emotional counseling in past year, compared by race/ethnicity, California, 2011-2012. California Health Interview Survey. http://ask.chis.ucla.edu/main/default.asp. Accessed April 2014.

[7] Aguilar-Gaxiola S, Loera G, Méndez l, Sala M, Nakamoto J, Latino Mental Health Concilio Community-Defined Solutions for Latino Mental Health Care Disparities: California Reducing Disparities Project, Latino Strategic Planning Workgroup Population Report. Sacramento, CA: UC Davis; June 2012.

THE CALIFORNIA STATEWIDE PLAN TO PROMOTE HEALTH AND MENTAL HEALTH EQUITY

[1] Luber G, Knowlton K, Balbus, et al. Human Health. In: Melillo JM, Richmond TC, Yohe GW, eds. *Climate Change Impacts in the United States: The Third National Climate Assessment.* Washington, DC: U.S. Global Change Research Program; 2014:220-256.

[2] Shonkoff SB, Morello-Frosch R, Pastor M, Sadd J. The climate gap: environmental health and equity implications of climate change and mitigation policies in California – a review of the literature. Clim Change. 2011;109(1):485-503.

[3] Kenney GM, Huntress M. *The Affordable Care Act: Coverage Implications and Issues for Immigrant Families.* Washington, DC: US Department of Health and Human Services, Office of Human Services Policy, Office of the Assistant.

HEALTH IN ALL POLICIES TASK FORCE

[1] Halter G, Hitchcock A, Kelly T. 2010 California Regional Progress Report. California Department of Transportation and California Strategic Growth Council; 2010.

Appendix A:
Goals to Support the Strategic Priorities

The following are the Plan's five-year strategic priorities:

> Through **assessment**, yield knowledge of the problems and the possibilities.

> Through **communication**, foster a shared understanding.

> Through **infrastructure** development, empower residents and their institutions to act effectively.

Goals for each of the strategic priorities were crafted for California overall as well as within the health field, among potential health partners, and within local communities, for Stage 1 (2015-2018) and Stage 2 (2018-2020) of the Plan. As an inaugural effort, goals have also been created aimed at building capacity for implementation of the strategic priorities.

The goals for both Stage 1 and Stage 2 are presented in the first matrix of this appendix. These goals are aspirational and will include substantial cross-sector collaboration.

We will strategize how to best implement the goals over time. The preliminary activities and resources planned by the California Department of Public Health for the implementation of Stage 1 goals are presented in the second matrix of this appendix.

KEY TO GOAL CODING:

STRATEGIES

A = Assessment
C = Communication
I = Infrastructure
CB = Capacity Building

TARGET AUDIENCES

O = Overall
HP = Health Partners
HF = Health Field
C = Communities

1 AND 2 FOLLOWING THESE CODES:

Stage 1 (2015-2018)
Stage 2 (2018-2020)

Numbers after the dot distinguish the goals from one another.

Stage 1 and Stage 2 Goals by Strategy and Target Audience

ASSESSMENT

Overall

AO1&2.1 Monitor continuously each of the goals to ensure that the Plan is progressing appropriately, and present updates at the quarterly Office of Health Equity Advisory Committee (OHE-AC) meetings and post a corresponding report online

AO1&2.2 Collect and analyze data that highlights the social determinants of health, and encourage this data for planning purposes

AO1.3 Assess health and mental health equity data shortcomings, and explore the feasibility of creating new data and/or disaggregating existing data

AO2.3 Build on Stage 1 by creating new data and/or disaggregating existing data, as feasible

Health Partners

AHP1.1 Identify the state's capacity to collect health and mental health equity practices in fields with potential health partners

Health Field

AHF1.1 Identify the health and mental health equity practices throughout state departments and state-funded programs in the health field

Communities

AC1.1 Identify how local communities are currently mobilizing to address the social determinants of health and how they are measuring their efforts toward progress

Stage 1 and Stage 2 Goals by Strategy and Target Audience

COMMUNICATION

Overall

CO1.1 Create a comprehensive marketing and communications plan for health and mental health equity, the Office of Health Equity, and the California Statewide Plan to Promote Health and Mental Health Equity

CO1.2 Build a network of communication and support for health and mental health equity work statewide, to include practitioners, community members, community-based organizations, consumers, family members/those with lived experience with mental health conditions, policy leaders, and other stakeholders

CO1&2.3 Develop, host, and regularly update an interactive, informative, and engaging state-of-the-art website with timely, accurate data; relevant research; and evidence-based and community-defined practices

CO1&2.4 Develop and disseminate issue briefs based on recommendations from the OHE-AC and other stakeholders

CO1&2.5 Provide leadership in sharing California's health and mental health equity efforts for adoption as appropriate throughout the state, nationally, and internationally

Health Partners

CHP1&2.1 Facilitate common understanding of health and mental health equity and the social determinants of health between potential health partner agencies and organizations

Health Field

CHF1.1 Facilitate common understanding of health and mental health equity and the social determinants of health between all departments that fall under California Health and Human Services (CHHS), while beginning this dialogue with key health-related state programs outside of CHHS

CHF1.2 Enhance understanding of and action on climate change as a critical public health issue that is likely to impact vulnerable populations in disparate ways

CHF2.1 Facilitate a common understanding of, and the ability to operationalize, health and mental health equity and the social determinants of health between all health, behavioral health, and social service departments inside and outside of the state system – and their grantees – through access to training, technical assistance, and leveraged funding relationships

Communities

CC1&2.1 Build broad-based community support on health and mental health equity issues through education and dialogue, heightening awareness of the social determinants of health

Stage 1 and Stage 2 Goals by Strategy and Target Audience

INFRASTRUCTURE

Overall

IO1&2.1 Partner on existing health and mental health equity summits for practitioners and policy makers

IO1&2.2 Catalyze workforce development opportunities aimed at increasing California's capacity to effectively address health and mental health inequities and disparities, starting with state employees and moving beyond the state system as resources and partnerships are secured

IO1&2.3 Recommend that health and mental health equity goals be considered during the allocation of existing funding streams

IO1&2.4 Closely monitor progress of the U.S. Department of Health and Human Services' Action Plan to Reduce Racial and Ethnic Health Disparities and of other health and mental health equity efforts that are addressing the needs of historically underserved communities, and seek opportunities to increase California's role and/or adopt successful models

IO1&2.5 Promote the use of a gender lens as appropriate when assessing health and mental health equity models to increase the likelihood of improving the often-distinct health needs of women and girls and of men and boys, particularly those of color and/or low income

IO2.6 Leverage the community support, relationships, and networks built in Stage 1 to coordinate impact on health and mental health equity issues statewide

Health Partners

IHP1&2.1 Use a Health in All Policies approach to embed health and equity criteria in decision-making, grant programs, guidance documents, and strategic plans

IHP1&2.2 Enhance understanding of climate change as a public health issue of increasing importance for the state's most vulnerable populations, and promote widespread efforts to reduce greenhouse gas emissions, achieve health co-benefits, and enhance climate resilience for vulnerable and disadvantaged communities

IHP2.3 Utilize results from the identification of health and mental health equity practices conducted in Stage 1 to make recommendations for addressing inequities and their social determinants in potential health partner practices

IHP2.4 Facilitate access to training and technical assistance for agencies and grantees of state programs on health and mental health equity, including incorporating health and mental health equity modules into current training provided by state and federal programs

Health Field

IHF1&2.1 Support the expansion of the National Culturally and Linguistically Appropriate Services (CLAS) Standards, including assessment, technical assistance, and training

IHF1.2 Explore health and mental health equity implications of the Affordable Care Act (ACA) as they relate to access, expanded coverage, and community-based prevention strategies

IHF2.2 Support health care institutions to partner with health allies (e.g., transportation and land use) to develop policies and programs that improve access to health, mental health, and health care services

IHF2.3 Utilize results from the exploration of health and mental health equity implications of the ACA conducted in Stage 1 to evaluate actionable next steps

Communities

IC1&2.1 Mobilize resources to reduce health and mental health inequities and disparities

IC1&2.2 Identify opportunities to build upon existing initiatives, implement new initiatives, replicate initiatives, and leverage local resources to increase health and mental health equity in all policies

IC1.3 Research Health Equity Zones and other place-based models to assess the feasibility of replicating or expanding such interventions at the neighborhood level in California

IC2.3 Increase the civic participation of the communities most impacted by health and mental health inequities and disparities

IC2.4 Incentivize, recognize, and publicize local efforts addressing health and mental health equity and the social determinants of health, both emerging and established

IC2.5 Connect local efforts with partners and resources to build health and mental health equity into strategic plans; train staff and volunteers; evaluate impact; and engage with funders, colleagues, and other communities

IC2.6 As feasible and appropriate, initiate or expand Health Equity Zones and/or other place-based models

Stage 1 and Stage 2 Implementation Goals

CB1&2.1. Build mechanisms for the OHE to establish ongoing public engagement and accountability on the strategic priorities, ensuring community participation in all goals at all levels of the Plan.

CB1&2.2. Strengthen the health and mental health equity workforce development pipeline by utilizing fellows and interns in the implementation of the strategic priorities, throughout the Plan's multiple partners.

CB1&2.3. Seek additional resources, including in-kind assistance, federal funding, and foundation support.

CB1&2.4. Develop and implement a process to foster public and private partnerships for all appropriate strategic priorities, including governmental, corporate, educational, research, and philanthropic institutions.

Stage 1 CDPH Preliminary Activities and Resources for Implementation

ASSESSMENT

Overall

AO1.1 Monitor continuously each of the goals to ensure that the Plan is progressing appropriately, and present updates at the quarterly Office of Health Equity Advisory Committee (OHE-AC) meetings and post a corresponding report online.

► The Supervisor for the OHE Health Research and Statistics Unit will provide leadership in further identifying the activities to support each of the goals for each of the target audiences in this strategy.

► OHE Health Research and Statistics Unit will prepare quarterly reports, and OHE's deputy director will present them at the OHE-AC meetings.

► AO1.2 Collect and analyze data that highlights the social determinants of health, and encourage this data for planning purposes.

► The Healthy Places Team in the OHE will continue to build the Healthy Communities Data and Indicators Project by: a) completing all 60 indicators identified in the research and development phase by December 2016 as resources allow, b) developing supporting materials for each indicator by December 2016 as resources allow, and c) conducting training workshops to disseminate knowledge and skills about the indicators among stakeholders by December 2016 as resources allow.

► Per the OHE mandate and through the Interagency Agreement with the California Department of Health Care Services (DHCS), the OHE will continue meeting with DHCS in the established Data Workgroup to discuss opportunities to coordinate data capacity.

► The OHE Community Development and Engagement Unit (CDEU) will continue to update and collaborate with DHCS through its Mental Health Services Division to partner, collaborate, inform, and offer technical assistance. CDEU will continue ongoing cultural and linguistic sensitivity technical assistance to DHCS such as with the Cultural Competence Plan Requirements that collect data from all county mental health plans.

► AO1.3 Assess health and mental health equity data shortcomings, and explore the feasibility of creating new data and/or disaggregating existing data.

► The OHE Health Research and Statistics Unit will work with other CDPH offices in a joint effort with California HealthCare Foundation's Free the Data project, which consists of a gateway for external data users to use one online portal for access to all our data at CDPH.

► The OHE Community Development and Engagement Unit will a) provide technical assistance (TA) on lessons learned and community recommendations relative to the data and disaggregation of the data (this information is documented in five target population-specific California Reducing Disparities Project [CRDP] Phase I Population Reports), b) provide TA on lessons learned and community recommendations relative to CRDP target population data evaluation efforts, and c) encourage CRDP contractors to share subject matter expertise on population-specific tools to collect culturally and linguistically appropriate data.

Health Partners

AHP1.1 Identify the health and mental health equity practices in fields with potential health partners.

Health Field

AHF1.1 Identify the health and mental health equity practices throughout state departments and state-funded programs in the health field.

Communities

AC1.1 Identify how local communities are currently mobilizing to address the social determinants of health and how they are measuring their efforts toward progress.

- Identification will be strengthened by data generated from the California Wellness Plan.

Stage 1 CDPH Preliminary Activities and Resources for Implementation

COMMUNICATION

Overall

CO1.1 Create a comprehensive marketing and communications plan for health and mental health equity, the Office of Health Equity, and the California Statewide Plan to Promote Health and Mental Health Equity

▶ A management-level position with expertise in both communications planning and execution will provide leadership in further identifying the activities to support each of the goals for each of the target audiences in this strategy.

CO1.2 Build a network of communication and support for health and mental health equity work statewide, to include practitioners, community members, community-based organizations, consumers, family members/those with lived experience with mental health conditions, policy leaders, and other stakeholders

▶ The OHE Community Development and Engagement Unit will continue California Reducing Disparities Project (CRDP) efforts, including the following: a) email regular communications through the OHE e-blast function to hundreds of stakeholders to keep them apprised of CRDP activities, b) post online and then update the CRDP contractor roster regularly, and c) encourage a continuous feedback loop from community stakeholders via meet-and-greets and an open-door policy (email/phone/at meetings in the community).

CO1.3 Develop, host, and regularly update an interactive, informative, and engaging state-of-the-art website with timely, accurate data; relevant research; and evidence-based and community-defined practices

▶ Subject to the availability of resources to fund such activities, the OHE Community Development and Engagement Unit will share critical outcome information associated with the following community-defined practices and evaluation efforts: a) host a CRDP webpage that is regularly updated; b) create a webpage posting of deliverable reports from the community participatory evaluation being conducted throughout Phase 2 activities; c) post online the categories of community-defined practices identified by the CRDP Population Reports; d) use a translation service contract to translate webpage information; and e) use a cultural competence consultant contract to incorporate recommendations made to the state by subject matter experts in cultural and linguistic competence, with the goal of improving culturally and linguistically appropriate mental health web information.

CO1.4 Develop and disseminate issue briefs based on recommendations from the OHE-AC and other stakeholders

▶ The OHE Community Development and Engagement Unit will support CRDP contractors in sharing issue briefs with their communities.

CO1.5 Provide leadership in sharing California's health and mental health equity efforts for adoption as appropriate throughout the state, nationally, and internationally

Health Partners

CHP1.1 Facilitate common understanding of health and mental health equity and the social determinants of health between potential health partner agencies and organizations

▶ The HiAP Task Force will a) hold quarterly meetings to engage nonhealth state agencies in developing collaborative approaches to promoting health, equity, and sustainability; and b) hold at least three collaborative learning sessions to provide leaders and staff at potential health partner state agencies with opportunities to explore the links between health and mental health equity and the social determinants of health.

Health Field

CHF1.1 Facilitate common understanding of health and mental health equity and the social determinants of health between all departments that fall under California Health and Human Services (CHHS), while beginning this dialogue with key health-related state programs outside of CHHS

CHF1.2 Enhance understanding of and action on climate change as a critical public health issue that is likely to impact vulnerable populations in disparate ways

▶ The OHE Climate and Health Team will a) work with local health departments, OHE-AC members, health equity and environmental justice advocates, and stakeholders in the public health and mental health arenas to build capacity to incorporate climate change issues into training and strategic planning;

b) offer online trainings, presentations, and resources to enhance awareness and understanding of climate change, with a focus on health equity; and

c) utilize the CAT Public Health Workgroup as an educational forum in which to raise climate and health equity issues, needs, and strategies with a variety of stakeholders.

Communities

CC1.1 Build broad-based community support on health and mental health equity issues through education and dialogue, heightening awareness of the social determinants of health

▶ The OHE Community Development and Engagement Unit will continue CRDP efforts to meaningfully engage diverse community stakeholders by a) meeting with local stakeholders around the state to hear concerns and feedback that will continue meaningful dialogue and build upon community engagement momentum, and b) collecting data pertaining to mental health equity outcomes, inequities, and community participatory evaluation processes.

Stage 1 CDPH Preliminary Activities and Resources for Implementation

INFRASTRUCTURE

Overall

IO1.1 Partner on existing health and mental health equity summits for practitioners and policy makers.

▶ The OHE Community Development and Engagement Unit will encourage CRDP contractors to participate in health and mental health equity summits to share population-specific, community-defined practices and recommendations relative to CRDP efforts.

IO1.2 Catalyze workforce development opportunities aimed at increasing California's capacity to effectively address health and mental health inequities and disparities, starting with state employees and moving beyond the state system as resources and partnerships are secured.

▶ CDPH has a Public Health Management Team that is committed to movement on this goal.

IO1.3 Recommend that health and mental health equity goals be considered during the allocation of existing funding streams.

▶ CDPH has a Public Health Management Team that is committed to movement on this goal.

IO1.4 Closely monitor progress of the U.S. Department of Health and Human Services' Action Plan to Reduce Racial and Ethnic Health Disparities and other health and mental health equity efforts that are addressing the needs of historically underserved communities, and seek opportunities to increase California's role and/or adopt successful models.

▶ OHE will monitor external health and mental health equity plans.

IO1.5 Promote the use of a gender lens as appropriate when assessing health and mental health equity models, to increase the likelihood of improving the often distinct health needs of women and girls and of men and boys, particularly those of color and/or low income.

▶ OHE will coordinate with gender experts and stakeholders to assist in the assessment of viable health and mental health equity models.

Health Partners

IHP1.1 Use a Health in All Policies approach to embed health and mental health equity criteria in decision-making, grant programs, guidance documents, and strategic plans.

▶ The HiAP Task Force will embed health equity as a key consideration in five decision-making processes, grant programs, state guidance documents, and/or strategic plans.

▶ The OHE Community Development and Engagement Unit will continue participation on the State Interagency Team Workgroup to Eliminate Disparities and Disproportionality (WGEDD), which has a special interest and a history in developing and implementing a racial impact tool to assist state agencies in making decisions that do not adversely impact vulnerable populations.

IHP1.2 Enhance understanding of climate change as a public health issue of increasing importance for the state's most vulnerable populations, and promote widespread efforts to reduce greenhouse gas emissions, achieve health co-benefits, and enhance climate resilience for vulnerable and disadvantaged communities.

▶ The OHE Climate and Health Team will a) incorporate health equity into the state's Climate Action Team and into specific climate mitigation and adaptation plans and policies; b) develop and share data and tools to identify climate risks, health impacts, and vulnerabilities in the state's diverse communities and populations for use in multi-sectoral planning efforts; and c) participate in cross-sector planning and consultation on climate mitigation and adaptation efforts that promote health equity and enhance the resilience of vulnerable and disadvantaged communities.

Stage 1 CDPH Preliminary Activities and Resources for Implementation

INFRASTRUCTURE

Health Field

IHF1.1 Support the expansion of the National Culturally and Linguistically Appropriate Services (CLAS) Standards, including assessment, technical assistance, and training

► The California Wellness Plan's second goal is "Optimal Health Systems Linked with Community Prevention." The OHE will work closely with the other CDPH offices implementing the objectives in Goal 2 that speak to CLAS. In particular, the OHE Community Development and Engagement Unit will continue to update and collaborate with DHCS to share in learning opportunities and provide technical assistance related to cultural and linguistic competence.

IHF1.2 Explore health and mental health equity implications of the Affordable Care Act (ACA) as they relate to access, expanded coverage, and community-based prevention strategies

► CDPH's partners on the California Wellness Plan are interested in focusing on a) building on strategic opportunities, current investments, and innovations in the Patient Protection and Affordable Care Act; and b) prevention and expanded managed care to create a systems approach to improving patient and community health. OHE and other CDPH offices will continue partnering with Covered California to ensure that the uninsured are moved into programs for which they are eligible.

Communities

IC1.1 Mobilize resources to reduce health and mental health inequities and disparities

► The OHE Community Development and Engagement Unit will oversee $60 million in resource allocation through the California Reducing Disparities Project over a four-year period.

IC1.2 Identify opportunities to build upon existing initiatives, implement new initiatives, replicate initiatives, and leverage local resources to increase health and mental health equity in all policies

► Through the implementation of CRDP Phase 2, community-based promising practices and strategies will be identified, implemented, and evaluated, utilizing a robust community-based participatory approach to demonstrate the effectiveness of community-defined practices in reducing mental health disparities. This will position community-defined practices for replication and additional resource acquisition.

IC1.3 Research Health Equity Zones and other place-based models to assess the feasibility of replicating or expanding such interventions at the neighborhood level in California

► The OHE Health Research and Statistics Unit will initiate research on Health Equity Zones and other place-based models.

Stage 1 CDPH Preliminary Activities and Resources for Implementation

All goals will be led by the OHE Deputy Director.

CB1&2.1. Build mechanisms for the OHE to establish ongoing public engagement and accountability on the strategic priorities, ensuring community participation in all goals at all levels of the Plan.

CB1&2.2. Strengthen the health and mental health equity workforce development pipeline by utilizing fellows and interns in the implementation of the strategic priorities, throughout the Plan's multiple partners.

Additional CDPH Activities and Resources: The California Epidemiologic Investigation Services (Cal-EIS) Fellowship and the Preventive Medicine Residency Program (PMRP) are two postgraduate programs that train epidemiologists and physicians. The Cal-EIS Fellowship's and the PMRP's mission is to build the public health workforce by training well-qualified candidates in preventive medicine and public health practice. Fellows and residents receive training that addresses health equity and social determinants of health, conducted through preventive medicine seminars. Focused discussions on these topics help build trainees' awareness of these issues and develop related competencies as they prepare for careers in public health. The training results in adding skilled epidemiologists and public health physicians to the state (and local) workforce (e.g., research scientists, public health medical officers, local health officers and administrators). If resources were identified for placement opportunities, Cal-EIS fellows and PMRP residents could be placed in local health departments or state programs and could train with a focus on health and mental health equity. During fellows' and residents' placement, major projects and activities could be developed that have a specific focus in this area, and fellows and residents could be utilized to help implement the strategic priorities.

CB1&2.3. Seek additional resources, including in-kind assistance, federal funding, and foundation support.

CB1&2.4. Develop and implement a process to foster public and private partnerships for all appropriate strategic priorities, including governmental, corporate, educational, research, and philanthropic institutions.

Additional CDPH Activities and Resources: The California Wellness Plan's fourth goal was established, due to external partner input, as "Prevention Sustainability and Capacity." Our partners are interested in focusing on a) collaborating with health care systems, providers, and payers to show the value of greater investment in community-based prevention approaches that address underlying determinants of poor health and chronic disease; b) exploring dedicated funding streams for community-based prevention; and c) aligning newly secured and existing public health and cross-sectoral funding sources to support broad community-based prevention. Partners selected the short-term strategy of Wellness Trust creation, with dedicated streams of funding for community-based prevention at the local, regional, and state levels.

Appendix B: Health in All Policies Task Force

The California Health in All Policies Task Force ("Task Force") provides a venue for 22 state agencies to develop collaborative approaches to promote health and health equity outcomes across California. The Task Force was created administratively in 2010, out of recognition that nearly all policy fields have an impact on health, as well as the complex relationship between health, equity, and environmental sustainability.

- In order to promote health, equity, and environmental sustainability, the Task Force:
- Reviews existing state efforts and best/promising practices used by other jurisdictions and agencies;
- Identifies barriers to and opportunities for interagency/inter-sector collaboration;
- Convenes regular public workshops and solicits input from stakeholders; and
- Develops and implements multi-agency programs to improve the health of Californians.

The Task Force's initial recommendations and implementation plans were developed by the Task Force and endorsed by the Strategic Growth Council (SGC) between 2010 and 2012. As new windows of opportunity emerge, staff and Task Force members vet ideas and create new recommendations and implementation plans, pending available resources and alignment with Task Force priorities.

Following are key highlights of the Task Force that are relevant to the goals of the Office of Health Equity.

Food Security and Access to Healthy Food:

The multi-agency Office of Farm to Fork (http://cafarmtofork.com/) was created in August 2012, when an interagency agreement was executed between the California Department of Education, the California Department of Food and Agriculture, and the California Department of Public Health, drawing resources from all three agencies to "help all Californians eat healthy, well-balanced meals." The office aims to increase "access to healthy, nutritious food for everyone in the state" by "connecting individual consumers, school districts, and others directly with California's farmers and ranchers, and providing information and other resources."

The Task Force gave rise to the creation of a multi-agency Food Procurement Working Group, a successful community-supported agriculture (CSA) pilot program on state property, and a partnership with the Department of General Services and the Department of Corrections and Rehabilitation as they integrate nutrition criteria into food purchasing contracts. This will effectively improve the nutritional content of food provided to over 100,000 inmates and will also create opportunities for other agencies to purchase healthier foods.

Active Transportation:

Health in All Policies staff gathered lessons learned from the Task Force and partnered with TransForm to develop and disseminate a report called *Creating Healthy Regional Transportation Plans*, released in January 2012 and available at http://www.transformca.org/resource/creating-healthy-regional-transportation-plans. This report was disseminated to metropolitan planning organizations and other stakeholders.

The Task Force hosted an orientation workshop, Complete Streets: Designing for

Pedestrian and Bicycle Safety, for staff from nine agencies, providing an opportunity for multisectoral dialogue among agencies with a stake in creating streets that serve all users, including bicyclists, pedestrians, and people with disabilities.

The Southern California Association of Governments created a public health subcommittee to support its Regional Transportation Plan and included Task Force staff on that committee to help the region make links to health and equity as it develops policy proposals for the upcoming plan.

Task Force members are currently engaged in a creative process to renew their active transportation goals and generate new action steps based upon current and emerging opportunities.

Healthy Housing:

The Department of Housing and Community Development facilitates a multi-agency workgroup that provides resources to support local communities in harmonizing goals related to housing, air quality, location efficiency, transit-oriented development, and public health.

Parks and Community Greening:

The Department of Forestry and Fire Protection worked with the Governor's Office of Planning and Research to develop a webpage resource for local governments to use in planning for a healthy urban forest that optimizes benefits to the environment, public health, and the economy.

The Task Force supported the Department of Forestry and Fire Protection in conducting an urban forest inventory and assessment pilot project in the city of San Jose that can be used to develop and demonstrate a feasible approach for mapping the state's urban forests and quantifying the value of ecosystem services they provide.

Health in All Policies staff regularly serve as reviewers for the SGC Urban Greening for Sustainable Communities grant applications

Integration of Health and Equity into Land Use Policy:

The Governor's Office of Planning and Research is engaging health partners and the Task Force as they revise California's General Plan Guidelines, with a particular focus on health, equity, and environmental sustainability.

The California Department of Education, the Governor's Office of Planning and Research, the SGC, and the Task Force formed the Land Use, Schools, and Health (LUSH) Working Group to explore the linkages between health, sustainability, and school infrastructure and to promote these goals through the state's General Plan Guidelines, K-12 school siting guidance, and school facilities' construction and rehabilitation.

Health in All Policies staff worked with the SGC to integrate health language into its Sustainable Communities Planning Grants Program in order to incentivize applicants to partner with local health departments and incorporate health into their planning processes.

The Healthy Community Framework, developed with input from the Task Force, has been incorporated into programs and reports such as the *2010 California Regional Progress Report*, which provides a framework for measuring sustainability using place-based and quality-of-life regional indicators.[1]

Neighborhood Safety:

The Task Force is working with the Local Government Commission and others to develop guidelines for local communities to use design elements to promote community safety while also promoting social cohesion; active transportation; and healthy, livable communities.

Detailed information about the recommendations, priorities, implementation plans, and progress of the Health in All Policies Task Force is available through a variety of documents posted on the Strategic Growth Council (SGC) website at www.sgc.ca.gov/.

Appendix C: Glossary

Active physicians are currently licensed physicians who are not retired, semiretired, working part time, temporarily not in practice, or inactive for other reasons and who work 20 or more hours per week. (American Medical Association and Medical Board of California)

Age checkpoints are defined according to whether or not children are up to date for age- appropriate doses of DTaP, polio, and MMR vaccines at 3, 5, 7, 13, 19, and 24 months. (CA Department of Public Health)

Bisexual is of or relating to persons who experience sexual attraction toward and responsiveness to both males and females. (CA Department of Justice)

Determinants of equity are defined as the social, economic, geographic, political, and physical environmental conditions that lead to the creation of a fair and just society. (CA Health and Safety Code Section 131019.5)

Ethnic bias is a preformed negative opinion or attitude toward a group of persons of the same race or national origin who share common or similar traits in language, custom, and tradition. (CA Department of Justice)

Ethnicity refers to two "ethnic" classifications: "Hispanic or Latino" and "not Hispanic or Latino." (U.S. Census Bureau)

Food insecurity is limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways. (U.S. Department of Agriculture via Life Sciences Research Office)

Food security means access by all people at all times to enough food for an active, healthy life. (U.S. Department of Agriculture)

Gay (homosexual male) is of or relating to males who experience a sexual attraction toward and responsiveness to other males. (CA Department of Justice)

Health equity refers to efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives. (CA Health and Safety Code Section 131019.5)

Health and mental health disparities are differences in health and mental health status among distinct segments of the population, including differences that occur by gender, age, race or ethnicity, sexual orientation, gender identity, education or income, disability or functional impairment, or geographic location, or the combination of any of these factors. (CA Health and Safety Code Section 131019.5)

Health and mental health inequities are disparities in health or mental health, or the factors that shape health, that are systemic and avoidable and, therefore, considered unjust or unfair. (CA Health and Safety Code Section 131019.5)

Heterosexual is of or relating to persons who experience a sexual attraction toward and responsiveness to members of the opposite sex. (CA Department of Justice)

Homosexual is of or relating to persons who experience sexual attraction toward and responsiveness to members of their own sex. (CA Department of Justice)

Household includes all the people who occupy a housing unit (e.g., house, apartment, mobile home). (U.S. Census Bureau)

Lesbian (homosexual female) is of or relating to females who experience sexual attraction toward and responsiveness to other females. (CA Department of Justice)

Limited English proficiency (LEP) refers to those who reportedly speak English less than "very well" (i.e., those who reported speaking English well, not well, or not at all). This definition is based on the results of the English Language Proficiency Survey (ELPS) conducted by the U.S. Census Bureau in 1982.

Married-couple household is a family in which the householder and his or her spouse are listed as members of the same household. (U.S. Census Bureau)

Net worth (wealth) is the sum of the market value of assets owned by every member of the household minus liabilities owed by household members. (U.S. Census Bureau)

Pollution burden scores are derived from the average percentile of the seven Exposure indicators (ozone concentrations, PM2.5 concentrations, diesel PM emissions, pesticide use, toxic releases from facilities, traffic density, and drinking water contaminants) and the five Environmental Effects indicators (cleanup sites, impaired water bodies, groundwater threats, hazardous waste facilities and generators, and solid waste sites and facilities). Indicators from the Environmental Effects are given half the weight of the indicators from the Exposures component. The calculated average percentile (up to 100th percentile) is divided by 10, for a pollution burden score ranging from 0.1 to 10. (CalEnviroScreen version 1.1)

Poverty status is determined by using a set of dollar-value thresholds that vary by family size and composition. If a family's total income in the past 12 months is less than the appropriate threshold of that family, then that family and every member in it are considered "**below the poverty level.**" (U.S. Census Bureau)

Race refers to five "racial" classifications: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, and White. (U.S. Census Bureau)

Reading proficiency is measured by the percentage of third-graders in public schools who score proficient or higher on the English Language Arts California Standards Test (CST). In order to score proficient on the CST, a student must demonstrate a competent and adequate understanding of the knowledge and skills measured by this assessment, at this grade, in this content area. (www.kidsdata.org)

Religious bias is a preformed negative opinion or attitude toward a group of persons based on religious beliefs regarding the origin and purpose of the universe and the existence or nonexistence of a supreme being. (CA Department of Justice)

Serious psychological distress is a dichotomous measure of mental illness using the Kessler 6 (K6) series. (CA Health Interview Survey)

Sexual orientation bias is a preformed negative opinion or attitude toward a group of persons based on sexual preferences and/or attractions toward or responsiveness to members of their own or opposite sexes. (CA Department of Justice)

Usual source of care means having a usual place to go when sick or in need of health advice. (CA Health Interview Survey)

Victim is an individual, a business or financial institution, a religious organization, government, or other. For example, if a church or synagogue is vandalized or desecrated, the victim would be a religious organization. (CA Department of Justice)

Violent crimes are composed of murder, forcible rape, robbery, aggravated assault, simple assault, and intimidation. (Federal Bureau of Investigation)

Vulnerable communities include, but are not limited to women; racial or ethnic groups; low-income individuals and families; individuals who are incarcerated or have been incarcerated; individuals with disabilities; individuals with mental health conditions; children; youth and young adults; seniors; immigrants and refugees; individuals who are limited English proficient (LEP); and Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQQ) communities, or combinations of these populations. (CA Health and Safety Code Section 131019.5)

Vulnerable places are places or communities with inequities in the social, economic, educational, or physical environment or environmental health and that have insufficient resources or capacity to protect and promote the health and well-being of their residents. (CA Health and Safety Code Section 131019.5)

Appendix D: Data Limitations

The findings in this report should be interpreted within the context of the limitations discussed in this section. First, the data limitations of vulnerable population groups and vulnerable places defined by California Health and Safety Code Section 131019.5 are still an issue. Data on sexual orientation (Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning [LGBTQQ]) and vulnerable places is limited in most data sets used in this report. For example, the American Community Survey (ACS) still does not collect data on LGBTQQ population groups. Although we attempted to capture the vulnerable places to include in this report, data is very limited in existing data sources.

Second, data on race and ethnicity is limited for some population groups. American Indian/Alaska Native, Native Hawaiian and other Pacific Islander (NHOPI), and subpopulations (e.g., Asian subpopulations such as Korean, Chinese, Vietnamese) data has to be analyzed with caution due to insufficient sample size and unstable data. For example, most NHOPI data in the California Health Interview Survey is represented as unstable due to the small sample size. Also, some data variables available in the ACS at the national level are not collected for California.

Third, data on discrimination stratified by vulnerable population groups identified in this report is limited and not available for California. Although there are numerous published journals and information for this topic available, the data is not often collected on most surveys. Even when the data is collected, usually it is considered "sensitive" data that are not available for public use.

Fourth, within the context of vulnerable population groups, mental health data is very limited in most data sets. Although there is data available on mental health, some people are not willing to answer survey questions relating to mental health issues because mental health issues are still considered a stigma or even taboo in some cultures. This data is sometimes considered "sensitive" and is therefore not available for public use.

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CALIFORNIA

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11. PURPOSEFUL AGING: A MODEL FOR AGE-FRIENDLY INITIATIVE

PURPOSEFUL AGING | AN AGE-FRIENDLY INITIATIVE LOS ANGELES

Announcement May 18, 2016
Supervisor Hilda Solis and Mayor Eric Garcetti

AREA AGENCY ON AGING

Federally designated Area Agencies on Aging (AAA) were established in 1973 under the Older Americans Act to respond to the needs of Americans 60 and over.

AAA's are part of a nationwide network helping older people to plan and care for their needs, with the goal of living independently in their own homes. They provide social services and nutrition services for elders, and support for caregivers.

The Los Angeles Region has two designated AAAs:
City of Los Angeles Department of Aging
and
Los Angeles County Department of Workforce Development, Aging, and Community Services

Core Functions

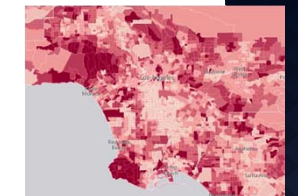
ADVOCACY - Advocate at all levels for the resources and policies that will help provide the choices older persons and persons with disabilities need to lead meaningful lives.

PLANNING - Responsible for identifying unmet needs of older adults and functionally impaired adults as well as planning, coordinating, and implementing programs that promote the health, dignity, and well-being.

SERVICES - Responsible for ensuring that an array of direct services is available at the neighborhood level in support older adults and their family caregivers.

Why is Purposeful Aging Los Angeles Needed?

LOS ANGELES REGION

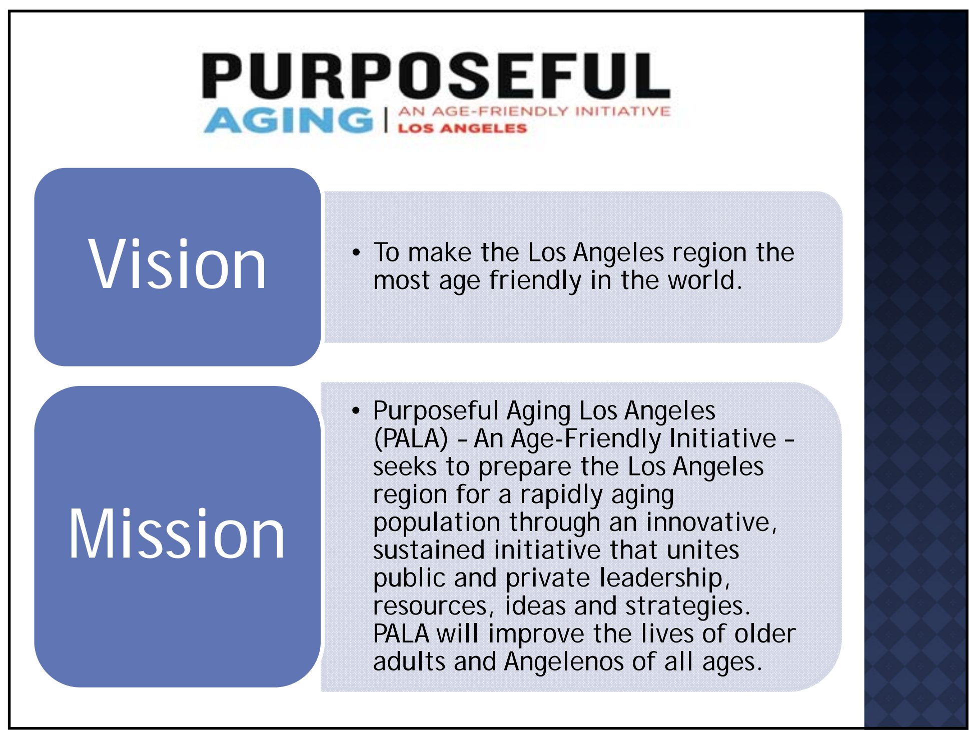


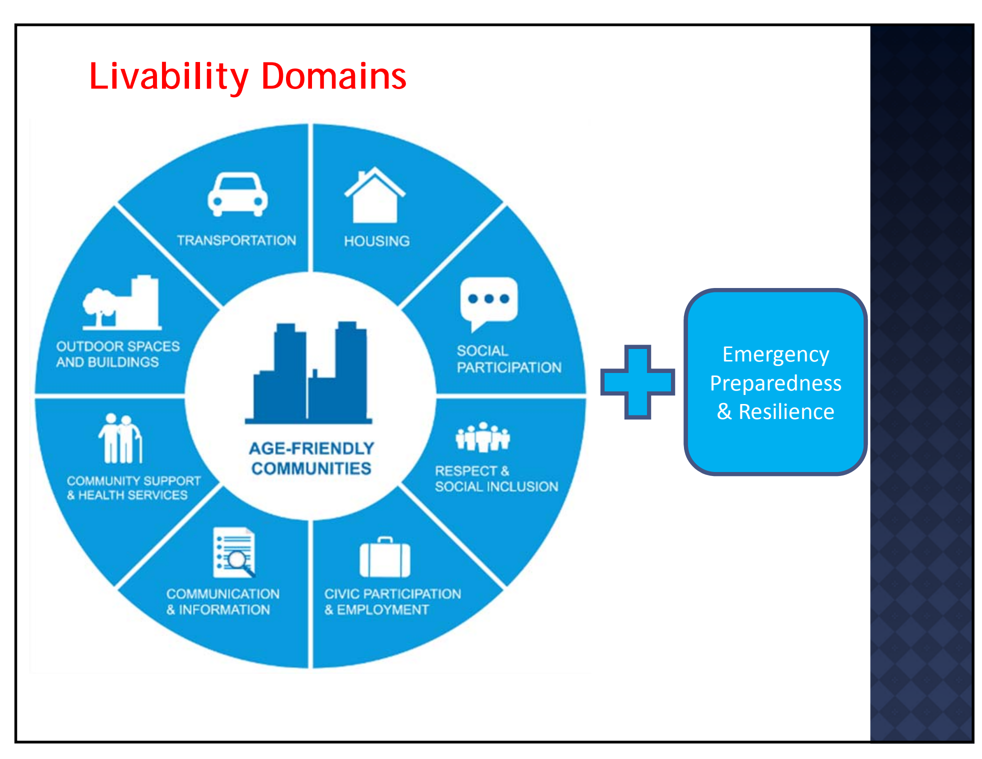
- The older adult population in the Los Angeles Region is larger than the older adult populations of 40 states
- Between 2010 and 2030, the older adult population in the Los Angeles region is expected to double, from approximately 1.1 million to more than 2.1 million individuals
- The older adult population is becoming more racially and ethnically diverse than ever before
- Life expectancy is increasing: it rose from 75.8 years in 1991 to 81.5 years in 2011

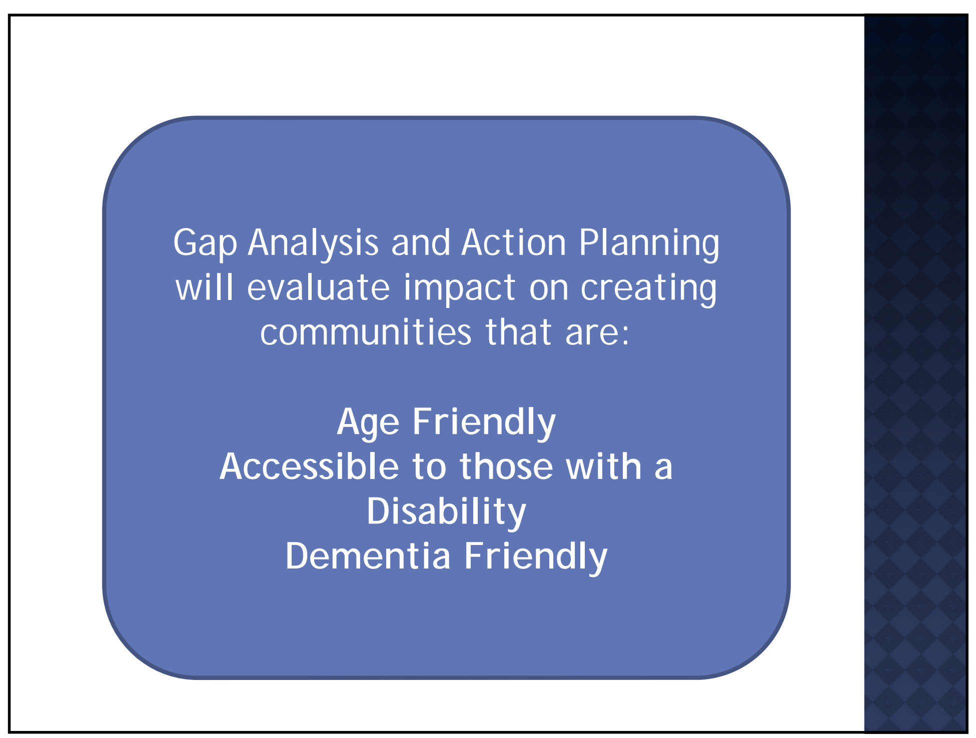
PURPOSEFUL
AGING
AN AGE-FRIENDLY INITIATIVE
LOS ANGELES
WDACS
WORKFORCE DEVELOPMENT
AGING & COMMUNITY SERVICES
CITY OF LOS ANGELES
Department of Aging
MILKEN INSTITUTE
Changing the World in Innovative Ways
Center for the Future of Aging
California
AARP
Real Possibilities
UCLA
L.A. CAPRA
Los Angeles Community Academic Partnership for Research in Aging
USC Leonard Davis
School of Gerontology

age-friendly
cities and communities
in practice
By local communities, for local communities
PROCESS
A designation process established by the World Health Organization
In U.S. AARP is the national entity that supports the initiative
Seeking designation requires commitment from highest elected official
GOALS
Adapting city/county structures to the needs of a growing older population is a strategic investment
A City of Choice For All Generations
Benefits of Age-Friendly Environments

Prepare the Los Angeles region for a rapidly aging population
Develop the region's "Age-Friendly Action Plan"
LOS ANGELES
PURPOSEFUL AGING
AN AGE-FRIENDLY INITIATIVE
Improve the lives of older adults and Angelenos of all ages
Click here to get started.
PurposefulAgingLA.com
You Can Help Change the Future of Aging in the Los Angeles Region.


PURPOSEFUL
AGING | AN AGE-FRIENDLY INITIATIVE LOS ANGELES
Vision
• To make the Los Angeles region the most age friendly in the world.
Mission
• Purposeful Aging Los Angeles (PALA) – An Age-Friendly Initiative – seeks to prepare the Los Angeles region for a rapidly aging population through an innovative, sustained initiative that unites public and private leadership, resources, ideas and strategies. PALA will improve the lives of older adults and Angelenos of all ages.


Livability Domains
TRANSPORTATION
HOUSING
SOCIAL PARTICIPATION
RESPECT & SOCIAL INCLUSION
CIVIC PARTICIPATION & EMPLOYMENT
COMMUNICATION & INFORMATION
COMMUNITY SUPPORT & HEALTH SERVICES
OUTDOOR SPACES AND BUILDINGS
AGE-FRIENDLY COMMUNITIES
Emergency Preparedness & Resilience


Gap Analysis and Action Planning will evaluate impact on creating communities that are:
Age Friendly
Accessible to those with a Disability
Dementia Friendly

Engagement Process includes:

Steering Committee**
Blue Ribbon Committee
Action Planning Committee **

Working Groups
City/County internal **
City Departments **
County Departments **
Research and Evaluation **
9 Livability Domains
Dementia Friendly**
Aging & Disability Collaborative
Task Force of Cities**
Others may be added as needed

*** Group is Active*

Planning Phase Timeline

LOS ANGELES PURPOSEFUL AGING AN AGE-FRIENDLY INITIATIVE

May 2016	Summer 2016- Winter 2017	Spring 2017- Summer 2017		Fall 2017	May 2018
Initiative Launch	Initial Planning	Older Adult Summit	Surveys & Listening Sessions	Develop Action Plan	Action Plan to Mayor, Board and Council

"With an older adult population that is rapidly growing, we must prepare our communities for the future of aging in Los Angeles County"
- Supervisor Hilda Solis

To Date

- Mayoral Directive 17
- L.A. County incorporates PALA into County's Strategic Plan
- Recruitment for Cities Task Force
- Listening Sessions
- Needs Assessment Survey
  - Phase I – City and County Employees - completed
  - Phase II – General Public –closing October 1st
- Recruitment of 90 City Neighborhood Council Liaisons
- Older Adult Summit with more than 400 in attendance

- 7/2016 *Time* Magazine - 240 Reasons to Celebrate America - #43 Cities that Embrace all Generations highlighting Purposeful Aging L.A.
- Next Avenue's 2016 Influencers in Aging - Mayor Eric Garcetti named among 50 advocates, researchers, thought leaders, innovators, writers and experts continue to push beyond traditional boundaries and change our understanding of what it means to grow older.
- May 2017 issue of *County Digest* publication cover story on Older Adult Summit.

Support and Engage with the Initiative

Purposeful Aging
Task Force of Cities

- Leverage our efforts to become an Age Friendly City
- Support each other in creating an Age Friendly region
- Identify best practice strategies, projects and resources
- Participate in worldwide movement

EVALUATION TEAM

Maria P. Aranda, PhD, MSW, MPA, LCSW
Associate Professor
USC Suzanne Dworak-Peck School of Social Work

Valentine M. Villa, PhD
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William A. Vega, PhD
Provost Professor
Cleofas and Victor Ramirez Professor of Practice, Policy, Research and Advocacy for the Latino Population
Executive Director, USC Roybal Institute
USC social work, preventive medicine, psychiatry, family medicine, psychology and gerontology

Laura Trejo, MSG, MPA
General Manager
Los Angeles Department of Aging

STEERING COMMITTEE

Cynthia Banks, Director, LA County Workforce Development, Aging and Community Services

Lorenza C Sanchez, Assistant Director, LA County Workforce Development, Aging & Community Services, Aging & Adult Services Branch

Paul H. Irving, Chairman, Milken Institute Center for the Future of Aging

Kate Wilber, PhD, Mary Pickford Professor of Gerontology, USC Leonard Davis School of Gerontology, Professor of Health Services Administration

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Laura Trejo, General Manager, Los Angeles Department of Aging

James Don, Assistant General Manager, Los Angeles Department of Aging

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Kevin Anderson, Special Assistant to the Director/Public Information Officer, LA County Workforce Development, Aging and Community Services

Rafi Nazarians, Associate State Director, Community, AARP California

Susan Stiles, Executive Assistant, Los Angeles Department of Aging

PURPOSEFUL
AGING | AN AGE-FRIENDLY INITIATIVE
LOS ANGELES

For Immediate Release
September 13, 2017

Contact: Kevin Anderson
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County and City of Los Angeles Extend Purposeful Aging Los Angeles Survey Deadline - Call on Residents to Complete Important Survey by October 1, 2017

The County and City of Los Angeles have extended the deadline to complete the Purposeful Aging Los Angeles (PALA) Survey to October 1, 2017 and are asking residents to complete this important survey.

"Thank you to those who have completed this vitally-important survey," said Cynthia D. Banks, Director of the Los Angeles County Department of Workforce Development, Aging and Community Services. "We are extending the deadline because we need to hear from residents of all backgrounds and communities in the County and City of Los Angeles."

"It is imperative for all County and City residents to participate in this survey," said Laura Trejo, General Manager of the City of Los Angeles Department of Aging. "We especially need to hear from additional non-English speakers, including those who speak Spanish, Mandarin, Tagalog, Korean, Armenian, Vietnamese, Farsi, Cambodian, and Russian."

Available in ten languages* at www.purposefulagingla.com, the confidential PALA survey takes about 20 minutes to complete and can be filled out by anyone 18 years of age or older who resides in the County or City of Los Angeles. Individuals and organizations are encouraged to help promote the survey to County residents using a Toolkit available at www.purposefulagingla.com. Feedback obtained through the PALA Survey will guide the development of an Age-Friendly Action Plan for 2018-2021 for the Los Angeles region.

About PALA
PALA is an Age-Friendly Initiative that seeks to prepare the Los Angeles region for a rapidly aging population through an innovative, sustained effort that unites public and private leadership, resources, and strategies. PALA will improve the lives of older adults and ensure a better future for residents of all ages in the Los Angeles region. PALA was launched in 2016 by the County and City of Los Angeles, AARP, the Milken Institute Center for the Future of Aging, the USC Leonard Davis School of Gerontology and the UCLA Los Angeles Community Academic Partnership for Research in Aging.

*English, Spanish, Armenian, Cambodian, Korean, Mandarin, Russian, Tagalog, Vietnamese and Farsi (hardcopy format only).

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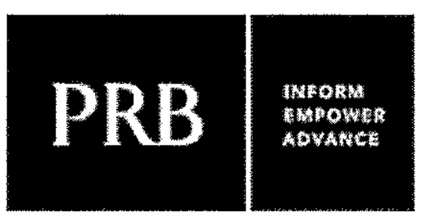

Population Reference Bureau
Inform. Empower. Advance.

Fact Sheet: Aging in the United States

Mark Mather

(January 2016) The Population Reference Bureau report, "Aging in the United States," examines recent trends and disparities among adults ages 65 and older, and how baby boomers born between 1946 and 1964 will reshape America's older population. In 2016, baby boomers will be between ages 52 and 70. Below are key findings from the report.

Demographic Shifts

- The number of Americans ages 65 and older is **projected to more than double** from 46 million today to over 98 million by 2060, and the 65-and-older age group's share of the total population will rise to nearly 24 percent from 15 percent.
- The older population is becoming more **racially and ethnically diverse**. Between 2014 and 2060 the share of the older population that is non-Hispanic white is projected to drop by 24 percentage points, from 78.3 percent to 54.6 percent.
- The changing racial/ethnic composition of the population under age 18, relative to those ages 65 and older, has created a "**diversity gap**" between generations.
- **Older adults are working longer.** By 2014, 23 percent of men and about 15 percent of women ages 65 and older were in the labor force, and these levels are projected to rise further by 2022, to 27 percent for men and 20 percent for women.
-

Many parts of the country—especially counties in the rural Midwest—are "**aging in place**" because disproportionate shares of young people have moved elsewhere.

Positive Developments

- **Education levels are increasing**. Among people ages 65 and older in 1965, only 5 percent had completed a bachelor's degree or more. By 2014, this share had risen to 25 percent.
- **Average U.S. life expectancy increased** from 68 years in 1950 to 79 years in 2013, in large part due to the reduction in mortality at older ages.
- The **gender gap in life expectancy is narrowing**. In 1990, there was a seven-year gap in life expectancy between men and women. By 2013, this gap had narrowed to less than five years (76.4 years versus 81.2 years).
- The **poverty rate** for Americans ages 65 and older has dropped sharply during the past 50 years, from nearly 30 percent in 1966 to 10 percent today.

Challenges

- **Obesity rates** among older adults have been increasing, standing at about 40 percent of 65-to-74-year-olds in 2009-2012.
- There are **wide economic disparities** across different population subgroups. Among adults ages 65 and older, 18 percent of Latinos and 19 percent of African Americans lived in poverty in 2014—more than twice the rate among older non-Hispanic whites (8 percent).
- **More older adults are divorced** compared with previous generations. The share of divorced women ages 65 and older increased from 3 percent in 1980 to 13 percent in 2015, and for men from 4 percent to 11 percent during the same period.
- More than one-fourth (27 percent) of women ages 65 to 74 **lived alone** in 2014, and this share jumps to 42 percent among women ages 75 to 84, and to 56 percent among women ages 85 and older.
- The aging of the baby boom generation could fuel a 75 percent increase in the number of Americans ages 65 and older requiring **nursing home care**, to about 2.3 million in 2030 from 1.3 million in 2010.
- Demand for elder care will also be fueled by a steep rise in the number of Americans living with **Alzheimer's disease**, which could nearly triple by 2050 to 14 million, from 5 million in 2013.

- The large share of elderly also means that **Social Security** and **Medicare** expenditures will increase from a combined 8 percent of gross domestic product today to 12 percent by 2050.
- Policymakers can also improve the outlook for the future by **reducing current gaps** in education, employment, and earnings among younger workers.

Mark Mather is associate vice president of U.S. Programs at the Population Reference Bureau.

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12. USING INNOVATIVE TECHNOLOGY TO PREVENT HIV AMOUNG YOUNG MSM

SOLVE-IT: USING INNOVATIVE TECHNOLOGY TO PREVENT HIV AMONG YOUNG MSM

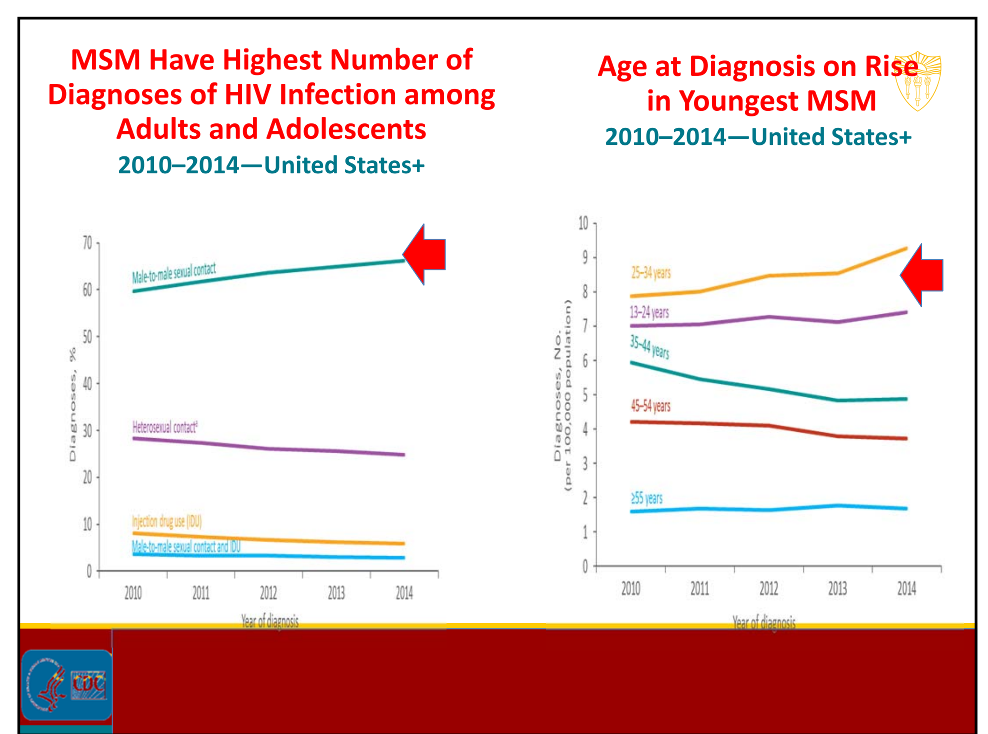
Lynn Carol Miller[1]
University of Southern California[1]

John L. Christensen[2], Benjamin J. Smith[1], Paul Robert Appleby[1],
Stacy Marsella[3], Feng Xue[1], Antoine Bechara[1], Zhong-Lin Lu[4],
Vitalya Droutman[1], Charisse L'Pree Corsbie-Massay[5],
Emily Barkley-Levenson[6], Carlos Gustavo Godoy[1], Mei Si[7] & Stephen Read[1]

University of Connecticut[2] Northeastern University[3] Ohio State University[4] Syracuse University[5] Hofstra University[6] Rensselaer Polytechnic Institute[7]

Grant funding for this line of work since 1991 from
NIH (NIAID, NIMH, NIDA, NIGMS), and CHRP (State of California)

University of Southern California



Curbing spread of HIV among YMSM:

- Pills and drugs for prevention (PrEP, PEP, ART)
- Condom Use
  - Goal: reducing condomless anal sex (CAS)

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School for Communication
and Journalism

University of Southern California

Curbing spread of HIV among YMSM:

- Reducing Condomless Anal Sex (CAS)
  - Few Effective Behavioral Interventions for YMSM
  - National Reach Problematic (If could, expensive)
  - Don't address YMSM's Affective (e.g., sexual shame) and contextual in-the-moment challenges

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Potential Solutions?

- **Develop an Intervention Game for YMSM** to Reduce Condomless Anal Sex (CAS) - Designed to be Delivered Over the Web
- **Test it Nationally (50-states) over the Web**

Potential Solutions?

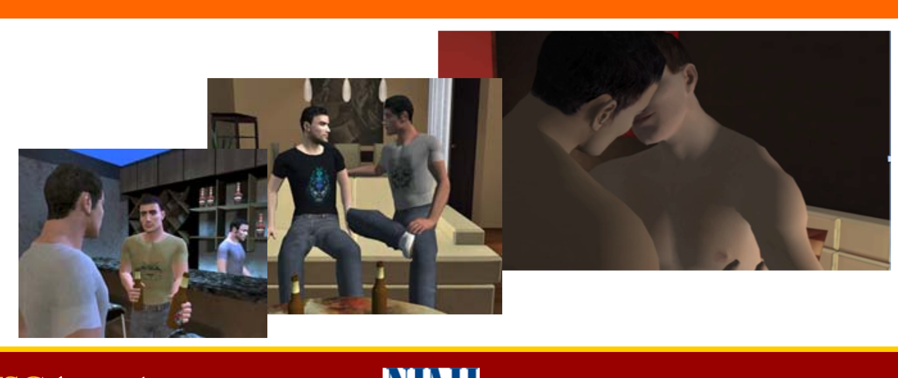
- **Develop an Intervention Game for YMSM** to Reduce Condomless Anal Sex (CAS) - Designed to be Delivered Over the Web
  - ✓SOLVE-IT: Socially Optimized Learning in Virtual Environments- Using Intelligent Technologies

Potential Solutions?

- **Develop an Intervention Game for YMSM** to Reduce Condomless Anal Sex (CAS) - Designed to be Delivered Over the Web
  - ✓SOLVE-IT: Socially Optimized Learning in Virtual Environments using Intelligent Technologies
- **Test it Nationally (50-states) over the Web**
  - RESULTS:
  - ✓ SOLVE-IT in a Randomized Controlled Trial over 6-months reduced CAS
  - ✓ SOLVE-IT reduced YMSM's sexual shame
  - ✓ Shame reduction-- due to the game -- reduced CAS

What Does SOLVE Game DO?

1. Immerses MSM in virtual world simulating virtual date and many common challenges to safer sex where MSM must make decisions for their avatar as in real-life that affect how the action proceeds.



University of Southern California

User creates his own character. The actions and scenarios are designed to be representative of real life challenges that are emotionally engaging (formative research).
MSM Can Customize Self Character
•Skin Color
•Eye Color
•Hair Color
•Clothing Choices
Character Customization - Alter the appearance of your avatar
Select your hair color
Character Customization - Alter the appearance of your avatar
Select your hair color
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National Institute of Mental Health
University of Southern California

After the user chooses a character, we age this character to create an important agent of change in the intervention - The Virtual Future Self.
Virtual Future Self (VFS) Acts as each MSM's Personalized Guide Scaffolding Changes in Cognitions, Skills, and Emotional Self-regulation
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National Institute of Mental Health
10

SOLVE-IT Intro
Welcome. This game gives you the opportunity to learn about safer sex practices while hooking up with hot guys in a fun virtual world. Whatever happens is up to you, so enjoy !
So?what do you look like?
Next ->
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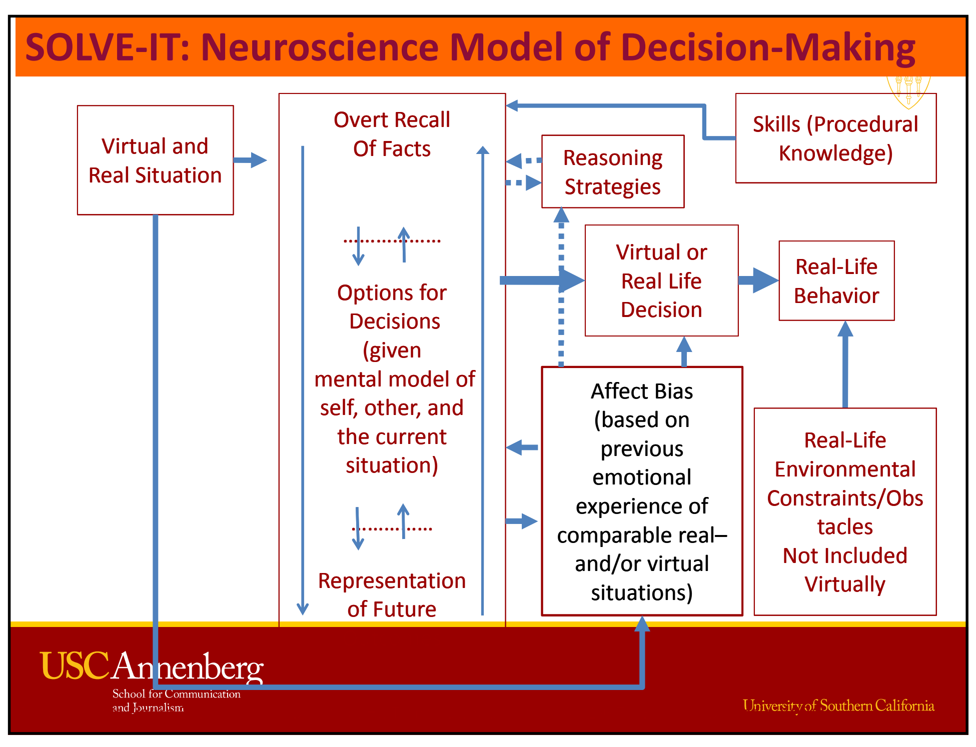
SOLVE-IT: Neuroscience Model of Decision-Making
Virtual and Real Situation
Overt Recall Of Facts
Options for Decisions (given mental model of self, other, and the current situation)
Representation of Future
Skills (Procedural Knowledge)
Reasoning Strategies
Virtual or Real Life Decision
Real-Life Behavior
Affect Bias (based on previous emotional experience of comparable real– and/or virtual situations)
Real-Life Environmental Constraints/Obstacles Not Included Virtually
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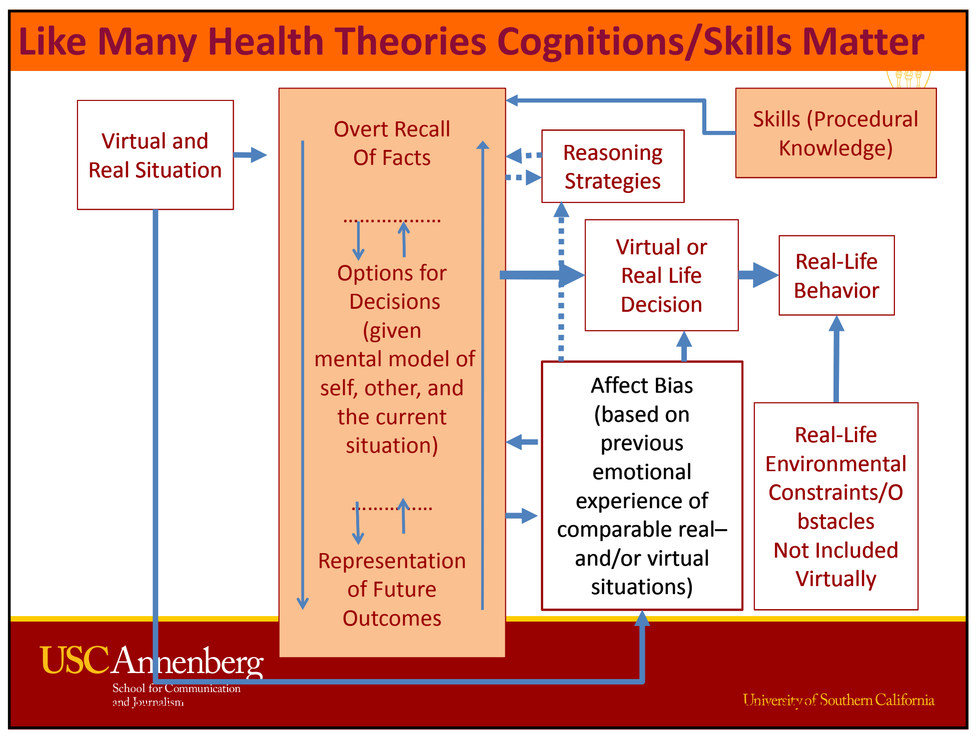

Like Many Health Theories Cognitions/Skills Matter
Virtual and Real Situation
Overt Recall Of Facts
Options for Decisions (given mental model of self, other, and the current situation)
Representation of Future Outcomes
Skills (Procedural Knowledge)
Reasoning Strategies
Virtual or Real Life Decision
Real-Life Behavior
Affect Bias (based on previous emotional experience of comparable real– and/or virtual situations)
Real-Life Environmental Constraints/Obstacles Not Included Virtually
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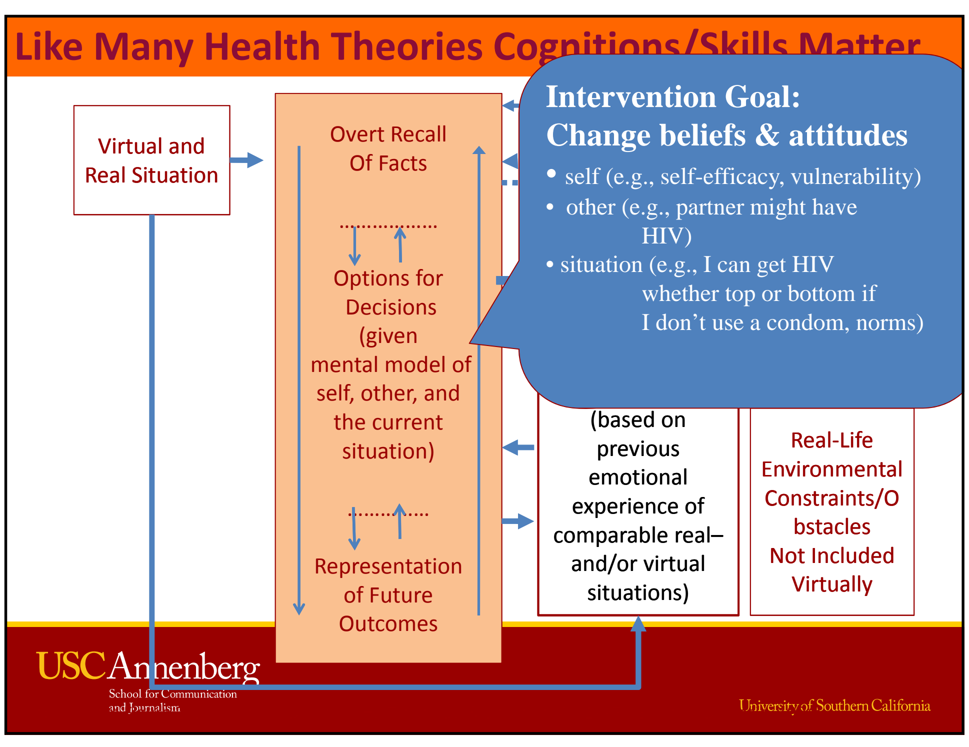

Like Many Health Theories Cognitions/Skills Matter
Virtual and Real Situation
Overt Recall Of Facts
Options for Decisions (given mental model of self, other, and the current situation)
Representation of Future Outcomes
Intervention Goal:
Change beliefs & attitudes
• self (e.g., self-efficacy, vulnerability)
• other (e.g., partner might have HIV)
• situation (e.g., I can get HIV whether top or bottom if I don't use a condom, norms)
(based on previous emotional experience of comparable real– and/or virtual situations)
Real-Life Environmental Constraints/Obstacles Not Included Virtually
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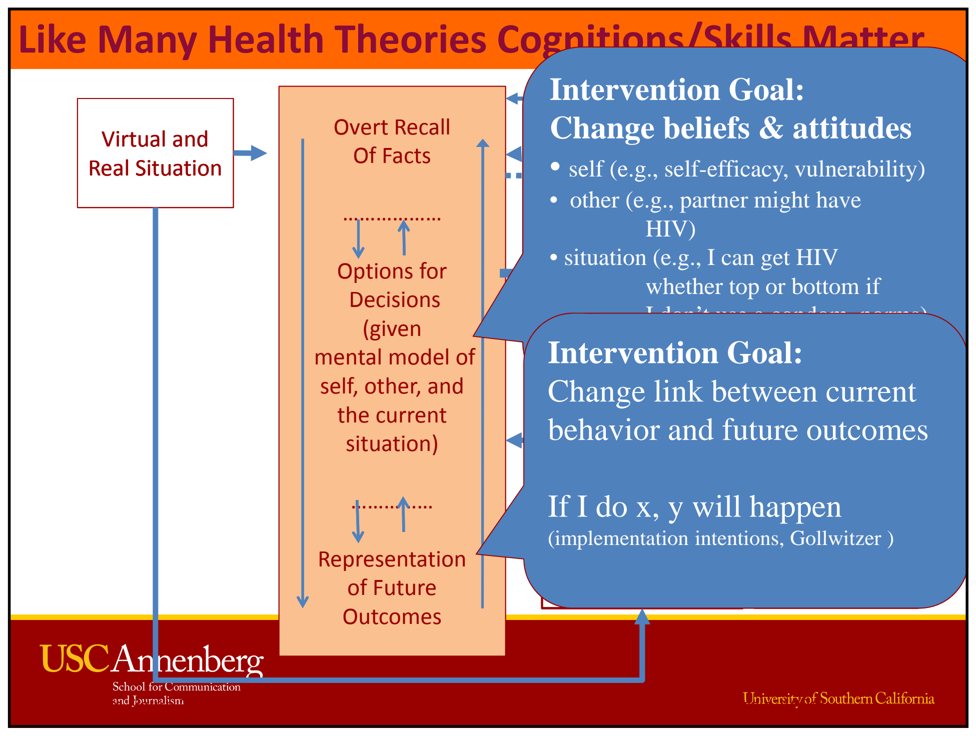
Like Many Health Theories Cognitions/Skills Matter
Virtual and Real Situation
Overt Recall Of Facts
Options for Decisions (given mental model of self, other, and the current situation)
Representation of Future Outcomes
Intervention Goal:
Change beliefs & attitudes
• self (e.g., self-efficacy, vulnerability)
• other (e.g., partner might have HIV)
• situation (e.g., I can get HIV whether top or bottom if
Intervention Goal:
Change link between current behavior and future outcomes
If I do x, y will happen
(implementation intentions, Gollwitzer)
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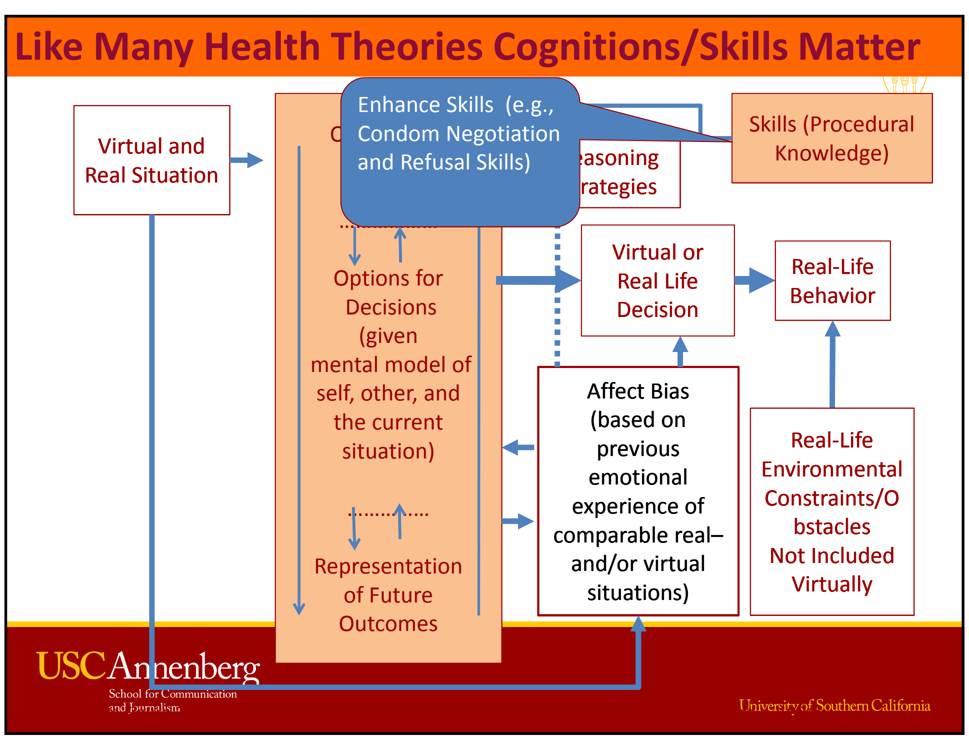
Like Many Health Theories Cognitions/Skills Matter
Virtual and Real Situation
Enhance Skills (e.g., Condom Negotiation and Refusal Skills)
Skills (Procedural Knowledge)
Options for Decisions (given mental model of self, other, and the current situation)
Representation of Future Outcomes
Virtual or Real Life Decision
Real-Life Behavior
Affect Bias (based on previous emotional experience of comparable real– and/or virtual situations)
Real-Life Environmental Constraints/Obstacles Not Included Virtually
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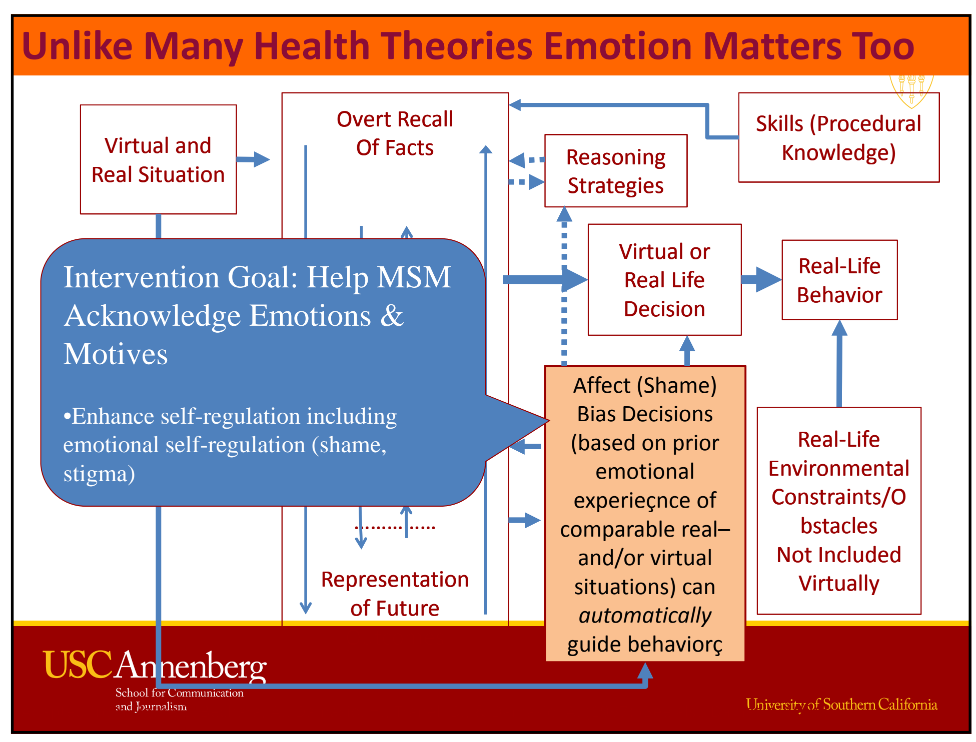
Unlike Many Health Theories Emotion Matters Too
Virtual and Real Situation
Overt Recall Of Facts
Skills (Procedural Knowledge)
Reasoning Strategies
Intervention Goal: Help MSM Acknowledge Emotions & Motives
•Enhance self-regulation including emotional self-regulation (shame, stigma)
Virtual or Real Life Decision
Real-Life Behavior
Affect (Shame) Bias Decisions (based on prior emotional experieçnce of comparable real– and/or virtual situations) can *automatically* guide behaviorç
Real-Life Environmental Constraints/O bstacles Not Included Virtually
Representation of Future
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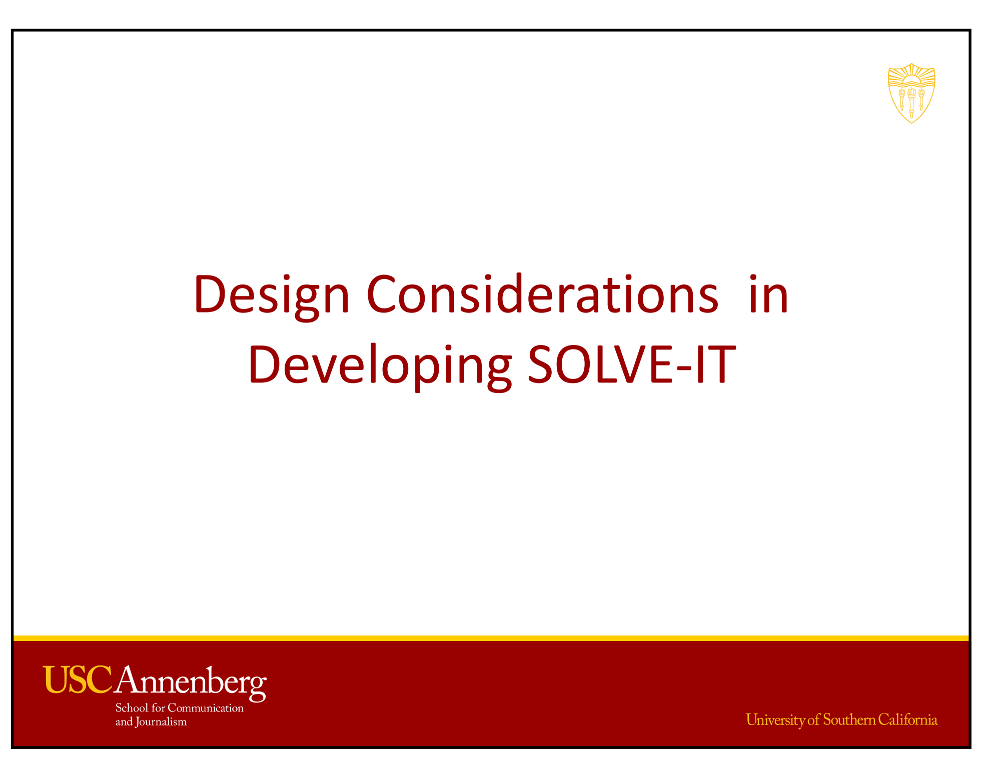
Design Considerations in Developing SOLVE-IT
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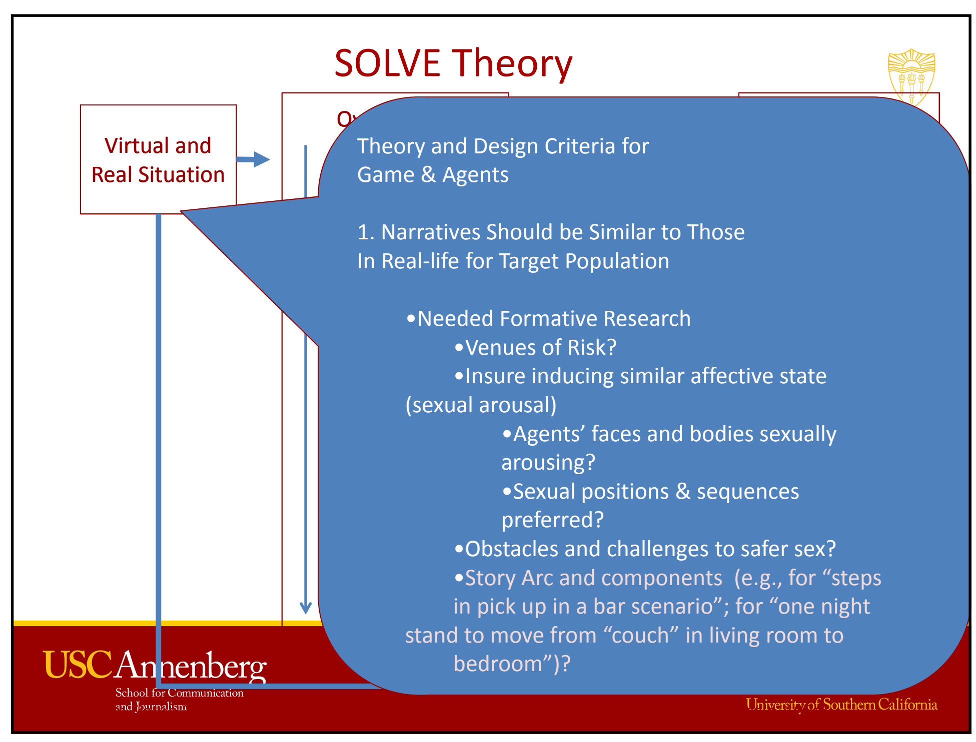
SOLVE Theory
Virtual and Real Situation
Theory and Design Criteria for Game & Agents
1. Narratives Should be Similar to Those In Real-life for Target Population
•Needed Formative Research
•Venues of Risk?
•Insure inducing similar affective state (sexual arousal)
•Agents' faces and bodies sexually arousing?
•Sexual positions & sequences preferred?
•Obstacles and challenges to safer sex?
•Story Arc and components (e.g., for "steps in pick up in a bar scenario"; for "one night stand to move from "couch" in living room to bedroom")?
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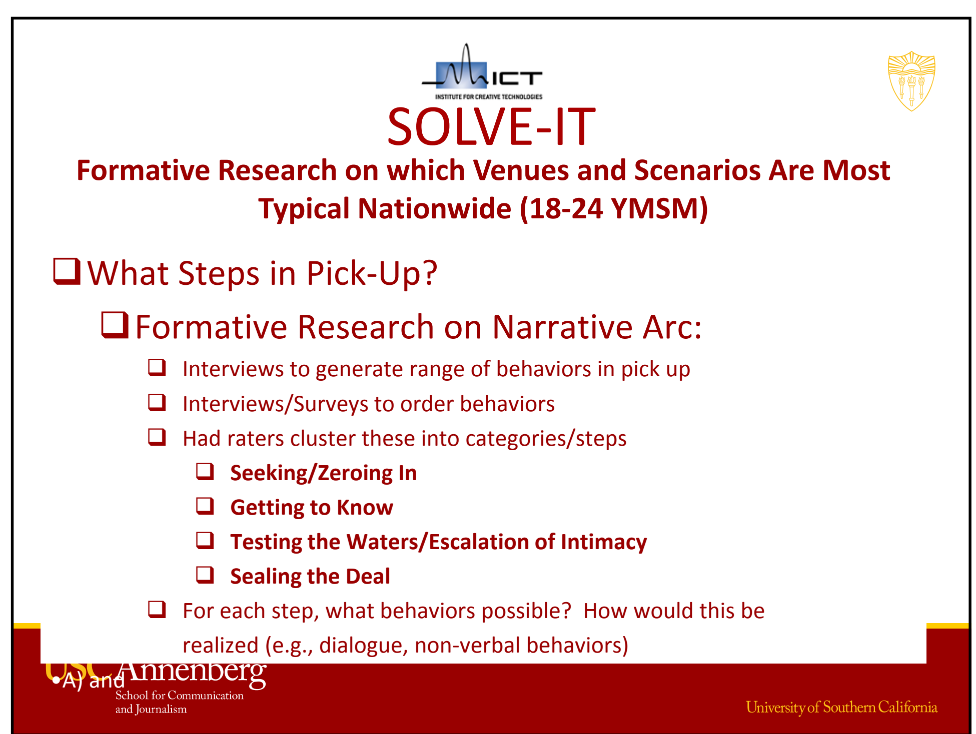
ICT
INSTITUTE FOR CREATIVE TECHNOLOGIES
SOLVE-IT
Formative Research on which Venues and Scenarios Are Most Typical Nationwide (18-24 YMSM)
What Steps in Pick-Up?
Formative Research on Narrative Arc:
Interviews to generate range of behaviors in pick up
Interviews/Surveys to order behaviors
Had raters cluster these into categories/steps
Seeking/Zeroing In
Getting to Know
Testing the Waters/Escalation of Intimacy
Sealing the Deal
For each step, what behaviors possible? How would this be realized (e.g., dialogue, non-verbal behaviors)
•A) and
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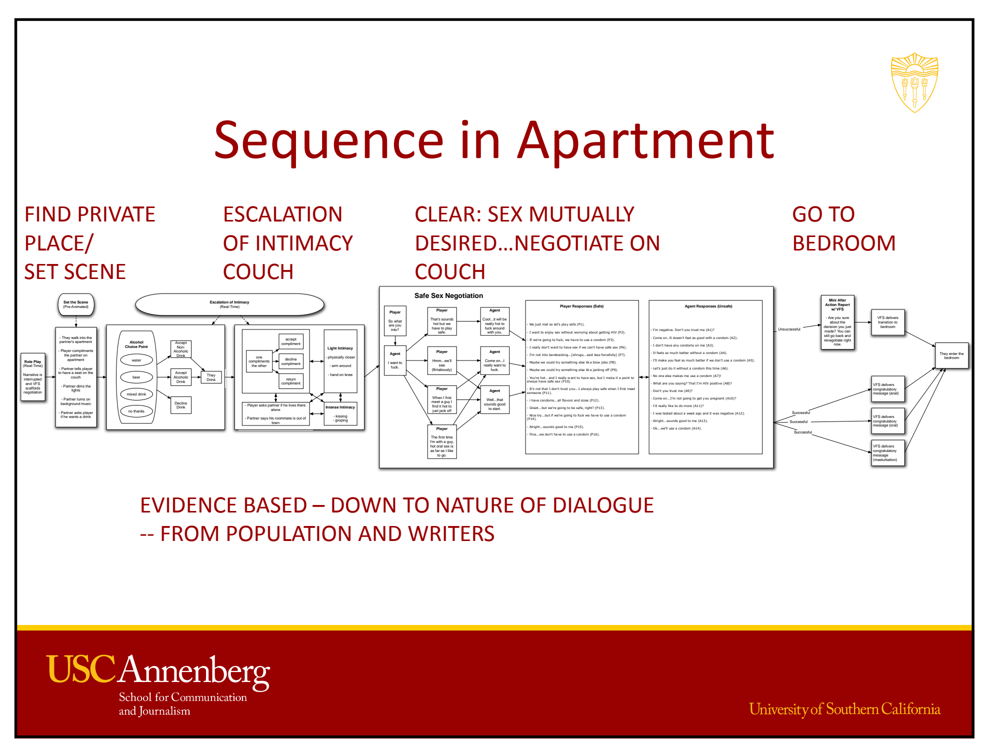
Sequence in Apartment
FIND PRIVATE PLACE/ SET SCENE
ESCALATION OF INTIMACY COUCH
CLEAR: SEX MUTUALLY DESIRED…NEGOTIATE ON COUCH
GO TO BEDROOM
EVIDENCE BASED – DOWN TO NATURE OF DIALOGUE
-- FROM POPULATION AND WRITERS
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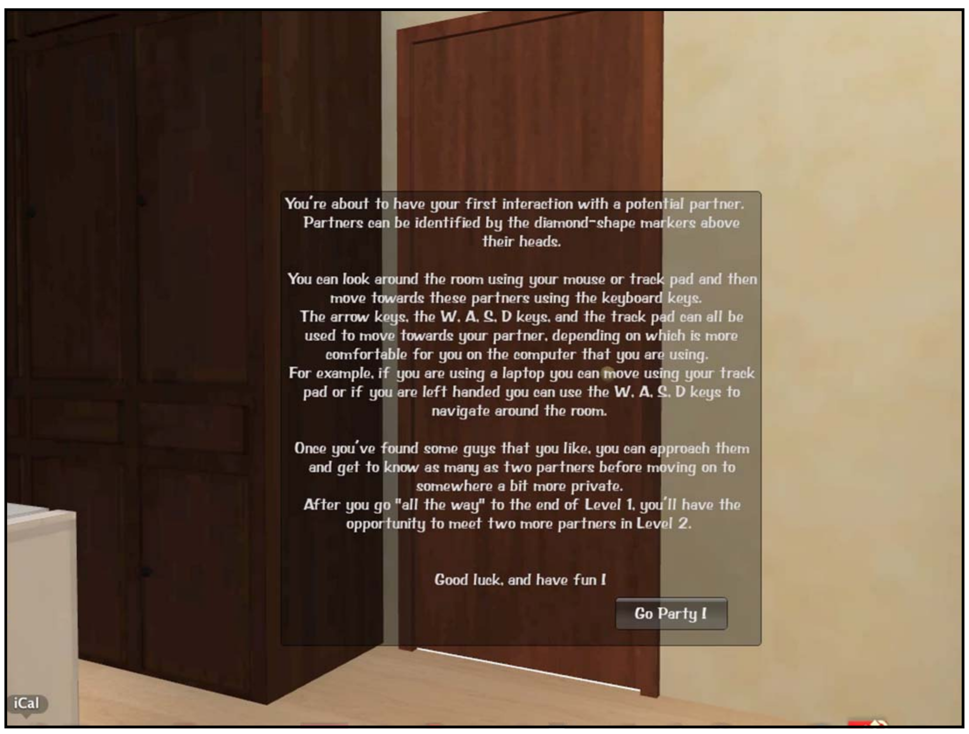
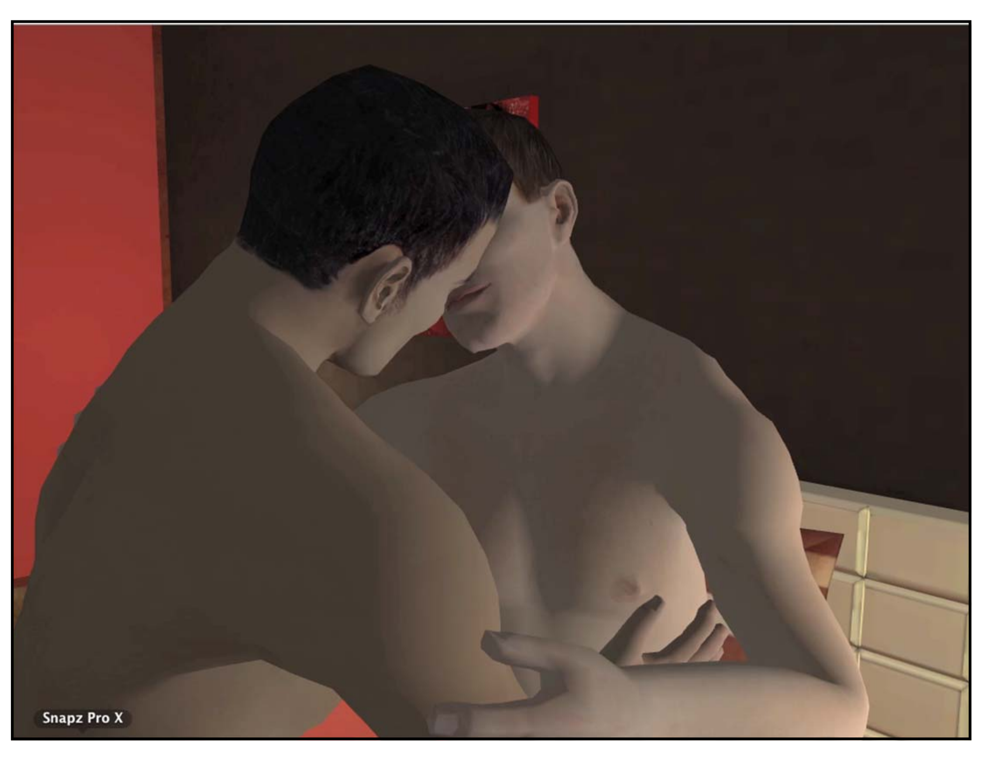
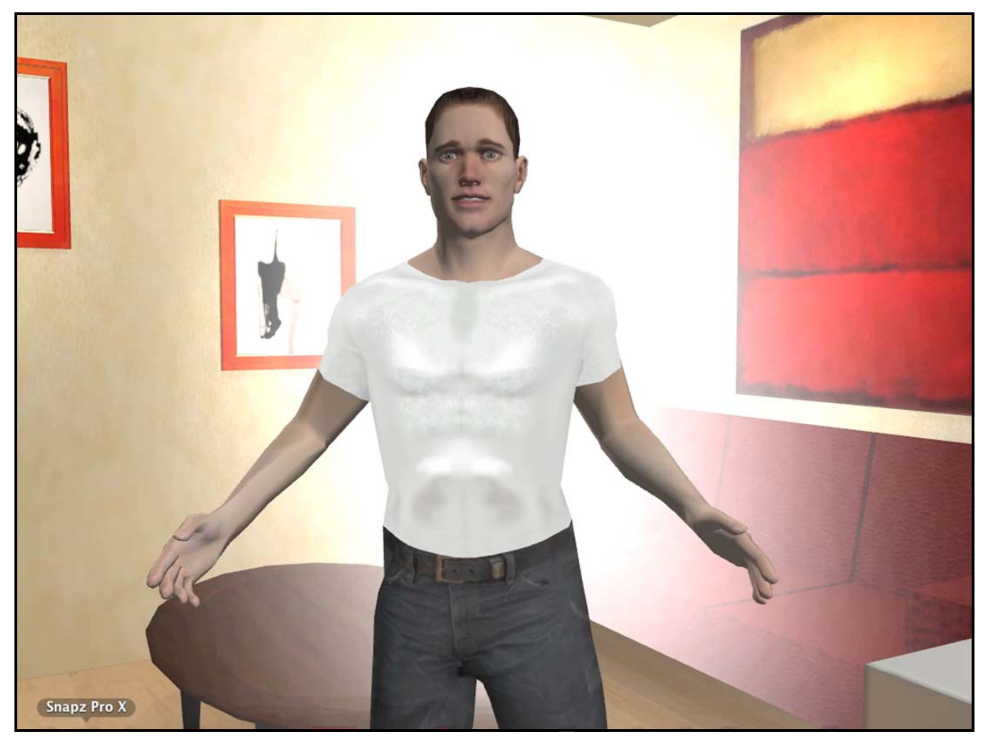

You're about to have your first interaction with a potential partner. Partners can be identified by the diamond-shape markers above their heads.
You can look around the room using your mouse or track pad and then move towards these partners using the keyboard keys.
The arrow keys, the W, A, S, D keys, and the track pad can all be used to move towards your partner, depending on which is more comfortable for you on the computer that you are using.
For example, if you are using a laptop you can move using your track pad or if you are left handed you can use the W, A, S, D keys to navigate around the room.
Once you've found some guys that you like, you can approach them and get to know as many as two partners before moving on to somewhere a bit more private.
After you go "all the way" to the end of Level 1, you'll have the opportunity to meet two more partners in Level 2.
Good luck, and have fun !
Go Party !
iCal


Snapz Pro X


Snapz Pro X

VFS Psychological Intervention

SOLVE's Self-Regulatory Narrative Circuit

Self-Regulation Matters – To enhance it …when MSM are making risky choices in the game we intervene with an…

ICAP Process: Interrupt, Challenge, Accept, Provide

Generate Possible Solutions; Develop Plans to Optimize Goals,Taking Resources into Account

Clarify Interpersonal Goals for Self and Other

Make a Decision Possible Decision-Making Process

Interpret and Make Inferences for Self & Other Affective Cues (what they may mean – cause, effect, intent)

Act on Decision Enact Behavior

Read Affective Cues •Self •Other

Read, Miller, Appleby, Nwosu, Reynaldo, Lauren, & Putcha (2006)

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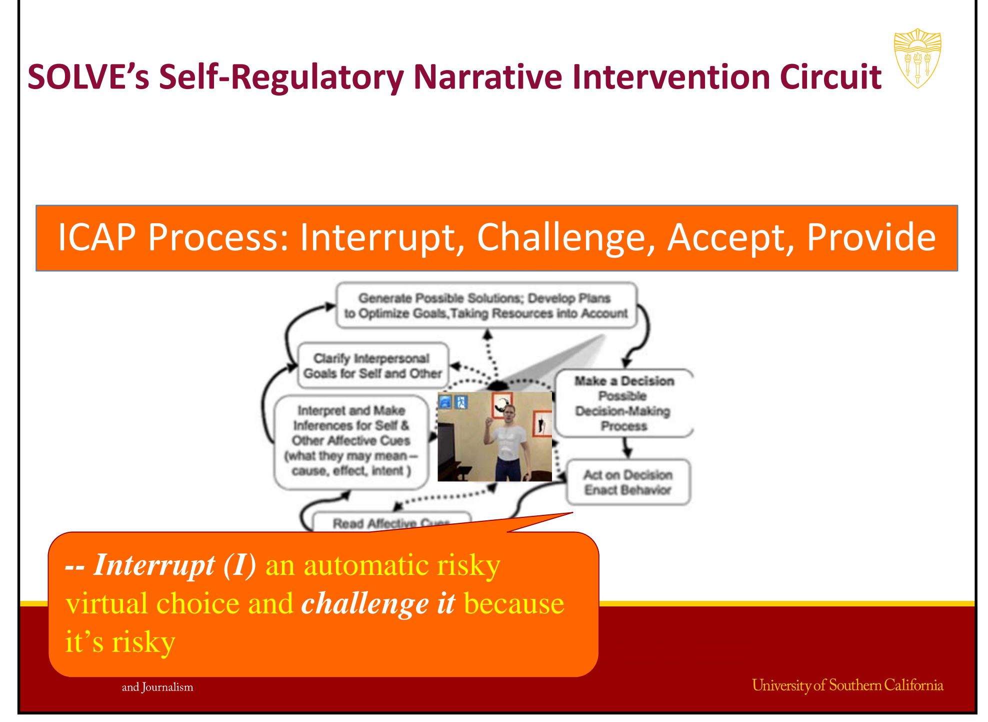

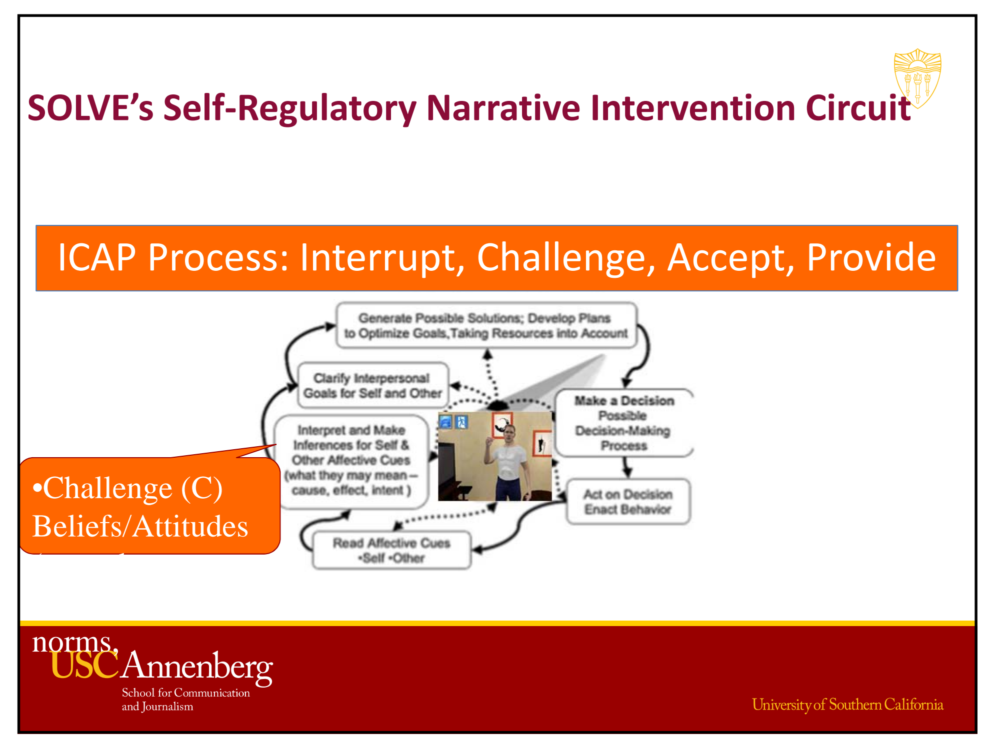
SOLVE's Self-Regulatory Narrative Intervention Circuit
ICAP Process: Interrupt, Challenge, Accept, Provide
Generate Possible Solutions; Develop Plans to Optimize Goals,Taking Resources into Account
Clarify Interpersonal Goals for Self and Other
Make a Decision Possible Decision-Making Process
Interpret and Make Inferences for Self & Other Affective Cues (what they may mean – cause, effect, intent)
Act on Decision Enact Behavior
Read Affective Cues •Self •Other
•Challenge (C) Beliefs/Attitudes
norms,
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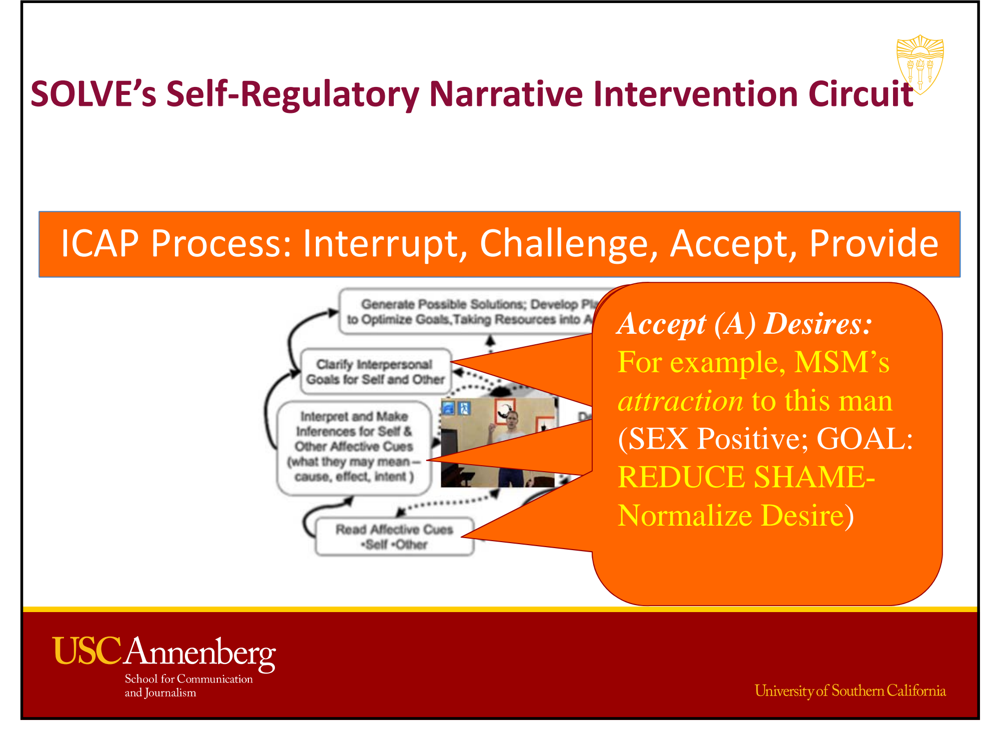
SOLVE's Self-Regulatory Narrative Intervention Circuit
ICAP Process: Interrupt, Challenge, Accept, Provide
Generate Possible Solutions; Develop Pl
to Optimize Goals,Taking Resources into A
Clarify Interpersonal Goals for Self and Other
Interpret and Make Inferences for Self & Other Affective Cues (what they may mean – cause, effect, intent)
Read Affective Cues •Self •Other
Accept (A) Desires:
For example, MSM's attraction to this man (SEX Positive; GOAL: REDUCE SHAME- Normalize Desire)
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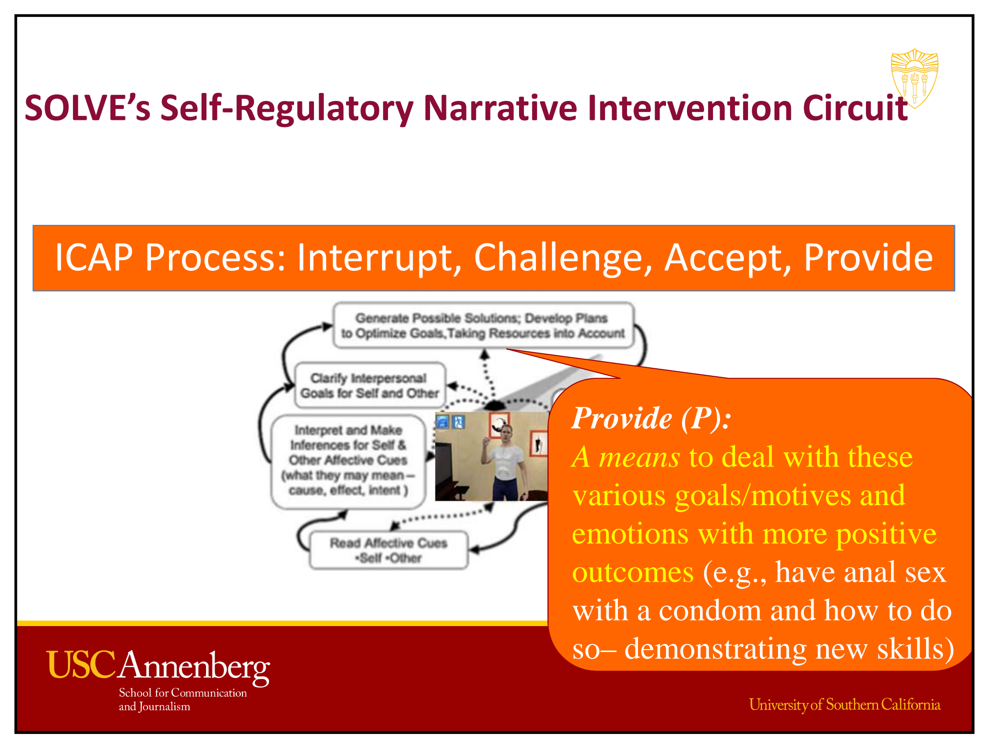

SOLVE's Self-Regulatory Narrative Intervention Circuit
ICAP Process: Interrupt, Challenge, Accept, Provide
Generate Possible Solutions; Develop Plans to Optimize Goals,Taking Resources into Account
Clarify Interpersonal Goals for Self and Other
Interpret and Make Inferences for Self & Other Affective Cues (what they may mean – cause, effect, intent)
Read Affective Cues •Self •Other
Provide (P):
A means to deal with these various goals/motives and emotions with more positive outcomes (e.g., have anal sex with a condom and how to do so– demonstrating new skills)
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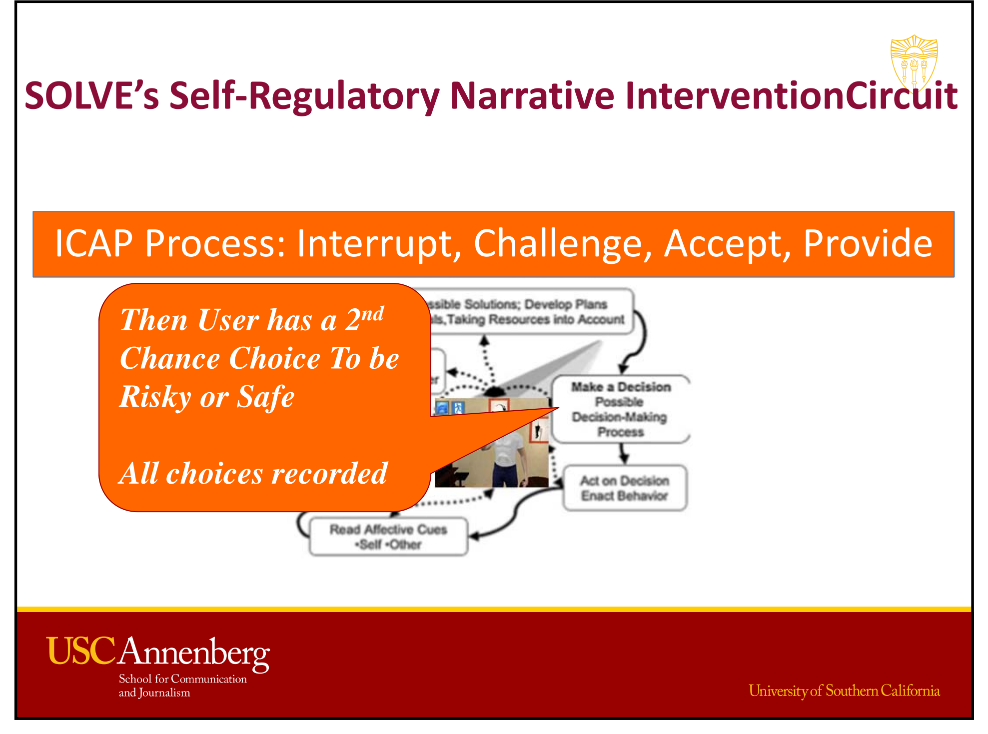

SOLVE's Self-Regulatory Narrative InterventionCircuit
ICAP Process: Interrupt, Challenge, Accept, Provide
Then User has a 2nd Chance Choice To be Risky or Safe
All choices recorded
Make a Decision Possible Decision-Making Process
Act on Decision Enact Behavior
Read Affective Cues •Self •Other
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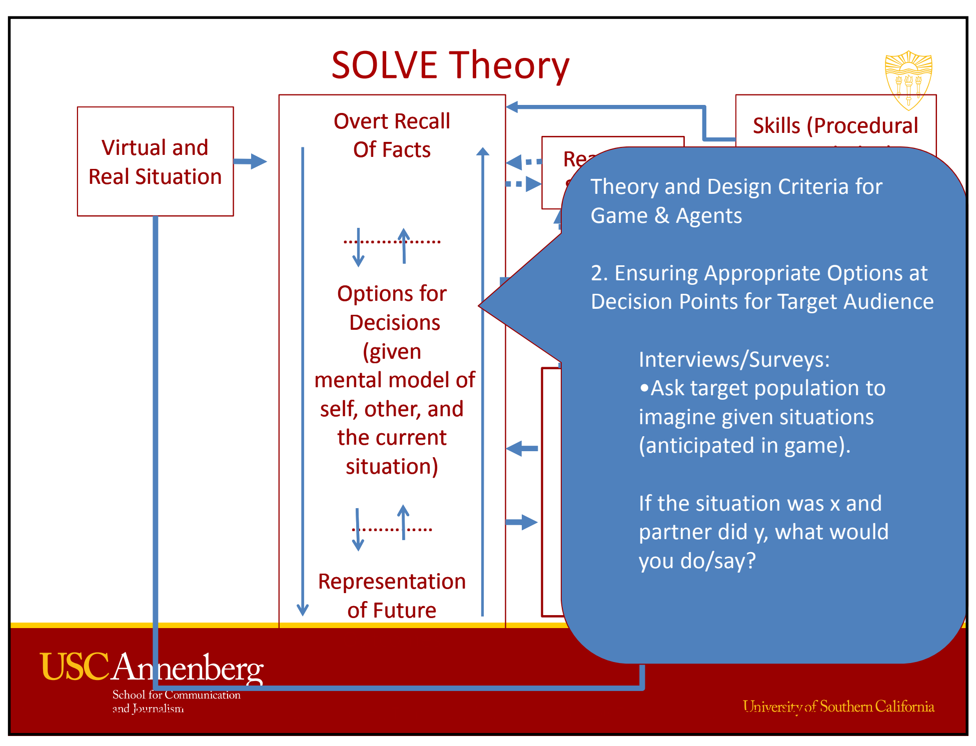
SOLVE Theory
Virtual and Real Situation
Overt Recall Of Facts
Options for Decisions (given mental model of self, other, and the current situation)
Representation of Future
Skills (Procedural
Theory and Design Criteria for Game & Agents
2. Ensuring Appropriate Options at Decision Points for Target Audience
Interviews/Surveys:
•Ask target population to imagine given situations (anticipated in game).
If the situation was x and partner did y, what would you do/say?
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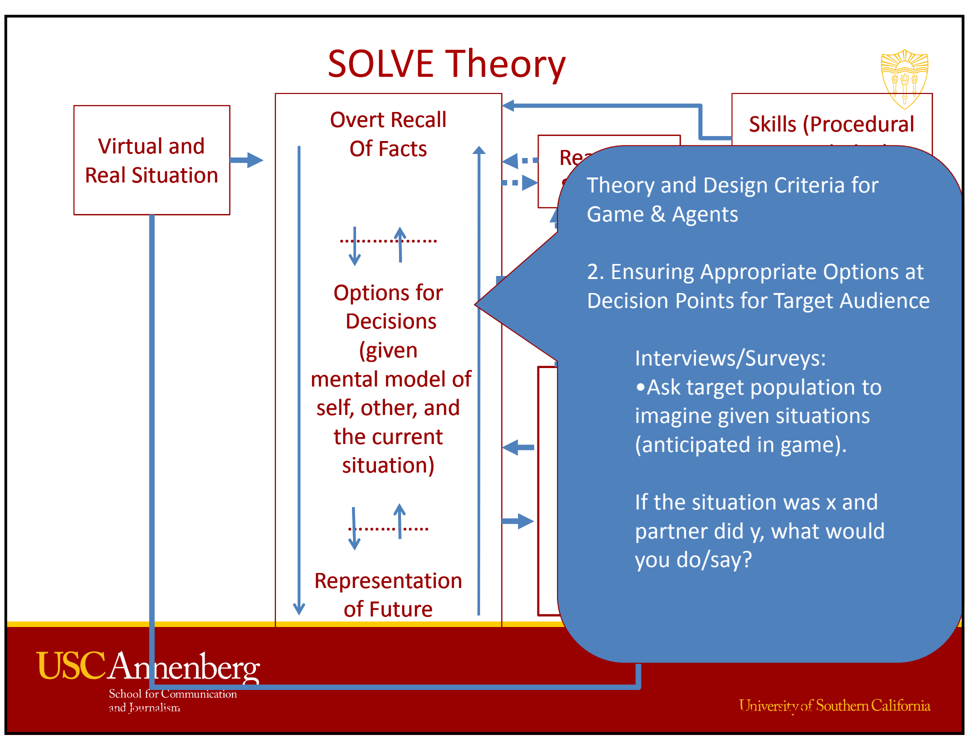
SOLVE Theory
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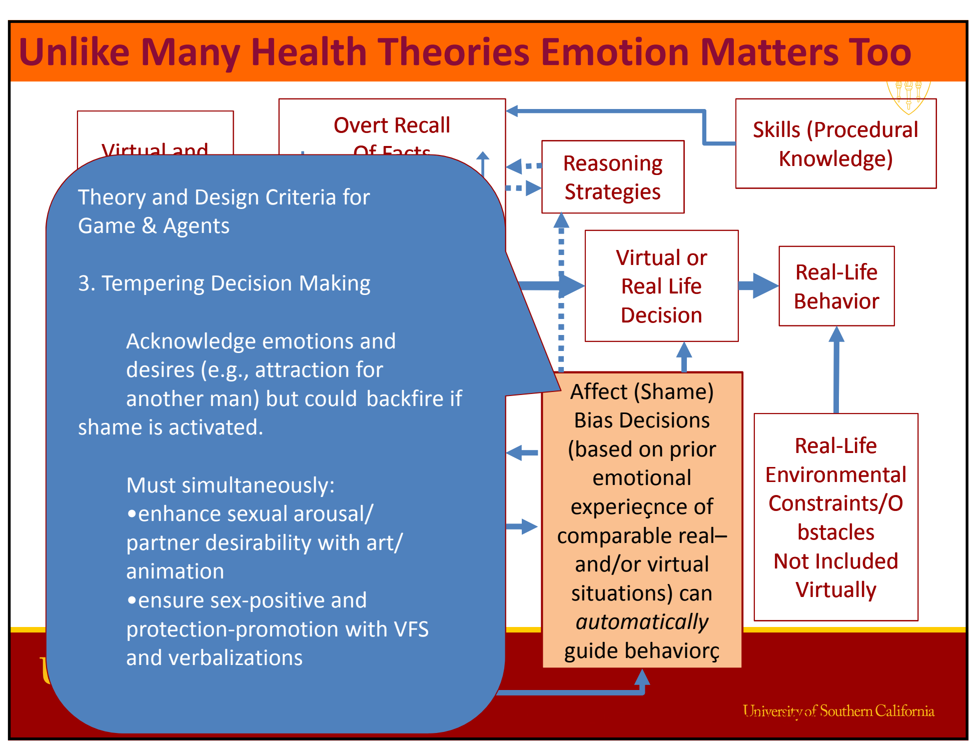
Unlike Many Health Theories Emotion Matters Too
Overt Recall
Skills (Procedural Knowledge)
Reasoning Strategies
Theory and Design Criteria for Game & Agents
3. Tempering Decision Making
Acknowledge emotions and desires (e.g., attraction for another man) but could backfire if shame is activated.
Must simultaneously:
•enhance sexual arousal/ partner desirability with art/ animation
•ensure sex-positive and protection-promotion with VFS and verbalizations
Virtual or Real Life Decision
Real-Life Behavior
Affect (Shame) Bias Decisions (based on prior emotional experieçnce of comparable real– and/or virtual situations) can *automatically* guide behaviorç
Real-Life Environmental Constraints/Obstacles Not Included Virtually
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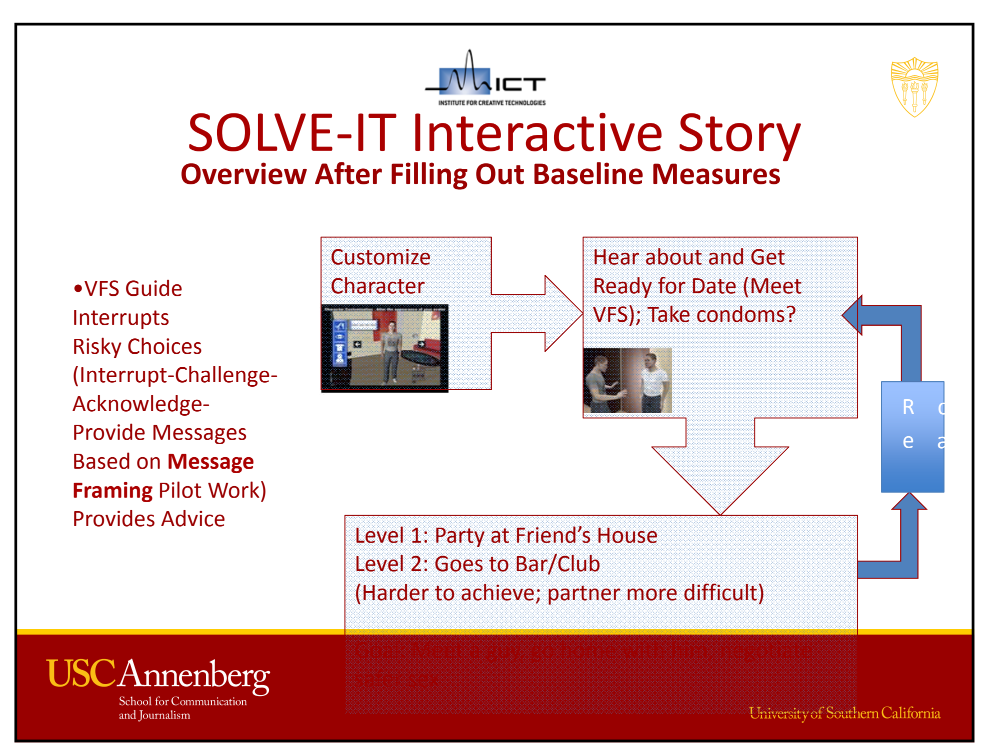
ICT
SOLVE-IT Interactive Story
Overview After Filling Out Baseline Measures
•VFS Guide Interrupts Risky Choices (Interrupt-Challenge-Acknowledge-Provide Messages Based on **Message Framing** Pilot Work) Provides Advice
Customize Character
Hear about and Get Ready for Date (Meet VFS); Take condoms?
Level 1: Party at Friend's House
Level 2: Goes to Bar/Club
(Harder to achieve; partner more difficult)
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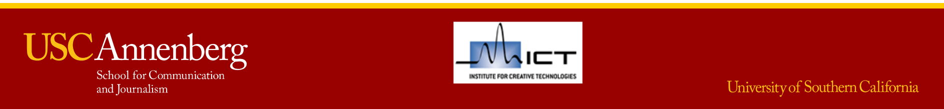
Technology Design

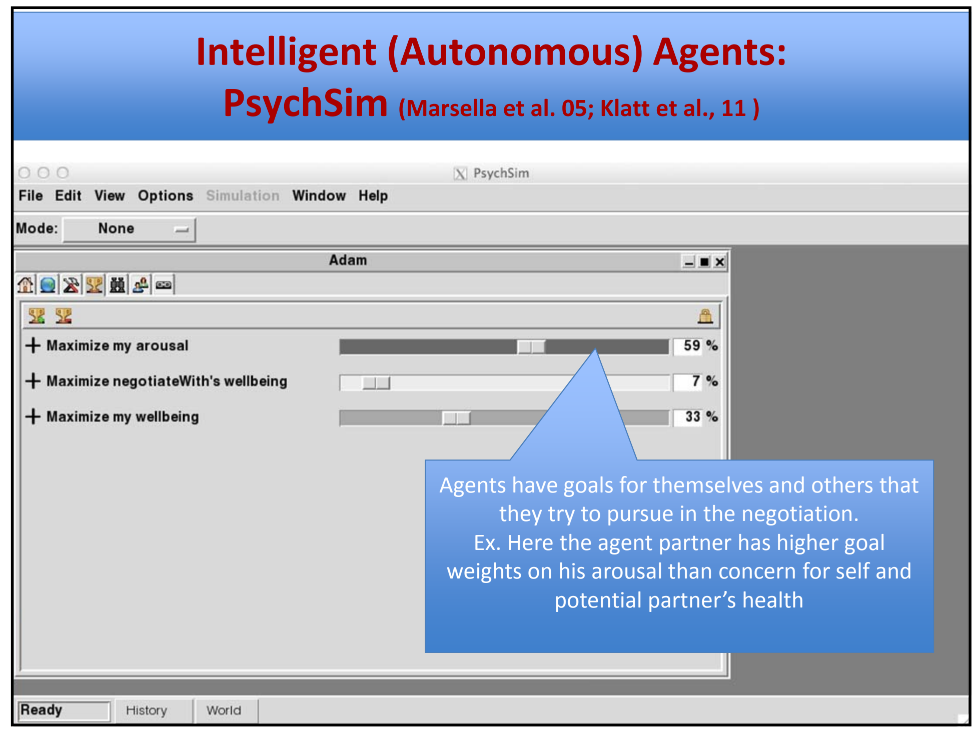
Design Challenges

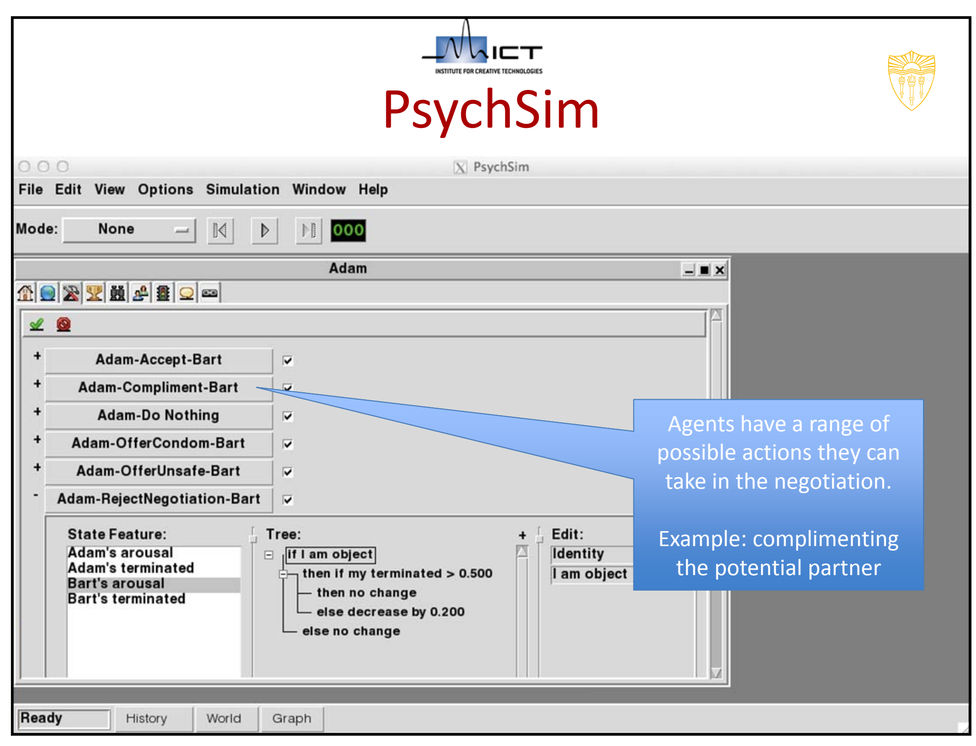
- Wanted cross-platform flexibility: Solution Unity
- Wanted numerous negotiation-rich risk challenges

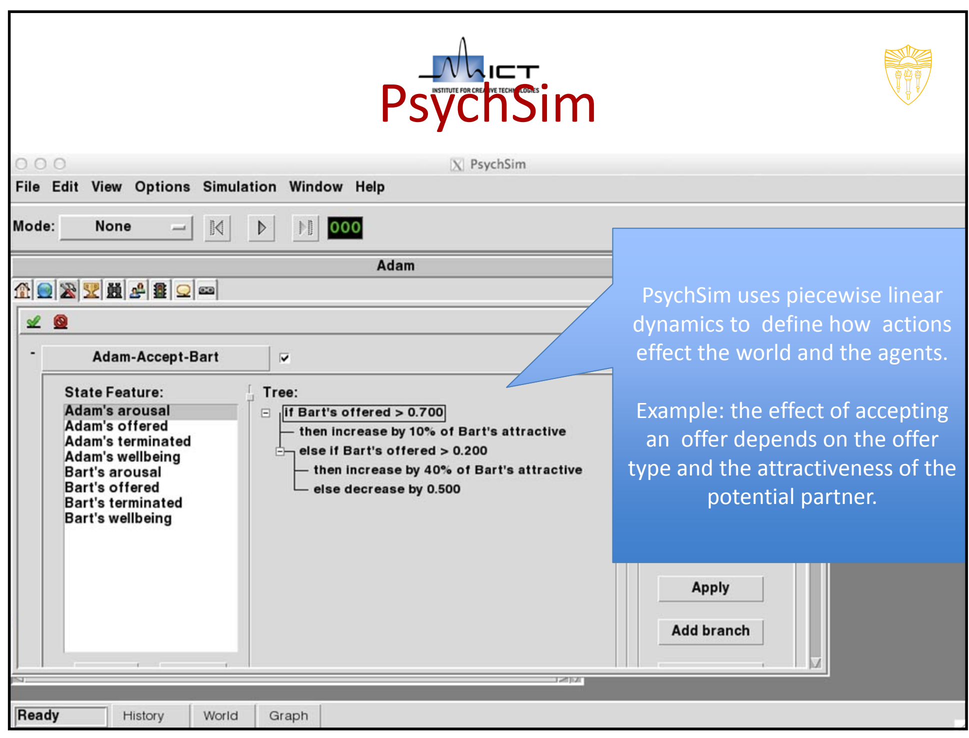
  But budget constrained animation. Solution: Get Creative (e.g., Used set of floating dialogues attached to a specific character activated when player talked to him; not reusable).
- Non-programmers would be informing design. Solution: develop XML scripting environment to control aspects of game

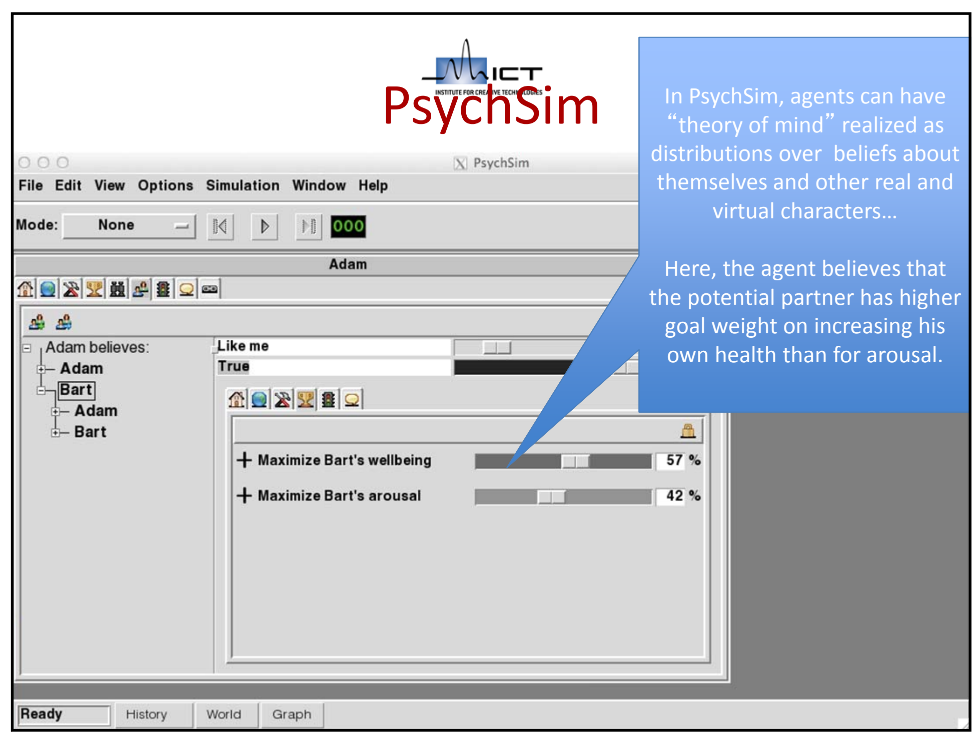


Intelligent (Autonomous) Agents: PsychSim (Marsella et al. 05; Klatt et al., 11)




PsychSim
File Edit View Options Simulation Window Help
Mode: None
Adam
Adam-Accept-Bart
Adam-Compliment-Bart
Adam-Do Nothing
Adam-OfferCondom-Bart
Adam-OfferUnsafe-Bart
Adam-RejectNegotiation-Bart
State Feature:
Adam's arousal
Adam's terminated
Bart's arousal
Bart's terminated
Tree:
if I am object
then if my terminated > 0.500
then no change
else decrease by 0.200
else no change
Edit:
Identity
I am object
Agents have a range of possible actions they can take in the negotiation.
Example: complimenting the potential partner
Ready
History
World
Graph


PsychSim
File Edit View Options Simulation Window Help
Mode: None
Adam
Adam-Accept-Bart
State Feature:
Adam's arousal
Adam's offered
Adam's terminated
Adam's wellbeing
Bart's arousal
Bart's offered
Bart's terminated
Bart's wellbeing
Tree:
if Bart's offered > 0.700
then increase by 10% of Bart's attractive
else if Bart's offered > 0.200
then increase by 40% of Bart's attractive
else decrease by 0.500
PsychSim uses piecewise linear dynamics to define how actions effect the world and the agents.
Example: the effect of accepting an offer depends on the offer type and the attractiveness of the potential partner.
Apply
Add branch
Ready
History
World
Graph



Methods RCT

- ***Eligible Participants***:
  - *HIV negative*
  - *Self-identified African-American, Latino, or White MSM*
  - *18 to 24 years of age*
  - *Had had CAS with a non-primary/casual partner in the past 3 months*

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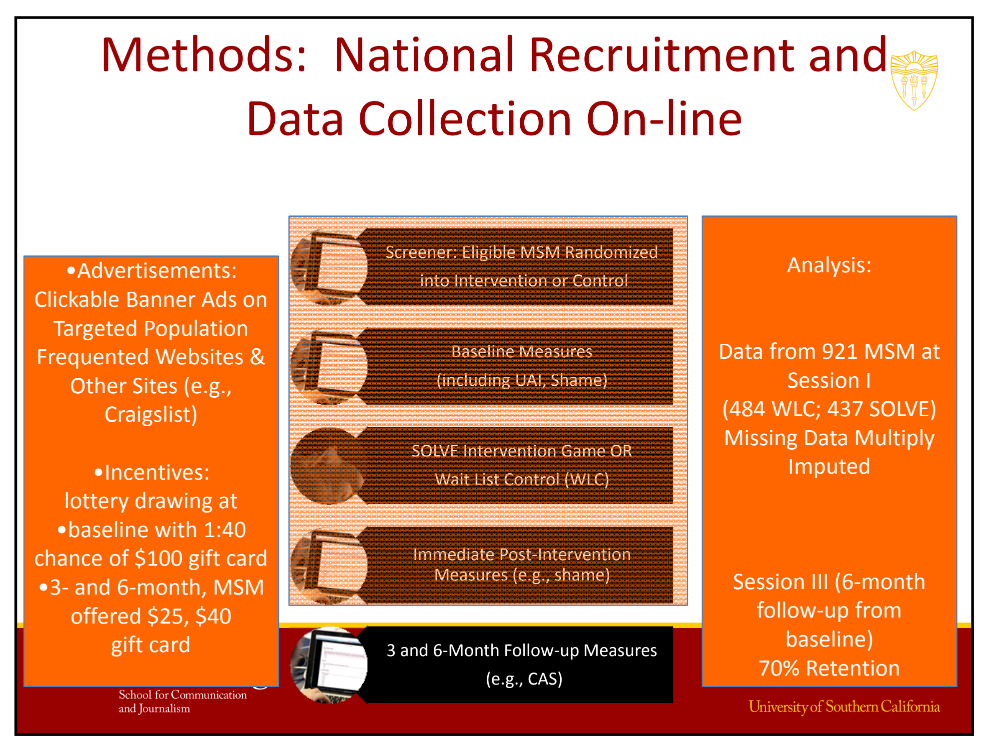
Methods: National Recruitment and Data Collection On-line
•Advertisements: Clickable Banner Ads on Targeted Population Frequented Websites & Other Sites (e.g., Craigslist)
•Incentives: lottery drawing at
•baseline with 1:40 chance of $100 gift card
•3- and 6-month, MSM offered $25, $40 gift card
Screener: Eligible MSM Randomized into Intervention or Control
Baseline Measures (including UAI, Shame)
SOLVE Intervention Game OR Wait List Control (WLC)
Immediate Post-Intervention Measures (e.g., shame)
3 and 6-Month Follow-up Measures (e.g., CAS)
Analysis:
Data from 921 MSM at Session I (484 WLC; 437 SOLVE) Missing Data Multiply Imputed
Session III (6-month follow-up from baseline) 70% Retention
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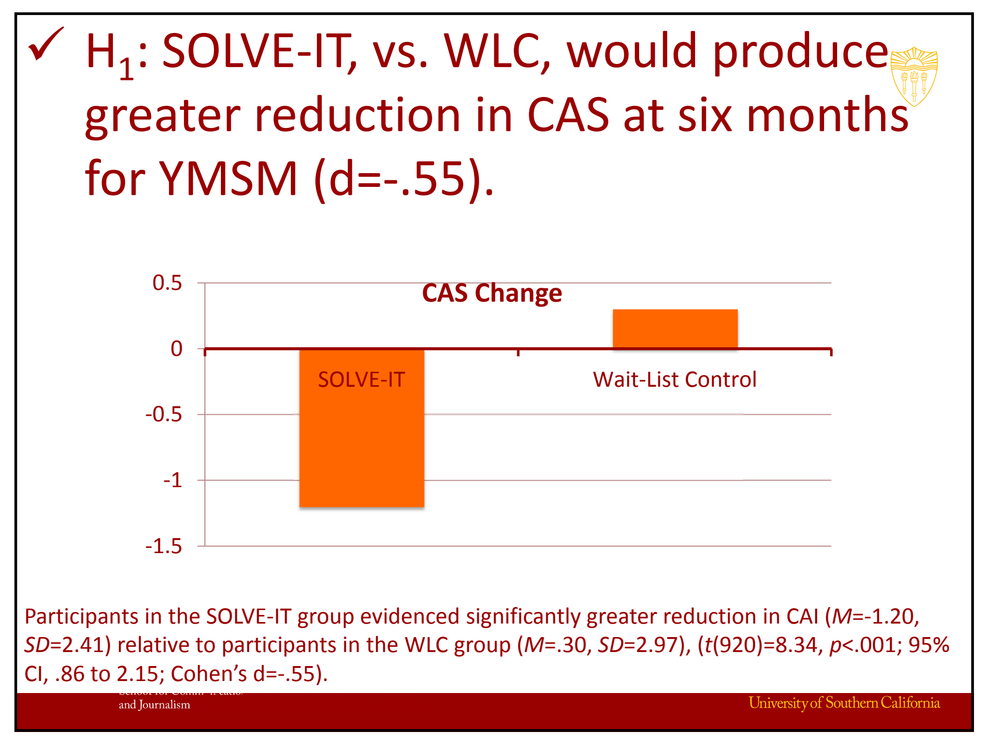
H1: SOLVE-IT, vs. WLC, would produce greater reduction in CAS at six months for YMSM (d=-.55).
CAS Change
0.5
0
-0.5
-1
-1.5
SOLVE-IT
Wait-List Control
Participants in the SOLVE-IT group evidenced significantly greater reduction in CAI (M=-1.20, SD=2.41) relative to participants in the WLC group (M=.30, SD=2.97), (t(920)=8.34, p<.001; 95% CI, .86 to 2.15; Cohen's d=-.55).
and Journalism
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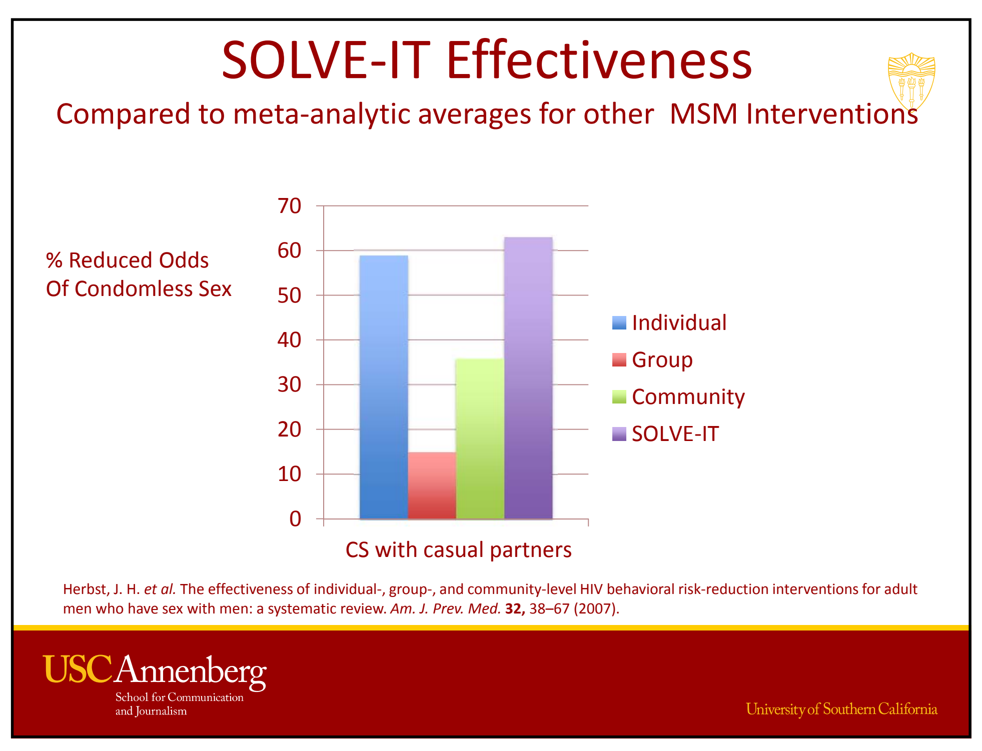
SOLVE-IT Effectiveness
Compared to meta-analytic averages for other MSM Interventions
% Reduced Odds
Of Condomless Sex
70
60
50
40
30
20
10
0
Individual
Group
Community
SOLVE-IT
CS with casual partners
Herbst, J. H. et al. The effectiveness of individual-, group-, and community-level HIV behavioral risk-reduction interventions for adult men who have sex with men: a systematic review. Am. J. Prev. Med. 32, 38–67 (2007).
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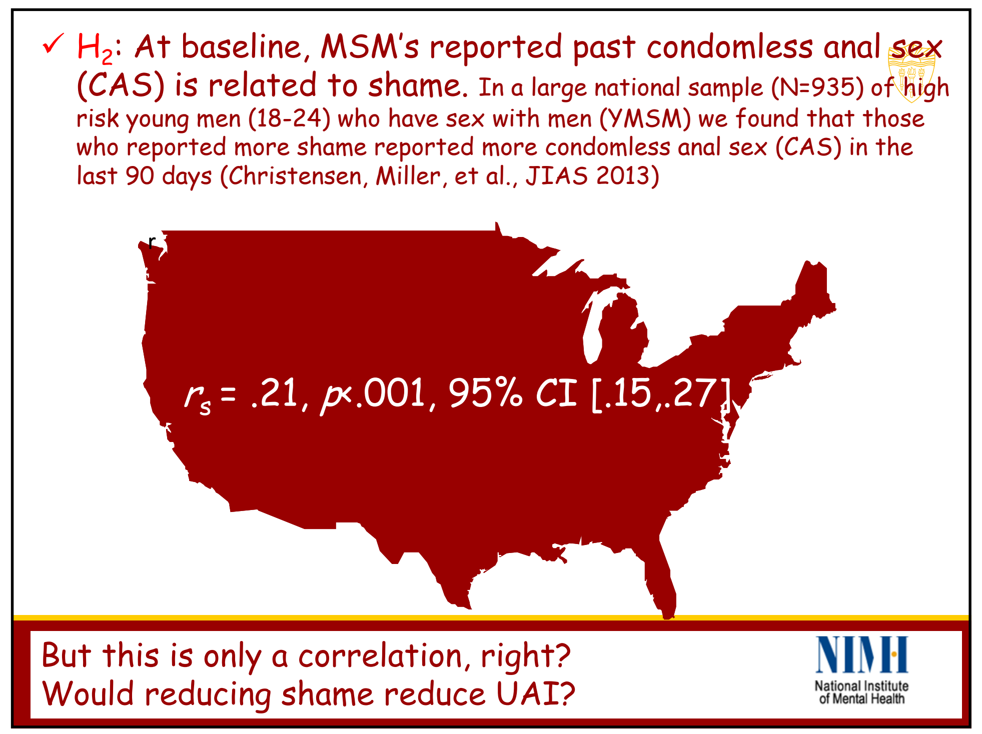
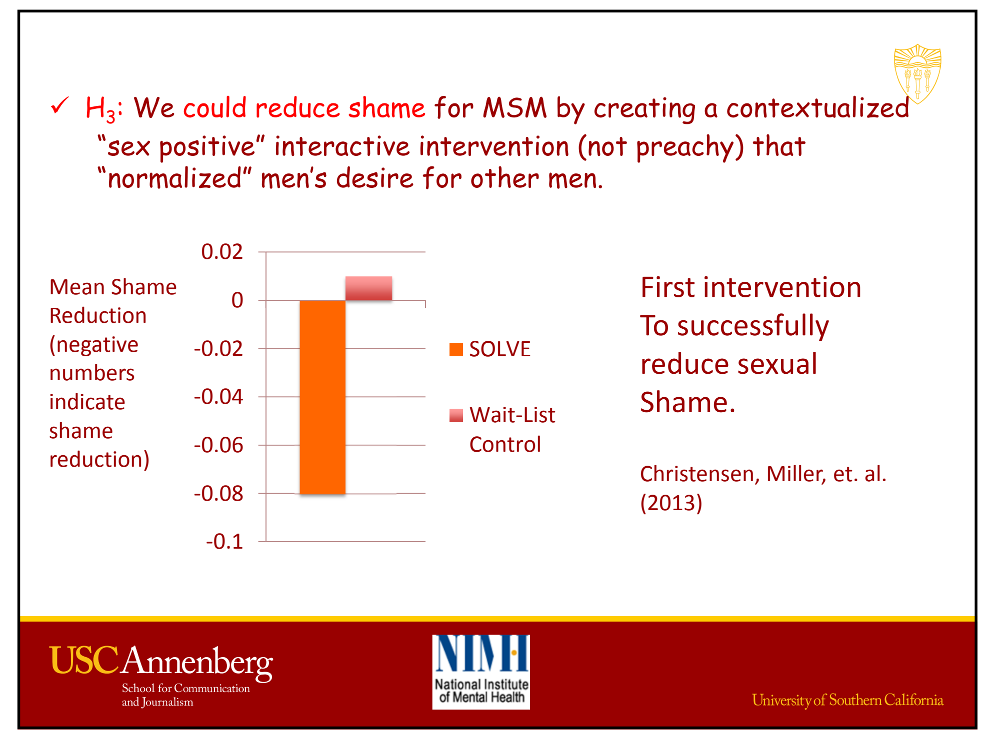

✓ H2: At baseline, MSM's reported past condomless anal sex (CAS) is related to shame. In a large national sample (N=935) of high risk young men (18-24) who have sex with men (YMSM) we found that those who reported more shame reported more condomless anal sex (CAS) in the last 90 days (Christensen, Miller, et al., JIAS 2013)
rs = .21, p<.001, 95% CI [.15,.27]
But this is only a correlation, right?
Would reducing shame reduce UAI?
NIMH
National Institute of Mental Health


✓ H_3: We could reduce shame for MSM by creating a contextualized "sex positive" interactive intervention (not preachy) that "normalized" men's desire for other men.
Mean Shame Reduction (negative numbers indicate shame reduction)
0.02
0
-0.02
-0.04
-0.06
-0.08
-0.1
SOLVE
Wait-List Control
First intervention To successfully reduce sexual Shame.
Christensen, Miller, et. al. (2013)
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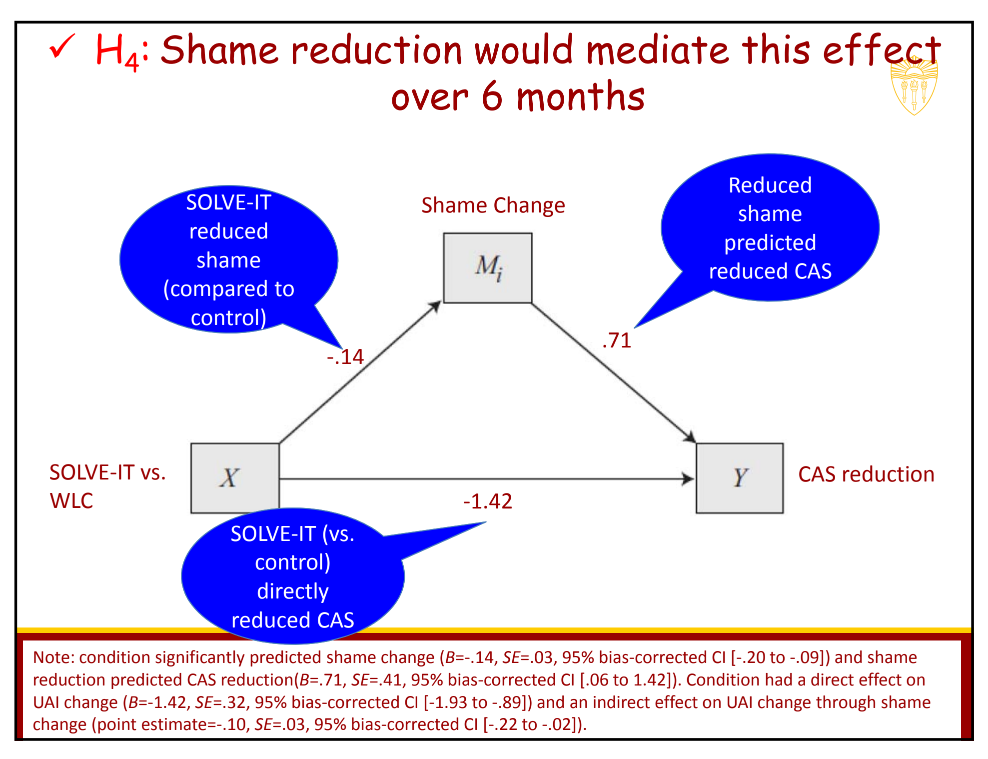
School for Communication and Journalism
NIMH
National Institute of Mental Health
University of Southern California


✓ H_4: Shame reduction would mediate this effect over 6 months
SOLVE-IT reduced shame (compared to control)
Shame Change
M_i
Reduced shame predicted reduced CAS
-.14
.71
SOLVE-IT vs. WLC
X
-1.42
Y
CAS reduction
SOLVE-IT (vs. control) directly reduced CAS
Note: condition significantly predicted shame change (B=-.14, SE=.03, 95% bias-corrected CI [-.20 to -.09]) and shame reduction predicted CAS reduction(B=.71, SE=.41, 95% bias-corrected CI [.06 to 1.42]). Condition had a direct effect on UAI change (B=-1.42, SE=.32, 95% bias-corrected CI [-1.93 to -.89]) and an indirect effect on UAI change through shame change (point estimate=-.10, SE=.03, 95% bias-corrected CI [-.22 to -.02]).

Broad National Reach
935 NIMH Participants Across the Nation; Conducted intervention over web (All 50 States)

Screened over 30,000 MSM to end up with our high risk sample of YMSM

Limitations and Conclusions

- **Limitations** –
  - Problems playing game (exclusion high at baseline).
- **Conclusions**—
  - •SOLVE-IT -***first online game*** specifically ***targeting at-risk YMSM*** to both:

    reduce CAS at 6-months

    reduce shame -> mediates intervention 6-month effect.

•Research:

- •***challenging*** but promising in providing effective interventions – ***with broad reach***.

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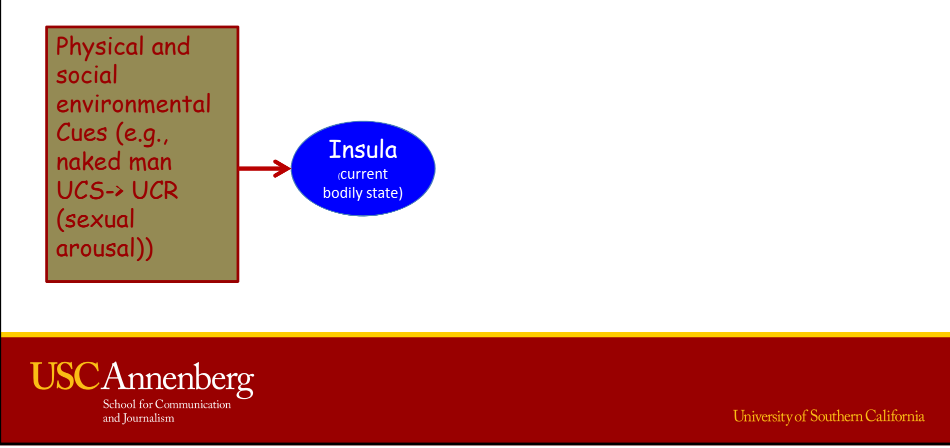
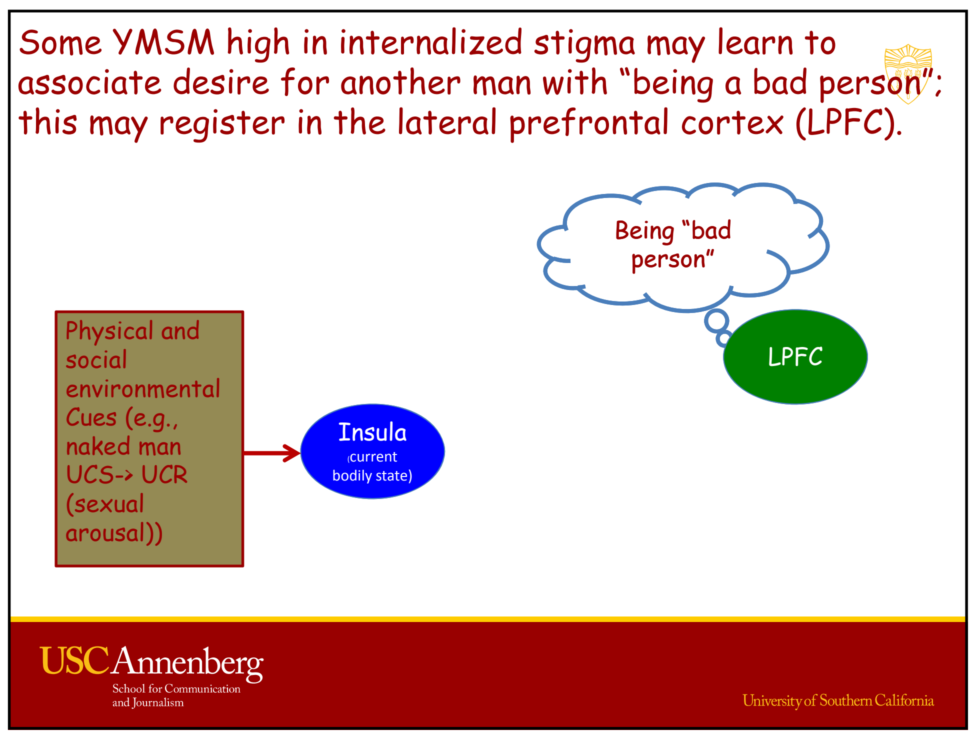
SOLVE-IT reduced shame, and reduced shame reduced CAS, but why exactly? Puzzle --what's happening neurally.

- For Risky MSM, we adapted the Bechara et al. neuroscience model or risky decision-making (Bechara was a collaborator)… for sexually risky decisions

We reasoned that if an attractive naked man is in front of a YMSM –likely that naked man would be an unconditioned stimulus (UCS)). YMSM may respond with an unconditioned response (UCR-sexual arousal); this bodily reaction would register in the Insula in the decision-making network of the brain (Insula monitors current bodily state)




Some YMSM high in internalized stigma may learn to associate desire for another man with "being a bad person"; this may register in the lateral prefrontal cortex (LPFC).
Being "bad person"
LPFC
Physical and social environmental Cues (e.g., naked man UCS-> UCR (sexual arousal))
Insula (current bodily state)
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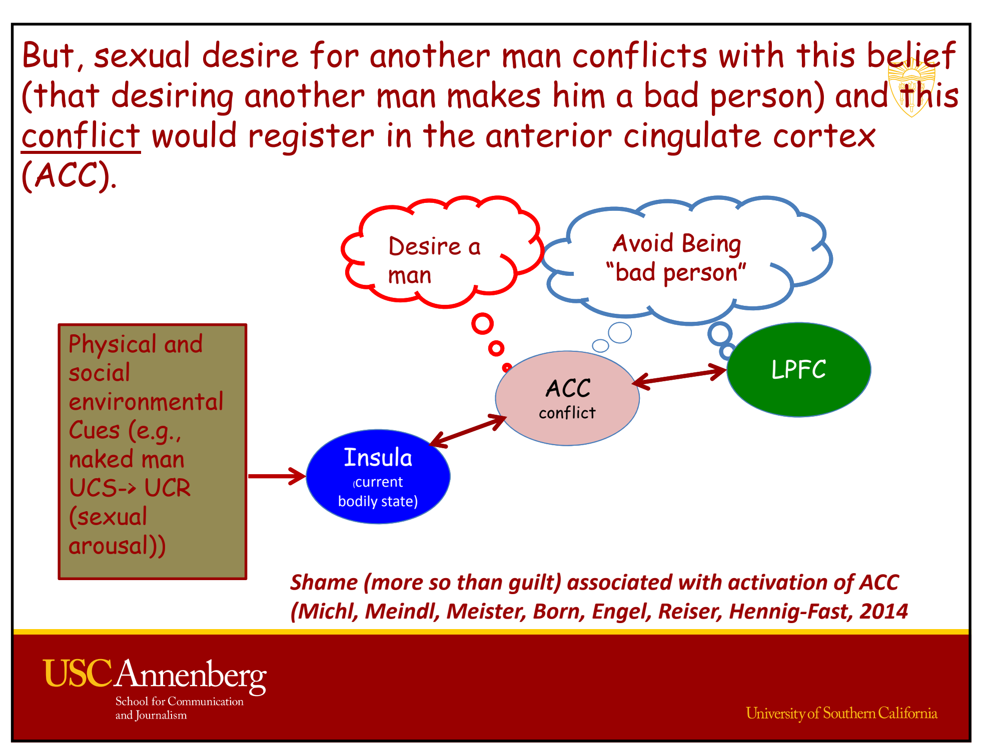
But, sexual desire for another man conflicts with this belief (that desiring another man makes him a bad person) and this conflict would register in the anterior cingulate cortex (ACC).
Desire a man
Avoid Being "bad person"
LPFC
ACC conflict
Physical and social environmental Cues (e.g., naked man UCS-> UCR (sexual arousal))
Insula (current bodily state)
Shame (more so than guilt) associated with activation of ACC (Michl, Meindl, Meister, Born, Engel, Reiser, Hennig-Fast, 2014
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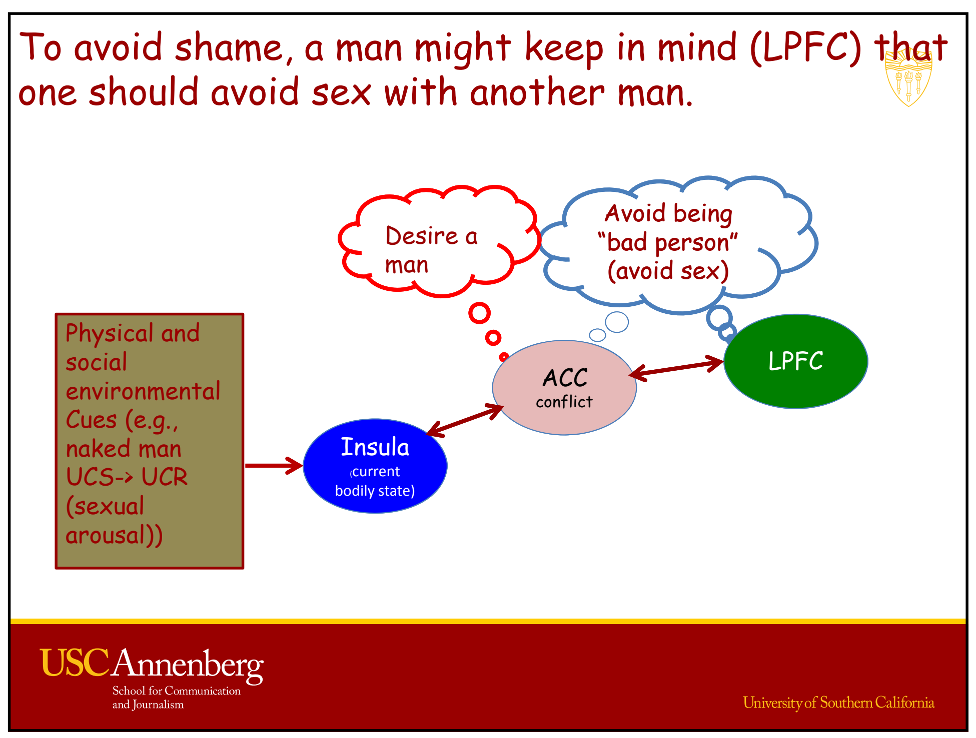
To avoid shame, a man might keep in mind (LPFC) that one should avoid sex with another man.
Desire a man
Avoid being "bad person" (avoid sex)
Physical and social environmental Cues (e.g., naked man UCS-> UCR (sexual arousal))
ACC conflict
LPFC
Insula (current bodily state)
USC Annenberg
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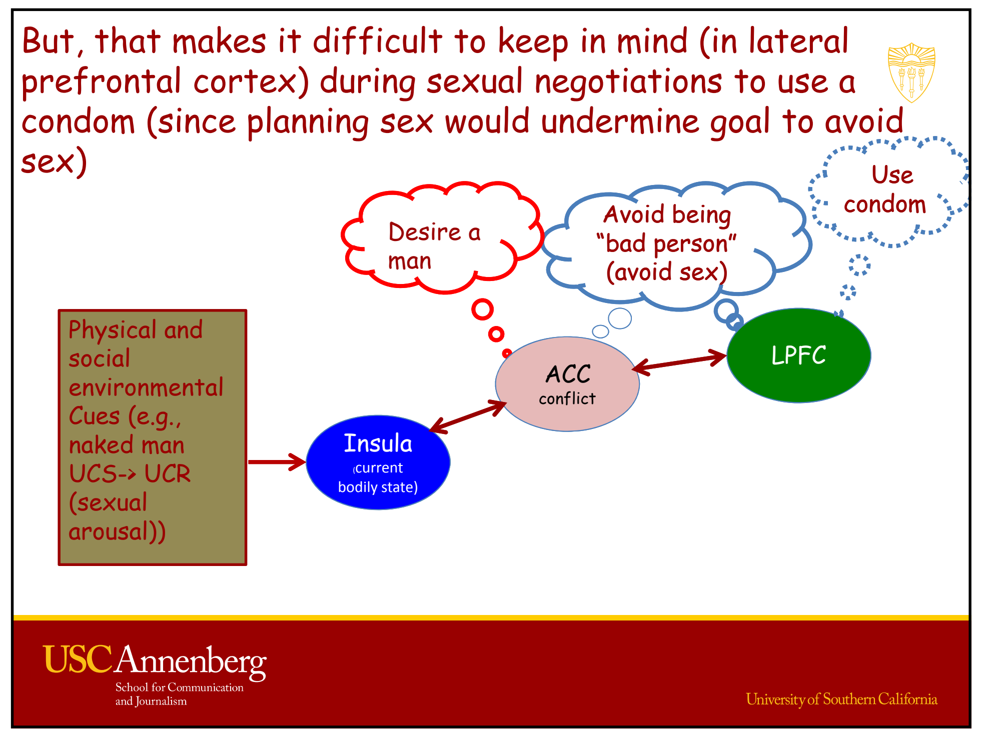
University of Southern California


But, that makes it difficult to keep in mind (in lateral prefrontal cortex) during sexual negotiations to use a condom (since planning sex would undermine goal to avoid sex)
Use condom
Desire a man
Avoid being "bad person" (avoid sex)
Physical and social environmental Cues (e.g., naked man UCS-> UCR (sexual arousal))
ACC conflict
LPFC
Insula (current bodily state)
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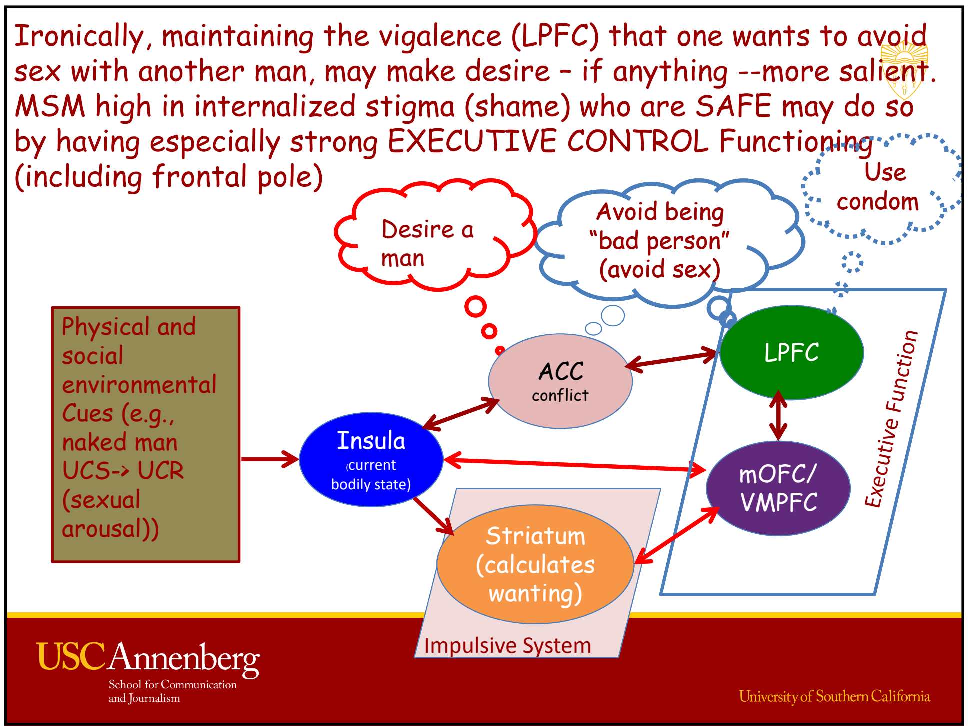
School for Communication and Journalism
University of Southern California


Ironically, maintaining the vigalence (LPFC) that one wants to avoid sex with another man, may make desire – if anything --more salient. MSM high in internalized stigma (shame) who are SAFE may do so by having especially strong EXECUTIVE CONTROL Functioning (including frontal pole)
Use condom
Desire a man
Avoid being "bad person" (avoid sex)
Physical and social environmental Cues (e.g., naked man UCS-> UCR (sexual arousal))
ACC conflict
LPFC
Insula (current bodily state)
mOFC/ VMPFC
Executive Function
Striatum (calculates wanting)
Impulsive System
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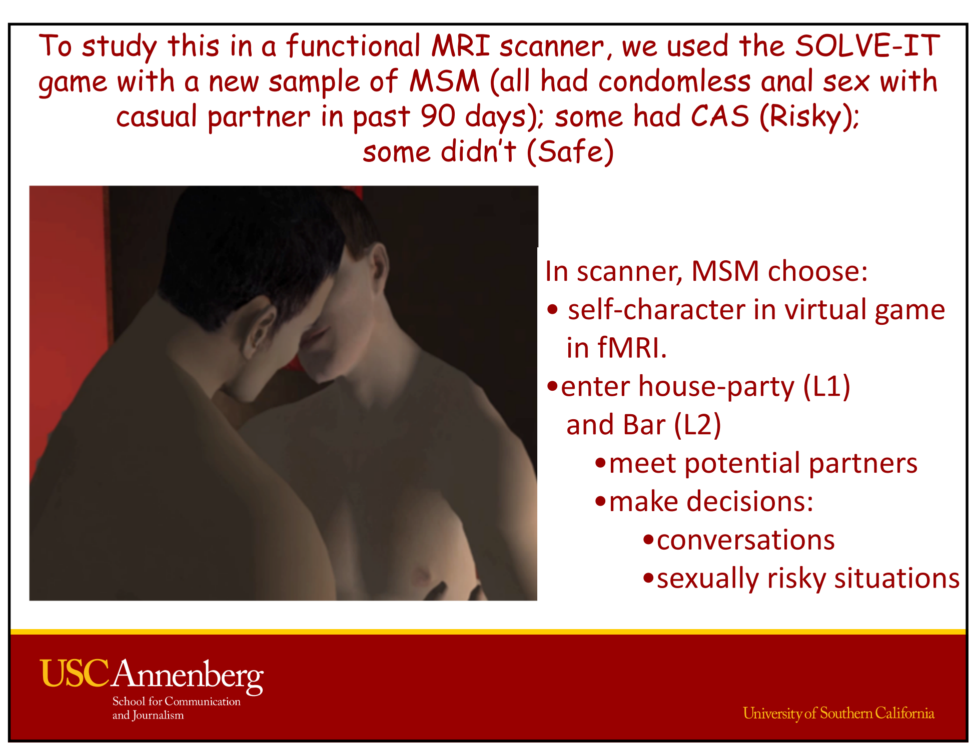
School for Communication and Journalism
University of Southern California


To study this in a functional MRI scanner, we used the SOLVE-IT game with a new sample of MSM (all had condomless anal sex with casual partner in past 90 days); some had CAS (Risky); some didn't (Safe)
In scanner, MSM choose:
• self-character in virtual game in fMRI.
•enter house-party (L1) and Bar (L2)
•meet potential partners
•make decisions:
•conversations
•sexually risky situations
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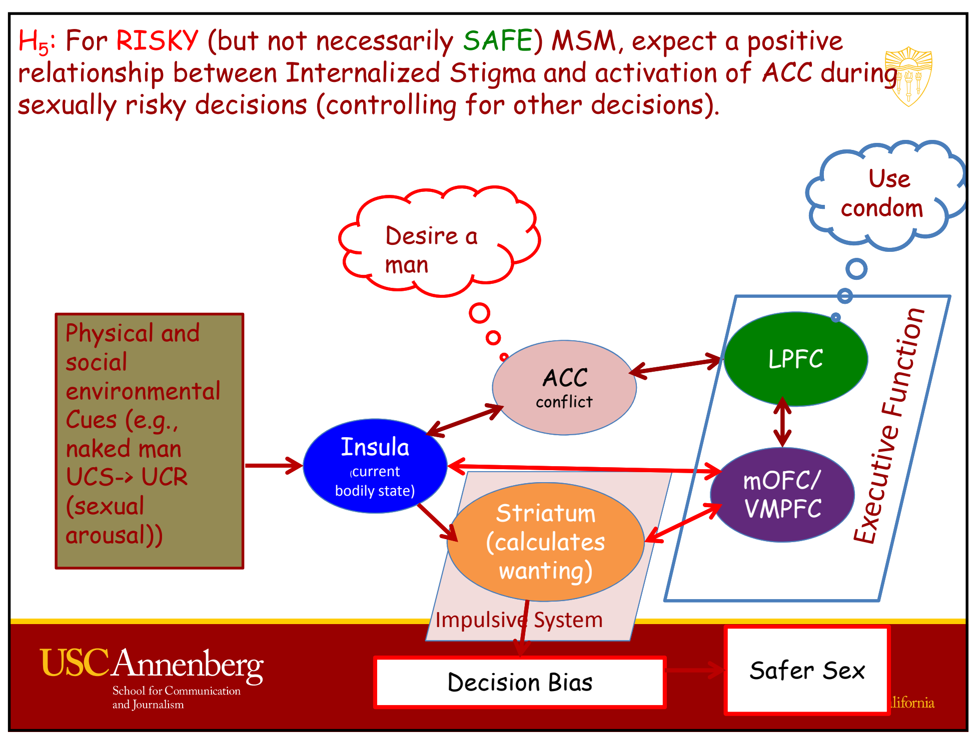
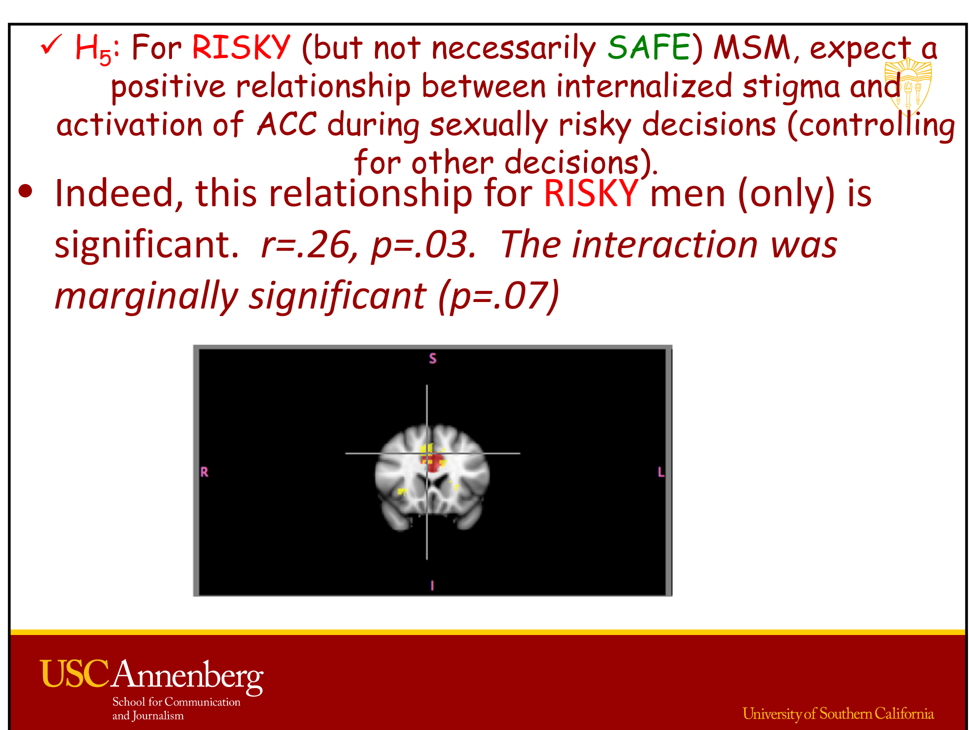

H5: For RISKY (but not necessarily SAFE) MSM, expect a positive relationship between Internalized Stigma and activation of ACC during sexually risky decisions (controlling for other decisions).
Use condom
Desire a man
Physical and social environmental Cues (e.g., naked man UCS-> UCR (sexual arousal))
ACC
conflict
LPFC
Insula
current bodily state)
mOFC/ VMPFC
Striatum (calculates wanting)
Executive Function
Impulsive System
Decision Bias
Safer Sex
USC Annenberg
School for Communication and Journalism


✓ H5: For RISKY (but not necessarily SAFE) MSM, expect a positive relationship between internalized stigma and activation of ACC during sexually risky decisions (controlling for other decisions).
• Indeed, this relationship for RISKY men (only) is significant. r=.26, p=.03. The interaction was marginally significant (p=.07)
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R
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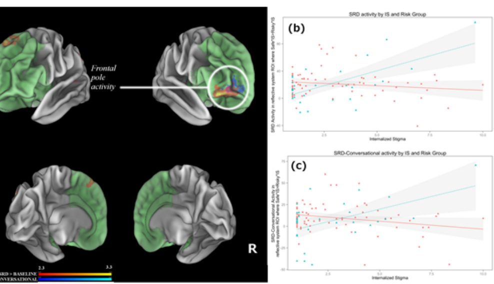
✓ H_6: For SAFE but not RISKY MSM, Internalized Stigma (IS) should be more strongly related to frontal pole activity (Executive function). Indeed interaction significant.



As predicted, contrasting SAFE (*n*=30) with RISKY (*n*=71) MSM during risky sexual decisions revealed that the association between IS score and activity in the (right dorsal) frontal pole in Broadmann Area 10 was more positive for SAFE than RISKY MSM; the contrast was observable whether or not risky sexual decisions were contrasted with baseline (*z*-max[44, 46, -12] = 3.8, *p*=0.03) or with other conversational decisions (z-max[26, 48, -4] = 4.4, *p*=0.01) .

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Conclusions:

- We can reduce condomless anal sex for high risk young MSM using games (designed to be representative of the real world scenarios and critical challenges young at-risk MSM face) that can be effectively delivered and tested nationally over the web.
- We do so in part by reducing sexual shame and enhancing self-regulation.

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Conclusions:

- Neurally, we showed that irresolvable conflict (ACC) may adversely affect decision making and that once we reduce it and add emotional self-regulation, this may allow MSM executive control to use condoms and avoid risk of HIV.

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Thank You!

- Additional thoughts:
  - Hard to get funding for distribution of SOLVE-IT
    Gap in sustainable access to Game Interventions
    downloadable from web from reliable source.

Questions?

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MULTICULTURAL MILLENNIALS:

THE MULTIPLIER EFFECT

JANUARY 2017: LITE VERSION

AN UNCOMMON SENSE
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MULTICULTURAL MILLENNIAL: THE MULTIPLER EFFECT REPORT LITE

The pages here represent a selection of highlights from the Multicultural Millennial: The Multiplier Effect report, a comprehensive, in-depth study of multicultural Millennials.

It explores key aspects of the population, including demographic information and trends, analyzes multicultural Millennials' choices of home cities, and outlines how culture, food and technology are essential points of entry for reaching this generation.

The report also outlines both the "multiplier effect" and "halo effect" that multicultural Millennials have on their peers as well as on older and younger generations. As they continue to expand in number and influence, adept marketers increasingly need a roadmap to reach them. The multiplier effect is that roadmap.

Many have written and spoken of a distant future, decades down the road, when African Americans, Asian Americans, and Hispanics will hold a position of dominance in the U.S. In our marketplace, and in terms of overall influence, that reality exists today. The multiplier effect updates information, trends and strategies for connecting with multicultural Millennials and, by association, other targeted demographic groups, allowing marketers and advertisers to maximize their investments.

EXECUTIVE SUMMARY

The U.S.' 75 million Millennials[1], age 18-34, are the country's second largest generation[2], and include the often overlooked multicultural Millennials, those young people of African American, Asian American, and Hispanic heritage who comprise 42%[1] of the cohort and are the nation's largest workforce demographic[3]. These young people are bridging the gaps between their own generation and both younger and older cohorts. They are also fully ambicultural, effortlessly bridging the gaps between their birth culture and other cultures. This multiplier effect should and can be harnessed by marketers and advertisers.

Twenty-one of the country's 25 most populated counties[4] boast a majority multicultural population, representing local markets that drive 47% of the total U.S. gross domestic product[5]. For the first time since the 1920s, populations in urban centers are growing more quickly than they are outside of cities[6]. Multicultural Millennials are choosing homes in a variety of metropolitan areas, having been driven by cultural connections, career options and economic opportunity, and they are profoundly influencing all of the communities in which they live.

Multicultural Millennials' broad, unique buying habits are inspiring successful, popular cultural trends, and are having a profound effect on their peers, their parents and their children. This halo effect is one of the cohort's key attributes.

The ambicultural multicultural Millennial expression of culture is interwoven into all aspects of their lives, and they take extra steps to maintain their critical connection to their culture. There are several portals to connecting with the cohort, including the sports, photography, fashion and food industries. It's important to note that what was once considered "multicultural" is now mainstream, and that shift will only accelerate over the next several decades.

[1] *Nielsen Pop-Facts*
[2] *Nielsen Scarborough*
[3] *Pew Research Study, 2015*
[4] *Nielsen Spectra*
[5] *Bureau of Economic Analysis*
[6] *Brookings Institution*

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Multicultural Millennials insist on expressing their connection to culture on their own terms, with palates that have been heavily influenced by their parents. Their food choices have become mainstream, and their insistence on their availability is influencing options in the marketplace in profound, permanent ways. Multicultural Millennials are also increasingly drawn to a variety of retail categories, including dollar stores, convenience / gas locations, warehouse clubs, online, and mass merchandise. Favored categories include ethnic hair and beauty products, toiletries, hosiery / socks and skin care products. When they dine out, multicultural Millennials want a comprehensive menu that reflects their diverse, culturally derived tastes, and the influence those tastes and demands are having on the grocery and restaurant industries is profound and indisputable.

Even more than the products they buy and the retail channels they employ, multicultural Millennials value experiences, and look to products to enhance and support their connections to their culture. One of the ways in which they cultivate those connections is via technology, with 96%[11] of multicultural Millennials having a smartphone as they influence more than $1 trillion in total consumer packaged goods and entertainment spending[7].

Marketers and advertisers should also consider social media when reaching multicultural Millennials, particularly Facebook Messenger, Google, Spotify and Twitter. Multicultural Millennials are also changing the television landscape - 31% of them have internet-enabled smart televisions[11].

[7] *The Cambridge Group*

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SECTION 1

YOUR PORTAL TO OTHER GENERATIONS, OTHER CULTURES, AND BUSINESS GROWTH

Making up 23%[2] of the U.S. population, our 75[1] million Millennials are the country's second largest generation[2]. Often overlooked within the cohort are multicultural Millennials: those individuals of African American, Asian American, and Hispanic heritage. Unquestionably, they are uniquely positioned to be the evangelists and amplifiers of any organization's brand or business, and are critical in today's marketplace.

Multicultural Millennials are bridging the gaps between their birth culture, their own children, and mainstream society. Most multicultural Millennials are fully ambicultural, shifting from what was once a dominant family-based culture to a posture that straddles cultures regularly, constantly, and holistically. Their profound influence on their peers as well as on both younger and older generations – the multiplier effect – can and should be harnessed as businesses and organizations make efforts to expand their market share.

In addition to the influence they command on their more mainstream peers, there is another reason marketing professionals should be interested in multicultural Millennials: many of them are first generation professionals who are in prime acquisition mode. Their disposable income is ripe for the picking to those companies who court them and cultivate their business. Half of all Millennials (and non-Hispanic whites) have an income of over $50,000, and over a third of multicultural Millennials command those salaries[2].

There are also a lot of multicultural Millennials to be reached: They comprise 42% of the cohort, and are the largest workforce demographic in the country. Their sheer numbers make them impossible to ignore.

SECTION 2

A TALE OF THREE CULTURES

For multicultural Millennials, culture and its expression are more than accessories to life; they are intrinsic, critical components to self that are interwoven into everything they think, do, and are. Each of the group's subsets – African American, Asian American, and Hispanic Millennials – take extra steps to remain connected to their cultures and, for those with whom it's appropriate, their home countries.

However, the methods by which multicultural Millennials remain connected differ from their older cohorts. Many multicultural Millennials stay connected to their family members and home countries through technology. 89%[2] of Millennials who have called Mexico for personal reasons are multicultural.

The population also values cultural experiences outside of their own. *This can be seen in the over two-thirds of all Millennials who agree that it's important to speak a language other than English*[9]. *While more than three-quarters of multicultural Millennials believe that it's important to speak a language other than English*[9]. As such, marketers who have been successful in reaching multicultural Millennials have taken extra steps to provide points of entry to products and services that will help members of that population stay connected with each other. In doing so, they have an easier time remaining top-of-mind with multicultural Millennials.

SPORTS & FASHION AND THE MULTICULTURAL MILLENNIAL

Sports, fashion, personal upkeep, and photographic supplies offer product lines that index very well with multicultural Millennials, as they intrinsically provide opportunities for the culture-based self-expression that they value. *Millennials sharply over index in the purchase of NBA and WWE-related apparel, and are 21% more likely to purchase sports apparel emblazoned with sports-related logos than Boomers*[2]. Seen across all multicultural Millennial sub-groups, the connection to a variety of spectator sports and the consumption of sports-related products allows multicultural Millennials to connect with and express affiliations with groups aside from their cultures of origin. To multicultural Millennials, connections to sports teams and leagues are as vital as those to ethnic groups or professional affiliations and provide yet another channel for marketers to connect with them.

[9] *The Harris Poll*

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SECTION 3

HAVING IT THEIR WAY IS THEIR WAY!

The "we, more, and now" generation's identity is intricately interwoven with their overall identity, and the population's buying habits reveal paths to connecting with this critical market segment. What was once thought of as "multicultural" is now mainstream, and that shift will further accelerate over the next several decades.

WHILE ALMOST HALF OF ALL MILLENNIALS WANT TO PURCHASE FOODS FROM COMPANIES THAT HARBOR A STRONG SOCIAL PURPOSE OR MISSION, IT IS ALMOST AS IMPORTANT THAT COMPANIES OFFER MULTICULTURAL PRODUCTS. 44 PERCENT OF ALL MILLENNIALS SAY THAT IT'S IMPORTANT OR ESSENTIAL FOR THEIR FOODS TO INCLUDE "MULTICULTURAL FLAVORS," WHILE 51 PERCENT SAY IT'S IMPORTANT OR ESSENTIAL FOR THEIR FOOD TO INCLUDE LOCALLY SOURCED AND SUSTAINABLE INGREDIENTS[9].

The multicultural Millennials palate has been heavily influenced by their parents, and the population places a high value on the authenticity of food options. Those acquired tastes are having a profound influence; what were once considered "ethnic" — tacos, chili, sushi, "soul food" — have become mainstream, with Millennials never knowing a world without them and actively seeking them out.

Another example of this is the effect that multicultural Millennials are having on the restaurant industry. Once considered a fringe product, pork belly has been added to restaurant menus nationwide and has enjoyed a 223%[10] increase in penetration over the last four years. A true halo effect is evident, as multicultural Millennials' evolving, ever-expanding tastes and consumption patterns are influencing those of their parents, their children, and mainstream culture and society.

[10] Data Essentials – 25 Fastest Growing Proteins

SECTION 4

MILLENNIALS, MULTICULTURAL, AND MOBILE: A MUST NOT MISS MANTRA

Millennials don't recall a world without the internet, nor one without a constant connection to the world around them via technology. The key to that connection is most often in their hands, pockets, and purses: 97 %[11] of multicultural Millennials have a smartphone, and almost two-thirds[11] carry a tablet. The Millennials/multicultural/mobile trifecta, as it were, is a must not miss mantra. As master multitaskers, their connection with handheld devices is pervasive and vital. *Over 30 million[7] multicultural Millennials are constantly connected to t he internet.*

Multicultural Millennials who are active on their mobile devices spend over $65 billion per year – with an increasing majority of those dollars being spent online – and influence more than $1 trillion in total consumer packaged goods and entertainment spending[7]. Multicultural Millennials prefer retailers with a broad, culturally diverse merchandise selection, and actively create content for and share on social media.

CAN YOU HEAR ME?

A full 74%[4] of those 13+ million multicultural Millennials who are connected to the internet via their smartphones say that the cell phone is expression of who they are. The cohort is using technology to stay connected, express themselves, and be heard.

Far more than a workplace tool, cell phones are helping almost two-thirds[4] of multicultural Millennials decide what they're going to do in their free time, and more often than not, that free time includes cell phone usage. They are 77%[4] more likely to say that they are fully connected to online resources from the moment they awake until they fall asleep.

Think about that: there's not a second of the day when multicultural Millennials aren't connected via their phones. Nearly half use their mobile devices to compare prices and browse when shopping, and almost 80%[2] agree that the internet is a great place to buy products – which is easier for that generation to do since they maintain and value their connection to the internet during the entire day.

[4] Nielsen Spectra Simmons Opinions
[11] Nielsen NPOWER based on avg scaled installed counts as of June 15, 2016

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METHODOLOGY

Insights utilized in this report were sourced from the following Nielsen analytical tools and solutions. All tools offer their own representative levels of consumer insights and behavior across Hispanic, Asian American, African American and non-Hispanic White respondents (based on data collection, survey/ panel design and/or fusion approaches).

Nielsen PopFacts 2016: Nielsen Pop-Facts Premier provides demographic data based on Census and American Community Survey (ACS) data. Pop-Facts Premier provides current-year estimates and five year projections. For this release, current-year and five-year refers to 2016 estimates and 2021 projections, respectively. The data set also provides data for 2000 and 2010 census years for current year geographies. This release of PopFacts Premier is the fourth to provide Nielsen demographic estimates in 2010 Census geographies and to make full use of all Census 2010 results.

Millennials were defined as individuals aged 18 to 34 years old and multicultural was defined as an additional of African American, Asian and Hispanic individuals.

Nielsen Spectra: Spectra 2016 Simmons Opinions March (Gen FW): Spectra partners with industry-leading data providers and integrates their data into the software. Homescan, MRI, Caritals, Panel Views, Retail Universe and other consumer data are all integrated into Spectra. The Homescan product libabray is a nationally representative panel of 125,000 U.S. households. Data is at a total U.S. level. It is a syndicated data set including profiles for over 16,00 food and non-food product categories, segements sand brands. Millennials were defined as adults aged 18-39 for this dataset.

Nielsen Scarborough USA+ 2016 Release 1, Gfk/MRI Attiduinal Insights Module: February 2015 - April 2016. (Base: Age of respondent summaries: Adults 18+ - Projected 246,843,172, Respondents: 203,267)

By integrating 400+ attitudinal statements and segmentations with Nielsen Scarborough's syndicated data set, this analysis reflects consumer psychographics in the studied categories. In the top 36 Hispanic Demographic Market Areas (DMAs) this is among both English and Spanish-speaking adults. This study sample is balanced for the Asian population only in Honolulu; the survey is not offered in an Asian language.

Millennial was defined as adults aged 21-34 for the income and restaurant related data set and as 18-34 for the rest of the metrics.

Nielsen Electronic Mobile Measurement: EMM is an observational user-centric approach that uses passive metering technology on smartphones to track device and application usage on an opt-in convenience panel. Panelists are recruited online and in English. There are approximately 9,000 panelists in the U.S. across both iOS and Android smartphones to track device and application usage on an opt-in convenience panel. There are approximately 5,000 panelists in the U.S. across both iOS and Android smartphone devices, and this method provides a holistic view of all activity on a smartphone, as the behavior is being tracked without interruption. The EMM data used for this report combined households that were both 21-34 years old and Asian, African American, Hispanic or non-Hispanic White respectively.

Nielsen Harris Poll: This Harris Poll was conducted online, in English, within the U.S. between September 19 and October 3, 2016 among a nationally representative sample of 2,223 adults ages 18+. Additionally, oversamples were collected, in English and in Spanish, among 441 Hispanic adults (representing Spanish-dominant, English-dominant and Bilingual profiles) and in English among 143 Asian adults. Figures for age, sex, race/ethnicity, education, region and household income were weighted where necessary to bring them into line with their actual proportions in the population. Propensity score weighting was also used to adjust for respondents'

Nielsen Homescan Panel Data: The Homescan national panel consists of a randomly dispersed sample of households that is intended to be representative of, and projectable to, the total U.S. market. Panel members use handheld scanners to record items with a UPC which they purchase from any outlet. In September 2014, the Spanish Dominant sample expanded from 4 to 8 major markets, with increased sample in eight markets through Expanded Hispanic Panel. Expanded Hispanic

Panel is used to capture the Hispanic Millennials section of the report. Data from this report is based on Homescan panel data from 8/03/14 through 7/30/16. Millennial was defined as having a head of household that's between the ages of 18 to 34.

Nielsen NPOWER Audience estimates based on a nationally representatitve panel of people whose televisions are metered with a device called the National People Meter that passively detects exposures to codes embedded in the content. A comprehensive questionnaire is also collected of the panel.

Data used in this report is inclusive of multicultural audiences. Although the sample design is not controlled by Asian language, we make significant efforts to accommodate non-English speaking respondents and as such our Asian panelists include both English and non-English language speaking populations.

ABOUT NIELSEN

Nielsen Holdings N.V. (NYSE: NLSN) is a global information and measurement company with leading market positions in marketing and consumer information, television and other media measurement, online intelligence and mobile measurement. Nielsen has a presence in approximately 100 countries, with headquarters in New York, USA and Diemen, the Netherlands.

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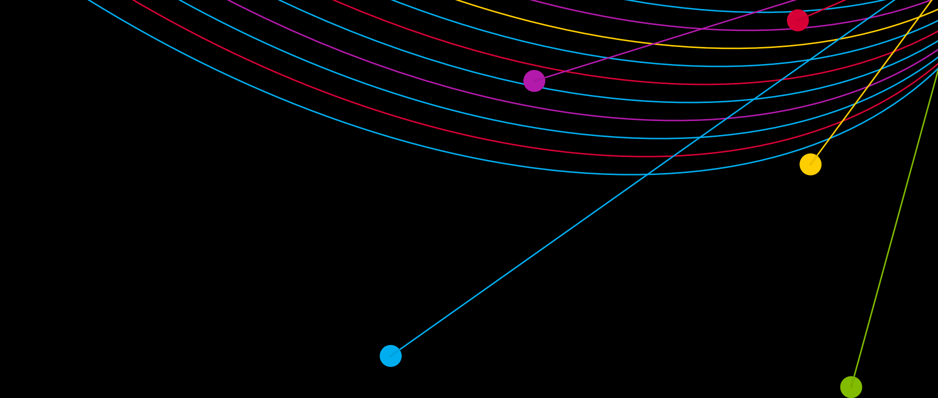

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The Media Insight Project

How Millennials Get News: Inside the Habits of America's First Digital Generation

March 2015

FOR FURTHER INFORMATION ON THIS REPORT:

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I. OVERVIEW

For years, researchers and social critics have worried that the newest generation of American adults is less interested in news than those who grew up in the pre-digital age.

Much of the concern has come from data that suggest adults age 18-34 – so-called Millennials – do not visit news sites, read print newspapers, watch television news, or seek out news in great numbers. This generation, instead, spends more time on social networks, often on mobile devices. The worry is that Millennials' awareness of the world, as a result, is narrow, their discovery of events is incidental and passive, and that news is just one of many random elements in a social feed.[1]

A new comprehensive study that looks closely at how people learn about the world on these different devices and platforms finds that this newest generation of American adults is anything but "newsless,"[2] passive, or civically uninterested.

Millennials consume news and information in strikingly different ways than previous generations, and their paths to discovery are more nuanced and varied than some may have imagined, according to the new study by the Media Insight Project, a collaboration of the American Press Institute and the Associated Press-NORC Center for Public Affairs Research.

How Millennials get news

Percent of Millennials who…	
Say keeping up with the news is at least somewhat important to them	85%
Get news daily	69%
Regularly follow five or more "hard news" topics	45%
Usually see diverse opinions through social media	86%
Pay for at least one news-specific service, app, or digital subscription	40%

This generation tends not to consume news in discrete sessions or by going directly to news providers. Instead, news and information are woven into an often continuous but mindful way that Millennials connect to the world generally, which mixes news with social connection, problem solving, social action, and entertainment.

Rather than having a narrowing effect on what Millennials know about, however, the data suggest this form of discovery may widen awareness.

Virtually all Millennials, for instance, regularly consume a mix of hard news, lifestyle news, and practical "news you can use," the study finds. Millennials are more likely to report following politics, crime, technology, their local community, and social issues than report following popular culture and

[1] These concerns have been raised repeatedly by researchers and authors, including Paula M. Poindexter in *Millennials, News and Social Media: Is News Engagement a Thing of the Past?* (Peter Lang Publishing, 2012); by various work from the Pew Research Center, http://www.poynter.org/news/mediawire/225139/pew-surveys-of-audience-habits-suggest-perilous-future-for-news/; and by political researchers such as Mark Mellman in "The Young and the Newsless," http://thehill.com/opinion/mark-mellman/230946-mark-mellman-the-young-and-the-newsless.

[2] The term appears in Poindexter's book, in Mellman's writing, and is the title of a book by Christina Tangora Schlachter, *Newsless: How the American Media is Destroying Democracy* (CSRL Publishing, 2009).

celebrities, or style and fashion. Fully 45 percent of these young adults regularly follow five or more "hard news" topics.

Millennials also appear to be drawn into news that they might otherwise have ignored because peers are recommending and contextualizing it for them on social networks, as well as on more private networks such as group texts and instant messaging. Once they encounter news, moreover, nearly 9 in 10 report usually seeing diverse opinions, and three-quarters of those report investigating opinions different than their own.

The data also suggest that social networks are exposing Millennials to more news than they were initially seeking. Overall, just 47 percent who use Facebook say that getting news is a main motivation for visiting, but it has become one of the significant activities they engage in once they are there. Fully 88 percent of Millennials get news from Facebook regularly, for instance, and more than half of them do so daily.

Some people, particularly older Millennials, are more inclined to actively seek news, while others tend to let news find them, but virtually all Millennials employ a blend of both methods, as well as a mix of platforms and activities.

"Social media keeps me more informed than I could be with the other forms of news," said Elese, a 25-year-old in Chicago. "By quickly scrolling through my feed, I can see the major stories going on. If I need to read deeper into it, I can go to a credible source's website."

These are some of the findings of the study, which extends the work from the Media Insight Project's 2014 Personal News Cycle[3] to provide a deeper investigation of the news and information habits of Millennials age 18-34. For this work, researchers combined different research methods, including in-depth interviews in four different cities and a national survey.

Facebook is not the only social network Millennials use for news. On average, those surveyed get news from more than three social media platforms – including YouTube (83 percent), and Instagram (50 percent), and places of active involvement such as Reddit.

While social media plays an enormous role – and for some topics a preeminent one – in how Millennials learn about the world, the research also reveals that this manner of encountering news is not strictly passive or random. People actively navigate and make choices about which sources in their social media feeds they consider to be reliable, and they take other steps of participating in news as well, including posting news stories, commenting on them, liking or favoriting them, and forwarding them to others.

People have always "discovered" news events partly by accident, by word-of-mouth, or by bumping into it while watching TV news or listening to the radio, and then turning to other sources to learn more. Technology, and the facility with which Millennials use it, has made this mix of random and intentional learning far greater.

"Social media has evolved a lot," said Marilu, a 29-year-old in Chicago. "Before, it would be all about you. Now it's about a lot of sharing articles, sharing of videos, sharing of memes. There's a lot of that."

[3]The Media Insight Project. 2014. "The Personal News Cycle." http://www.mediainsight.org/Pages/the-personal-news-cycle.aspx.

Among the study's findings:

- While Millennials are highly equipped, it is not true they are constantly connected. More than 90 percent of adults age 18-34 surveyed own smartphones, and half own tablets. But only half (51 percent) say they are online most or all of the day.
- Email is the most common digital activity, but news is a significant part of the online lives of Millennials, as well. Fully 69 percent report getting news at least once a day – 40 percent several times a day.
- Millennials acquire news for many reasons, which include a fairly even mix of civic motivations (74 percent), problem-solving needs (63 percent), and social factors (67 percent) such as talking about it with friends.
- Contrary to the idea that social media creates a polarizing "filter bubble," exposing people to only a narrow range of opinions, 70 percent of Millennials say that their social media feeds are comprised of diverse viewpoints evenly mixed between those similar to and different from their own. An additional 16 percent say their feeds contain mostly viewpoints different from their own. And nearly three-quarters of those exposed to different views (73 percent) report they investigate others' opinions at least some of the time – with a quarter saying they do it always or often.
- Facebook has become a nearly ubiquitous part of digital Millennial life. On 24 separate news and information topics probed, Facebook was the No. 1 gateway to learn about 13 of those, and the second-most cited gateway for seven others.
- At the same time, younger Millennials express growing frustration with Facebook, and there are signals in the research that the use of social media will continue to splinter with time. Younger Millennials use more social networks (an average of four) than older ones (who average three). They are also more likely than older ones to have cut back on their social media use or dropped a social network completely. In our longer interviews, these younger Millennials describe Facebook like a utility they have to use rather than one they enjoy.
- When Millennials want to dig deeper on a subject, search is the dominant method cited by 57 percent (and it is the one cited most often as useful), followed by news sites (23 percent). Only 7 percent cite checking Facebook to learn more.
- And when Millennials do dig deeper, the most important qualities that make a destination useful are that they know the source well (57 percent) and that this digital source is transparent and rich with references and links (52 percent).
- Millennials, however, do not worry much about privacy. Only 2 in 10 worry a good deal about privacy in general. And when asked about specific concerns, only 22 percent worry even a little about government surveillance; 30 percent worry even a little about corporate America knowing too much about them. The biggest worry, 38 percent, is identity theft.
- Despite this lack of overall concern, the vast majority of Millennials (86 percent) have changed their behavior online, mostly to control what people know about them. Fifty-two percent have changed their privacy settings, while 37 percent say they are now more likely to remove information or photos of themselves that are embarrassing or immature.

ABOUT THE STUDY

This study was conducted by the Media Insight Project, a collaboration between the American Press Institute and the Associated Press-NORC Center for Public Affairs Research. It included two components – a quantitative survey of Millennials nationwide and qualitative interviews and follow-up exercises with small friend groups of Millennials in Chicago, Illinois; San Francisco and Oakland, California; and at the University of Mary Washington in Fredericksburg, Virginia. The researchers sought to supplement the quantitative survey research with a qualitative component to obtain a deeper understanding of Millennials' online lives and news consumption habits.

The survey reached 1,045 adults nationwide between the ages of 18 and 34. Study recruitment was completed through a national probability telephone sample, while the main portion of the questionnaire was administered online. The margin of error was +/- 3.8 percentage points.

The qualitative component included three semi-structured group interviews conducted in Chicago, Illinois, on December 11, 2014; two conducted in San Francisco, California, on January 7, 2015; two conducted in Oakland, California, on January 7-8, 2015; and three conducted at the University of Mary Washington in Fredericksburg, Virginia, on January 22, 2015. A total of 23 Millennials were interviewed. Select participants in each of the locations also consented to complete follow-up activities. These activities included 1) a self-reflection, interview, and essay exercise about news attitudes and behaviors, and 2) a news story tracking diary. These exercises were intended to gather additional information about how these Millennials think about news and information, what news and information is important to them, and how they follow a news story of interest. A total of 10 participants completed one of the follow-up exercises.

All point estimates described in the report are derived from the nationally representative survey of adults age 18 to 34. All quotes specified in the report are derived from the qualitative research. A full description of the study methodology can be found at the end of the report.

II. MILLENNIALS ARE HARDLY NEWSLESS, UNINTERESTED, OR DISENGAGED FROM NEWS AND THE WORLD AROUND THEM

By any number of measures, staying in touch with the world is an important part of the lives of the first generation of digital adults.

Yet rather than news consumption occurring at certain times of the day as a defined activity – in "news sessions" – keeping up with the world is part of being connected and becoming aware more generally, and it often but not always occurs online. In many cases, news comes as part of social flow, something that may happen unexpectedly and serendipitously as people check to see what's new with their network or community of friends. At other times news is something they seek out on their own. Most see news as an enjoyable or entertaining experience.

All of this reinforces findings from a previous study by the Media Insight Project entitled the Personal News Cycle.[4] That research provided a broad challenge to the notion that these young digitally native adults are uninterested or are turning away from news about the world. Across a range of metrics – frequency, enjoyment,[5] variety of topic interests, and more – younger adults are engaged news consumers.

NEWS IS A BIG PART OF MILLENNIALS' ONLINE ACTIVITY

The world is now literally in the pockets of the vast majority of Millennials much of the day. Fully 94 percent of those surveyed own smartphones connected to the internet. That compares with 69 percent of adults of all ages in our Personal News Cycle survey a year earlier. Fifty percent use a tablet, compared with 39 percent of all adults in the earlier survey.

What's more, when asked how much of their news and information comes from online sources, 82 percent say at least half of it. The average Millennial reports getting 74 percent of her news from online sources, and that does not vary much by age or other demographic factors.

This does not mean all Millennials are constantly connected. Only about half, 51 percent, say they are connected most of the time. When they are online, news ranks relatively high among the list of activities, particularly those they engage in daily.

Just under two-thirds (64 percent) of Millennials say that they regularly keep up with what's going on in the world and/or read or watch news.

This puts news roughly in the middle of a list of nine online activities that the survey asked about, but close to the most popular ones. Keeping up with the news falls only slightly behind the three most popular digital activities: checking and sending email (72 percent), keeping up with what friends are doing (71 percent), and streaming music, TV, or movies (68 percent).

Keeping up with the world and news ranks about the same as researching hobbies and other topics of interest (65 percent), and ahead of shopping or researching products (56 percent); finding information about events, movies, restaurants, etc. (56 percent); or playing games (45 percent). Fifty-seven percent report going online regularly for a practical form of the news – checking the weather, traffic, or public transportation.

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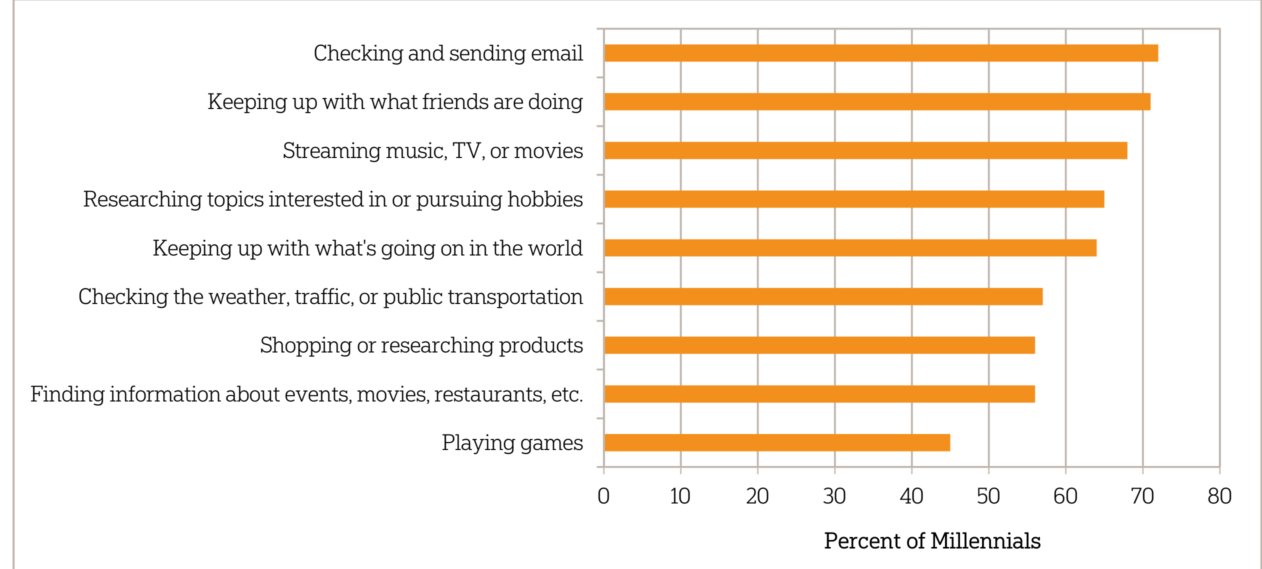
[4] The Media Insight Project. 2014. "The Personal News Cycle." http://www.mediainsight.org/Pages/the-personal-news-cycle.aspx.

[5] The Personal News Cycle study from early 2014 offers some sense of how Millennials enjoyment with news compares with other age groups. Thirty-five percent of 18- to 34-year-olds in that study report that they enjoy keeping up with the news a lot compared to 63 percent of those 35 years and older. Still though, 85 percent of 18-to 34-year-olds said they get at least some enjoyment from keeping up with the news, similar to the 89 percent of adults 35 and over who said the same. These numbers are somewhat higher than what different questions asked in surveys by the Pew Research Center. Its latest research found that 29 percent of people age 18-31 said they enjoyed following the news a lot, versus 45 percent of those age 33-47 and 58 percent of those age 48 or older. One reason for the difference is what we have discovered in this report, that Millennials do not "follow" news in long news sessions the way previous generations did, but consume it as part of other engagement. In this study, we have asked people to place their motivations for acquiring news on a list or scale.

More than 6 in 10 Millennials regularly keep up with news and information when online



Question: Which of the following activities, if any, would you say you do regularly online? Please select all that apply.

To get a stronger sense of the intensity of this news acquisition, the study probed not just where news ranked on the list but also *how often* they acquired news online. We found that news ranked even higher among Millennials' online priorities by this measure. Of the 64 percent who say they regularly keep up with the news online, about 7 in 10 (69 percent) do so at least once a day, and 40 percent do so multiple times a day.

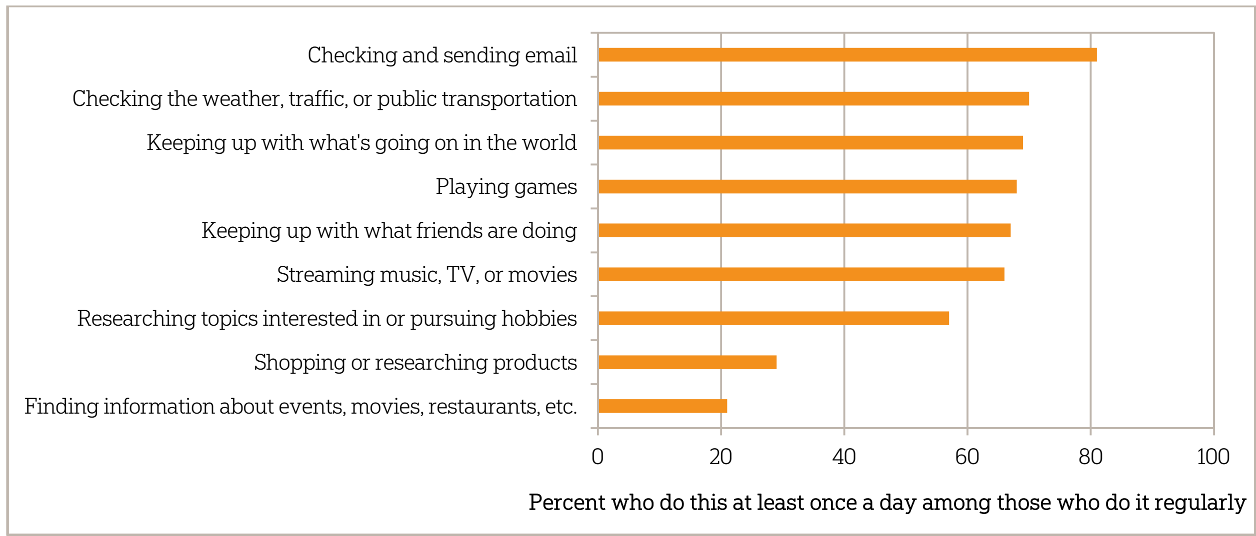
That is similar to the proportion who say they keep up with their friends at least once a day (67 percent) and the proportion streaming music, TV, or movies (66 percent) daily. Indeed, keeping up with the news ranks below only checking and sending email (81 percent) and checking weather, traffic, and public transportation (70 percent) as activities these younger Americans do every day.

More Millennials keep up with news online at least once a day than pursue hobbies (57 percent), research products (29 percent), and find information about restaurants or movie times (21 percent).

In Millennials' Words: What are the top three things you do online?

"Probably top three would be I use Facebook a lot to talk to my friends, like a big group chat because we all go to different colleges. And then my next one would be Netflix; I watch a lot of that. And then I go on Reddit a lot and other news things."
– Connor, sophomore, University of Mary Washington

News ranks third among most frequent online activities



MILLENNIALS HAVE A MIX OF MOTIVATIONS – CIVIC, SOCIAL, AND PRACTICAL – FOR KEEPING UP WITH NEWS

One question is whether this news acquisition is accidental or whether Millennials are conscious and motivated to learn about the world around them.

To get at this, the survey and qualitative interviews probed three different areas about motivation. The first asked how important news was to people in general. The second explored a list of reasons that people use news. The third asked why people choose to go to platforms such as Facebook and Twitter in the first place, and then what they do when they get there.

The findings suggest that Millennials view news as fairly important and use it in ways that are an almost equal mix of social, civic, and practical. They also acquire more news on social media than they set out to.

Overall, nearly 4 in 10 Millennials (38 percent) say it is very or extremely important to them personally to keep up with the news. An additional 47 percent consider it somewhat important. The same sentiment was echoed in our in-depth, qualitative discussions with younger adults. One reason that news is important, some said, is that they see so much of it in social media feeds. The news, in effect, is already contextualized as important to their lives because it is important to the members of their social networks.

In Millennials' Words: What role does news play in your life?

"The news plays a big role in my life. Between school and work, I need to keep up-to-date with certain aspects of the news. I access the news everyday via the internet and social media. I usually use my laptop or smartphone to access news. Usually, it is easy to find breaking news on my [Facebook] news feed. I also follow certain news outlets and groups that constantly post different articles on the news that I am interested in." – Breanna, age 25, Chicago

"It would be best to keep up with this type of thing [Ferguson protests] because even though it's out of town, even though it's in a different state, it affects us, because people out here are taking this out on our city as well. We're protesting out here, so we have to be safe." – Stephanie, age 34, Oakland

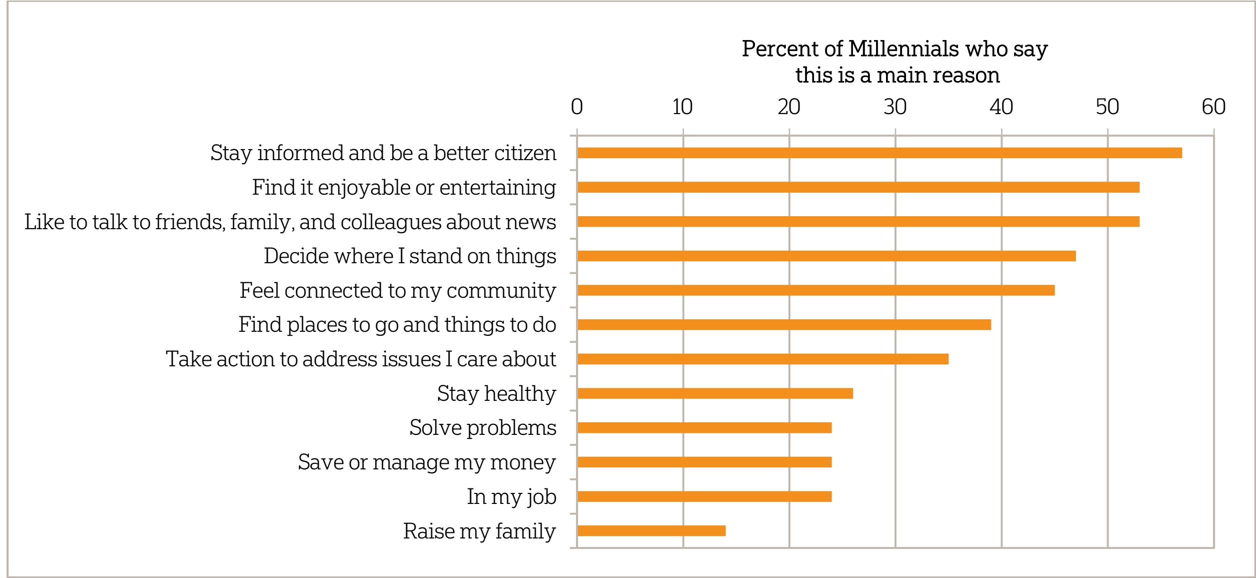
In our qualitative discussions, we also heard about another factor that makes news important to some younger adults. This has to do with the notion that, partly because technology is so altering modern life, their generation is changing the world for the better, and they are excited to see how that is happening. The news tells them that.

"I have so much faith in my generation to change the course of this country, and I love seeing that play out in the news, whether it be through health care changes, gay marriage acceptance, sexual education and access to information, and race issues," said Lauren, age 23 in Chicago. "Sure, 1 out of every 10 articles I read about these issues is sensationalized, but for the most part I have so much respect for the impact that my generation is making on these social issues, and I love staying up-to-date on the justice that is happening for the poor, the discriminated, etc."

The survey also asked people about how they use the news. We asked about 13 different ways that people might use news, which fell into three general categories. One category was civic (such as helping me be a better citizen, take action on issues I care about, or identify where I stand on issues). A second category was social (so I can talk about the news with friends or feel connected). The third category was practical (to help save money, stay healthy, or solve problems).

Millennials are fairly evenly split in their motivations for getting news and information. Seventy-four percent report following the news for at least one civic reason. Sixty-seven percent cite social reasons, and 63 percent cite at least one practical or "news-you-can-use" reason like finding things to do or managing money.

Becoming an informed citizen is the number one reason cited for using news and information



Question: People use news and information in different ways. What are the main reasons you, personally, tend to use news and information? Please select all that apply.

Finally, as we will discuss in more detail later, news may not be the reason that people initially go to Facebook or Twitter, but it has become one of the biggest activities they engage in when they are there.

NEWS AS PART OF THE CONNECTED LIFE

For most Millennials, the way they learn about the world is a blend of actively seeking out some news and information and bumping into other information as they do other things throughout their day. Many of their encounters with news occur online.

When asked to choose which comes closer to their behavior on a typical day, 60 percent of Millennials overall say that they mostly bump into news and information as they do other things, while 39 percent say they actively seek out news and information.

Those who see themselves as more proactive news consumers are more likely than those who mostly bump into news to cite some reasons for consuming news. For instance, they are more likely to say that news helps them stay informed and be better citizens (66 percent vs. 52 percent) and that they like to talk to friends, family, and colleagues about news (63 percent vs. 46 percent). They are also more likely to say it helps them feel connected to their communities (52 percent vs. 41 percent), and to feel that it helps them take action on issues they care about (41 percent vs. 31 percent).

But the data show an intra-generational divide. Only a third of the youngest Millennials, those under age 25, describe themselves as mostly proactive news consumers. By contrast, fully half of those over age 30 do so. These older Millennials are evenly divided between those who mostly seek out news and those who mostly bump into it.

When the research probed more deeply by topic, as described in a later section of this report, it reveals that almost all Millennials engage in both kinds of news acquisition – more proactive and random – no matter what their age.

In Millennials' Words: How easy or hard is it to find news and information these days?

Easy: "Very easy. If it's something big, it's going to be on social media within seconds. You're going to see it. It doesn't take that long for anything to start trending." – Sam, age 19, San Francisco

Hard: "I feel like you have to scout for [general news]. It's not easy for me to get public news. I had no idea about the French terrorist [event]. I only caught a glimpse of that a couple of days ago on the TV in the restaurant." – Liz, sophomore, University of Mary Washington

III. MILLENNIALS' NUANCED PATHS TO NEWS AND INFORMATION

A good deal of past research about this newest generation of adults has focused on technology use. That research has revealed Millennials spend a good deal of their time on social media rather than heading directly to news destinations on the web. That in turn may have encouraged the idea that civic awareness is at risk.

This study set out to go further, to learn not just where people go online but what they do when they get there. Platforms such as Facebook or search engines such as Google are gateways to many activities, not just personal and social information. And asking people about how much they get "news" in a generic sense can be elusive. What do people think of as news? Does it include traffic and weather, food and restaurants, sports scores?

To solve this problem, this study probed what topics people pay attention to and how they get information about them. The survey probed 24 different topics, all of which increasingly today

might be found in news products such as newspapers, TV news broadcasts, or online-only news websites.[6] The qualitative interviews we conducted were even more open ended, asking people about what subjects they spend the most time with online.

The findings debunk the notion that younger Americans are choosing to focus their attention on only a few things, particularly so-called soft news and entertainment, or, in the famous phrase of critic Neil Postman, that we are "amusing ourselves to death."

Millennials regularly follow a wide range of topics, and virtually everyone's information diet in this generation involves a mix of hard news, soft news, and more practical or news-you-can-use topics.

"I think there's a lot of news out there these days, and I feel that if you limit yourself to just watching what's on the news on TV, you're not getting the whole picture. And I feel that a lot of, maybe, newer news places, there's so much more you can get online to kind of supplement what you see on TV that you can get closer to the truth and find what you're looking for."
– Connor, sophomore, University of Mary Washington

Moreover, these digital natives are rational and discriminating in how they employ different information sources for different types of news – using social networks and word-of-mouth more for certain topics suited to those platforms, going directly to news reporting organizations for topics where professional news gathering from a single source has high value, and actively turning to search engines and news aggregators when seeking multiple sources and community input makes sense for the topic.

MILLENNIALS FOLLOW MANY TOPICS, INCLUDING INFORMATION ABOUT ENTERTAINMENT, NEWS, AND THEIR DAILY LIVES

To begin with, Millennials follow news about a wide variety of subjects and do so across a range of sources. The average Millennial reports regularly following 9.5 different news and information topics among the 24 included on the survey.

The most popular topic is "TV, music, and movies." Two out of three Millennials say they follow news about it on a regular basis.

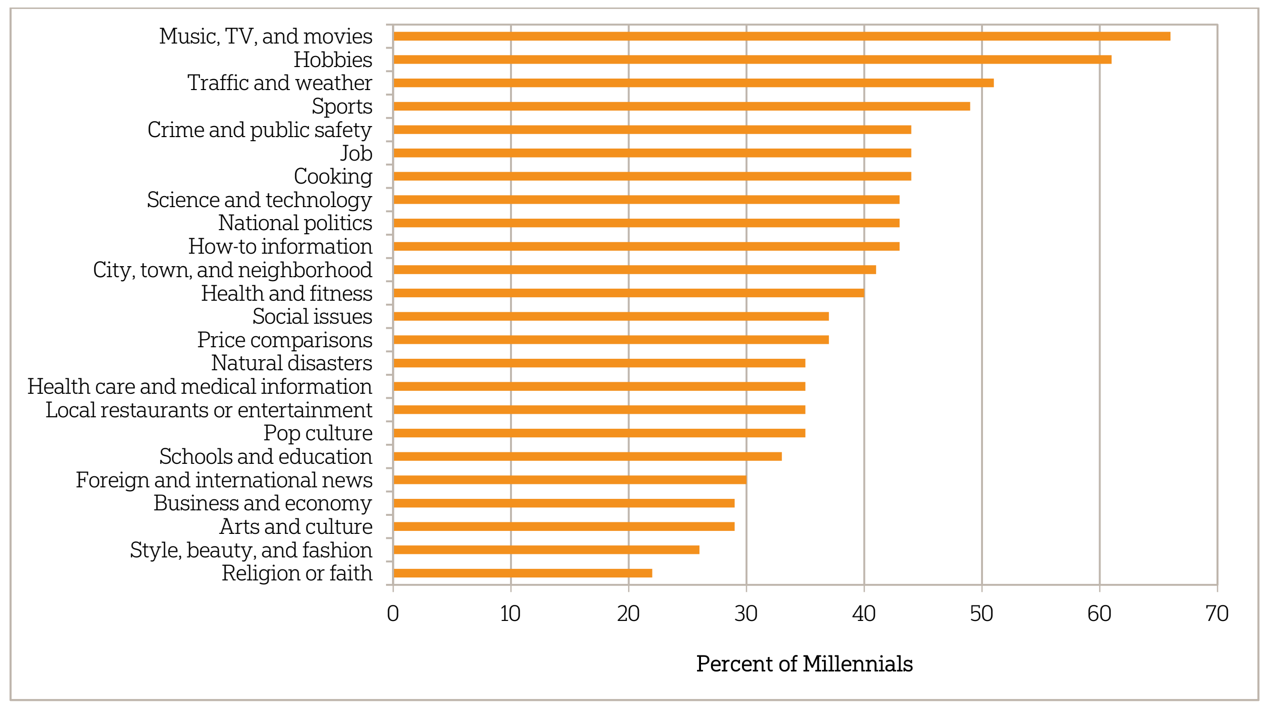
The second-highest proportion of Millennials, more than 60 percent, regularly get news and information about a hobby.

But more civically oriented news topics are a significant part of the information diet of this generation, too. More people under 35 say they follow politics, crime, technology, their local community, and social issues, for instance, than report following popular culture and celebrities or style and fashion.

Nearly all of these young adults follow what are traditionally considered "hard" news topics.[7] The average Millennial follows about four hard news topics and 45 percent of Millennials follow 5 or more.

[6] News and information was defined in the survey as follows: By news and information, we mean the information that you use to understand the world around you. This can include sports, traffic, weather, current events, stocks, politics, lifestyle, entertainment, or any other kinds of news or information that you need to understand the world around you.

[7] Hard news topics include: Social issues; Crime and public safety; Natural disasters and environment; Religion or faith; National politics and government; Science and technology; Business and economy; Traffic and weather; City, town, and neighborhood; Foreign affairs; Schools and education; and Health care.



Question: Which of these topics, if any, do you regularly follow?

Interest in hard news is not correlated with age. Younger Millennials are just as likely to follow hard news topics as older ones. In our qualitative interviews, we saw what may be clear reasons why. Virtually everyone we talked to had some areas of passion or deep interest, which may have been related to career, heritage, travel experience, or some other factor. And they tended to be quite conscious and active in the ways they sought information about those areas, identifying experts that they followed, news organizations that they trusted, and more.

"I do a lot of research on genetic engineering, so I look up what scientists in the world are doing. Biology and chemical research," said Kristina, a student at the University of Mary Washington. "I do like to keep up with celebrities, and then I'm very big into heroes and stuff, so comics."

In Millennials' Words: What news and information topics do you follow?

"I definitely follow all the political events. Also, current events, like the most volatile things that are going on around the country. I like national news. Also, I follow celebrity news — I have to admit that."
– Lauren, age 23, Chicago

"I woke up this morning and checked Bleacher Report, which is a sports blog. I check game scores. I check all the latest trade rumors and everything like that. I check a music website called ILLROOTS.com and then from there I see all the latest news on the artists I like to keep up with, their songs and music videos. Just looking up music and just trying to see what my favorite artists are doing right now."
– Sam, age 19, San Francisco

THE POWERFUL ROLE OF SOCIAL MEDIA, ESPECIALLY FACEBOOK, IN THE NEWS AND INFORMATION LIVES OF YOUNG ADULTS

Even though it is not the only path to news, social networks play a preeminent role in Millennials' news acquisition, even as many Millennials express frustration with it, particularly the youngest.

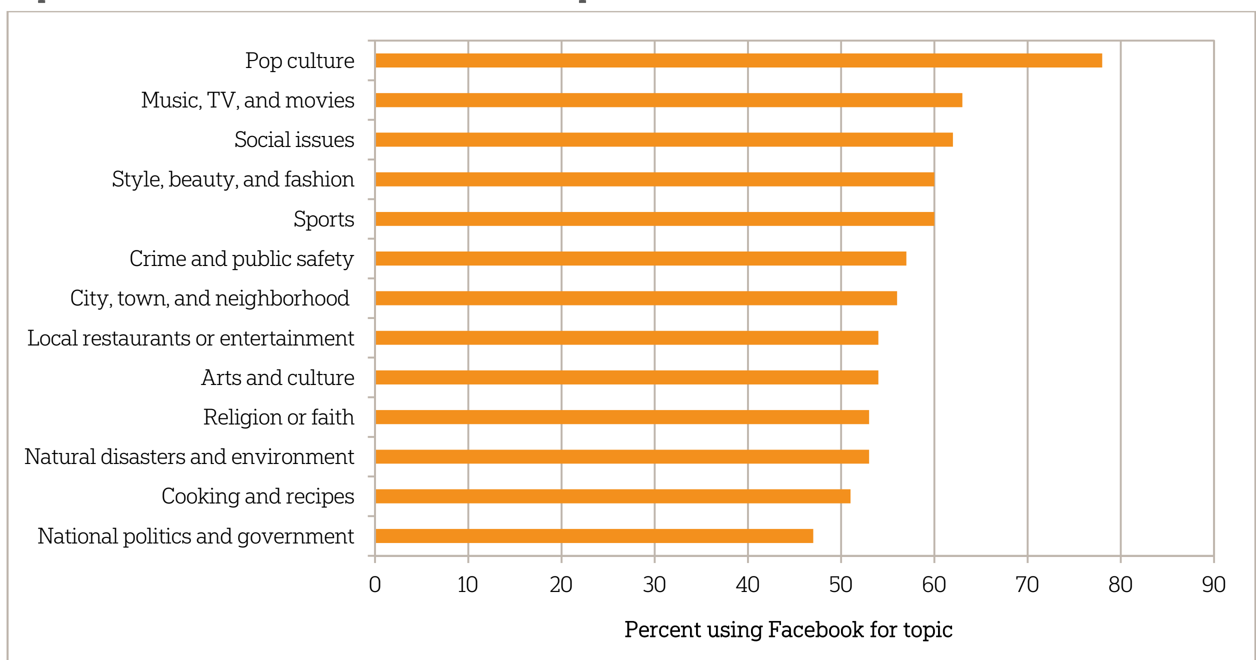
Facebook's outsized role is evident by any number of metrics. Of the 24 different news and information topics asked about, for instance, Facebook ranked as the No. 1 gateway for 13 and the second-most popular choice for seven others – meaning it ranked No. 1 or 2 for 20 out of 24 topics.

For 9 of the 24 topics, Facebook was the only destination cited by a majority.

> "[Social media] has introduced me to a lot of news that I wouldn't have known about or wasn't paying attention to."
> – Haley, age 22, San Francisco

In other words, although most of these people had multiple ways of getting information on these topics, more of them included Facebook in that mix than any other place.

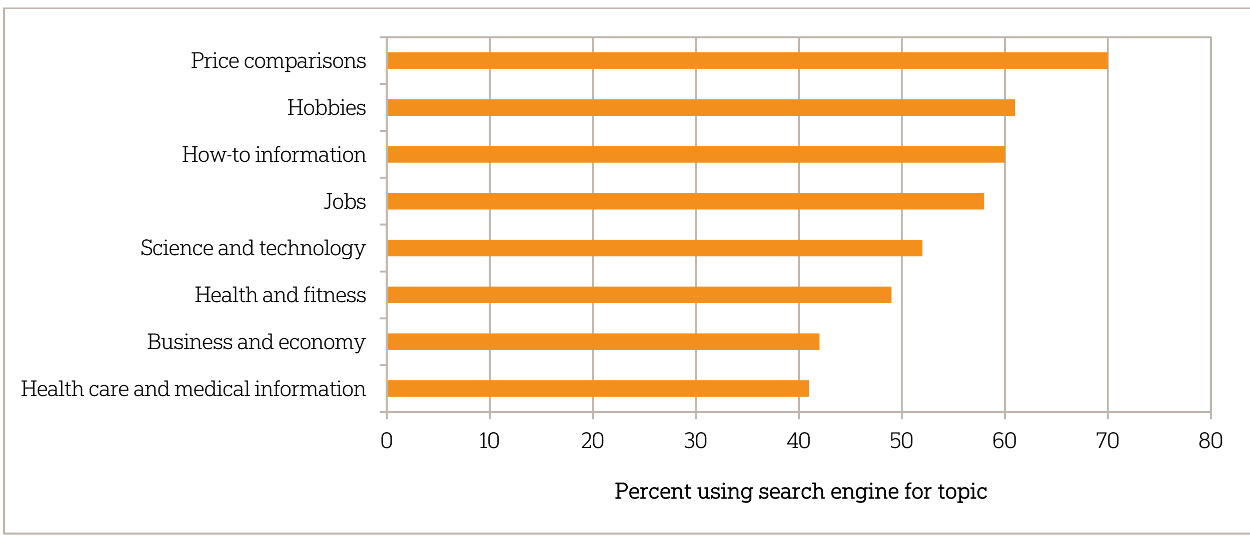
Topics for which Facebook is the most common point of access



Question: Where do you most often get your information on this topic? Please select all that apply.

Search ranked as the second-most common means of acquiring news and information. It was the most cited way of accessing news for 8 of the 24 information topics asked about, and it was the second-most cited means for five more, meaning it was No. 1 or 2 on 13 of the 24.

Topics for which search is the most common point of access



Question: Where do you most often get your information on this topic? Please select all that apply.

Topics for which other sources are most popular

Topic	Source
Schools and education	Word of mouth (46%)
Foreign and international news	National TV (43%)
Traffic and weather	Local TV (49%)

Question: Where do you most often get your information on this topic? Please select all that apply.

No other single platform (such as national TV, specialized news sources, newspapers, or even other social media platforms) ranked first or second for more than six topics.

Simply put, social media is no longer simply social. It long ago stopped being just a way to stay in touch with friends. It has become a way of being connected to the world generally – to send messages, follow channels of interest, get news, share news, talk about it, be entertained, stay in touch, and to check in and see what's new in the world.

At the same time, in our qualitative interviews. we also repeatedly heard a pushback against Facebook and to some degree social networks as an environment. Various people told us they are beginning to see Facebook and other platforms as

In Millennials' Words: And how do you use search engines for news?

"I use Google at first [to find news]. Sometimes I'll go to specific sources, because I use Google just to get like a broad sense and then I'll try to narrow that."
– Adriana, age 23, San Francisco

"Who's playing? Oh, Warriors and Cleveland. You just Google Warriors Cavaliers score, right there. It just comes right up."
– Steve, age 20, Oakland

places that are often prone to negativity, that some people use to start arguments, or that are filled with useless, inaccurate, or untrustworthy information.

Adriana, age 23 from San Francisco, does not like what she sees on Facebook. "I have [a Facebook account]. I don't really use it. It's a stupid thing. It kind of turned into useless information, like 15 reasons this, 20 reasons that."

They also expressed concern about the amount of time they spend on social networks and whether they were wasting time and being distracted.

In another San Francisco interview, Sam, age 19, put into words the sentiment of many interview subjects. "I use Facebook, too. But I don't like to … anymore," he said. "I'm trying to scale back because it's really time consuming, and you can get addicted. And it takes up a lot of valuable time that I could do something else."

It isn't only Facebook he has tried to get control of. "I've noticed since I've gotten off of Twitter, I've been a lot more attentive at work and what's going on around me instead of being on social media and looking at somebody's picture from a thousand miles away."

MILLENNIALS GET NEWS AND INFORMATION FROM A VARIETY OF PLACES AND WHERE THEY GO IS TOPIC DRIVEN

Although the number of Millennials who get news through Facebook and social media is large, it would be a mistake to think that Millennials get all their news this way.

Virtually every one of these digitally native young adults surveyed and interviewed use a blend of paths to news, mixing social, search, aggregators, online-only news sites, and traditional reporting sources such as newspapers, television, and specialized media.

To understand this, we divided the various news platforms and sources into three basic categories that represent different pathways to news and information.

One pathway is *social*. Here people tend to bump into news organized by their social network. Social includes Facebook, Twitter, various other social media platforms, and traditional word-of-mouth.

A second pathway to information is *curated*. Here users seek out these platforms to find news from many sources organized by subject, either sorted by algorithm, human editors, or a combination. Curated media includes search, aggregators, and blogs.

In Millennials' Words: What's the role of social media when it comes to news and information?

According to two friends from Chicago:

"So if you're on your Facebook or Twitter there's a handful, maybe five things that are trending. It's up to you to click on it and then you'll see more. But if you don't click on it you just see those things like, 'Oh wow, an Eric Gardner story. That's sad, that's terrible.' But if you don't actually click on it, you don't read it. But you see it. So like you know something's going on, but you're not knowledgeable."
– Lauren, age 23

"I think social media used to be just personal. Facebook was just keeping in touch with friends. And then I think maybe when Twitter came around, it wasn't just posting pictures, it was statuses. Then it became this 140-character thing and that got the ball rolling with news. And then Facebook got on board and it like slowly became more news-centered, whereas before it was personal."
– Elese, age 23

The third pathway to news and information is *reportorial media*. These are content creators with teams of news gatherers, whether legacy publishers or new digital only publishers. While people may end up at these destinations by other means, when they seek out these sources directly – by watching a newscast, using a news organization's app, reading a newspaper in print or digitally – they are turning to an individual organization to get information. The reported media includes all legacy organizations (local and national TV, newspaper media, and radio), online content creators, and specialty media (ethnic, sports media, specialty magazines, etc.).

Which path people use, the data reveal, tends to depend on the topic they want to learn about.

Millennials tend to lean toward social media, though not exclusively, for what might be considered "soft news" or lifestyle topics, such as popular culture, music, film and TV, local restaurants and entertainment, and style and beauty. About three-quarters of Millennials who follow these topics report using at least one social source.

The only so-called lifestyle or entertainment topic where social was not the most popular path was sports. Here people were more inclined to turn to reporting organizations directly.

Original reporting sources are also important destinations for at least three of these eight lifestyle topics. More than 7 in 10 Millennials cite them as paths to information about the arts, celebrities, and music/TV/film.

Social platforms predominate as the gateway to lifestyle news

Topic	Percent use a social source	Percent use a reporting source	Percent use a curated source
Celebrities or pop culture	91	77	49
Food and cooking	80	51	61
Health and fitness	74	54	64
Local restaurants or entertainment	82	57	59
Music, TV, and movies	82	70	55
Sports	78	84	41
Style, beauty, and fashion	84	52	54
The arts and culture	83	71	66

*Shading indicates most commonly cited source type for each topic.

Twelve of the 24 subjects analyzed might be traditionally considered "hard news" topics. For six of these, Millennials are most likely to get their news directly from a reporting organization – including such subjects as government, business, international news, health care, the environment, and traffic and weather.

For these hard news topics, Millennials rely in large numbers on reporting media. More than 6 in 10 Millennials cited at least one reporting source for all but one of the 12 hard news topics.

For hard news topics, Millennials continue to embrace original news reporting sources.

Topic	Percent use a social source	Percent use a reporting source	Percent use a curated source
Business and the economy	64	77	58
Crime and public safety	73	77	46
Foreign or international news	63	77	57
Health care and medical information	63	68	56
Information about my city, town, or neighborhood	77	77	42
National politics and government	68	76	53
Religion and faith	81	51	46
Schools and education	74	68	53
Science and technology	65	63	69
Social issues like abortion, race, and gay rights	79	69	53
The environment and natural disasters	69	77	55
Traffic or weather	48	75	46

*Shading indicates most commonly cited source type for each topic.

Finally, people tend to look to curated media for subjects that might be considered practical or news-you-can-use-topics, such as product information, how-to advice, hobbies, and news or information about their career.

Including search engines, news and information aggregators like Google News, and blogs (where curation is typically an important function), at least 7 in 10 Millennials cite these types of sources for practical topics.

There are also a few topics for which there is no favored path, or for which people use at least two of them equally. For instance, Millennials have no clear preferred path to news about science and technology. Social, curated, and reporting platforms are cited equally for these topics.

Similarly, Millennials are just as inclined to cite social platforms as reporting organizations for crime or public safety news and news about their town or neighborhood. And they are just as likely to cite curated sources as social pathways to get how-to advice.

Search engines and news aggregators are most often utilized for "news you can use"

Topic	Percent use a social source	Percent use a reporting source	Percent use a curated source
Advice or how-to information	72	48	73
Information related to my interests or hobbies	79	49	70
Information related to my job, industry, or profession	66	56	73
Price comparisons or product research	58	38	79

*Shading indicates most commonly cited source type for each topic.

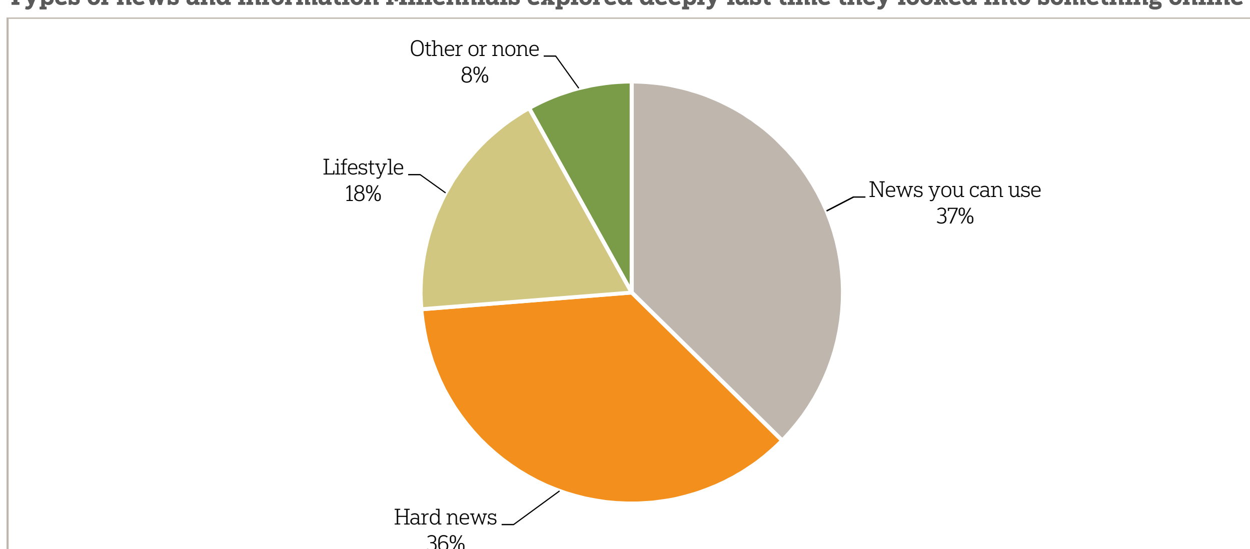
The virtue of looking at news consumption this way is that it reveals something more nuanced than simply the prevalence of Facebook in people's digital lives and news environment. The great majority of Millennials, on almost every topic, actually find news multiple ways.

What's more, as we will see later when we explore what Millennials do *after* they encounter news on social media, even bumping into news may lead to more active participation and engagement by sharing, commenting, or investigating differing perspectives and opinions.

HOWEVER THEY FIRST DISCOVERED IT, WHEN MILLENNIALS WANT TO LEARN MORE, THEY MOST OFTEN TURN TO SEARCH

In both the qualitative interviews and the survey, we also asked people to recall the last time they delved more deeply into a subject online.

Types of news and information Millennials explored deeply last time they looked into something online



Question: Now thinking of the last time you spent a fair amount of time online getting news or information, or learning about something. We mean looking into something fairly deeply, not just casually searching. What were you looking for?

We asked them first to identify in an open-ended question what the subject was. Those who recalled a subject (87 percent) were asked to recall where they went to learn more. Finally we asked if they could say which destination was most useful and why.

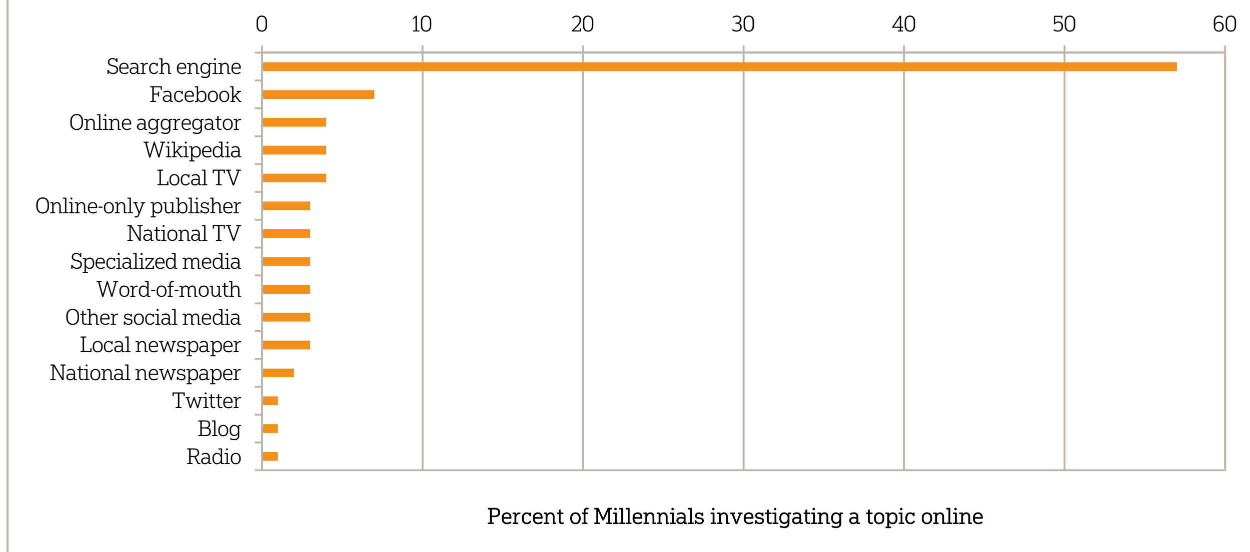
Millennials were most likely to say that their last deep dive was to find information about a subject that was a news-you-can-use topic or information about current events.

Nearly 4 in 10 Millennials (37 percent) who recalled a subject said that the last time they spent a fair amount of time online they were looking for practical, news-you-can-use information, such as advice or how-to information, researching products, or investigating topics related to school or career.

> Millennials feel like they have control over their information environment. "It's so much easier to find what you're looking for. But it's also so much easier to cut out things that you would otherwise have seen, because it's so much easier to segregate information." – Shelton, sophomore, University of Mary Washington

The number of Millennials who said they delved more deeply into a current event/breaking news story or information on a major issue is nearly identical, at 36 percent.

When Millennials want to dive deeply into a topic, the majority first turn to search engines



Question: Where did you go first for information?

By contrast, about half as many, 18 percent, went deeper to find out more about a topic that was categorized as lifestyle, like sports, food and cooking, health and fitness, or music, TV, and movies.

Once people had recalled the last time they began looking more deeply for something online, we asked them where they turned first. More than half (57 percent) reported first going to a search engine to learn more. Nineteen percent cited a specific news organization (led at 7 percent by TV news and 5 percent by newspapers). Seven percent recalled going to Facebook; 4 percent said Wikipedia or a similar site.

From there, if people went to additional sources, they scattered in many directions. Eighteen percent said they went to Wikipedia or a similar site to follow up, 17 percent received information from word-of-mouth, 16 percent went to Facebook, and 16 percent went to a search engine.

And what kinds of sources, when people dove deeply into a topic, did they find most useful? Half of Millennials (50 percent) cited a search engine, which of course is a gateway to other sources. Another quarter cited some type of news organization. Again, just 7 percent cited Facebook as the most useful path for learning more, the same percentage that cited going there as their first choice for more information. And 3 percent cited Wikipedia.

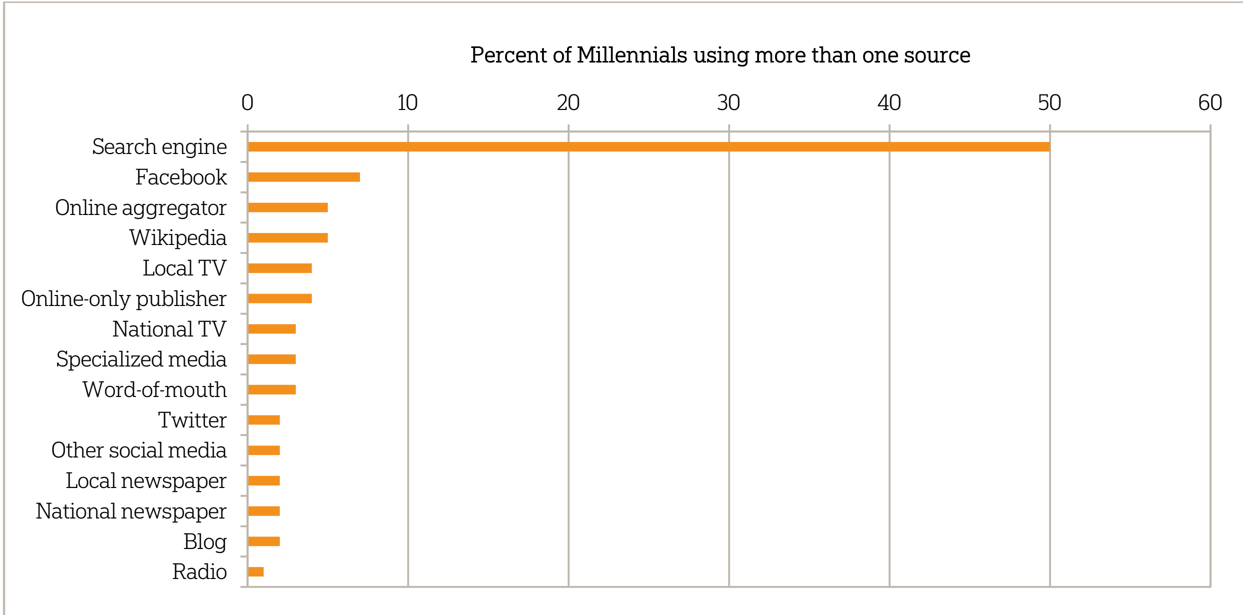
In Millennials' Words: How do you decide what sources to use?

"I feel that the sources I look for, I take them with a grain of salt usually. If something's interesting and I think it's reliable, like okay, I'll believe that until I hear something else more convincing."
– Connor, sophomore, University of Mary Washington

"[I like to] pick out facts [and] read a couple of different sources, so I have an idea of what to trust and what I don't trust."
– Lauren, age 23, Chicago

In other words, while Facebook is the most popular means of discovering something, when people want to dig in, they find other paths, including news organizations, more useful.

Search engines are the most helpful source when Millennials dive deeply into a topic



Question: Of the sources you used, which was the most useful to you?

We heard the same thing in our qualitative interviews. A Chicago interviewee, age 30, who asked not to be named said, "[I]f I'm on social media and I see people are posting about something, then I'm like, is this really factual information or is it possibly fictional information? And it triggers a domino effect for me to look at multiple other sites because I get curious sometimes. Then I can interpret things for myself. [A] lot of it starts at social media."

And what made one destination more useful than another for those now actively trying to learn more? Was it simplicity of design, ease of navigation, quick load times or something else?

The answer appears to be that two factors make a web destination most useful: familiarity and transparency — or citations of sourcing, and links.

Fifty-seven percent reported a source is useful to them because they have used it a lot and usually get what they need.

About half also said a source was useful because it cited multiple sources and offered links to learn more (52 percent).

A smaller number, 41 percent, said a source was useful because the design made it easy to find what they needed. Brand reputation fell slightly further down the list, though this may also

In Millennials' Words: What makes you question a source?

"Experience, educational background, and how they build their credibility."
– Female, Chicago

"A lot of the times when I don't even believe their stories because the website doesn't look credible. Just like the font — just like the whole web layout — how the links are organized. It's just like it doesn't look professional at all."
– Sam, age 19, San Francisco

be closely connected to the most popular reason — familiarity. But overall, 37 percent cited a long and trusted reputation as a factor that made a source useful or reliable. Only 19 percent said a source is useful because their friends use it and trust it.

We also asked people in the qualitative interviews what makes them skeptical of sources. The notion that every source is biased surfaced repeatedly. This is a generation steeped in having to navigate information on their own. We heard over and over that there is a lot of material out there that people have discovered is unreliable, and often highly subjective.

Shelton, a sophomore at the University of Mary Washington, said, "I understand that no matter what, there will be a slight tinge of bias from anyone giving out the news. I feel like someone whose job it is to give the news [should] make sure there is the least possible amount of bias. And unfortunately, I don't see that a lot, nowadays."

IV. DIGITAL LIVES OF MILLENNIALS

Born in 1980, this first generation of digital natives entered high school as the web became a public space. Half of this group, those age 26 and under, entered high school with social media, first MySpace and soon enough Facebook.

For most of this generation, in other words, the digital revolution does not represent disruption. It represents the norm and, to a significant degree, their generation's opportunity.

Perhaps as a consequence, few Millennials are worried much about privacy, and particularly not about the data kept by government or corporations.

A large majority of these digital natives pay for some type of online subscription service, including a significant minority who pay for some type of news. Yet, in the qualitative discussions we had with them, many Millennials expressed a belief that they shouldn't have to pay for news at all. As a key ingredient for democracy, some said, it should be free and accessible as a civic right.

A MAJORITY OF MILLENNIALS FEEL CONNECTED MOST OF THE TIME, BUT NOT ALWAYS ENTHUSIASTICALLY

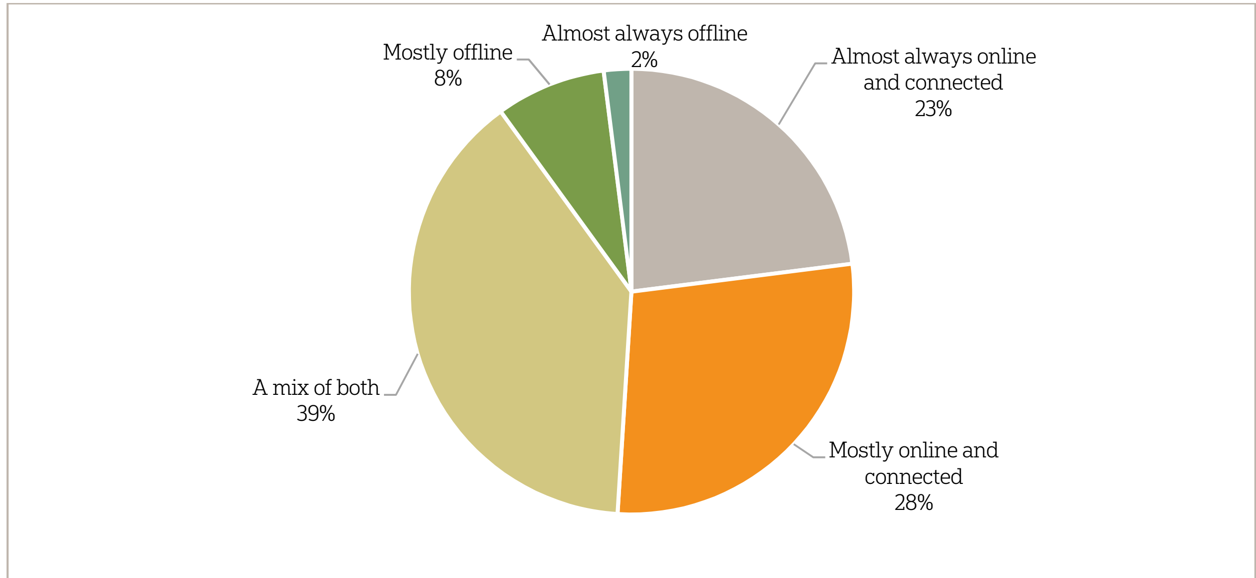
While they have the capacity to be online all the time, many Millennials are not.

All told, 51 percent say they are mostly or almost always online and connected. And in the qualitative interviews, we heard a good deal about the desire to control that connectivity.

A smaller but still significant number, 39 percent, say their lives are a mix of online and offline. Just 10 percent are almost always or always offline. Millennials in the qualitative interviews often acknowledged their high levels of connectivity but expressed concern and even some active efforts to scale back.

Brenna, age 25 from Chicago, noted that, "I think that it's life-consuming, because when I travel abroad I like not having it. And I like turning off my data, leaving my phone, not even being on Twitter because it's kind of refreshing not to have all of this information thrown at you."

Majority of Millennials are almost always or mostly online and connected



Question: How much of the time do you spend [online and connected, and how much do you spend offline]?

MANY MILLENNIALS PAY FOR SUBSCRIPTIONS, BUT MORE OFTEN IT IS FOR ENTERTAINMENT THAN INFORMATION AND NEWS

Contrary to the stereotype that digital natives believe everything on the web should be free, the great majority of this generation use subscription services of some kind. More often than not, they pay for these things themselves, but for some types of content, substantial portions also gain access through subscriptions paid for by others. Fewer, but still a sizable minority, have paid for news and information.

Overall, 93 percent of Millennials used some kind of subscription in the past year, and 87 percent personally paid for at least one service. And 40 percent paid for at least one news-specific service, app, or digital subscription themselves.

The most popular types of paid content accessed by Millennials are movies and television. Fifty-five percent say they personally have paid to download, rent, or stream movies or television shows on iTunes, Netflix, or other paid services in the past year. An additional 23 percent have these services paid for by others, one of the higher rates of using someone else's subscription.

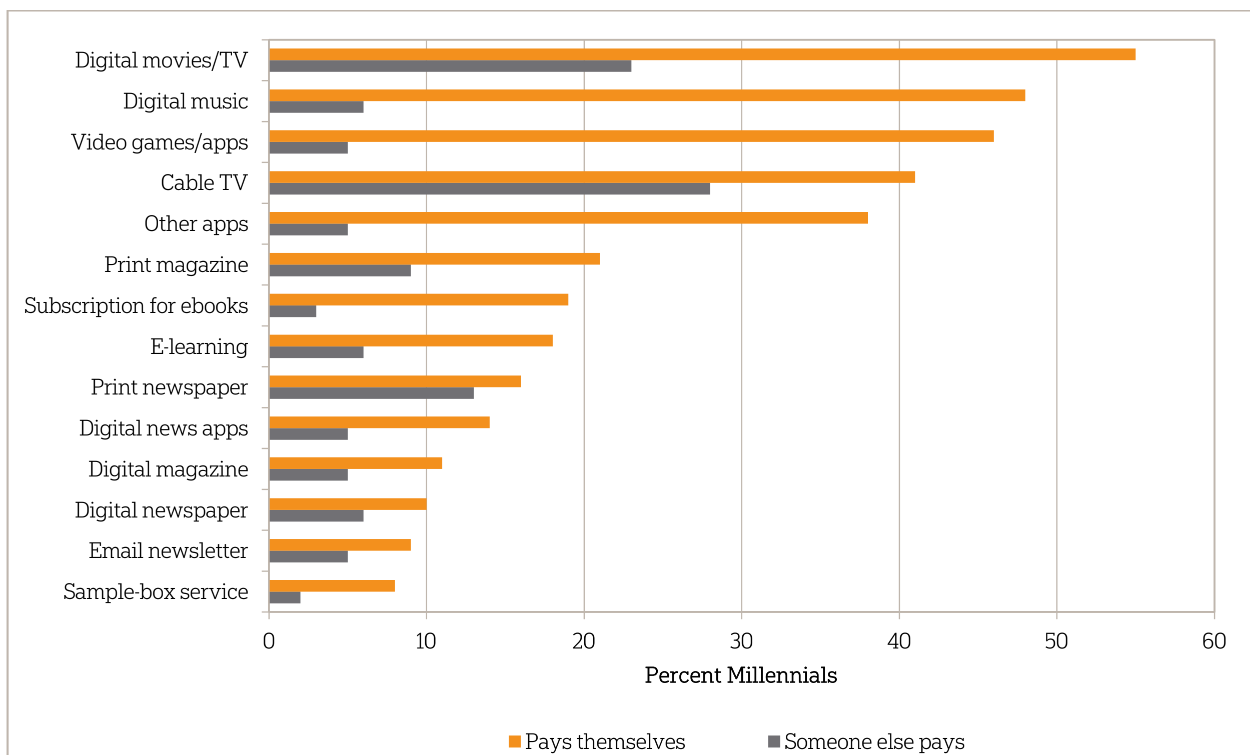
And 20 percent of Millennials say they *do not* watch movies or TV online using a subscription service.

Slightly behind movies and TV comes music, where 48 percent say they have paid to download or stream it on iTunes, Spotify, or other music platforms. Unlike with video, only 6 percent say someone else pays for them to access these services. And roughly 4 in 10 (39 percent) report not using any type of paid music downloading or streaming service in the past year.

Fewer than half (46 percent) have paid by any means for video games or video game apps.

Just 19 percent say they have paid in the last year for a subscription service for eBooks or audiobooks such as Kindle Unlimited or Audible, about the same number (18 percent) who say they paid for an e-learning service or online course.

A large majority of Millennials use paid services for movies, television, and music, and often pay for it themselves



Question: Please select any of the following paid products or services that you have regularly used in the past year. For each one, please check whether you pay for the product or service yourself, someone else pays for it, or both.

When it comes to paying for the news, 40 percent of Millennials report paying for at least one subscription themselves, including a digital news app (14 percent), a digital magazine (11 percent), a digital subscription to a newspaper (10 percent), or a paid email newsletter (9 percent). When subscriptions used but paid for by others are added, that number rises to 53 percent who have used some type of paid subscription for news in the last year.

Interestingly, this digital generation is more likely to have paid for non-digital versions of these products. For instance, 21 percent say they have paid in the last year for a subscription to a print magazine, and 16 percent for a print newspaper, rates that are higher than for digital versions of the same products.

News publishers also may have some work to do in the digital space when it comes to subscriptions. In the qualitative interviews, we heard the notion that, because news is important for democracy, people feel they should not have to pay for it. It should be more of a civic right because it is a civic good.

"I don't think you should pay for news," said Eric, age 22 in Chicago. "That's something everybody should be informed in. Like, you're going to charge me for information that's going on around the world?"

Or Sam, age 19 from San Francisco, who said in his interview, "I really wouldn't pay for any type of news because as a citizen it's my right to know the news."

Just 8 percent pay for a personalized shopping service such as Birchbox or Goodebox, where products are selected based on your profile.

Most Millennials pay for all their digital subscription services themselves, though some have higher rates of someone else footing the bill than others. For example, just 1 in 10 who use a subscription for eBooks or audio books have someone else paying for that subscription, while more than 4 in 10 who use a print newspaper say they use someone else's subscription.

When it comes to offline services other than print, 41 percent of Millennials still subscribe to cable TV, and 28 percent say they use cable TV paid by someone else. Twenty-seven percent say they do not access any pay cable television.

"It's just too easy to get things for free online." – Adriana, age 23, San Francisco

Being a more active news seeker, meanwhile, is associated with more willingness to pay for some types of news. The 39 percent of Millennials who identified themselves as more likely to actively seek out news are roughly twice as likely as those who say they mostly bump into it to personally pay for digital news apps (21 percent vs. 10 percent) and print newspapers (21 percent vs. 11 percent).

THOSE WHO WORRY ABOUT PRIVACY ARE MOSTLY WORRIED ABOUT IDENTITY THEFT

For all of their connectivity, however, Millennials are not particularly worried about privacy. Just 2 in 10 say they worry a good deal or all of the time about their information being available online. The most common response, at 46 percent, is worrying only a little. And 34 percent do not worry at all.

Millennials are not very worried about their privacy online

Percent Millennials
50
45
40
35
30
25
20
15
10
5
0
Worry all/most of the time
Worry a little
Don't worry at all

Question: How much do you worry, if at all, about information about you being available online?

Of those who do worry, what concerns them? In general, it is not government spying, or even that big corporations will know too much about them.

The biggest concern, among those worried about privacy, is that someone will steal their identity or financial information (58 percent), which represents 38 percent when those who are not worried are included. That is followed by 46 percent who worry that people they don't know very well will learn too much about their personal lives (or 30 percent when those not worried at all are included).

Even among the 66 percent who worry about privacy, less than half are concerned that big companies will know too much or sell their information (45 percent). That means that of all Millennials surveyed, only 30 percent are worried about corporations knowing too much about their lives.

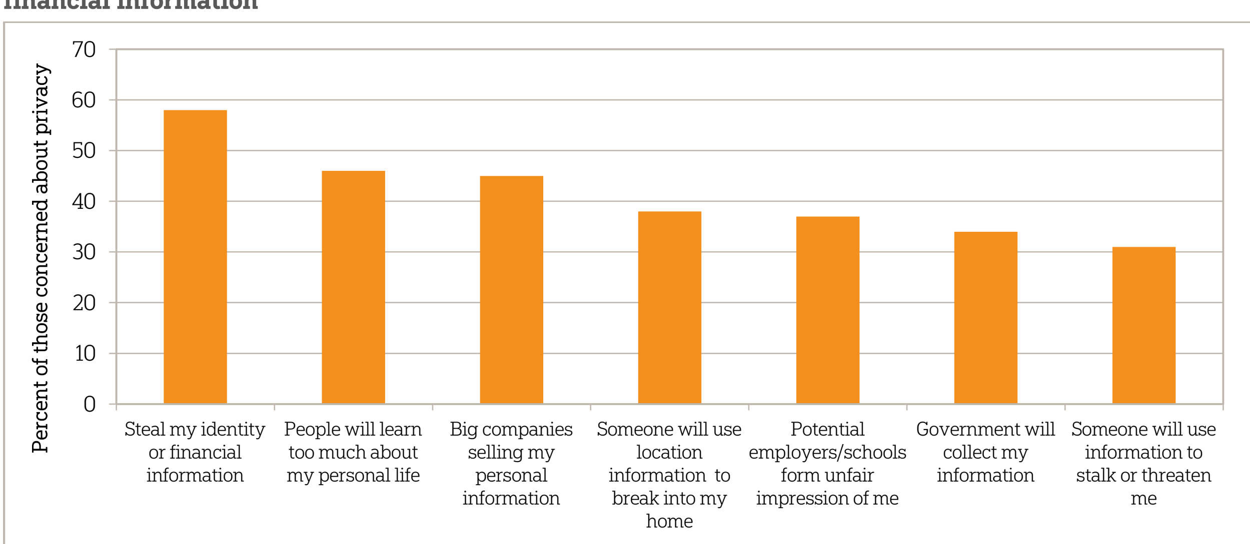
Almost 4 in 10 who have privacy concerns worry about potential employers or schools forming an unfair impression of them based on their online footprint, though this rate was higher among those who do share personal information or content on Facebook or Twitter than among those who do not.

About 4 in 10 Millennials also express concern that someone will use information about their location to break into their home when they are not there (38 percent).

And only about a third of those with any privacy concerns at all are worried about the government collecting information about them (34 percent). When those who don't worry about their privacy online are included, the number of adults under age 35 worried about government surveillance of their digital lives falls to 22 percent.

Lowest on the list, 31 percent of those with privacy concerns say they worry someone will use it to stalk or threaten them.

Millennials who worry about privacy are most concerned that someone will steal their identity or financial information



Question: What is it you are worried about? Please select all that apply.

Those who say they are worried either a good deal or all of the time are more likely to express concern about each of these potential invasions than are those who worry only a little, with one exception. Those worried only a little are about as likely as those who worried a lot that employers or schools will form an unfair impression of them.

The study also found evidence contradicting the idea that load times are a critical factor in influencing the behavior of this digital native generation. Only a minority of Millennials say they gave up on web content because it didn't load fast enough. Just 9 percent say they do so frequently. Another 25 percent say it happens fairly often. The majority (65 percent) say it happens not that often or almost never.

V. HOW MILLENNIALS USE AND CONTROL SOCIAL MEDIA

By taking a deep look into the information habits of Millennials, the study also sheds more detailed light on how Millennials are using social media.

Social networks are an extraordinarily important part of Millennials' digital lives, in part because social networks have become much more than a way to connect about personal matters.

At the same time, we heard in various ways that people increasingly want to take more control over social media, manage their time there, and improve the quality of what they see. Various people expressed a sense of frustration, particularly with Facebook, for having too much information, taking up too much of their time, and containing too much content that wasn't trustworthy or worthwhile.

"I don't like to go on Facebook anymore, but, I mean, I still do it," said Sam, age 19 in San Francisco.

MILLENNIALS USE A VARIETY OF SOCIAL NETWORKS FOR NEWS AND INFORMATION, ESPECIALLY FACEBOOK

The survey measured the use of seven different social networks as pathways to news and information. That analysis provides a landscape view of social media and news. One striking finding is that every one of these social networks, to greater or lesser degrees, are now news platforms.

Fully 88 percent of those surveyed get news from Facebook at least occasionally, 83 percent from YouTube, and 50 percent from Instagram.

Sizable minorities of Millennials also report getting news from Pinterest (36 percent), Twitter (33 percent), Reddit (23 percent), and Tumblr (21 percent). And while these numbers are smaller, they represent quite large percentages of those who use these social media platforms at all.

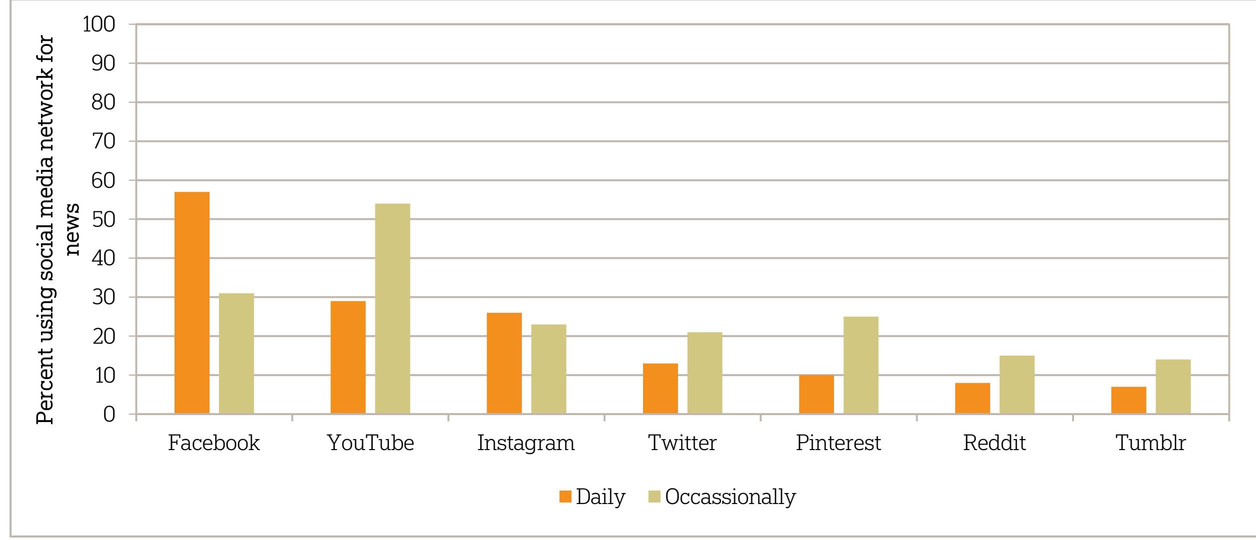
For all that, the omnipresence of Facebook stands out. Fully 57 percent of Millennials who get news from Facebook do so at least once a day (including 44 percent who say at least several times a day).

That is roughly double the number using YouTube (29 percent) or Instagram (26 percent) on a daily basis to get news and information, the next most popular social networks for doing so.

Far fewer report getting news on a daily basis from Twitter (13 percent), Pinterest (10 percent), Reddit (8 percent), or Tumblr (7 percent).

People who describe themselves as active news and information seekers are more likely to use certain social networks for news. In particular, these more active news seekers are more likely to use Reddit (13 percent vs. 4 percent) and somewhat more likely to use YouTube (33 percent vs. 26 percent) at least once a day than those who say they mostly bump into news.

Facebook dominates as a social media platform for news and information



Question: How often, if at all, do you get news and information from each of the following?

Although Facebook is popular among all adults under age 35, younger Millennials are even more likely to use a mix of social networks for news than older members of this generation. The average 18-to-21-year-old uses 3.7 social networks out of seven platforms asked about in the survey. For the average older Millennial age 30-34, that decreases to 2.9.

Stevie, age 19 from Oakland, has deleted his Facebook entirely in favor of other platforms, though he acknowledges that he may be missing out on some of his social network as a result. "I shouldn't have [deleted it] because a lot of older people still use it; college students, and all my college friends still have it, but I deleted it because I felt like I had too many things. I stopped using it because there are other things to use."

WHILE SOCIAL NETWORKS MAY BE A PLACE THAT PEOPLE BUMP INTO NEWS, MANY MILLENNIALS ENGAGE MORE ACTIVELY WITH THE NEWS ONCE THERE

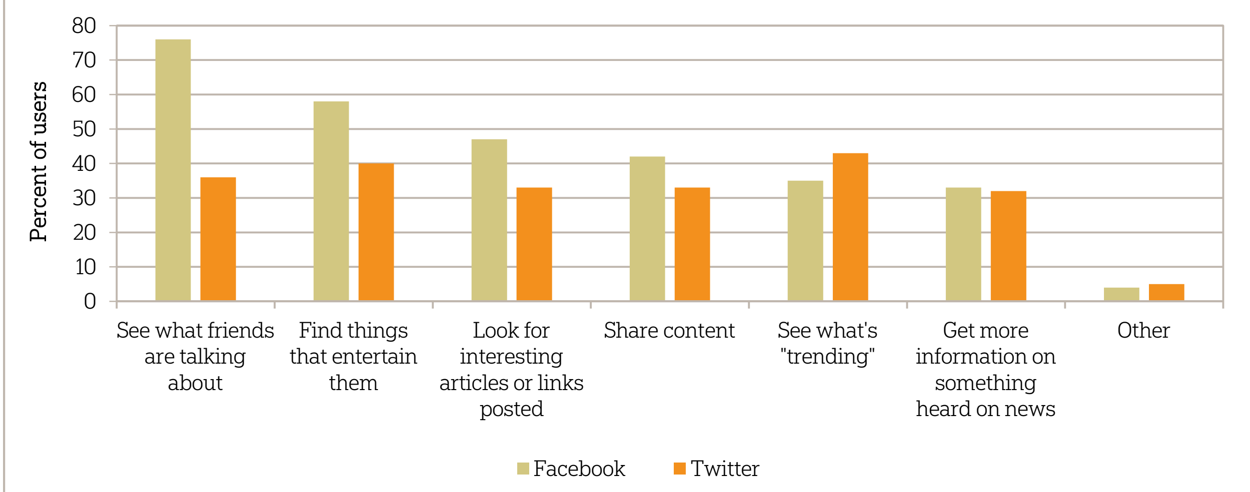
The survey asked the 91 percent of Millennials who report using Facebook for any reason about their behavior there. Seven in 10 click on and regularly read or watch news stories or headlines posted by other people. They also participate in news in ways that are not entirely possible in more traditional platforms. Six in 10, for instance, say they regularly "like" a posted news story, headline, or link. Nearly half, 42 percent, say they regularly post or share news content to Facebook themselves, and 34 percent say they regularly comment on news stories, headlines, or links. Only 11 percent of Facebook users say they do not do any of these things.

The data also suggest that Facebook may be increasing news awareness and consumption in ways that even its users do not anticipate or intend. A good deal of this news consumption is unexpected, or serendipitous. For instance, while 7 in 10 regularly click on news stories on Facebook, less than half (47 percent) of Millennials using Facebook say that hunting for interesting articles is one of the main reasons they use the platform.

The more common motivations for turning to Facebook, these users say, are social. Fully 76 percent of these Facebook Millennials cite seeing what their friends are talking about and what's happening in

their friends' lives, as a main reason they turn to Facebook. A clear majority (58 percent) cite using Facebook to find things that entertain them, such as funny lists, articles, or videos.

The main reasons people turn to Facebook vs. Twitter



Questions: Which of these, if any, are the main reasons that you use Facebook? Which of these, if any, are the main reasons that you use Twitter?

Along with getting news, fewer than half cite sharing content (42 percent), or seeing what's trending and what people are talking about on social media (35 percent) as a main motivation for turning to Facebook. Even lower percentages of this generation say they look to Facebook as a way of learning more about things, or a means to getting more information on something they heard about either on social media or in the news (33 percent).

Twitter, by contrast, is a different kind of platform. While it is a significantly less popular social network overall than Facebook, it is more popular among this group of younger Millennials than it is among adults overall. In general, recent surveys of adults of all ages show that 23 percent have a Twitter account.[8] Among Millennials, however, fully 37 percent say they use Twitter.

The reasons they use Twitter are related but slightly different than the reasons they turn to Facebook. Twitter is a place to learn about what people in general are talking about, not just the lives of people they know. For instance, the number one reason these Twitter users say they use the social platform is to see what's "trending" and what people are talking about (43 percent). The number two reason is to find things that entertain them, such as funny lists, articles, or videos (40 percent). About half as many Twitter users as Facebook users (36 percent vs. 76 for Facebook)

In Millennials' Words: Why do you prefer Facebook/Twitter?

"My reasoning for using Facebook is to communicate with people and be able to find more friends and to stay in contact with [my] friends."
– Francis, age 20, Chicago

"I like Twitter. I use it like a foundation. You can post photos, you can post articles. You can also post just thoughts, and it's fast paced so it's not like a Facebook wall. [On Facebook,] everything gathers and stays there. It's like still water. Twitter is constantly moving, changing every hour or so."
– Marwa, age 25, Chicago

[8] http://www.pewinternet.org/fact-sheets/social-networking-fact-sheet/

say a main reason they use Twitter is to see what's happening in their friends' lives and what they're talking about.

News is not the primary reason that Millennials use Twitter. About one-third say they go to Twitter mainly to look for interesting articles or links their followed friends or organizations post, to share their own content, or to get more information on something they heard either on social media or in the news.

But as with Facebook, the reasons people look at Twitter and the ways they say they actually use it are also different. When asked about action rather than motivation, news becomes far more important.

About half (49 percent) of these Twitter-using Millennials say they regularly read or watch news stories or headlines posted there, and one-third regularly re-tweet news stories, headlines, or links posted by others on Twitter. Fewer regularly compose their own tweets about something news related (26 percent) or tweet news stories, headlines, or links from other websites (23 percent). Just 22 percent of those who use Twitter say they do not use it for any of these news engagement activities.

MILLENNIALS SAY SOCIAL MEDIA EXPOSES THEM TO DIFFERENT OPINIONS AND VIEWS

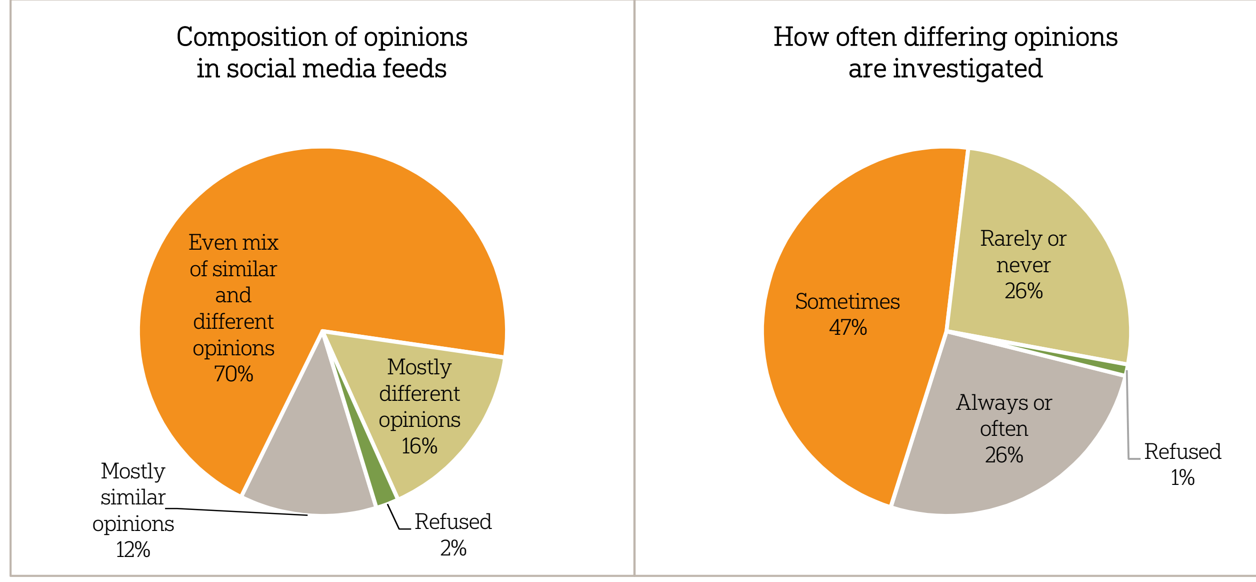
One concept that some critics have wondered about in the age of almost complete consumer choice is whether people are insulated from opinions and ideas that are different than their own. This has been called the "filter bubble," among other names, and there is a question about whether younger adults, who grew up with these choices rather than the agenda-setting of more traditional media are more prone to this risk.

In our earlier study, the Personal News Cycle, we found that the filter bubble was probably overstated when considered broadly. Most Americans did not make their choices about where to learn about most news topics based on ideology. The study found that Americans are discriminating consumers of news whose news habits vary depending on the topic. That study challenged the notion that with limitless choices people follow only a few subjects in which they are interested and only from sources with which they agree.

For this deeper look at people under age 35, we found Millennials perceive themselves to be exposed to a variety of opinions and say they are willing to investigate those opinions.

In all, 70 percent of Millennials say that their social media feeds are composed of a relatively even mix of similar and different opinions to their own. Just 12 percent say the opinions they see in social media are mostly similar to their own. A slightly larger number, 16 percent, say, interestingly, that the opinions and viewpoints they see are mostly different than their own.

Millennials encounter a wide mix of opinions in social media



Questions: Choose the statement that best describes you, even if it is not exactly right. Would you say that the opinions you see in your social media feeds are mostly similar to my own, an even mix of similar and different to my own, or mostly different than my own? How often, if at all, would you say that you click on or investigate opinions you see in your social media feeds that are different than your own?

Those who describe themselves as *less active* seekers of news are even more likely to say they encounter diverse opinions and viewpoints in social media. Fully 73 percent of those Millennials who say they mostly bump into news and information throughout their day say the opinions in their feeds are an even mix of viewpoints, compared with 65 percent of those who call themselves active news seekers. Bumping into news, in other words, may widen the perspectives one is exposed to, not narrow them.

Exposure is one thing. Clicking on those opinions you disagree with is another. To what extent do these younger Millennials then take that next step and read the things that don't reflect their own viewpoints?

Of those who say they see either a mix or mostly dissimilar opinions to their own in their social media feeds, 26 percent say they always or often investigate these different opinions. About half, 47 percent say they do sometimes. Thus nearly three-quarters of these Millennials (73 percent) say they investigate opinions different than their own in social media at least some of the time.

Only a minority, 26 percent, say they rarely or never click on or investigate opinions in their social media feeds that are different from their own.

In other words, the study suggests a wide exposure to different points of view in social media, and a sizable consciousness of taking the next step and investigating those views.

We heard the same awareness in our qualitative interviews, where we were able to press people to see if these responses are simply answers to a survey or are evident in the way people voluntarily describe their behavior.

"[Social media] creates such good dialogue because there are so many places you can get ideas," said Lauren, age 23 in Chicago. "You don't know where your friend or your parent is getting their news from. So you can openly have a dialogue, and you have just totally different views on the same event. I think, overall, it's so cool that it opens up that dialogue."

MILLENNIALS REPORT CHANGING THEIR SOCIAL MEDIA BEHAVIOR OVER TIME

Another trend about the lives of Millennials in social media is that their behavior there has changed over time. Whether this is because they have gotten older, their attitude toward social networks has changed, or they think social media itself has changed is harder to know. We heard in our qualitative interviews examples of all three of those factors.

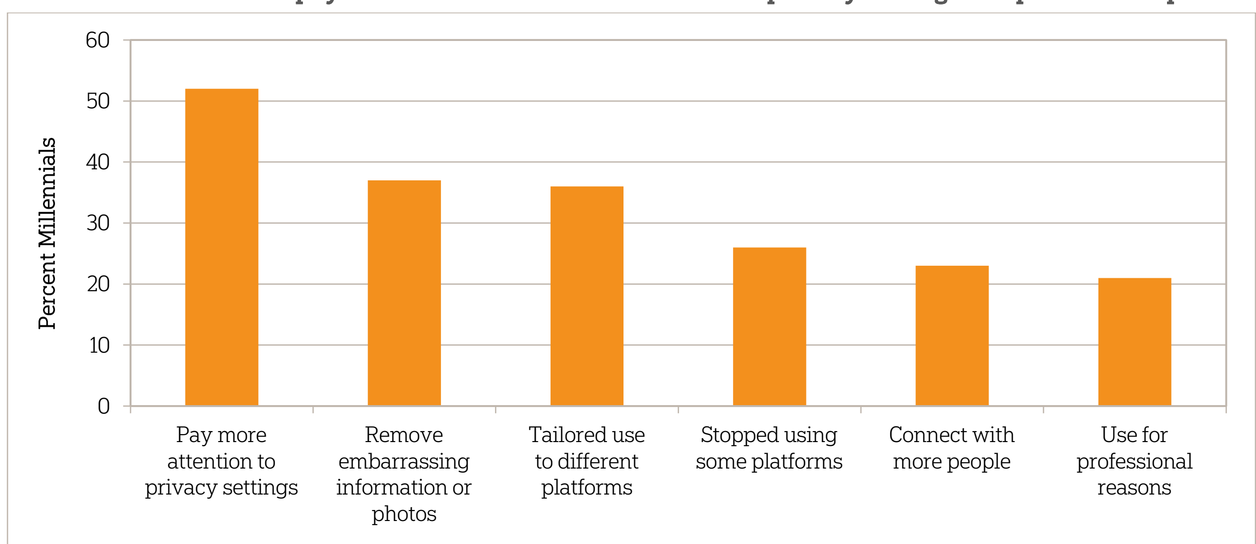
Whatever the reason, fully 86 percent say they have changed how they use social media in some way compared to the past.

While in general this generation is not highly concerned about privacy (as noted above), the most frequently cited change in social media behavior is paying more attention to and actively controlling their privacy settings than they once did. This was true of over half (52 percent) of all respondents. That was the only change cited by a majority.

The second-biggest change had to do with removing content. Fully 37 percent say they are now more likely to remove information or photos of themselves that are embarrassing or immature.

And those who share content on Facebook or Twitter are more likely than those who do not share content to monitor their privacy settings (60 percent vs. 46 percent) as well as remove information or photos that could be embarrassing (47 percent vs. 30 percent).

Over half of Millennials pay more attention to and control their privacy settings compared to the past



Question: In which of the following ways, if any, has your use of social media networks changed over time? Please select all that apply.

The composition of some Millennials' networks is also changing. Thirty-six percent say they have tailored the way they use social media, with different platforms having different purposes.

We heard this often in our qualitative interviews as well. Elese, age 23 from Chicago, notes that she'll "get up and I always have a routine of what I check out on social media. It's always Instagram first, because it's nice pictures, then I'll check out Facebook because, okay, this is what my friends are doing, and then I'll go to Twitter and I'll be like, okay, what's the news."

There is also some but not overwhelming evidence of what might be called social fatigue. In all, 26 percent of Millennials say they have stopped using some of their social networks altogether.

At the same time, however, another notion about the web – that it widens one's network of people in an ever-expanding manner, is also not borne out in the data. In all, only about 1 in 5 Millennials say they now connect with a broader range of people (23 percent) than they once did. Similarly, only about 1 in 5 says they use social networks for professional reasons more frequently (21 percent) than they used to.

VI. DIFFERENCES WITHIN THE MILLENNIAL GENERATION

One risk of trying to analyze a generation is that it may be an arbitrary demarcation. When does a generation begin or end?

The research shows that across different cohorts within the Millennial generation there is a great deal of diversity in attitudes, experiences, and behaviors. These differences cut across age, gender, ethnicity, partisanship, income, education, and other socioeconomic variables.

These differences are potentially significant. As Millennials age and as demographics shift, these could reveal how news consumption, particularly online, will change in the future. We will touch on a few of them here, but plan to explore these variations more fully in future reports.

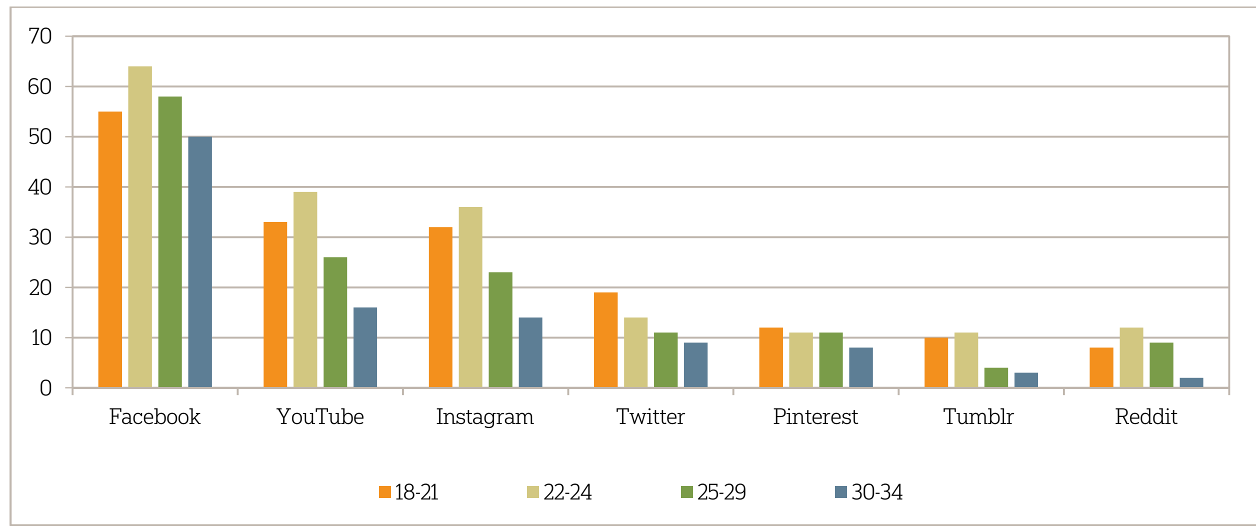
EVEN WITHIN THE MILLENNIAL GENERATION THERE ARE DIFFERENCES BY AGE

The data suggest a sizable difference between Millennials over age 30 and those under age 25, even those out of college.

This is particularly true when it comes to social media. Younger Millennials are more connected to social media, use it more frequently, and use a greater variety of social networks.

It is also true of news. Younger Millennials use social media sites for news and information more frequently than older Millennials, and this holds true across a variety of social media platforms. For instance, those age 18 to 21 are more likely than those age 30 to 34 to say they get news or information at least once a day from Twitter (19 percent vs. 9 percent), Reddit (8 percent vs. 2 percent), Tumblr (10 percent vs. 3 percent), and Instagram (32 percent vs. 14 percent).

Percent of Millennials who use each social media site at least once a day, by age



Question: How often, if at all, do you get news and information from each of the following?

Motivations for using social media also vary somewhat by age. Among Facebook users, 52 percent of those age 22-24 years old look for interesting articles or links posted by their friends. That is 11 percentage points higher than the 41 percent of those age 30-34 years old. For these older Millennials, Facebook appears to be more about social interaction than about connecting with the world around them.

There are other differences by age that touch on web activity in general. Millennials over age 30, for instance, are far more likely to describe themselves as active seekers of news than people who mainly bump into it, compared to younger Millennials under age 25. For those age 30-34, by contrast, active seekering versus more passive is evenly split (49 percent active vs. 50 percent more passive). Among those under age 25, only a third describe themselves as active seekers, while two-thirds say the news finds them. How one finds news, the data suggest, may be partly a function of age and experience rather than whether one is a digital native. The evidence probably leans against the idea that these younger Millennials might move away from social media to get news as they age, however. This is the group that grew up with social media for all of their adult lives. Their use of it, if anything, has grown with time, and become more complex.

One area where age made little difference is in the motivations for getting news in general. Whether people are college age or in their 30s, their reasons for getting news were strikingly similar and balanced across the three main categories — civic, social, and practical.

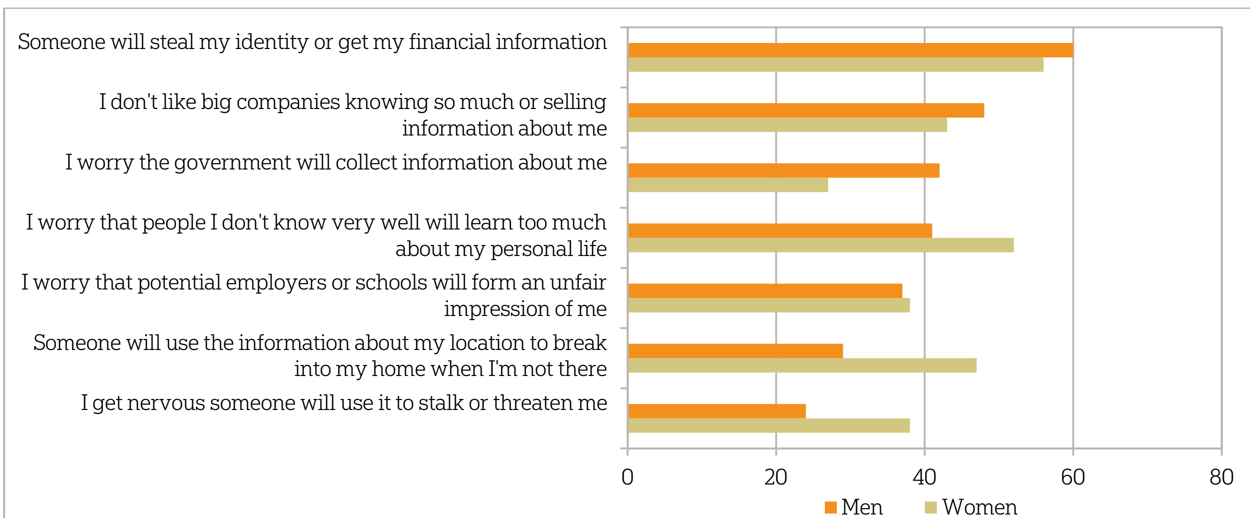
MEN AND WOMEN HAVE DIFFERENT ONLINE PRIVACY CONCERNS, USE DIFFERENT SOCIAL MEDIA SITES, AND FOLLOW DIFFERENT TOPICS

In addition to age, there are gender differences in the online and social media behavior of Millennials. Many of these are related to online privacy, social media use, and the types of information and news followed online. Women and men have different privacy concerns about the web. Women, for instance, are significantly more likely than men to worry someone will use their location information to break into their home (47 percent vs. 29 percent), and to use their information to stalk or threaten them (38 percent vs. 24 percent).

Women are also more likely than men to worry that people they don't know very well will learn too much about their personal lives (52 percent vs. 41 percent).

On the other hand, men are significantly more likely than women to worry that the government will collect information about them (42 percent vs. 27 percent).

Men and women worry about different aspects of online privacy



Question: What is it you are worried about? Please select all that apply.

There are also some gender differences in the use of social media for news. Men are more likely than women to say they use Reddit (10 percent vs. 5 percent) and YouTube (35 percent vs. 21) at least once a day. In contrast, women are more likely than men to report using Pinterest (16 percent vs. 5 percent) and Instagram (36 percent vs. 17 percent) for news at least once a day.

With Facebook, women are more likely than men to see what's happening with friends (74 percent vs. 64 percent) and to tell people what is going on in their lives (48 percent vs. 29 percent).

Men and women have also adapted their social media use differently over time. Men are more likely than women to say they now connect with a broader range of people (26 percent vs. 19 percent), while women are more likely than men to say they now pay more attention to privacy (57 percent vs. 47 percent). Fully 44 percent of women say they are now more likely to remove information or photos that are embarrassing compared with 31 percent of men.

Women and men also follow different topics and search for different information online.

Women, for instance, are more likely than men to follow news about celebrities (47 percent vs. 23 percent), style and fashion (44 percent vs. 10 percent), and health and fitness (49 percent vs. 32 percent). More women than men follow how-to information (51 percent vs. 36 percent), and traffic and weather information (57 percent vs. 46 percent). Women are also more likely than men to follow news about health care (45 percent vs. 27 percent), schools and education (43 percent vs. 24 percent), and social issues (44 percent vs. 31 percent).

There are a few topics about which men are more interested. One of them is sports (58 percent of men say they regularly follow it vs. 39 percent of women), though that difference may be smaller than some might expect. But this is not the only subject where men expressed more interest. They also were more likely to say they regularly follow national politics (48 percent vs. 38 percent) and science (52 percent vs. 32 percent).

On many more elements of digital life, what is striking is how similar men and women are. There are few differences in what activities men and women do online, or how often.

RACIAL DIFFERENCES AMONG MILLENNIALS IN ONLINE ACTIVITIES AND SOCIAL MEDIA

The digital and social media behavior of Millennials also differs somewhat by ethnicity.

These differences, however, have little to do with device ownership. Across all ethnic groups, more than 90 percent of Millennials surveyed own a smartphone and roughly half own tablets.

The differences, instead, relate to behavior online. Millennial Hispanics, for instance, are less likely than others to engage in various online activities. Fewer report being online to keep up with friends (63 percent Hispanic vs. 71 percent all Millennials), keep up with news (53 percent vs. 64 percent), or pursue hobbies (50 percent vs. 65 percent). Hispanic Millennials are also less likely to play games online (37 percent vs. 45 percent), stream video (53 percent vs. 68 percent), and check weather or traffic (48 percent vs. 57 percent).

African American Millennials, by contrast, differ from Millennials overall on only one of these activity categories. They are less likely to be online to keep up with friends (59 percent vs. 71 percent).

There are differences in social media use, as well, correlated to race and ethnicity. Hispanics and African Americans, to begin with, are more likely to use certain social media sites than the population overall, and whites in particular. Hispanic and African American Millennials, for instance, are more likely to turn to YouTube for news every day (38 percent Hispanics and 33 percent for African American) than are white Millennials (20 percent). Hispanic and African American young adults also look to Instagram for news every day more so than white Millennials (45 percent of African Americans, 30 percent Hispanics, and 19 percent whites).

VII. LOOKING AHEAD

In our interviews, we also asked this generation what they see coming, and how they would like the media to change.

One theme we heard was a desire that the crowded media marketplace would calm down, and that there would be less fear mongering — which interestingly is a theme scholars have identified in the digital landscape. "I'd like if the media in the next five years is actually stripped down and is more factual as opposed to sensationalized," said Marwa, age 25 in Chicago. "I feel like the news creates so much drama for us, it creates so much fear instead of just saying, 'okay, this is what happened.'"

We heard this in other cities as well. "[O]ne thing that I want to see change is that news is less sensationalist, and don't use big buzzwords or click bait just to get a message out there that isn't necessarily true or relevant," said Connor, a sophomore at the University of Mary Washington.

"I want the news to find a balance. That's my most important thing. I don't want to turn on the news and just see nothing but negativity and you know, nothing but sadness," said Sam, age 19 in San Francisco. "Like I found out the Richmond death rate or homicide rate has been the lowest in many years. I found that out from social media. I didn't find that out from the news."

For Sam, the professional news media seems to be straining for his attention so much he doubts that they would have even reported something that wasn't negative or alarming. "The news wouldn't tell you anything like that. The news would be quick to tell you, 'okay, the homicide rate is up, that it's the highest in five years.'"

Another theme we heard is a desire for the news media to be more of an arbiter of truthfulness and not just a carrier of potentially polarizing rhetoric or alarming allegations.

Marilu, age 29 from Chicago, was concerned not only with what some media outlets cover, but with what they ignore. "Some news stations need to grow up. And I say this because, when Obama made the announcement [about immigration], some news stations didn't report it or they didn't televise it. I feel like whether they agree with something or not, no matter what their political agenda is, this was the news [and they should cover it]."

No matter the type of media, Devon in San Francisco is waiting for journalists of his generation to come to the fore and speak in ways that are more relevant to him. "Find a way to make it different points of view. .... Bring in more people with a different opinion, like maybe a different age group that could reach a different audience. [B]ring somebody else along so that they can maybe [speak] to our age group."

VIII. ABOUT THE STUDY

SURVEY METHODOLOGY

This survey was conducted by the Media Insight Project, an initiative of the American Press Institute (API) and the Associated Press-NORC Center for Public Affairs Research. The survey was conducted from January 5 through February 2, 2015. The survey was funded by API. The API, NORC at the University of Chicago, and AP staff collaborated on all aspects of the study.

The study included multiple modes of data collection. The portion of the survey involving screening for age eligibility and recruitment was completed by telephone, while the main portion of the questionnaire was administered online. The telephone component included only cell telephone numbers (no landlines), and used both random-digit-dial (RDD) and age-targeted list sample from the 50 states and the District of Columbia. During recruitment efforts, a total of 6,635 adults provided age information, and 2,297 (35 percent) were deemed eligible because they fell between the ages of 18 and 34. Of those 2,297, a total of 1,759 respondents (77 percent) went on to complete the recruitment phase of the survey, which involved agreeing to receive an invitation for the web survey either by email or text message, and providing one's email address or cell telephone number. Of the recruited participants, 1,045 (59 percent) completed the web survey. The final response rate was 14 percent, based on the American Association for Public Opinion Research Response Rate 3 method.

Respondents were offered one small monetary incentive for participating in the telephone portion of the survey, as compensation for telephone usage charges, and another small monetary incentive for

participating in the web portion of the survey. Interviews were conducted in both English and Spanish, depending on respondent preference. All telephone recruitments were completed by professional interviewers who were carefully trained on the specific survey for this study.

The RDD sample was provided by a third-party vendor, Marketing Systems Group. The age-targeted list sample was provided by a second vendor, Scientific Telephone Samples. The sample design aimed to ensure the sample representativeness of the population in a time- and cost-efficient manner. The sampling frame utilizes the standard cell telephone RDD frame, with a supplemental sample of cell telephone numbers targeting adults between the ages of 18 and 34. The targeted sample was pulled from a number of different commercial consumer databases and demographic data.

Sampling weights were appropriately adjusted to account for potential bias introduced by using the targeted sample. Sampling weights were calculated to adjust for sample design aspects (such as unequal probabilities of selection) and for nonresponse bias arising from differential response rates across various demographic groups and for noncoverage of the population without access to cell phones. Poststratification variables included age, sex, race/ethnicity, region, and education. The weighted data, which thus reflect the U.S. population of 18- to 34-year-old adults, were used for all analyses. The overall margin of error was +/- 3.8 percentage points, including the design effect resulting from the complex sample design.

All analyses were conducted using STATA (version 13), which allows for adjustment of standard errors for complex sample designs. All differences reported between subgroups of the U.S. population are at the 95 percent level of statistical significance, meaning that there is only a 5 percent (or less) probability that the observed differences could be attributed to chance variation in sampling. Additionally, bivariate differences between subgroups are only reported when they also remain robust in a multivariate model controlling for other demographic, political, and socioeconomic covariates. A comprehensive listing of all study questions, complete with tabulations of top-level results for each question, is available on the Media Insight Project's website: www.mediainsight.org.

QUALITATIVE GROUP INTERVIEWS

The Associated Press-NORC Center for Public Affairs Research, in collaboration with the American Press Institute, conducted 10 semi-structured interviews with groups of Millennials, age 18-34. Three group interviews were conducted in Chicago, Illinois, on December 11, 2014; two were conducted in San Francisco, California, on January 7, 2015; two were conducted in Oakland, California, on January 7-8, 2015; and three were conducted in Fredericksburg, Virginia, on January 22, 2015.

Select participants in each of the locations also consented to completing follow-up activities. These activities included: 1) a self-reflection, interview, and essay exercise, and 2) a data diary. These exercises were intended to gather additional information about how these Millennials think about news and information, what news and information is important to them, and how they follow a news story of interest.

All participants received a monetary incentive for the discussion and an additional incentive to complete the follow-up activities. With the consent of the participants, all but one of the interviews were videotaped. There was a lead moderator for each group, and additional researchers asked probing questions. While there was a moderator guide to provide some direction, the interviews were meant to simulate a casual conversation to learn more about 1) how Millennials conceptualize news, 2)

what topics and types of news Millennials value and why, and 3) how Millennials engage with news – or not – and how has this changed for them over their lifetime.

Across all sites, 17 Millennials between the ages of 18-24, and six between the ages of 25-34, were interviewed. The Chicago interviews took place in a coffee shop downtown. The San Francisco interviews took place in a coffee shop in the Financial District. The Oakland interviews were conducted in a downtown coffee shop. The Fredericksburg interviews took place outside a dining hall in a university building.

Chicago

For the Chicago interviews, the AP-NORC Center commissioned a recruiter, FocusScope, to pre-recruit "friend groups" of Millennials, age 18-34. In each group, one participant was initially recruited by FocusScope, and he or she was asked to bring a friend or two to the discussion. The participants were recruited based on age, and to achieve a mix of demographics – income, education, race/ethnicity, and gender. All of the recruited respondents reported that they read, hear, or watch the news at least once a day.

Bay Area – San Francisco and Oakland

For the Bay Area interviews conducted in San Francisco and Oakland, AP-NORC commissioned Nichols Research to pre-recruit four friend groups. Again, recruiting was done based on age, a mix of demographic groups were recruited, and all recruited respondents reported that they read, hear, or watch the news at least once a day. In addition, there was an emphasis to find respondents in San Francisco who identified as being always online and connected, as well as extremely tech-savvy. For the Oakland groups, respondents who were not always online were targeted, and they were not recruited based on the tech-savvy criteria.

Fredericksburg, Virginia – University of Mary Washington

For interviews conducted in Fredericksburg, AP-NORC staff used an intercept approach where participants were recruited onsite at a student center at the University of Mary Washington. Groups of friends were approached and asked if they were available to participate in the interviews in the next half hour. Three groups of participants were recruited this way, two pairs and one group of three.

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ABOUT THE MEDIA INSIGHT PROJECT

The Media Insight Project is a collaboration of the American Press Institute and the AP-NORC Center for Public Affairs Research with the objective of conducting high-quality, innovative research meant to inform the news industry and the public about various important issues facing journalism and the news business. The Media Insight Project brings together the expertise of both organizations and their respective partners, and involves collaborations among key staff at API, NORC at the University of Chicago, and The Associated Press.

About the American Press Institute

The American Press Institute conducts research and training, convenes thought leaders, and creates tools to help chart a path ahead for journalism in the 21st century. API is an educational non-advocacy 501(c)3 nonprofit organization affiliated with the Newspaper Association of America. It aims to help the news media, especially local publishers and newspaper media, advance in the digital age.

About the Associated Press-NORC Center for Public Affairs Research

The AP-NORC Center for Public Affairs Research taps into the power of social science research and the highest-quality journalism to bring key information to people across the nation and throughout the world.

The Associated Press (AP) is the world's essential news organization, bringing fast, unbiased news to all media platforms and formats.

NORC at the University of Chicago is one of the oldest and most respected, independent research institutions in the world.

The two organizations have established the AP-NORC Center for Public Affairs Research to conduct, analyze, and distribute social science research in the public interest on newsworthy topics, and to use the power of journalism to tell the stories that research reveals.

The founding principles of the AP-NORC Center include a mandate to carefully preserve and protect the scientific integrity and objectivity of NORC and the journalistic independence of AP. All work conducted by the Center conforms to the highest levels of scientific integrity to prevent any real or perceived bias in the research. All of the work of the Center is subject to review by its advisory committee to help ensure it meets these standards. The Center will publicize the results of all studies and make all datasets and study documentation available to scholars and the public.

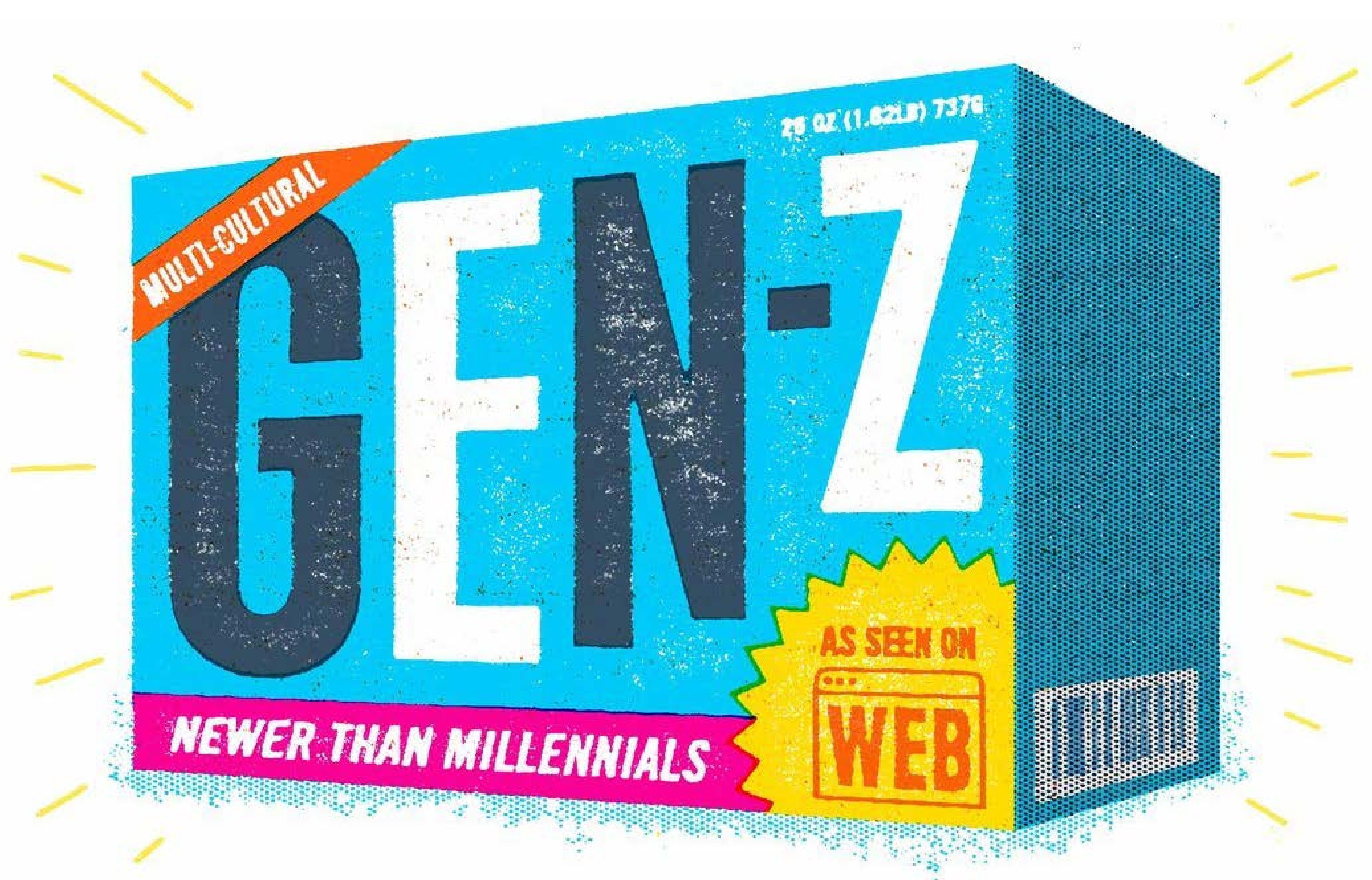
PHOTO CREDITS

Cover Photo: This May 21, 2013 file photo shows an iPhone in Washington with Twitter, Facebook, and other apps. (AP Photo/Evan Vucci, File)

FASHION & STYLE

Move Over, Millennials, Here Comes Generation Z

By ALEX WILLIAMS SEPT. 18, 2015



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Hear the word "millennial," and plenty of images spring to mind.

There's Facebook's Mark Zuckerberg, in his hoodie, earning his first billion by the age of 23.

There's Miley Cyrus, preening for the cameras in a flesh-baring act that recalls a Snapchat sexting session.

There's Lena Dunham, TV's queen of overshare, spiraling into navel-gazing soliloquies that seem scripted from the therapist's couch.

They're brash, they're narcissistic, they're entitled. Or so the cliché goes.

But what about "Generation Z," the generation born after millennials that is emerging as the next big thing for market researchers, cultural observers and trend forecasters?

With the oldest members of this cohort barely out of high school, these tweens and teens of today are primed to become the dominant youth influencers of tomorrow. Flush with billions in spending power, they promise untold riches to marketers who can find the master key to their psyche.
No wonder the race to define, and market to, this demographic juggernaut is on. They are "the next big retail disrupter," according to Women's Wear Daily. They have "the weight of saving the world and fixing our past mistakes on their small shoulders," according to an article on Fast Company's Co.Exist site by Jeremy Finch, an innovation consultant. Lucie Greene, the worldwide director of the Innovation Group at J. Walter Thompson, calls them "millennials on steroids."

Read More: How to Spot a Member of Generation Z

While it is easy to mock the efforts of marketers to shoehorn tens of millions of adolescents into a generational archetype, à la the baby boomers, it is also clear that a 14-year-old in 2015 really does inhabit a substantially different world than one of 2005.

Millennials, after all, were raised during the boom times and relative peace of the 1990s, only to see their sunny world dashed by the Sept. 11 attacks and two economic crashes, in 2000 and 2008. Theirs is a story of innocence lost.

Generation Z, by contrast, has had its eyes open from the beginning, coming

along in the aftermath of those cataclysms in the era of the war on terror and the Great Recession, Ms. Greene said.

“If Hannah Horvath from ‘Girls’ is the typical millennial — self-involved, dependent, flailing financially in the real world as her expectations of a dream job and life collide with reality — then Alex Dunphy from ‘Modern Family’ represents the Gen Z antidote,” Ms. Greene said. “Alex is a true Gen Z: conscientious, hard-working, somewhat anxious and mindful of the future.”

Generational study being more art than science, there is considerable dispute about the definition of Generation Z. Demographers place its beginning anywhere from the early ’90s to the mid-2000s. Marketers and trend forecasters, however, who tend to slice generations into bite-size units, often characterize this group as a roughly 15-year bloc starting around 1996, making them 5 to 19 years old now. (By that definition, millennials were born between about 1980 and 1995, and are roughly 20 to 35 now.)

CRAIG BLANKENHORN /HBO, VIA ASSOCIATED PRESS

ERIC MCCANDLESS/ABC

	Millennials (born 1980-1995)	Generation Z (born 1996-2010)
TV ICON	Hannah Horvath, "Girls"	Alex Dunphy, "Modern Family"
MUSIC	Lady Gaga	Lorde
SOCIAL MEDIA	Facebook	Snapchat, Whisper
WEB STAR	PewDiePie, YouTube	Lele Pons, Vine
STYLE INFLUENCER	Olsen twins	Tavi Gevinson
CLOTHES	American Apparel	Shop Jeen
FIRST GADGET	iPod	iPhone

Even accepting those rather narrow boundaries, Generation Z still commands attention through its sheer size. At approximately 60 million, native-born American members of Generation Z outnumber their endlessly dissected millennial older siblings by nearly one million, according to census data compiled by Susan Weber-Stoger, a demographer at Queens College.

The fact that some are still in their post-toddler years, however, makes it difficult for marketers trying to distill their generational essence. Among the 5-year-olds, cultural tastes do not reach much further than “Shaun the Sheep” and “Bubble Guppies.”

As for the older end of the Generation Z spectrum, some demographers still lump them in with the millennials, but increasingly, many marketers see them as a breed apart.

So, who are they? To answer that question, you have to take a deeper look at the world in which they are coming of age.

“When I think of Generation Z, technology is the first thing that comes to mind,” said Emily Citarella, a 16-year-old high school student in Atlanta. “I know people who have made their closest relationships from Tumblr, Instagram and Facebook.”

Sure, millennials were digital; their teenage years were defined by iPods and MySpace. But Generation Z is the first generation to be raised in the era of smartphones. Many do not remember a time before social media.

“We are the first true digital natives,” said Hannah Payne, an 18-year-old U.C.L.A. student and lifestyle blogger.
Max Whittaker for The New York Times

“We are the first true digital natives,” said Hannah Payne, an 18-year-old U.C.L.A. student and lifestyle blogger. “I can almost simultaneously create a document, edit it, post a photo on Instagram and talk on the phone, all from the user-friendly interface of my iPhone.”

“Generation Z takes in information instantaneously,” she said, “and loses interest just as fast.”

That point is not lost on marketers. In an era of emoji and six-second Vine videos, “we tell our advertising partners that if they don’t communicate in five words and a big picture, they will not reach this generation,” said Dan Schawbel, the managing partner of Millennial Branding, a New York consultancy.

So far, they sound pretty much like millennials. But those who study youth trends are starting to discern big differences in how the two generations

view their online personas, starting with privacy.

While the millennial generation infamously pioneered the Facebook beer-bong selfie, many in Generation Z have embraced later, anonymous social media platforms like Secret or Whisper, as well as Snapchat, where any incriminating images disappear almost instantly, said Dan Gould, a trend consultant for Sparks & Honey, an advertising agency in New York.

Open Thread Newsletter

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"As far as privacy, they are aware of their personal brand, and have seen older Gen Y-ers screw up by posting too openly," Mr. Gould said.

That point was driven home in a 2013 Mashable article titled "I'm 13 and None of My Friends Use Facebook," in which Ruby Karp, a New York teenager, wrote: "Let's say I get invited to a party and there's underage drinking. I'm not drinking, but someone pulls out a camera. Even if I'm not carrying a red Solo cup, I could be photographed behind a girl doing shots."

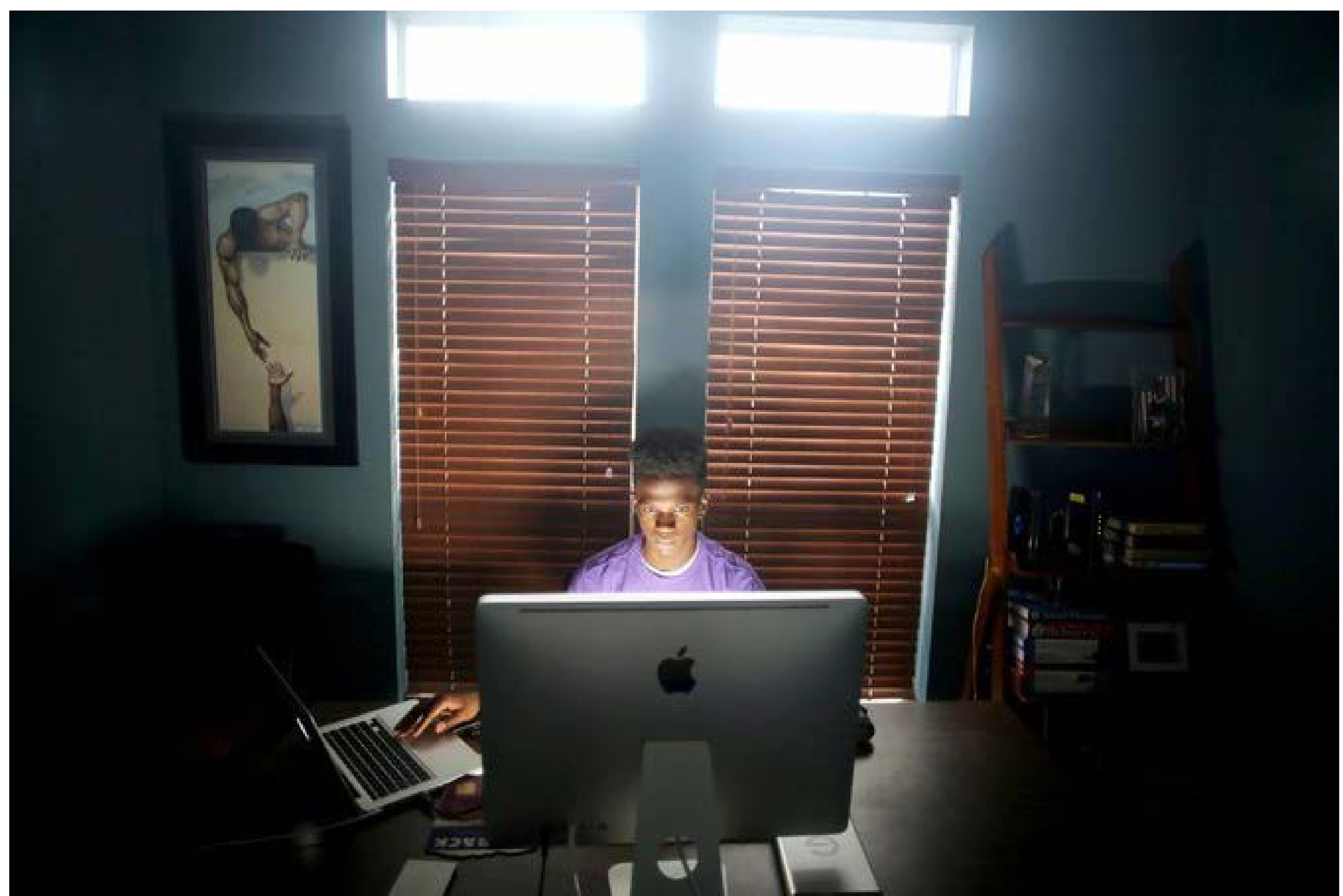
But the difference between generations goes much deeper than choosing Snapchat over Facebook.

Between 2000 and 2010, the country's Hispanic population grew at four times the rate of the total population, according to the Census Bureau. The number of Americans self-identifying as mixed white-and-black biracial rose 134 percent. The number of Americans of mixed white and Asian descent grew by 87 percent.

Those profound demographic shifts are reflected at the cultural level, too.

Attitudes on social issues have shifted, in some cases seismically, in the decade since millennials were teenagers.

Same-sex marriage, for example, has gone from a controversial political issue to a constitutional right recognized by the Supreme Court. For today's 14-year-olds, the nation's first African-American president is less a historic breakthrough than a fact of life.



"America becomes more multicultural on a daily basis," said Anthony Richard Jr., a 17-year-old in Gretna, La.
Jennifer Zdon for The New York Times

"America becomes more multicultural on a daily basis," said Anthony Richard Jr., a 17-year-old in Gretna, La. "It's exponential compared to previous generations."

This vision of a generation with wired brains, making their way in an ethnic-stew society of the future, makes them sound like the replicants from "Blade Runner."

But the parents of Generation Z teenagers play an equally powerful role in shaping their collective outlook. Millennials, who are often painted, however unfairly, as narcissistic brats who expect the boss to fetch them coffee, were largely raised by baby boomers, who, according to many, are the most iconoclastic, self-absorbed and grandiose generation in history. Think: Steve Jobs. (To be more charitable, maybe it's no surprise that a New York Times article from last year called millennials "Generation Nice," and lauded their communal spirit, given that their parents were save-the-world boomers.)

By contrast, Generation Z tends to be the product of Generation X, a relatively small, jaded generation that came of age in the post-Watergate, post-Vietnam funk of the 1970s, when horizons seemed limited. Those former latchkey kids, who grew up on Nirvana records and slasher movies, have tried to give their children the safe, secure childhood that they never had, said Neil Howe, an economist and the co-author of more than a dozen books about American generations.

"You see the mommy blogs by Generation X-ers, and safety is a huge concern: the stainless-steel sippy cups that are BPA-free, the side-impact baby carriages, the home preparation of baby food," said Mr. Howe, who runs Saeculum Research, a Virginia-based social trends consultancy. (As a historian who takes the long view, however, Mr. Howe defines the cohort quite differently; he has called it the "Homeland Generation" because they grew up in post-9/11 America, and argues that it did not begin until around 2004.)

Part of that obsession with safety is likely due to the hard times that both Generation Z members and their parents experienced during their formative years.

"I definitely think growing up in a time of hardship, global conflict and economic troubles has affected my future," said Seimi Park, a 17-year-old high school senior in Virginia Beach, who always dreamed of a career in fashion, but has recently shifted her sights to law, because it seems safer.

"This applies to all my friends," she said. "I think I can speak for my generation when I say that our optimism has long ago been replaced with pragmatism."

That sober sensibility goes beyond career, it seems. A Sparks & Honey trend report called "Meet Generation Z: Forget Everything You Learned About Millennials" asserted that the cohort places heavy emphasis on being "mature and in control." According to a survey of risky behavior by the

Centers for Disease Control and Prevention, the percentage of high school students who had had at least one drink of alcohol in their lives declined to about 66 percent in 2013, from about 82 percent in 1991. The number who reported never or rarely wearing a seatbelt in a car driven by someone else declined to about 8 percent, compared with about 26 percent in 1991.

Put it all together — the privacy, the caution, the focus on sensible careers — and Generation Z starts to look less like the brash millennials and more like their grandparents (or, in some cases great-grandparents), Mr. Howe said.

Those children of the late 1920s through the early '40s, members of the so-called Silent Generation, were shaped by war and the Depression and grew up to be the diligent, go-along-to-get-along careerists of the '50s and '60s — picture Peggy from "Mad Men."

"The parallels with the Silent Generation are obvious," Mr. Howe said. "There has been a recession, jobs are hard to get, you can't take risks. You've got to be careful what you put on Facebook. You don't want to taint your record."

Those children of the New Deal, epitomized by the low-key Warren Buffett, "didn't want to change the system, they wanted to work within the system," Mr. Howe said. "They were the men in the gray flannel suits. They got married early, had kids early. Their first question in job interviews was about pension plans."

That analogy only goes so far for a generation predisposed to making Vine videos of themselves doing cartwheels over their cats. (Let's not forget that the Silents, too, had no shortage of mavericks who made noise on the world stage — Martin Luther King Jr., Elvis Presley and Andy Warhol, to name but a few.) As for the gray flannel suits, parents may not want to send their teenagers off to the tailor just yet. The Sparks & Honey report argued that "entrepreneurship is in their DNA."

"Kids are witnessing start-up companies make it big instantly via social media," said Andrew Schoonover, a 15-year-old in Olathe, Kan. "We do not want to work at a local fast-food joint for a summer job. We want to make our own business because we see the lucky few who make it big."

Which leads to a final point worth mentioning about the Silent Generation. As Mr. Howe pointed out, it was not just the most career-focused generation in history. It was also, he said, the richest.

LOS ANGELES COUNTY COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140, Los Angeles, CA 90010 · TEL. (213) 7382816 · FAX (213) 637-4748
Website: http://hiv.lacounty.gov Email: hivcomm@lachiv.org

19. LOS ANGELES COUNTY HEALTH AGENCY: CENTER FOR HEALTH EQUITY

Regular Meeting of the Los Angeles County Commission on HIV

Center for Health Equity

November 9, 2017

Barbara Ferrer, PhD, MPH, MEd
Director, Los Angeles County Department of Public Health

Slide 1

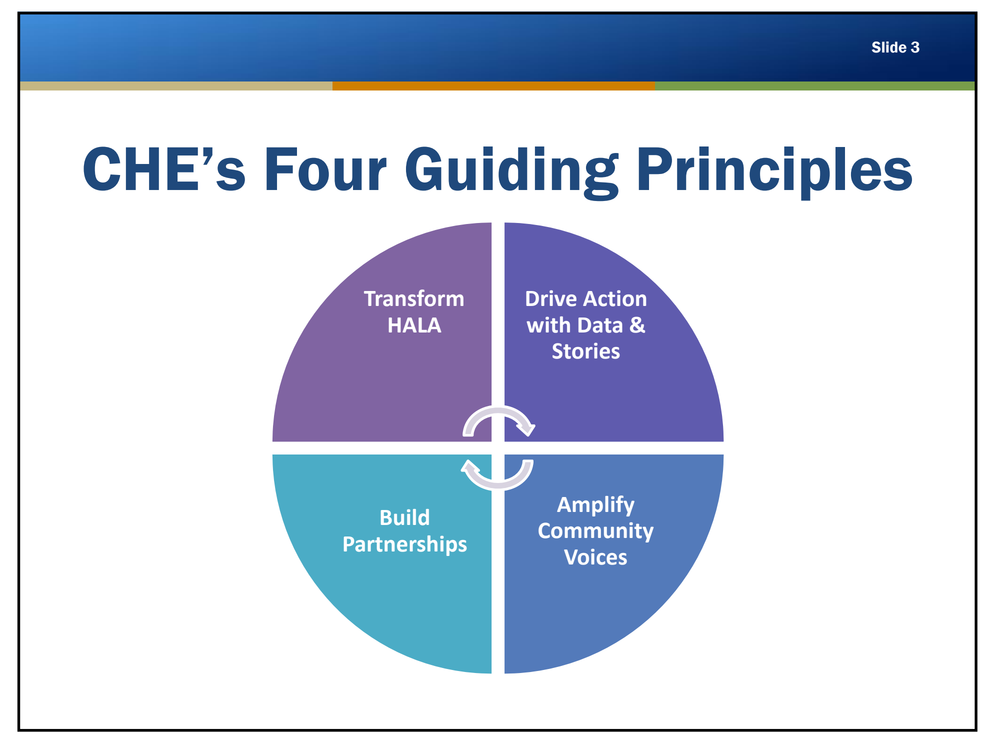
The Center for Health Equity (CHE)

- **CHE efforts will span across the Health Agency of Los Angeles (HALA) and will:**
  – Leverage existing resources and efforts;
  – Ensure a racial and social justice lens; and
  – Serve as a critical touchpoint for partners and community

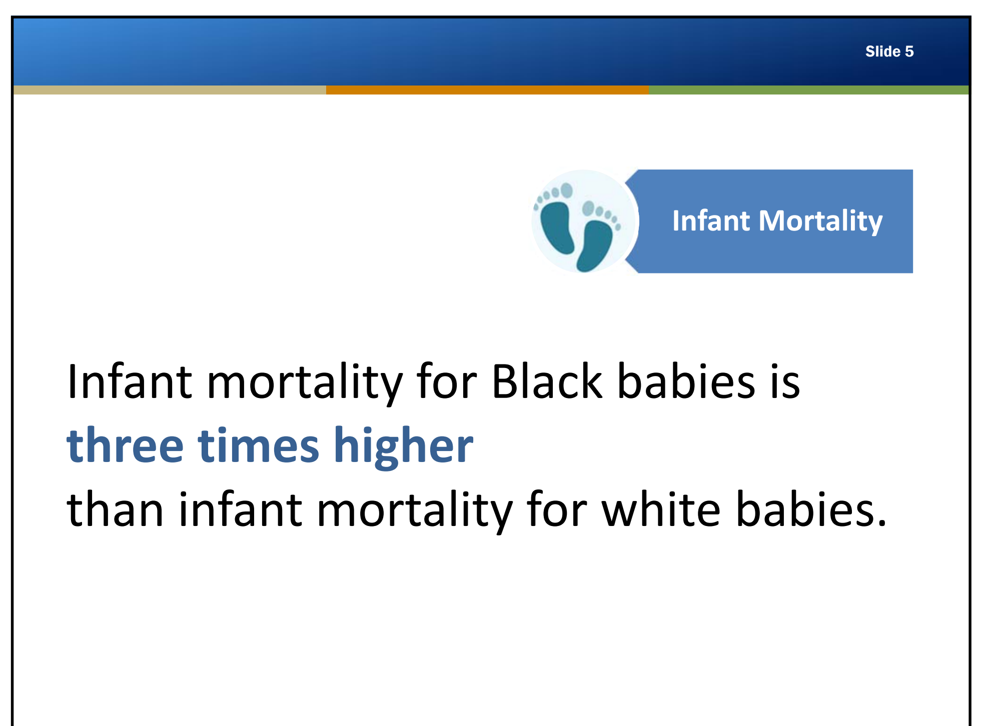
Slide 2

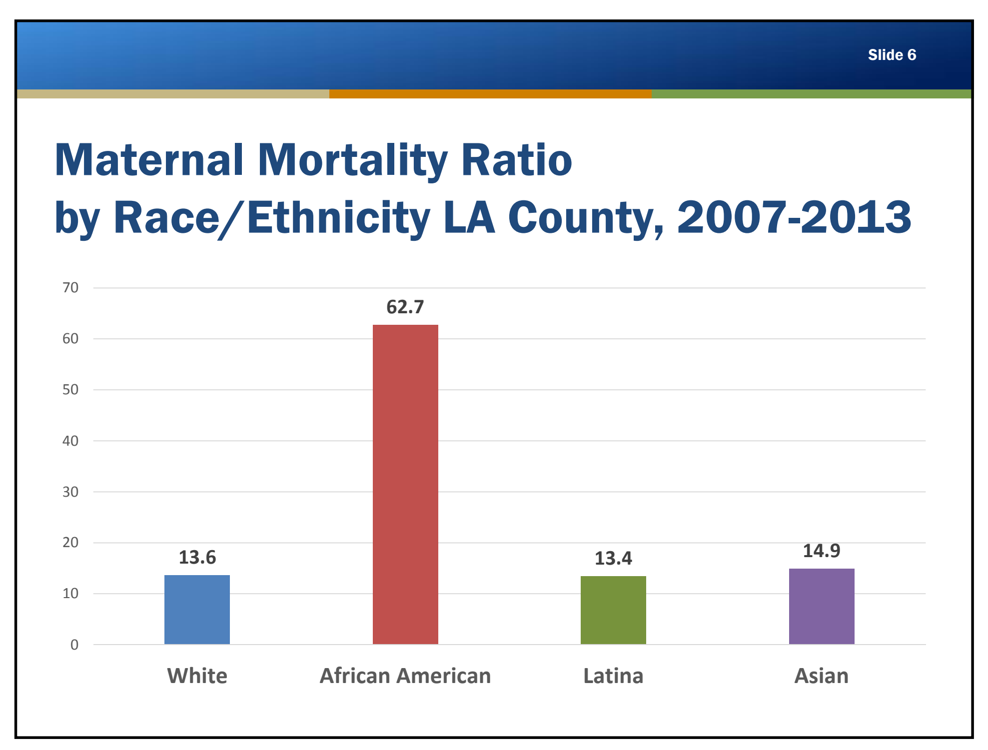
About the Center for Health Equity

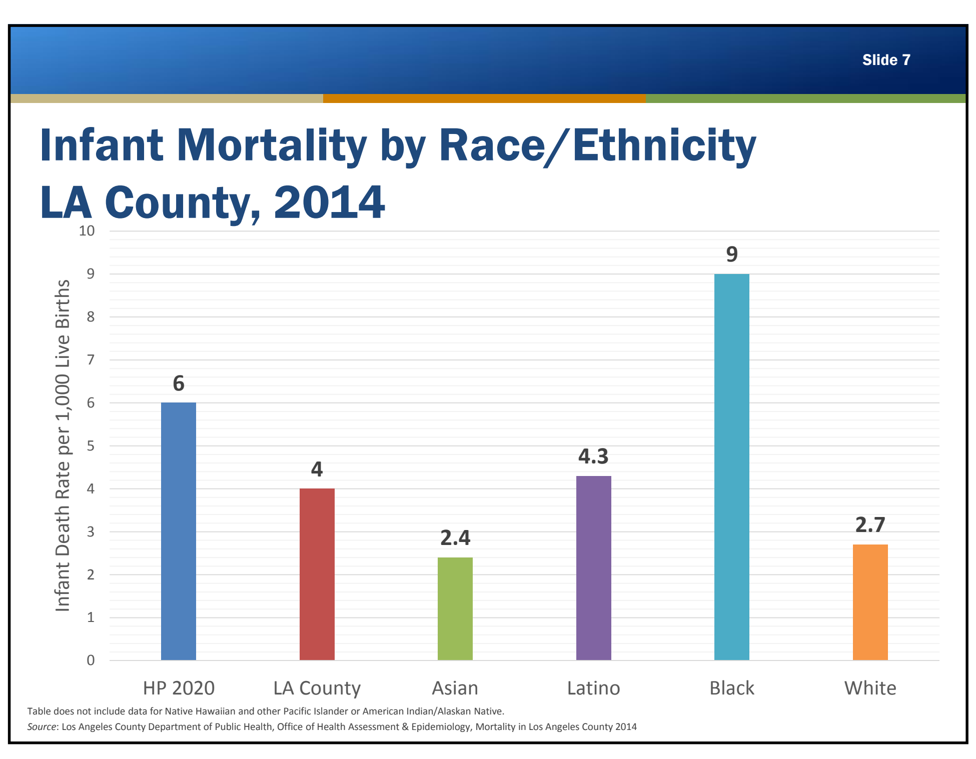
- Staffing
  - 5 full time DPH positions
  - Staff on loan from DMH and DHS
- Location
  - Virtual center

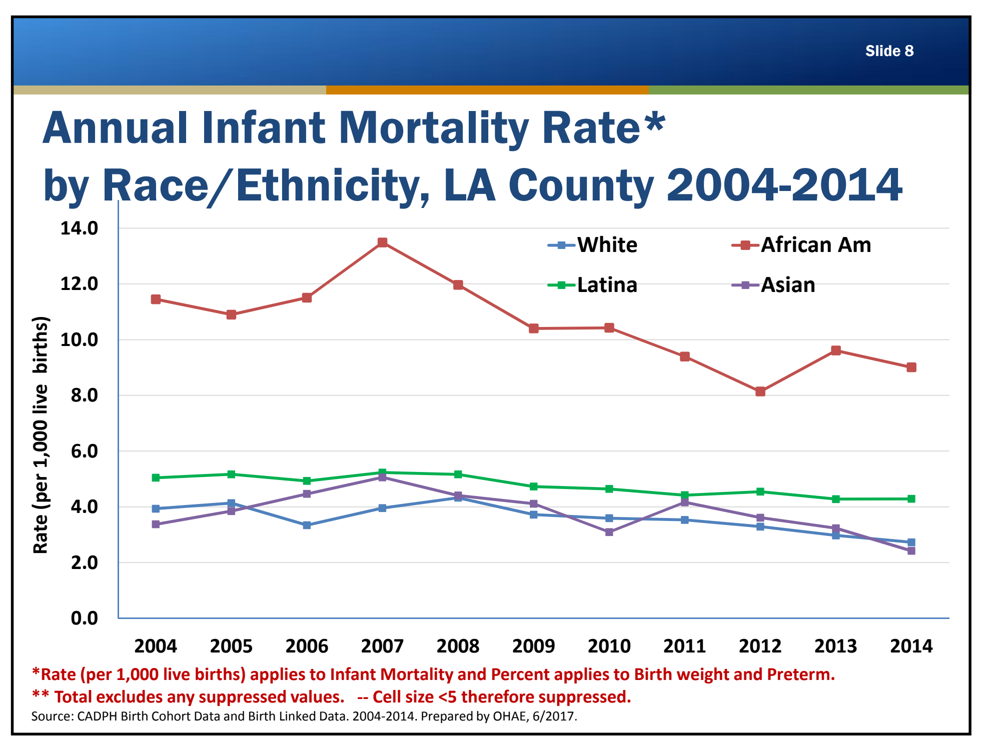


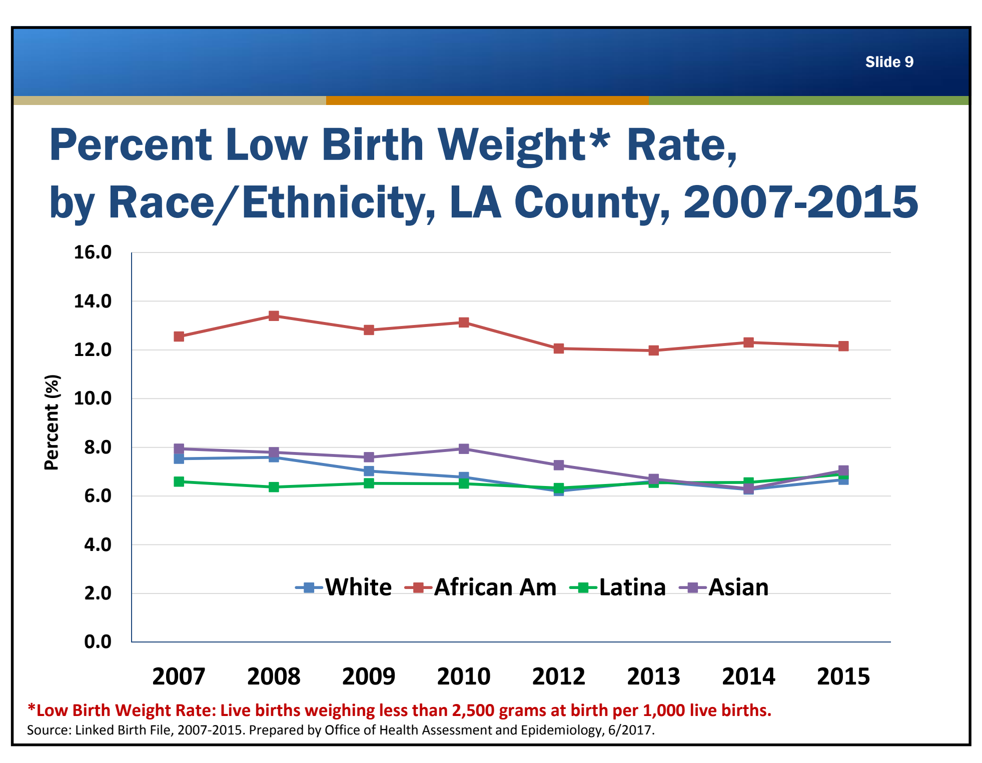
Slide 4
The Center's Initial Focus Areas
Infant Mortality
Sexually Transmitted Infections (STIs)
Environmental Justice
Health Neighborhoods
Cultural & Linguistic Competency

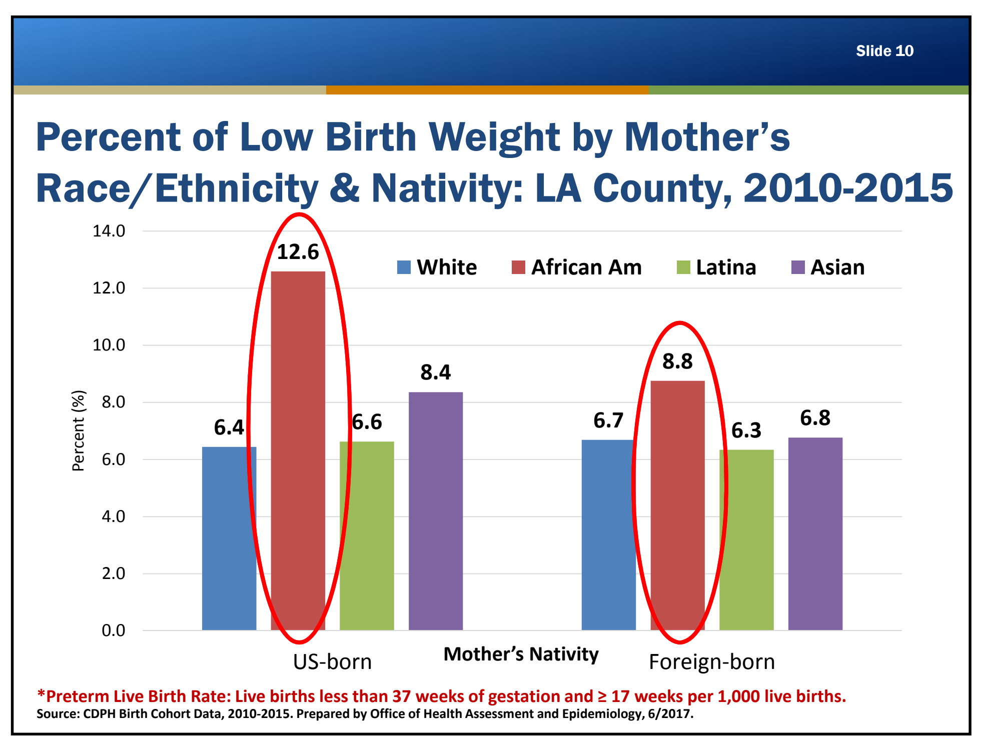

Slide 5
Infant Mortality
Infant mortality for Black babies is
three times higher
than infant mortality for white babies.

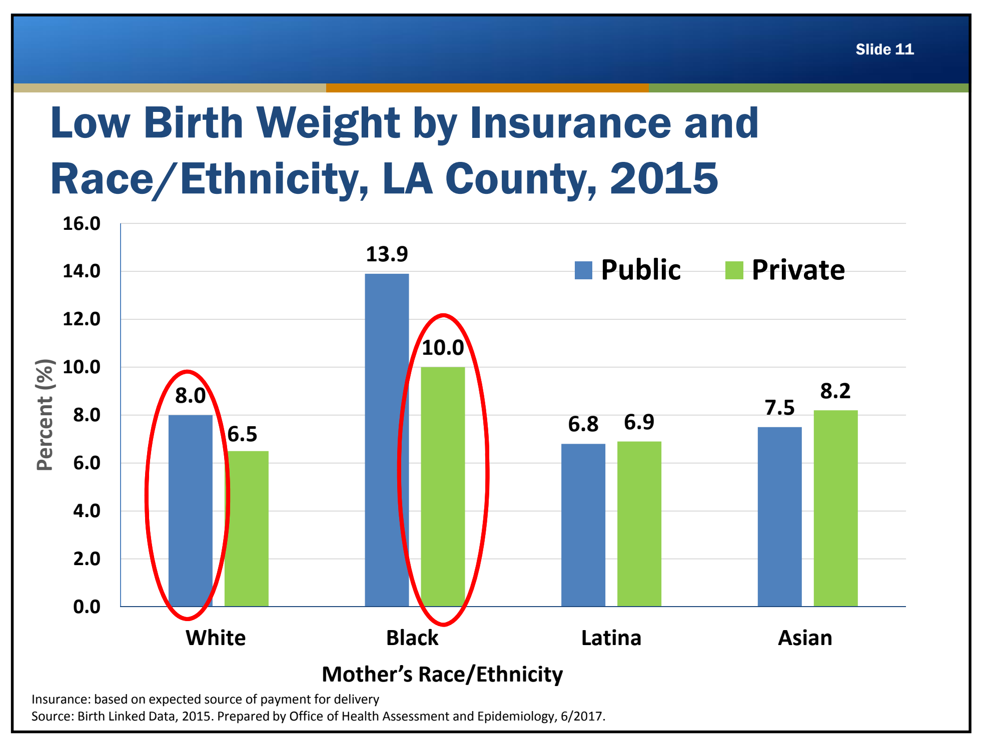

Slide 6
Maternal Mortality Ratio
by Race/Ethnicity LA County, 2007-2013
70
60
50
40
30
20
10
0
62.7
13.6
13.4
14.9
White
African American
Latina
Asian

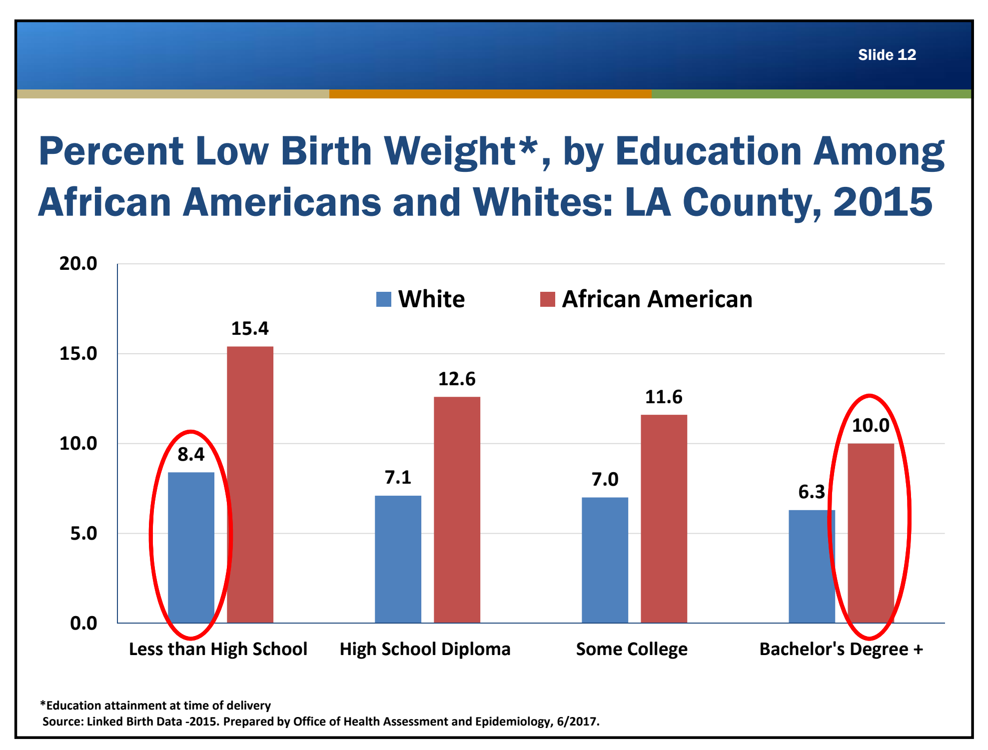

Slide 7
Infant Mortality by Race/Ethnicity
LA County, 2014
Infant Death Rate per 1,000 Live Births
10
9
8
7
6
5
4
3
2
1
0
6
4
2.4
4.3
9
2.7
HP 2020
LA County
Asian
Latino
Black
White
Table does not include data for Native Hawaiian and other Pacific Islander or American Indian/Alaskan Native.
Source: Los Angeles County Department of Public Health, Office of Health Assessment & Epidemiology, Mortality in Los Angeles County 2014

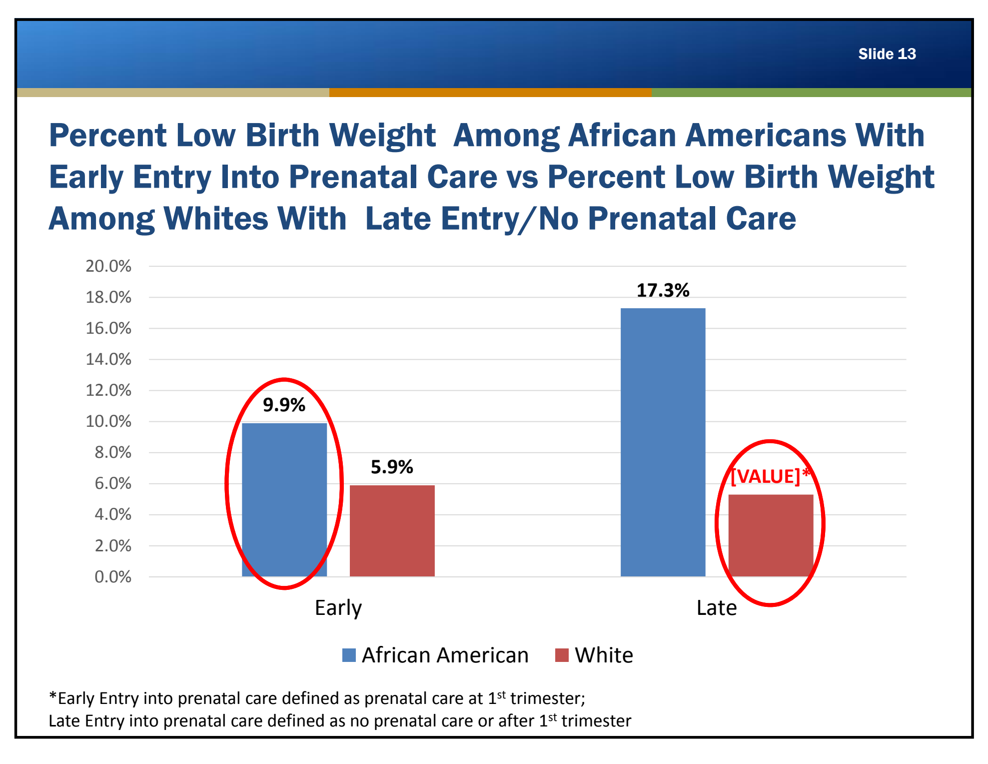

Slide 8
Annual Infant Mortality Rate*
by Race/Ethnicity, LA County 2004-2014
White
African Am
Latina
Asian
Rate (per 1,000 live births)
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
*Rate (per 1,000 live births) applies to Infant Mortality and Percent applies to Birth weight and Preterm.
** Total excludes any suppressed values. -- Cell size <5 therefore suppressed.
Source: CADPH Birth Cohort Data and Birth Linked Data. 2004-2014. Prepared by OHAE, 6/2017.

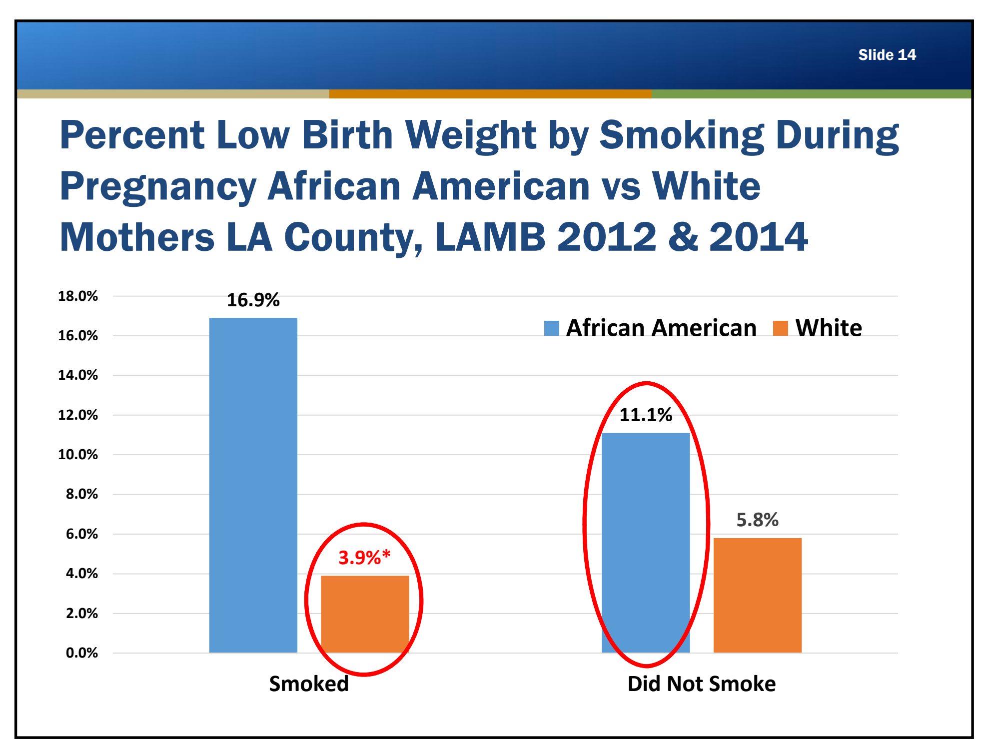

Slide 9
Percent Low Birth Weight* Rate,
by Race/Ethnicity, LA County, 2007-2015
Percent (%)
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
White
African Am
Latina
Asian
2007
2008
2009
2010
2012
2013
2014
2015
*Low Birth Weight Rate: Live births weighing less than 2,500 grams at birth per 1,000 live births.
Source: Linked Birth File, 2007-2015. Prepared by Office of Health Assessment and Epidemiology, 6/2017.

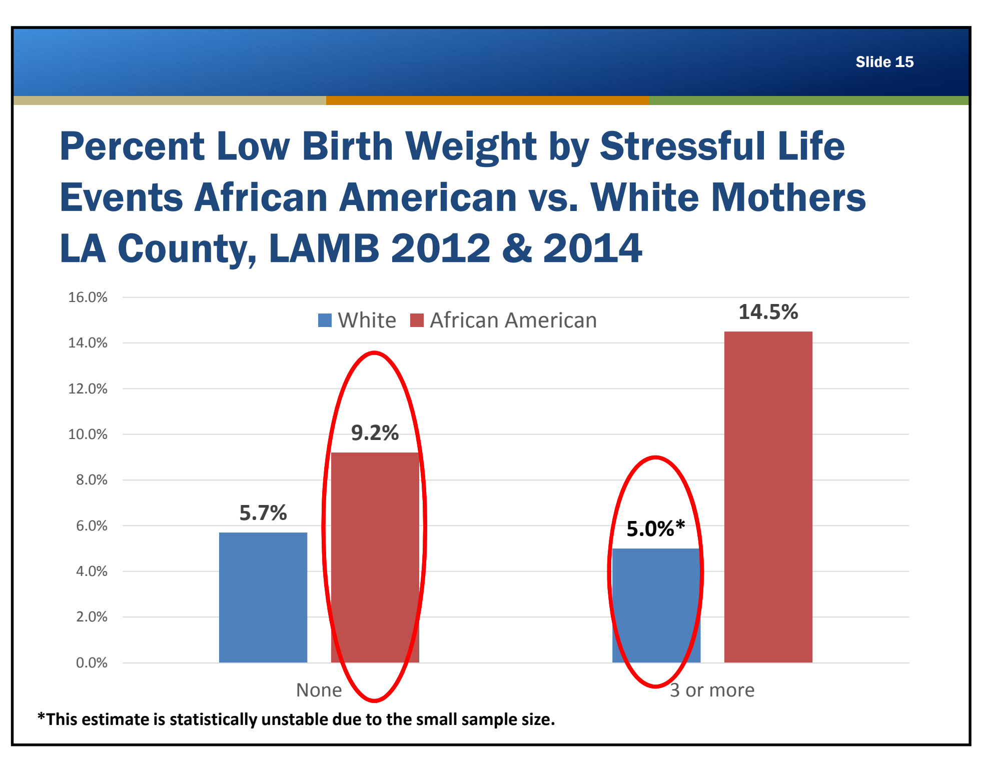

Slide 10
Percent of Low Birth Weight by Mother's Race/Ethnicity & Nativity: LA County, 2010-2015
White
African Am
Latina
Asian
Percent (%)
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
6.4
12.6
6.6
8.4
6.7
8.8
6.3
6.8
US-born
Mother's Nativity
Foreign-born
*Preterm Live Birth Rate: Live births less than 37 weeks of gestation and ≥ 17 weeks per 1,000 live births.
Source: CDPH Birth Cohort Data, 2010-2015. Prepared by Office of Health Assessment and Epidemiology, 6/2017.


Slide 11
Low Birth Weight by Insurance and Race/Ethnicity, LA County, 2015
Public
Private
Percent (%)
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
8.0
6.5
13.9
10.0
6.8
6.9
7.5
8.2
White
Black
Latina
Asian
Mother's Race/Ethnicity
Insurance: based on expected source of payment for delivery
Source: Birth Linked Data, 2015. Prepared by Office of Health Assessment and Epidemiology, 6/2017.


Slide 12
Percent Low Birth Weight*, by Education Among African Americans and Whites: LA County, 2015
20.0
15.0
10.0
5.0
0.0
White
African American
15.4
8.4
12.6
7.1
11.6
7.0
10.0
6.3
Less than High School
High School Diploma
Some College
Bachelor's Degree +
*Education attainment at time of delivery
Source: Linked Birth Data -2015. Prepared by Office of Health Assessment and Epidemiology, 6/2017.


Slide 13
Percent Low Birth Weight Among African Americans With Early Entry Into Prenatal Care vs Percent Low Birth Weight Among Whites With Late Entry/No Prenatal Care
20.0%
18.0%
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
17.3%
9.9%
5.9%
[VALUE]*
Early
Late
African American
White
*Early Entry into prenatal care defined as prenatal care at 1st trimester;
Late Entry into prenatal care defined as no prenatal care or after 1st trimester


Slide 14
Percent Low Birth Weight by Smoking During Pregnancy African American vs White Mothers LA County, LAMB 2012 & 2014
18.0%
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
16.9%
3.9%*
11.1%
5.8%
African American
White
Smoked
Did Not Smoke


Slide 15
Percent Low Birth Weight by Stressful Life Events African American vs. White Mothers LA County, LAMB 2012 & 2014
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
White
African American
5.7%
9.2%
5.0%*
14.5%
None
3 or more
*This estimate is statistically unstable due to the small sample size.

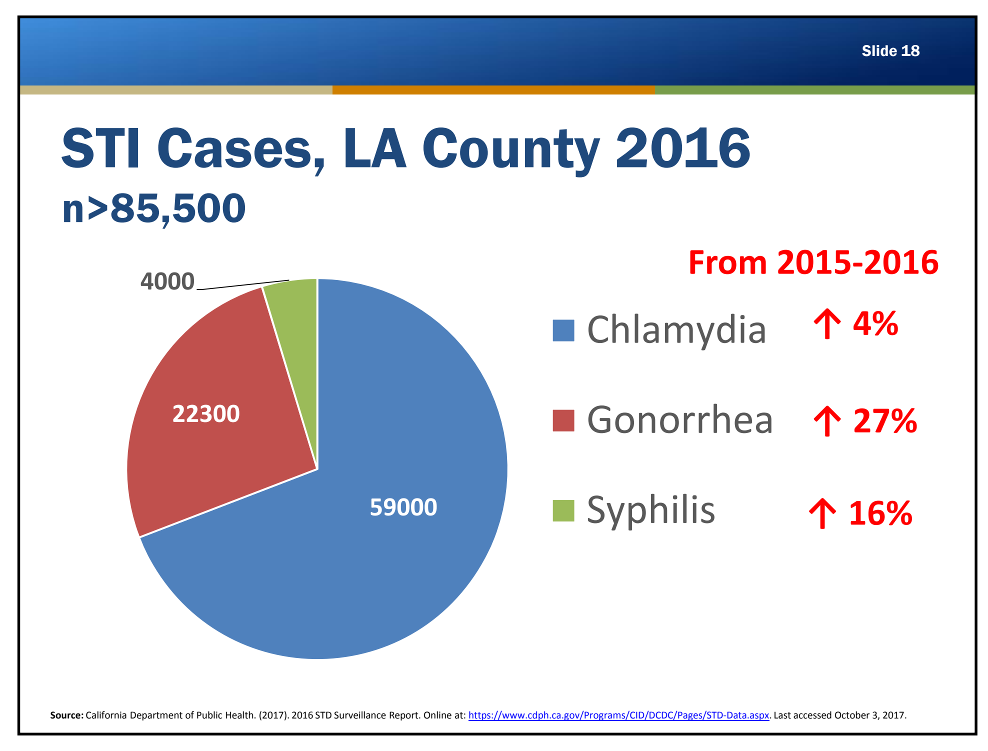
Slide 16

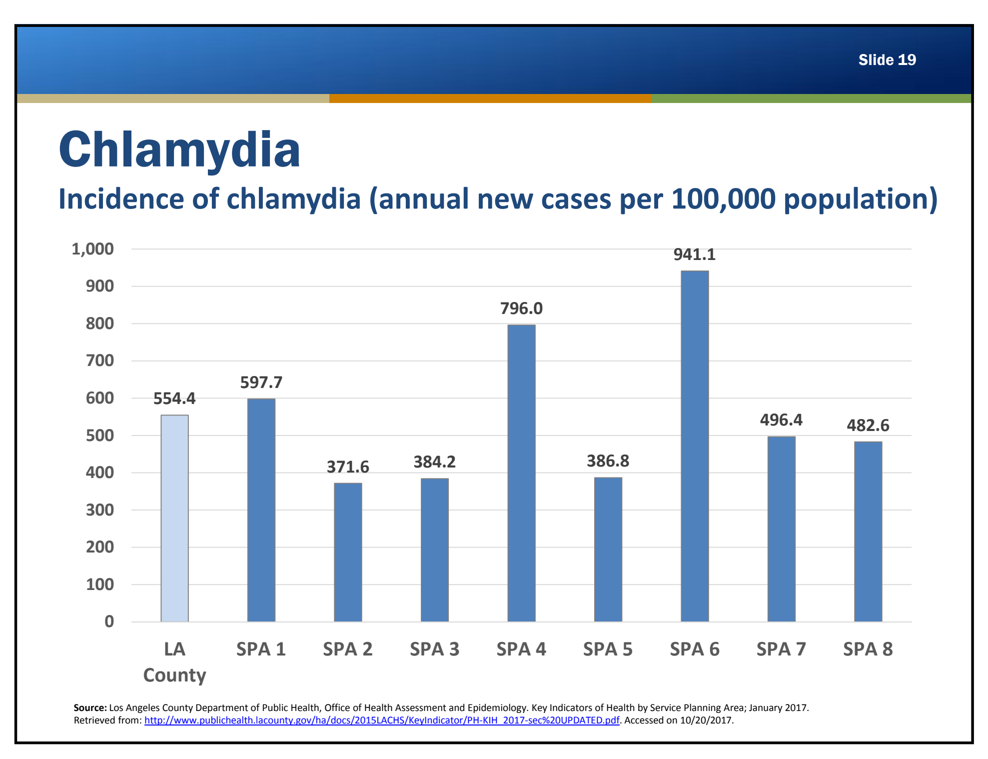
Factors to Consider

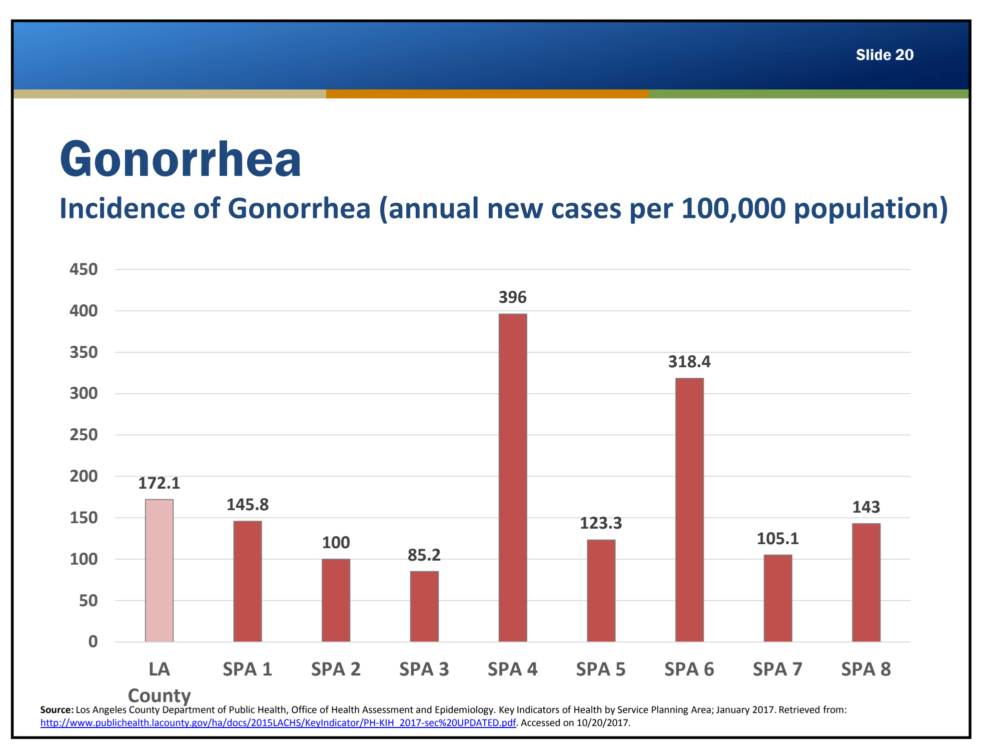
- Impact of structural racism
- Lack of social support
- Exposure to environmental hazards
- Residential segregation
- Differences in access to medical services/treatment
- Chronic stress

Slide 17

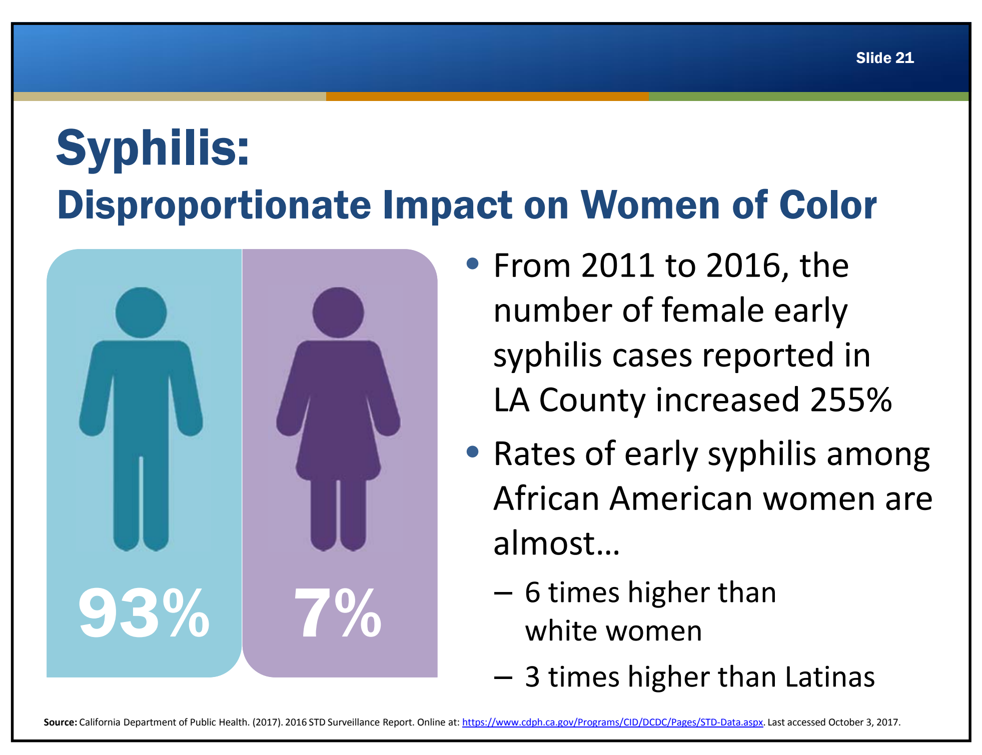
In recent years, rates of STIs have **increased dramatically** with a disproportionate impact on **men of color, Black women, and people identifying as LGBTQ.**


Slide 18
STI Cases, LA County 2016
n>85,500
4000
22300
59000
From 2015-2016
Chlamydia ↑ 4%
Gonorrhea ↑ 27%
Syphilis ↑ 16%
Source: California Department of Public Health. (2017). 2016 STD Surveillance Report. Online at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/STD-Data.aspx. Last accessed October 3, 2017.


Slide 19
Chlamydia
Incidence of chlamydia (annual new cases per 100,000 population)
1,000
900
800
700
600
500
400
300
200
100
0
554.4
597.7
371.6
384.2
796.0
386.8
941.1
496.4
482.6
LA County
SPA 1
SPA 2
SPA 3
SPA 4
SPA 5
SPA 6
SPA 7
SPA 8
Source: Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology. Key Indicators of Health by Service Planning Area; January 2017.
Retrieved from: http://www.publichealth.lacounty.gov/ha/docs/2015LACHS/KeyIndicator/PH-KIH_2017-sec%20UPDATED.pdf. Accessed on 10/20/2017.



Slide 20
Gonorrhea
Incidence of Gonorrhea (annual new cases per 100,000 population)
450
400
350
300
250
200
150
100
50
0
172.1
145.8
100
85.2
396
123.3
318.4
105.1
143
LA County
SPA 1
SPA 2
SPA 3
SPA 4
SPA 5
SPA 6
SPA 7
SPA 8
Source: Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology. Key Indicators of Health by Service Planning Area; January 2017. Retrieved from: http://www.publichealth.lacounty.gov/ha/docs/2015LACHS/KeyIndicator/PH-KIH_2017-sec%20UPDATED.pdf. Accessed on 10/20/2017.



Slide 21
Syphilis:
Disproportionate Impact on Women of Color
93%
7%
• From 2011 to 2016, the number of female early syphilis cases reported in LA County increased 255%
• Rates of early syphilis among African American women are almost…
– 6 times higher than white women
– 3 times higher than Latinas
Source: California Department of Public Health. (2017). 2016 STD Surveillance Report. Online at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/STD-Data.aspx. Last accessed October 3, 2017.

Slide 22

Congenital Syphilis on the Rise

- In 2016, there were 37 probable congenital syphilis cases reported in LA County
  - 61% increase from the previous year

Source: California Department of Public Health. (2017). 2016 STD Surveillance Report. Online at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/STD-Data.aspx. Last accessed October 3, 2017.

Slide 23

STIs Among LA County Youth

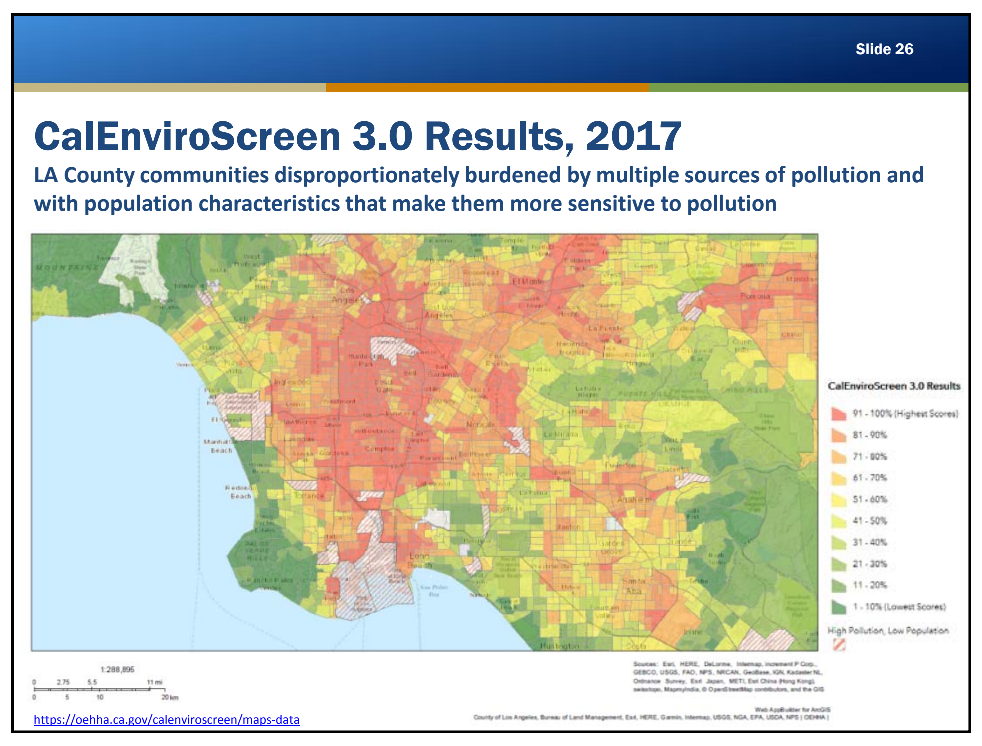
- Of cases reported in LA County in 2016, youth between 15 and 24 years old represented…
  - 33% gonorrhea cases
  - 50% chlamydia cases
- Racial/ethnic disparities stubbornly persist

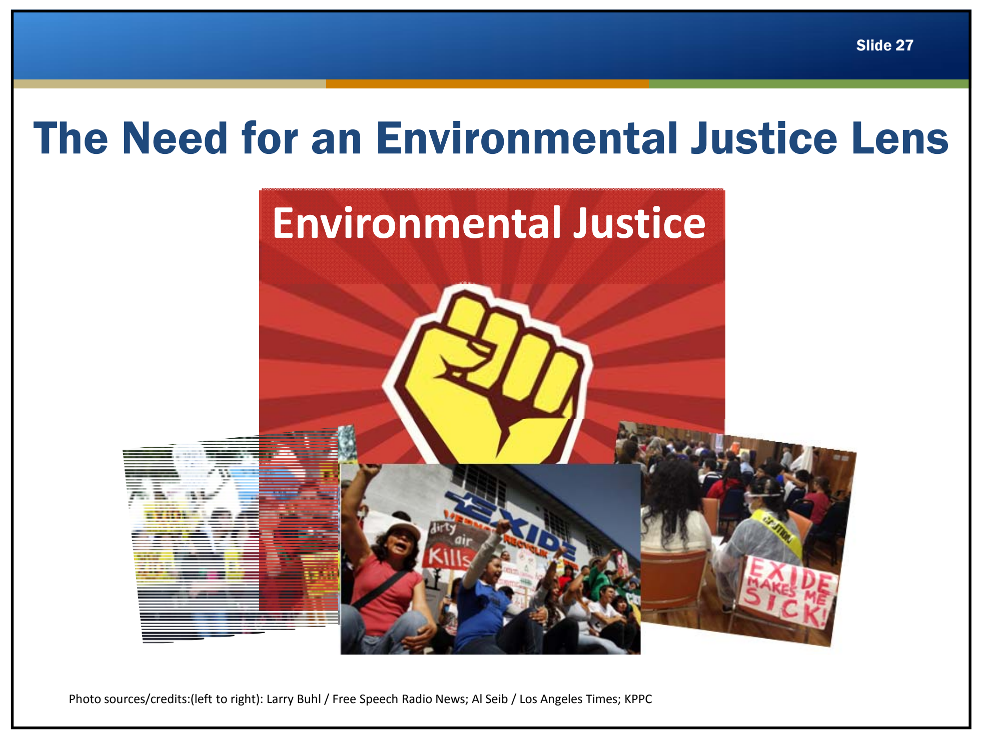
Source: California Department of Public Health. (2017). 2016 STD Surveillance Report. Online at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/STD-Data.aspx. Last accessed October 3, 2017.

What causes the health inequities in STIs?

Provider Practices	Individual Behavior	Socioeconomic Factors
• Inadequate screening and testing • Reluctance to offer expedited partner therapy • Limited follow-up with sexual partners • Lack of sex-positive sexual health messages	• Declining condom use • Use of smartphone technology to access sexual partners • Lack of appropriate STI screening and treatment • Substance use	• Unemployment, poverty, and homelessness • Sex in exchange for resources and forced sexual activity • Homophobia, transphobia, stigma, racism, and threats of violence • Incarceration • Lack of access to culturally competent healthcare/education materials

Lower-income communities and communities of color are exposed to significant **environmental hazards** that contribute to poor health.


Slide 26
CalEnviroScreen 3.0 Results, 2017
LA County communities disproportionately burdened by multiple sources of pollution and with population characteristics that make them more sensitive to pollution
CalEnviroScreen 3.0 Results
91 - 100% (Highest Scores)
81 - 90%
71 - 80%
61 - 70%
51 - 60%
41 - 50%
31 - 40%
21 - 30%
11 - 20%
1 - 10% (Lowest Scores)
High Pollution, Low Population
https://oehha.ca.gov/calenviroscreen/maps-data


Slide 27
The Need for an Environmental Justice Lens
Environmental Justice
dirty air Kills
EXIDE MAKES ME SICK!
Photo sources/credits:(left to right): Larry Buhl / Free Speech Radio News; Al Seib / Los Angeles Times; KPPC

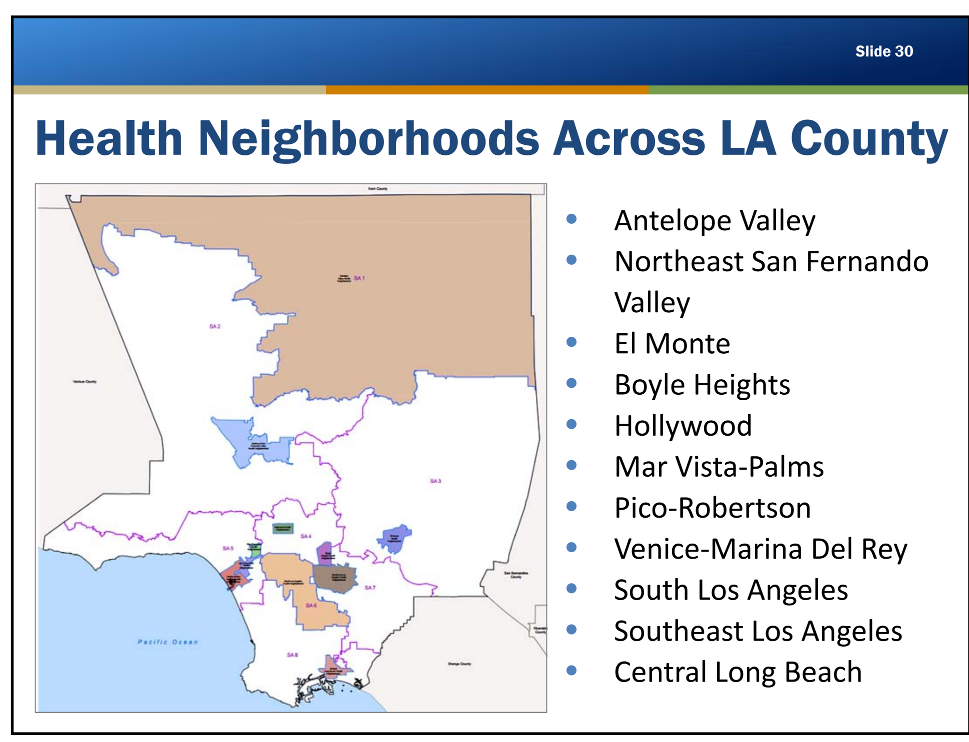
Slide 28

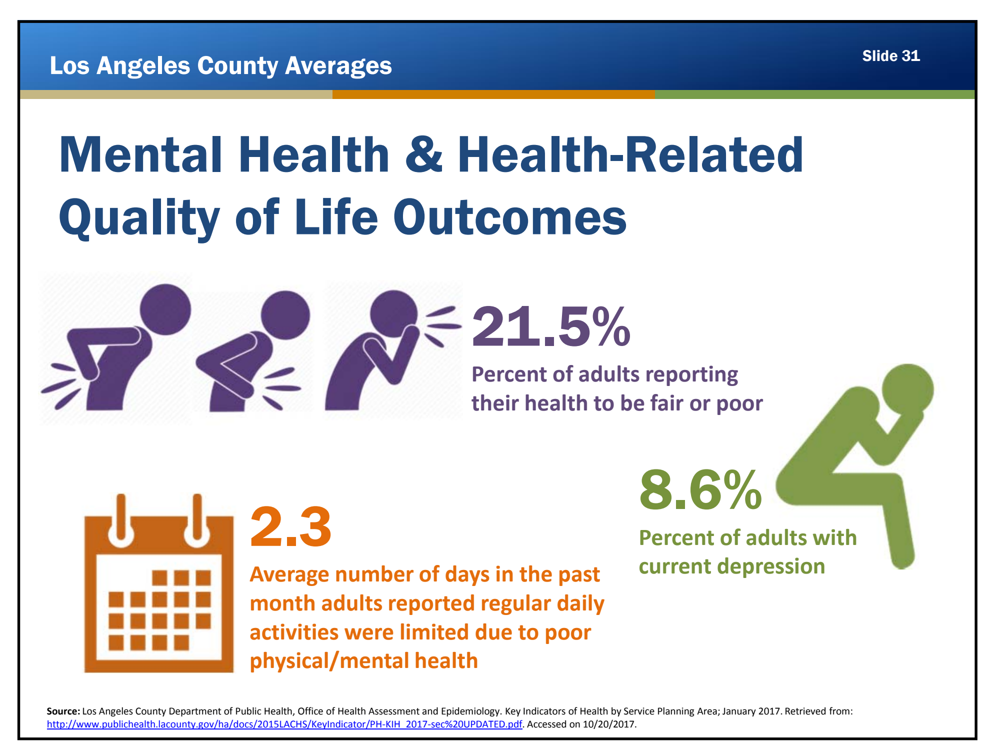
Areas of Focus

- Gas leaks
- Oil wells
- Refineries
- Heavy industry
- Clean water

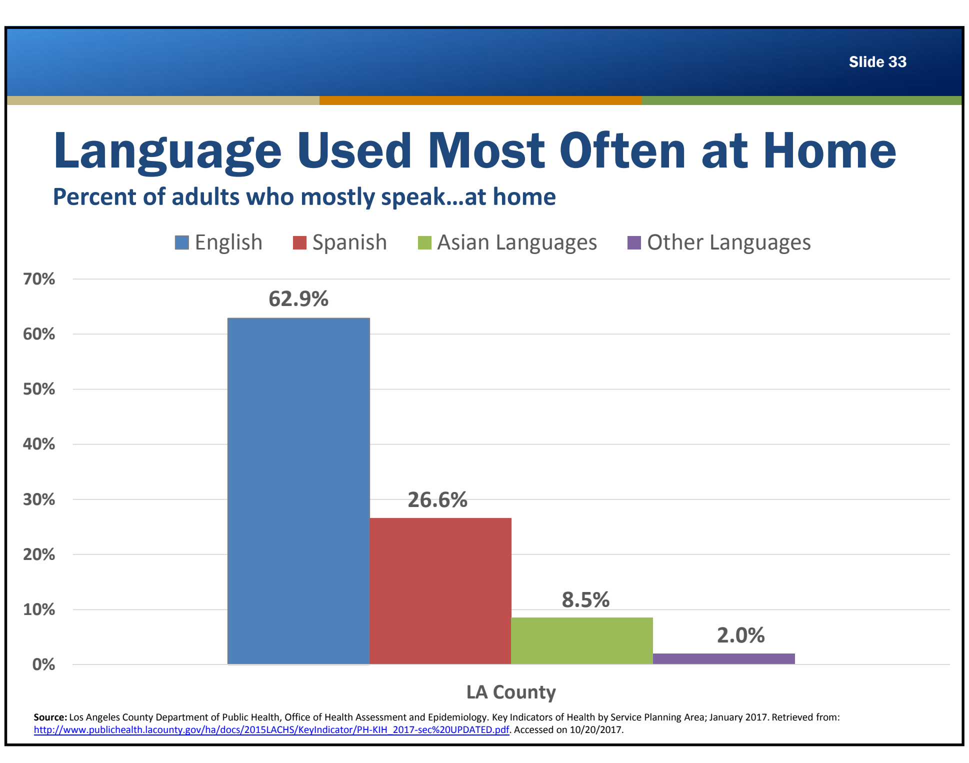
Slide 29

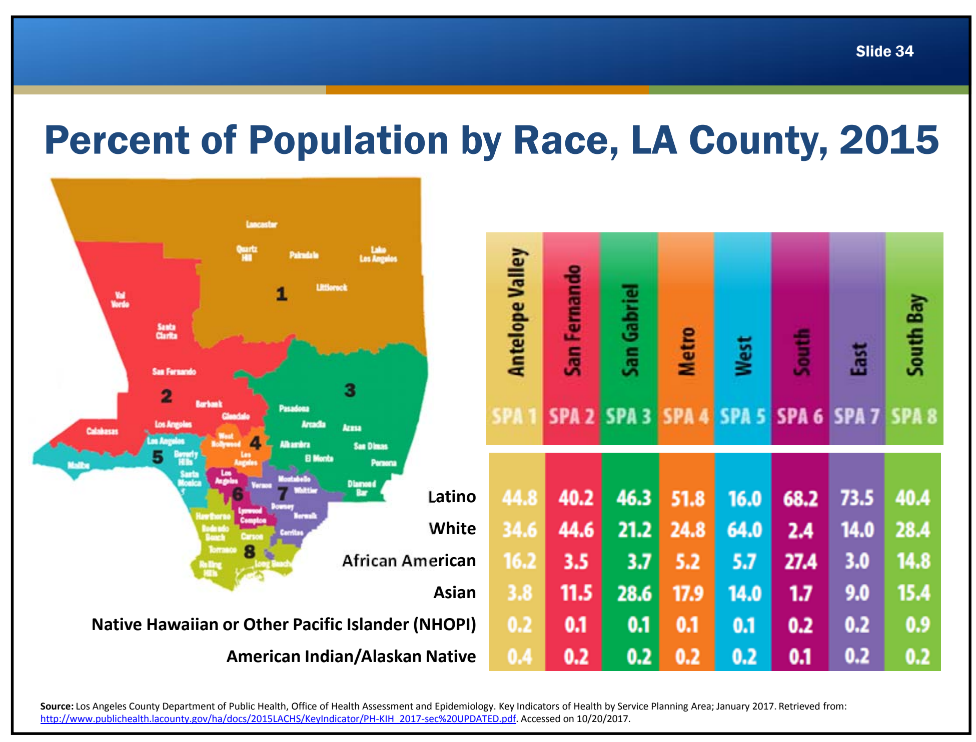
Those with complex health issues often face **fragmented care** and **few community supports** which leads to frustration and poor outcomes.


Slide 30
Health Neighborhoods Across LA County
Pacific Ocean
Antelope Valley
Northeast San Fernando Valley
El Monte
Boyle Heights
Hollywood
Mar Vista-Palms
Pico-Robertson
Venice-Marina Del Rey
South Los Angeles
Southeast Los Angeles
Central Long Beach


Los Angeles County Averages
Slide 31
Mental Health & Health-Related Quality of Life Outcomes
21.5%
Percent of adults reporting their health to be fair or poor
8.6%
Percent of adults with current depression
2.3
Average number of days in the past month adults reported regular daily activities were limited due to poor physical/mental health
Source: Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology. Key Indicators of Health by Service Planning Area; January 2017. Retrieved from: http://www.publichealth.lacounty.gov/ha/docs/2015LACHS/KeyIndicator/PH-KIH_2017-sec%20UPDATED.pdf. Accessed on 10/20/2017.

Failing to recognize a patient's social, cultural, and linguistic context contributes to **inadequate care** and **health inequities**.




Slide 34

Percent of Population by Race, LA County, 2015

	Antelope Valley SPA 1	San Fernando SPA 2	San Gabriel SPA 3	Metro SPA 4	West SPA 5	South SPA 6	East SPA 7	South Bay SPA 8
Latino	44.8	40.2	46.3	51.8	16.0	68.2	73.5	40.4
White	34.6	44.6	21.2	24.8	64.0	2.4	14.0	28.4
African American	16.2	3.5	3.7	5.2	5.7	27.4	3.0	14.8
Asian	3.8	11.5	28.6	17.9	14.0	1.7	9.0	15.4
Native Hawaiian or Other Pacific Islander (NHOPI)	0.2	0.1	0.1	0.1	0.1	0.2	0.2	0.9
American Indian/Alaskan Native	0.4	0.2	0.2	0.2	0.2	0.1	0.2	0.2

Source: Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology. Key Indicators of Health by Service Planning Area; January 2017. Retrieved from: http://www.publichealth.lacounty.gov/ha/docs/2015LACHS/KeyIndicator/PH-KIH_2017-sec%20UPDATED.pdf. Accessed on 10/20/2017.

Slide 35

Next Steps

- Community Engagement
  - One listening session in each Supervisorial District being scheduled
  - Events for specific stakeholder groups (e.g. philanthropy)
- Workforce Engagement
  - Webinar/Workshops for each Health Agency department

THANK YOU!

Stay Connected. Email us to join the CHE Listserv:
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20. HIGHLIGHTS AND EXPECTATIONS FOR 2018

2017 HIGHLIGHTS: LOS ANGELES COUNTY COMMISSION ON HIV

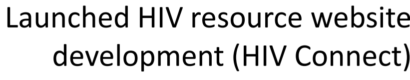
Completed 10 member training and orientation sessions with over 70 participants; continued efforts to recruit new members

Completed 12 community outreach events reaching nearly 100 individuals

Convened 6 expert review panels to guide the development of prevention service standards

Over 100 years of combined service and leadership on the Commission

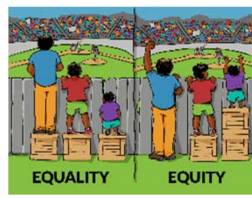
Formation of Housing Task Force and elevating the importance of housing in planning, service standards and policy discussions



Launched HIV resource website development (HIV Connect)

Established positions on 23 legislative policies with 12 supported bills signed by the Governor

Strengthened the Comprehensive HIV Continuum to highlight the critical role that equity plays in achieving health for all.



Cultivation of new COH leadership among Committees, Caucuses and Task Forces

Onboarding new Commission staff

Los Angeles County Commission on HIV
Expectations and Goals for 2018

Please write down your top 3 goals or expectations for the Los Angeles County Commission on HIV for the year 2018. Consider answering the questions, "what should be our focus for 2018?; what is the most strategic use of our collective efforts and time?"
Thank you.

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21. ANNOUNCEMENTS AND EVALUATION

Los Angeles County Commission on HIV
2017 Annual Meeting Evaluation

We value your feedback!

Thank you for attending the Commission on HIV Annual Meeting on*Understanding HIV from Intergenerational Perspectives: Exploring Partnerships, Innovations, and Solidarity*. Please answer the following questions to help us improve future meetings. The survey should take 5-10 minutes.

1. What best describes you? Please check only one.

- ◯ Commission Member
- ◯ DHSP Staff
- ◯ CBO Staff
- ◯ Other (please specify)

2. How would you rate the 2017 Annual Meeting?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
2a. The meeting time and place were convenient	◯	◯	◯	◯	◯
2b. The meeting covered the promised goals and objectives	◯	◯	◯	◯	◯
2c. The meeting format was an effective method for sharing information and ideas	◯	◯	◯	◯	◯
2d. Facilitators encouraged participation and questions	◯	◯	◯	◯	◯

3. How would you rate the presentation, *Health Equity Across Generations & Places*, by Jahmal Miller, MHA?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
3a. The presentation/discussion will be useful in the work I do at my agency.	◯	◯	◯	◯	◯
3b. The presentation/discussion increased my knowledge on the subject matter.	◯	◯	◯	◯	◯
3c. The presentation/discussion met my overall expectations.	◯	◯	◯	◯	◯
3d. I would recommend this presentation to my colleagues.	◯	◯	◯	◯	◯

4. How would you rate the presentation, *Purposeful Aging: A Model for Age-Friendly Initiative* , by James Don?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
4a. The presentation/discussion will be useful in the work I do at my agency.	◯	◯	◯	◯	◯
4b. The presentation/discussion increased my knowledge on the subject matter.	◯	◯	◯	◯	◯
4c. The presentation/discussion met my overall expectations.	◯	◯	◯	◯	◯
4d. I would recommend this presentation to my colleagues.	◯	◯	◯	◯	◯

5. How would you rate the presentation, *Using Innovative Technology to Prevent HIV Among Young MSM*, by Lynn Miller, Ph.D?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
5a. The presentation/discussion will be useful in the work I do at my agency.	○	○	○	○	○
5b. The presentation/discussion increased my knowledge on the subject matter.	○	○	○	○	○
5c. The presentation/discussion met my overall expectations.	○	○	○	○	○
5d. I would recommend this presentation to my colleagues.	○	○	○	○	○

6. How would you rate the panel on *Leading the Way: How can the COH Sharpen our Intergenerational Lenses for Impactful Leadership*?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
6a. The discussion will be useful in the work I do at my agency.	○	○	○	○	○
6b. The discussion increased my knowledge on the subject matter.	○	○	○	○	○
6c. The discussion met my overall expectations.	○	○	○	○	○
6d. I would recommend discussing this topic to my colleagues.	○	○	○	○	○

7. How would you rate the *Learning in Motion: Interactive Activity*?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
7a. The activity will be useful in the work I do at my agency.	○	○	○	○	○
7b. The activity increased my knowledge on the subject matter.	○	○	○	○	○
7c. The activity met my overall expectations.	○	○	○	○	○
7d. I would recommend the activity to my colleagues.	○	○	○	○	○

8. How would you rate the *Los Angeles County Health Agency: Center for Health Equity* presentation by Dr. Barbara Ferrer?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
8a. The presentation/discussion will be useful in the work I do at my agency.	○	○	○	○	○
8b. The presentation/discussion increased my knowledge on the subject matter.	○	○	○	○	○
8c. The presentation/discussion met my overall expectations.	○	○	○	○	○
8d. I would recommend discussing this topic with my colleagues.	○	○	○	○	○

9. Please list three other topics you would like to hear about in the future.

10. What did you least like about today's event?

11. What, if anything, could be improved for future meetings?

12. What did you like most about today's event?

13. Any additional comments?