2-2006

Racial and Ethnic Health Disparities: A Review of Selected State Programs

California Research Bureau

Recommended Citation

California Research Bureau, "Racial and Ethnic Health Disparities: A Review of Selected State Programs" (2006). *California Agencies.* Paper 313.
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Racial and Ethnic Health Disparities: A Review of Selected State Programs

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& Administration Intern

Requested by Assemblymember Wilma Chan
Chair, Assembly Health Committee

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FEBRUARY 2006

CRB 06-002

C IFORNIA RESEARCH BUREAU

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By Barbara Steel Lowney
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ISBN 1-58703-135-3

Contents

Acknowledgements

Lisa Foster, Senior Policy Analyst, California Research Bureau, contributed additional research to this report; she also completed the editing necessary to turn the review document prepared for Assemblymember Wilma Chan into a CRB report. Diana Kenlow, M.S.W. intern with the Bureau, also provided research assistance. The author thanks them both for their efforts.

The author also thanks Pat Kinnard, Brian Cote and Ivy Branaman for their work in producing and distributing this report.

Internet Access

This report is also available through the Internet at the California State Library's home page (www.library.ca.gov) under California Research Bureau Public Policy Reports. The report is formatted for printing pages on both sides (back to back) so some pages are intentionally left blank.

Introduction

Assemblymember Wilma Chan, Chair of the Assembly Committee on Health, requested that the California Research Bureau assess how California state departments are addressing racial and ethnic health disparities. This report describes how programs in four state departments address these disparities through program design, data collection and program evaluation.

RACIAL AND ETHNIC HEALTH DISPARITIES

The National Institutes of Health defines health disparities as the "differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States." Health disparities can result from differences in risk factors, lack of access to health care, inadequately targeted prevention messages and cultural differences between the health care system and the population it serves.

A number of studies show that members of communities of color are much more likely to experience poor quality of health and healthcare than their White counterparts across a broad spectrum of illnesses, injuries and treatment outcomes.[1] African Americans, Alaska Natives, American Indians, Asian Americans, Hispanic Americans, and Pacific Islanders are more likely than Whites to have poor health, to be uninsured, and to die prematurely. According to some experts, socioeconomic, racial, and ethnic disparities in health status are large, persistent, and increasing in the United States.[2]

These findings are troubling for a variety of reasons. Poor health outcomes carry both individual and societal costs. Communities of color carry a disproportionate and inequitable burden of disease and poor health outcomes. California's demographic makeup continues to shift toward increased diversity – by 2020, Whites' share of the population is expected to shrink to less than 34 percent, while Latinos' share is projected to grow to 43 percent and Asians' share is expected to increase to almost 13 percent.[3] This means that more and more Californians will face poor health outcomes if present racial and ethnic health disparity trends continue.

Health and Healthcare Disparities

"Health disparities" refer to differences in the impact of both direct and indirect causes of disease. In comparison, "healthcare disparities" relate specifically to access to and quality of medical services.

The health of an individual is a combination of hereditary, environmental, behavioral, economic, and structural factors.[4] One study reports that "behavior and environmental factors are responsible for about 70 percent of premature deaths in the United States."[5] For example, the neighborhood one lives in affects health through such factors as access to exercise space; availability of healthy food; air and water quality; and proximity to healthcare services. As a result, while actions to alleviate disparities for people of color must include attention to quality and access of *healthcare* factors, a focus on *health* factors (including indirect causes) is also necessary.

Isolating the causes of health disparities is difficult because of indirect influences and the interplay of race and ethnicity with other social factors such as socio-economic status and acculturation. This increases the difficulty of designing public programs and highlights the need for inter-agency collaboration to address all aspects of the problem. These complexities must be incorporated into program planning and evaluation in order to effectively address the gap in health disparities.

Data Collection: Needs and Limitations

Quality data collection plays an integral role in understanding and alleviating racial and ethnic health disparities. Data is necessary for three major purposes:

1. To identify specific health disparities and isolate causal relationships
2. To evaluate the effectiveness of programs that target communities of color
3. To verify whether programs that target poor health outcomes actually reach communities of color

Currently, most data collection and research focuses on identifying specific health disparities. There are many considerations to take into account when collecting data to understand health disparities. Important elements include:

- Using consistent terminology for racial and ethnic groups across state agencies to facilitate data sharing and analysis.
- Collecting adequate sample-sizes for minority populations. Many target populations (such as recent immigrants) are not large enough to be accurately surveyed through a random sample of a state or even a national population.[6]
- Broad racial or ethnic categories can potentially gloss over important differences between members of a social group. An Hispanic person from Cuba might have very different health or healthcare experiences than an Hispanic person from Chile.
- Age, income, gender, language acquisition, and other variables can also aid in understanding why racial and ethnic health disparities exist.
- While socio-economic status and race are often interconnected, many scholars criticize the practice of using one of these factors as a proxy for the other.[7]
- Data must be localized enough to show any existing links between health outcomes and specific community settings.[8]

This report provides information on state public programs in California that gather data on program effectiveness and outreach.

Recent studies at both the state and national level analyze the relationship between racial/ethnic groups and the prevalence of disease. The *Healthy People 2010* project (and the previous *Healthy People 2000* report) outline goals for improving health outcomes and measure progress towards these goals, placing significant focus on racial and ethnic health and healthcare disparities.[9]

SELECTED SOURCES FOR CALIFORNIA HEALTH DATA

California Health Interview Survey: http://www.chis.ucla.edu

Healthy People 2010: http://www.healthypeople.gov/Publications

Healthy People 2000 Outcomes-CA: http://216.190.132.97/UserFiles/2001Obj.pdf

County Health Status Report:
http://www.dhs.ca.gov/hisp/chs/phweek/cprofile2003/cprofile2003.htm

DHS Center for Health Statistics: http://www.dhs.ca.gov/hisp/chs/OHIR/default.htm

Federal Race and Ethnicity Data

Many state health-related programs receive funding from federal sources and, as a result, collect racial and ethnic demographic data according to federal standards.[10] The goal of these standards is to provide uniformity and cohesion among federal agencies. Minimum data collection standards include:

- Use of five categories for race:
    - Indian or Alaska Native
    - Asian
    - Black or African American
    - Native Hawaiian or Pacific Islander
    - White or Caucasian
- Use of two categories for ethnicity:
    - Hispanic or Latino
    - Not Hispanic or Latino

Data collection questions can either ask for race and ethnicity as two separate designations or combine them. The standards state that "self-reporting or self-identification using two separate questions is the preferred method for collecting data on race and ethnicity."[11] There may be exceptions to data collection standards in cases where racial and ethnic data is either unnecessary or inappropriate for program operation.

REPORT DESCRIPTION AND PURPOSE

This report focuses on programs within four California state departments: Department of Health Services (DHS), Department of Education (CDE), Department of Mental Health (DMH), and Department of Transportation (CalTrans). It examines eight priority medical issues: Cardiovascular Disease; Breast Cancer; Cervical Cancer; Diabetes; HIV/AIDS; Asthma; Mental Health; and Trauma (both intentional and unintentional).[*] Given the disease-specific focus of the study, programs featured in this report primarily address prevention, education, and alleviation of indirect causes of disease. The following information is included:

- How programs address health needs (direct and indirect) for communities of color
- Current program-specific data collection on health outcomes for communities of color
- Methods of data analysis and program evaluation
- Strategic planning and future programming related to health disparities

Purpose

This report is not intended to be read "cover to cover." Rather, it is a resource that provides information on what state programs are currently doing in relation to racial and ethnic health disparities. Describing the current system is an important first step in addressing racial and ethnic health disparities in state departments and programs.

Methodology

The primary research methodology was personal communication – in-person and telephone interviews – with program administrators and staff. This information was supplemented by material from program websites, surveys, reports, evaluations and strategic plans. Interviewees were provided the opportunity to comment on the final drafts of the report.

The author conducted and completed this study during her nine-week internship with the California Research Bureau in the summer of 2005. She made every effort to identify programs that directly or indirectly address health disparities in the eight disease priority areas. However, pertinent programs may have been inadvertently excluded due to project time and resource limitations.

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[*] This report covers eight of the nine priority medical issues for health disparities identified by the American Public Health Association and the California Health and Human Services Agency in the Prevention Institute report, *Health for All: California's Strategic Approach to Eliminating Racial and Ethnic Health Disparities*, November 2003. It does not address infant mortality due to project time and resource constraints.

NON-DISEASE SPECIFIC PROGRAMS

DEPARTMENT OF HEALTH SERVICES (DHS) - OFFICE OF MULTICULTURAL HEALTH[12]

Structure

The Office of Multicultural Health (OMH) was created in 1993 by Executive Order and established by statute in 1999. It is organizationally located in the DHS Office of the Director and serves as the focal point within DHS for improving planning and coordinating activities and programs related to racial and ethnic populations in California. OMH is funded primarily through the federal Health and Human Services Centers for Disease Control and Prevention (CDC) Block Grant.

Responsibilities

Policy Analysis on Health Issues

OMH analyzes proposed legislation and policies from the perspective of their impact on ethnic and racial populations. The Office also coordinates the Council on Multicultural Health which advises the director on policy issues, assists DHS in developing culturally competent programs and policies, and acts as liaison between DHS and communities of color. Council members are appointed by the DHS director and represent various ethnic communities.

Training and Technical Assistance

OMH sponsors cultural competency[*] training for DHS programs and maintains directories of resource consultants, trainers, and other experts on health care for ethnic/racial communities. The Office also provides technical assistance. The level of interaction between OMH and specific programs depends on program needs. There are no formal reporting or evaluation requirements.

Communication and Liaison with Internal and External Groups

OMH facilitates communication related to multicultural health issues between DHS programs and California's ethnic and racial communities. It collects and disseminates information about health needs, cultural patterns, and resources, and staff participate on DHS and local committees and advisory groups. In addition, staff network with health providers and advocates to promote culturally-appropriate practices, speak at conferences about multicultural health issues, and collaborate with other states' similar offices.

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[*] Cultural competency is the willingness and ability of a system to value the importance of culture in delivering services to all segments of the population. It is a perspective that values differences and diversity at all levels of an organization: policy, governance, administrative, workforce, provider, and client.

Strategic Planning

OMH collaborated with other DHS programs in the development of *Healthy California: A Strategic Plan for the California Department of Health Services (2001-2005).* It also assists individual programs in strategic planning efforts. For example, it recently aided in developing the Medi-Cal Managed Care Program cultural and linguistic standards.

Assistance in Obtaining Funds

OMH identifies sources of funding that support its objectives. It also gathers information on funding opportunities for DHS programs in order to improve the effectiveness of services to ethnic and racial communities.

For example, OMH initiated a project to develop an outline for a comprehensive curriculum in cultural competency for trainers within DHS and local public health departments. The 2004 report by the University of California, San Francisco – *Cultural Competency for California's Public Health Staff: Train the Trainers State Partnership Project* –identifies gaps in cultural competency education, provides the curriculum outline (including content, learning objectives and evaluation criteria), and makes other recommendations, such as establishing a communication network to promote cultural competency.[13] OMH is currently seeking funds from public agencies and private foundations to enact the report's recommendations and implement county-level training. The Office plans to collaborate with other stakeholder organizations to develop pilot projects that address culturally competent health care.

Data Collection/Analysis

OMH does not perform its own data collection; instead, it uses existing data sources to create reports on statewide health trends and to document racial disparities. Reports include:

- *County Health Profiles*, created in collaboration with the Office of Health Statistics
- *Multicultural Health Disparities in California 1990-1999*, a report documenting disease-specific disparities, created in collaboration with the Health Information and Strategic Planning Office

The Office does not generally collect program-specific data or evaluate program practices. OMH did conduct a 2004 survey to identify information on DHS program activities around racial and ethnic health disparities. However, to date no reports or findings based on this data have been completed, although OMH plans to produce such a report in the future for departmental use. [14] The survey instrument asked for the following information:[15]

- Program focus area
- Program target populations

- Direct and indirect services provided
- Goals/objectives around health disparities
- Program collaboration
- Data collection and monitoring
- Community outreach and input techniques

Office of Multicultural Health, Department of Health Services, at http://www.dhs.ca.gov/director/omh/default.htm

DHS - REFUGEE HEALTH SECTION[16]

Structure

The Refugee Health Section, Office of County Health Services (Health Information and Strategic Planning Division), provides the first point of contact for health services for refugee populations entering the United States. Its mission is to improve the health status of newly arriving refugees (which includes asylees, parolees, and trafficking victims) and to promote a coordinated system of care to enable them to achieve successful resettlement and self-sufficiency. The Section consists of a state office and local health department programs.

Refugees enter California with a variety of past experiences and lifestyles, so catering to such a diverse population can be very complex; planning and flexibility are essential for program success. Because refugee influxes vary over time, the program must adapt quickly to new cultural and linguistic staffing needs when a large refugee population enters California with little advance notice.

Newly arriving refugees are eligible for eight months of Refugee Medical Assistance funded by the Federal Office of Refugee Resettlement, or for Medi-Cal. In addition, the Federal Office of Refugee Resettlement funds the program operations of the Refugee Health Section, which in turn funds programs delivered at the local level.

Responsibilities

The Refugee Health Section performs a variety of activities: it coordinates initial health services for refugees, formulates policy, advocates for refugee health services within DHS programs, and networks with other states, international organizations, and the federal government. In addition, it supports local service efforts.

The Refugee Health Section administers two programs.

The Refugee Health Assessment Program

This program allocates funding annually to 12 local refugee health programs statewide. It oversees local health department planning, data collection and federal reporting requirements, and:

- Provides technical assistance, evaluation and training sessions to local health departments
- Evaluates the ability of local health jurisdictions* to ensure that local health departments have culturally and linguistically appropriate staff
- ~~Provides training and funding for medical interpreters~~
- Encourages local collaboration and partnerships to educate the community and share resources

The Refugee Health Section connects refugees who are entering California with a local health jurisdiction for an initial comprehensive assessment. The assessment provides an "American Baseline" for each refugee and the results become part of his/her medical file. A full assessment includes demographic information (including country of origin, primary language and education level), screening and treatment for communicable diseases, immunization updates, physical exam (including referrals for identified health conditions), minimal mental health screening, and lifestyle questions.

The community health worker also asks the client to identify the most helpful formats for receiving educational information (such as language) and provides information on United States laws and protocols (such as seat belt and domestic violence laws). Clients have the option to decline to participate in any part of the process.

Refugee Preventive Health Program

The Refugee Preventive Health Program distributes grant funding to 12 local health departments and non-profit community organizations to implement strategies, interventions and activities related to tuberculosis (TB) infection prevention and treatment for refugees. Grantees design their own program structure within objectives established by the Refugee Health Section. Objectives would include improving the general health status of the refugee population in California, and preventing and controlling health problems among populations.

Current efforts focus on improving treatment initiation and completion rates for latent tuberculosis infection. Community organizations assist health departments with follow-up, outreach, and health education. Grantees must report semi-annually on the program to the Refugee Health Section; the Section submits state reports to the federal funders.

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* Local health jurisdictions are generally county health departments. However, there are three city-operated local health jurisdictions in the state: Berkeley, Long Beach, and Pasadena. For purposes of this report, the term "county health departments" will be used interchangeably with and will include all local health jurisdictions.

Data Collection/Analysis

The Refugee Preventive Health Programs operated in local health departments and non-profit community organizations are evaluated on an annual basis to assess if they are meeting their objectives and identify both successes and barriers. Grantees must administer knowledge, attitude and belief surveys to refugees to monitor the information that they are receiving. Local projects are expected to adjust services based on these surveys.

In addition, grantees provide a quantitative data report detailing the number of positive TB tests, number of patients initiating treatment, and the number of patients that completed the treatment cycle. This information is used for program planning and decision-making purposes.

The Refugee Health Assessment Program designed and utilizes an extensive Internet-based system that collects statewide health assessment information of newly arriving refugees: the Refugee Health Electronic Information System. Information captured includes demographic data identifying refugees by country and language, and comprehensive health data. The system also tracks program accountability data and creates progress reports that provide feedback to local health departments. It has the ability to match data with federal CDC and state databases to identify the location and screening status of individual refugees during disease outbreaks.

This information is used to strengthen policy and program implementation and to support funding requests. While the Section does not currently publish reports, outside organizations can request information. Information is provided in aggregate form per the Health Insurance Portability and Accountability Act regulations (known as HIPAA),* and no other DHS programs have direct access to this database.

Collaboration

In addition to working with other DHS programs, the Section Chief is a member of the statewide advisory committee on refugee resettlement, which advises the Department of Social Services on refugee health issues. This advisory committee includes representatives from the Employment Development Department, Department of Mental Health, Department of Education, and local representatives.

Refugee Health Section, Department of Health Services, at
http://www.dhs.ca.gov/hisp/ochs/refugeehealth/

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* HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) that requires standards that address privacy and security of electronic health information systems.

DHS - HEALTHY FAMILIES PROGRAM – REPORTS[17]

Structure

The Healthy Families Program, HFP, administered by the California Managed Risk Medical Insurance Board, is a low cost state health insurance program. It provides health, dental and vision coverage to children and youth up to age 19 who meet the program requirements and do not qualify for free Medi-Cal.

Data Collection/Analysis

HFP produces *Monthly Enrollment Reports*. These reports include information about:

- Participants currently enrolled and disenrolled by ethnicity (19 ethnic categories)
- Participants currently enrolled and disenrolled by country
- Single point of entry[*] reports by primary language (24 languages)
- Single point of entry reports by children, ethnicity, and program (Medi-Cal or HFP)

In addition, HFP generates several special reports.[18] Some examples are:

- Health Status Assessment Reports – *The Healthy Status Assessment Project: Analysis of "At-Risk" and Adolescent Populations* report summarizes the first year results of the Health Status Assessment Project for the adolescent sample population (13-18 years). It provides data on children who reported no chronic health condition at baseline but reported one after a year in the HFP, and on children who were reported to have declines in health status during their HFP participation.
- Mental Health Services Reports – *The 2003 County Mental Health Services for Seriously Emotionally Disturbed (SED) Children Status Report* provides an annual update on the number of HFP subscribers who were referred by their health plan to the county mental health departments for SED evaluation and treatment, and on county expenditures for SED treatment. A description of basic mental health services provided by HFP-participating health plans is also included in the report.
- Cultural and Linguistic Services Reports – HFP plan contractors must provide culturally and linguistically appropriate services. The *Summary of the Healthy Families Program Participating Plans' 2003 Cultural and Linguistic Services Report* includes information on services provided, and proposed to be provided, by the HFP contractors to meet the needs of limited-English-proficient HFP subscribers. The report addresses activities including, but not limited to, providing

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[*] "Single point of entry" refers to the joint HFP/MediCal enrollment pathway. Applications for both programs are sent to the same location where they are reviewed. If the child is eligible for HFP, the application is processed; if the child is eligible for MediCal, the application is forwarded to the county for processing.

interpreter services, marketing materials, information packets, translated written materials, and referrals to community services programs.

California Managed Risk Medical Insurance Board; reports at http://www.mrmib.ca.gov/MRMIB/HFP/HFPReports1.shtml

DHS - MEDI-CAL/MANAGED CARE DIVISION

Responsibilities

The Medi-Cal/Managed Care Division mandates cultural and linguistic competency standards for the managed care plans with which it contracts.*

- Managed care plans and subcontractors must provide interpretive services on a 24-hour basis for all limited-English-proficient plan members.[19] These may be provided in person or via telephone.
- Family members or interpreters provided by the patient are only admissible under the patient's express wish, after he or she has been advised that professional interpretive services are also available.[20]
- Medi-Cal Plan members who are limited-English-proficient must receive additional language services including translation of written documents, including efforts to ensure that they know about available translated materials.[21]
- Managed care plans must assess the quality of interpretation and translation services within the plans they offer.[22]
- Managed care plans must provide cultural and linguistic competency education for staff and medical providers.[23]
- If mandated in their contract, managed care plans must convene Community Advisory Committees comprised of various stakeholders. These advisory committees provide the opportunity for plans to gather cultural and linguistic information about the communities that they serve, including the following:[24]
    - "Culturally appropriate" service or program design
    - Priorities for health education and outreach programs
    - Member satisfaction survey results
    - Health education and cultural and linguistic group needs assessment

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* The Civil Rights Act of 1964, Title VI, mandates many of these cultural and linguistic competency requirements.

    - Plan marketing materials and campaigns
    - Community resources and information, including provider networks

- Managed care plans must conduct Health Education and Cultural and Linguistic Needs Assessments using multiple data sources and methodologies. Plans must submit thorough needs assessment reports to DHS.[25]

- DHS provides guidelines for implementing cultural competency and essential elements of culturally competent care.[26]

- DHS encourages incorporating cultural competency within all managed care plan quality improvement initiatives. This includes the recommendation that quality measurement should be based on timely, valid and reliable data that considers race, ethnicity, and language.[27] Sources of data may include:
    - Self-assessment survey data
    - Patient satisfaction survey data
    - Provider survey data
    - Disenrollment survey data
    - Quality of care studies
    - External audits
    - Administrative data
    - Group Needs Assessment results
    - Community Advisory Committee feedback

Medi-Cal/Managed Care Division, Department of Health Services, at
http://www.dhs.ca.gov/mcs/mcmcd/

DHS - Medi-Cal Statistics Section[28]

Structure

The Medi-Cal Statistics Section (MCSS) is located in the Fiscal Forecasting and Data Management Branch (Administration Division).

Responsibilities

MCSS collects information and provides data and reports on Medi-Cal enrollments, service utilization, and the Medi-Cal population.

Data Collection/Analysis

Medi-Cal service utilization data is collected for each county. The data is aggregated by aid categories and outlines the number of Medi-Cal points of service and costs for each service. No racial or ethnic data is collected because information is collected by transaction, not by individual user.

Beneficiary data is collected through:[29]

- Eligibility information gathered by county intake workers, DSS staff, or federal Social Security Insurance intake workers
- Claims data on services rendered by individual services providers (collected by Medi-Cal's fiscal intermediary)
- Services rendered through contracted managed care plans

Data from these three sources are linked into a larger database system within MCSS.[30] Data collected for each individual beneficiary includes self-declared ethnicity and primary language information. Beneficiaries may select one of 19 race/ethnicity categories and 20 primary language categories. Beneficiary data is analyzed in a variety of ways including by county and zip code. All types of analysis include demographic data information. One data report specifically organizes beneficiaries by age and racial/ethnic group.

Website viewers may conduct bi-variate analysis of these data sets. Available variables are ethnicity and primary language. Other variables include age, gender, county, managed care versus fee-for-service care, and aid codes.

The Health Insurance Portability and Accountability Act (HIPAA)[*] regulates the dissemination and use of data on Medi-Cal beneficiaries.[31]

- Elements of this data are divided into three classifications: De-Identified, Limited, and Confidential Data Sets.
- Many important variables are classified as De-Identified: Race, Primary and Secondary Diagnosis Code, Patient Status Code, and Type of Service.

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[*] HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) that requires standards that address privacy and security of electronic health information systems.

- Guidelines to HIPAA-regulated data usage state that limited and confidential data sets may be disclosed only for the purposes of research, public health, or standard health care operations.[32] Research to access racial and ethnic health disparities would most likely be considered within these limitations.

Medi-Cal Statistics Section, Department of Health Services, at http://www.dhs.ca.gov/mcss/.

CALIFORNIA DEPARTMENT OF EDUCATION (CDE) - MIGRANT, INDIAN AND INTERNATIONAL EDUCATION[33]

MIGRANT EDUCATION

Structure

The California Migrant Education Program, in the Learning Supports and Partnerships Division, consists of a state office and 24 regional offices that provide a variety of services to children of migrant families. The Program allocates federal funds from the National Migrant Education Office to regional programs through a grant application process.

Responsibilities

To enter the California Migrant Education Program, children receive a certificate of eligibility during their enrollment interview at a new school. While the national focus of the program centers on academic performance, the California Program also emphasizes the holistic needs of the child. Regional office staff conduct an initial family needs assessment – including collecting demographic data – to connect children with appropriate services and existing community service providers. If social services do not exist to meet the child's needs, the Program provides services in-house. Staff make contact with families at least once a year to reassess needs and provide resources, and advocate for them within schools and the community.

In addition, most migrant education offices reserve funds specifically for medical needs such as eyeglasses or dentistry. Some regions document the services provided to migrant students (both in house and through community organizations) to keep school districts informed about the specific needs of this population.

Data Collection/Analysis

The state office of the Migrant Education Program provides program oversight, reviews grant applications, and coordinates reporting requirements. These include:

- State performance reports for federal funders that aggregate regional data on family travel patterns, types of employment, and countries/states of origin
- Yearly process self-evaluations conducted by each regional office

The data collected about individual students has varied over time. Prior to 1995, the federal government required a standardized data collection system that included information on demographics, immunization, and specific health needs. The system's goal was to make student records readily available to the new schools that they attended. The program ended because schools were not using the information enough to warrant the time-intensive nature of the data collection.

Since 1995 each state has developed its own monitoring system. In California, regions developed their own data collection systems; data has not been coordinated at the state level. However, a new database is being developed at the federal level that will link state databases and will collect demographic data, state assessment data and other secondary information.

INDIAN EDUCATION

The state office coordinates 32 American Indian community centers throughout California. The funding is provided at the state level and allocated through a grant process. Community centers create programs to strengthen educational outcomes and provide other services for Indian children and communities. None of the program's goals specifically address health outcomes.

INTERNATIONAL EDUCATION

The state office aids schools that wish to employ teachers from Spain and Mexico by recruiting teachers, organizing interviews, and helping with visa applications.

Some regional migrant education offices use this program to bring Spanish-speaking doctors and dentists to work in tandem with English-speaking health providers, in order to provide culturally accessible services to Spanish-speaking migrant families.

Migrant, Indian and International Education, Department of Education, at
http://www.cde.ca.gov/sp/me/mt/programs.asp

ASTHMA PROGRAMS

DHS - STRATEGIC PLAN FOR ASTHMA IN CALIFORNIA[34]

Structure

Asthma surveillance, prevention, education, and management services are divided among a variety of DHS Branches. The California Asthma Public Health Initiative in the Chronic Disease Control Branch and the Environmental Health Investigations Branch houses the majority of asthma programs. The Occupational Health Branch and the Maternal Child and Adolescent Health Branch also have asthma programs.

Responsibility

DHS asthma programs are strengthening their asthma prevention activities and management structure. The CDC collaborative agreement, "Approaching Asthma from a Public Health Perspective," funds this effort. In the first phase, various stakeholders within and outside of state government collaborated to write the *Strategic Plan for Asthma in California*. The plan highlights five areas: 1) Research, Epidemiology, and Evaluation; 2) Public Education; 3) Asthma Treatment and Management; 4) Secondary Prevention;[**] and 5) Policy.

Many of the *Strategic Plan* objectives affect communities of color along with all Californians. Some objectives explicitly address alleviating racial and ethnic disparities. These include:

- Producing surveillance research that assesses the risk factors and incidence of asthma among population subgroups.
- Creating a resource list of organizations and experts on different cultures to aid in the development of linguistically and culturally appropriate programs and materials.
- Collaborating with partners to disseminate culturally and linguistically appropriate materials.
- Implementing asthma awareness programs within targeted populations.

The second phase of the strategic plan focuses on implementation. Called "California Breathing," it is housed within the DHS Environmental Health Branch (as described on page 20).

[**] Secondary prevention is focused on finding common asymptomatic diseases that commonly occur and present a significant risk for negative outcomes without treatment. Screening tests are examples of secondary prevention activities.

Collaboration

California Asthma Partners is a statewide partnership of over 250 non-governmental organizations that work together to build political support to implement the *Strategic Plan*. The California Interagency Asthma Interest Group is comprised of stakeholders within state government. It functions as a roundtable where partners network, share resources and collaborate on activities.

Strategic Plan for Asthma in California, Department of Health Services, at http://www.dhs.ca.gov/ps/cdic/cdcb/medicine/asthma/Documents/SP/Final%20Strategic%20Plan.pdf

DHS - CALIFORNIA ASTHMA PUBLIC HEALTH INITIATIVE[35]

Structure

The California Asthma Public Health Initiative (CAPHI) is housed within the Chronic Disease Control Branch, in the Chronic Disease and Injury Control Division. CAPHI focuses on the implementation of effective programs and policies in asthma education, management, and prevention. It utilizes coordinated approaches and partnerships with communities, state and local organizations, health care providers, health departments, foundations, and academic institutions to achieve its goals.

In the past, the program received state funding from First 5 California, and federal funding from the CDC Prevention Block Grant and other grants. The FY 2005/2006 state budget establishes first time funding for asthma through a one-year allocation from Proposition 99 funds.* Most of this funding targets children; the program hopes to expand its focus to include adults in the future.

Responsibilities

CAPHI programs focus on children with asthma in underserved communities. Within this target group, they work to make programming culturally and linguistically appropriate. The Initiative collects racial and ethnic data on program participants to ensure that health disparities are addressed.

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* The California Tobacco Health Protection Act of 1988, commonly known as Proposition 99, increased the state cigarette tax by 25 cents per pack and added an equivalent amount of tax on other tobacco products. The new revenues were earmarked for programs to reduce smoking, provide health care services to indigents, support tobacco-related research, and fund resource programs for the environment.

CAPHI Projects

The Initiative worked in partnership with California Department of Education on *Guidelines for the Management of Asthma in California Schools* and the *DHS Asthma Action Plan for Schools and Families*. The CAPHI website compiles asthma resources for asthma organizations and health care providers, including "*Better Asthma Care for California Kids*" – an online asthma quality improvement training series for health care providers.

CAPHI collaborates with other asthma-related programs. It is currently developing a childhood asthma program proposal that combines the Childhood Asthma Initiative and the California Asthma Among the School-Aged Project (see below) in order to provide better coordination and strategies to improve the quality of asthma care for children ages 0-18.

Childhood Asthma Initiative

In 2000, the Department of Health Services received funding (through 2005) from First 5 California to establish a statewide Childhood Asthma Initiative (CAI). The goals of the CAI were to decrease asthma deaths and to improve the quality of life for children aged 0 to 5 years with asthma and their families by improving the delivery, quality, and coordination of preventive, educational, and medical care services for childhood asthma. Initiative partners from DHS were the Chronic Disease Control, Environmental Health Investigation, and Children's Medical Services Branches.

CAPHI manages the largest CAI program: the Community Asthma Intervention. Eight California communities receive funding for community asthma projects. These projects include asthma coalitions, asthma quality improvement activities, and the use of trained coordinators/outreach workers to provide patient/family education, self-management training, and assessments of in-home asthma triggers (such as molds and dust). A community assessment process identifies local needs in each community. Some communities developed culturally and linguistically appropriate resources and hired bilingual and/or bicultural staff.

In 2005, CAPHI conducted an evaluation of the Community Asthma Intervention to determine how participation in the program affected asthma management and the quality of life for children participating in the program. Parents/guardians completed both baseline and follow-up surveys that included the following information: demographic data (including race/ethnicity, age, gender, insurance); symptoms management, medicine utilization, and other components of care; and quality of life indicators. In addition to this evaluation, a qualitative research report on the CAI program includes information about culturally appropriate programming.[36]

California Asthma Public Health Initiative, Department of Health Services, at
http://www.dhs.ca.gov/ps/cdic/cdcb/medicine/asthma/

DHS - CALIFORNIA BREATHING[37]

Structure

California Breathing, housed within Environmental Health Investigations Branch (EHIB), (Division of Environmental & Occupational Disease Control, Prevention Services), is charged with implementing the *Strategic Plan for Asthma in California.*[*] Most of the funding for California Breathing comes from a CDC collaborative agreement. (The *Strategic Plan* and CDC agreement are described on page 17). Asthma programs also receive state funding.

Responsibilities

California Breathing has a website for asthma service providers and advocates that provides program information, fact sheets, research, and data.[38] The Branch is planning to develop an asthma awareness website designed for the general public. In addition, the project targets two areas of activities: health disparities, and school and childcare environments.

Health Disparities-Related Activities

The California Breathing website has a section on health disparities, including links to a range of resources (such as research publications and other websites). The project has convened a statewide meeting on asthma and health disparities, consulted with persons knowledgeable about the issue, and coordinates with the Office of Multicultural Health as it plans and implements its activities.

California Breathing awards mini-grants ($2,000 - $5,000) to local organizations with programs to reduce economic and racial health disparities in asthma. Grantees provide a range of diverse services tailored to the needs of their communities. Examples include educating physicians with large asthma patient populations, educating parents and communities about early warning signs of asthma attacks and environmental triggers (like dust and mold) in the home and childcare environments, and conducting in-home assessments.

California Breathing is currently developing reporting requirements for grantees and creating an evaluation tool to assess its effectiveness in reaching targeted communities. It is also standardizing demographic data collection methods across grantee programs.

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[*] The Environmental Health Investigation Branch also conducts other asthma-related activities. One effort is the Border Asthma and Allergies Study program that surveys 13 and 14 year-old students with Hispanic backgrounds in Imperial County to examine family, environmental, and socio-economic influences on asthma prevalence in the area.

School and Childcare Environments

California Breathing promotes healthy air quality in environments which children frequent. It uses the *California Healthy Kids Survey* data to monitor asthma health. California Breathing collaborated with CDE to develop asthma-related survey questions in order to conduct data analysis that is disaggregated by race (especially Asian and Hispanic subcategories).

California Breathing provides training to schools and advocacy groups by:

- Targeting outreach through workshops and dissemination of "good school" asthma policies
- Distributing to schools *California Healthy Kids Survey* data analysis, asthma awareness information, and fact sheets about asthma-related laws
- Promoting the "Dirty Diesel" program to reduce school bus idling in neighborhoods

California Breathing works within childcare centers to promote asthma health. This project entails working with DHS Children's Medical Services and California Childcare Health to develop a teacher curriculum about asthma and a Spanish translation of that curriculum.

Data Collection/Analysis

California Breathing conducts asthma-related surveillance, data analysis, and research using various secondary sources. These sources include:

- *Mortality Data Automated Vital Statistics System*
- Hospital Discharge Data, Office of Statewide Health Planning and Development
- *Behavioral Risk Fact Surveillance System*
- *California Healthy Interview Survey*
- *California Healthy Kids Survey*

California Breathing plans to create more racial and ethnic health disparities-specific reports in the future. Other data analysis efforts include:

- Focus groups to understand issues and causes of disparities
- A report on asthma and African American communities
- Local data needs assessments
- Surveys of stakeholders about data collection needs and format preferences

California Breathing, Department of Health Services, at
www.californiabreathing.org

BREAST AND CERVICAL CANCER PROGRAMS

DHS – CANCER DETECTION PROGRAMS: EVERY WOMAN COUNTS[39]

Structure

The Every Woman Counts (EWC) program is housed in the Cancer Detection Section, Cancer Control Branch (Division of Chronic Disease and Injury Control, Prevention Services). EWC provides free breast and cervical cancer screening and diagnostic services for eligible low-income women, age 40 and over.

Both federal and state funds support this program. Federal funds come from the CDC through the Breast and Cervical Cancer Mortality Prevention Acts of 1990. State funding is provided through Proposition 99 and the California Breast Cancer Act of 1993.

Responsibilities

EWC uses a program model that was originally developed by the CDC. It includes several components.

Screening, Tracking, Follow-up and Case Management to Reduce Breast Cancer Deaths

Women wishing to receive screening services may apply online, at local doctors' offices, or call a toll free line where EWC staff members speak English, Spanish, Mandarin, Cantonese, Korean and Vietnamese. Consent forms are available in these seven languages. Eligibility and education worksheets are available only in English and Spanish. EWC patients are referred to participating neighborhood doctors for comprehensive case management of periodic screenings.

Quality Assurance and Improvement Systems to Save Lives

The program performs ongoing medical record reviews to ensure program quality and to develop policy and evidence-based training. All women participating in the program receive written materials explaining diagnosis and treatment in order to assist them to become informed participants in their care.

Professional Education to Improve Practice Standards and Public Education to Promote Innovative Strategies for Reaching the Underserved

EWC provides training and educational materials to participating doctors. It also provides public education and outreach through:

- Television public service announcements
- Low-literacy level educational materials in five languages
- Breast and Cervical Cancer Fact Sheets outlining disease prevalence in California, with special attention to ethnic trends and patterns[40]

- A public awareness program delivered through hair salons
- A toll-free consumer referral line where telephone operators speak seven languages

Surveillance and Evaluation to Provide Accountability and Guide Program Improvements

The program conducts surveillance, evaluation and research activities to understand trends and evaluate quality of service. EWC has maintained program activity data since its inception in 1991. Information from this database may be requested through the program's website.

Data Collection/Analysis

EWC uses data from surveys to assess breast and cervical cancer screening knowledge, attitudes and behaviors among California women.

Collaboration

The Cancer Detection Section works with other state programs and community-based organizations to advocate for breast and cervical cancer awareness. These collaborative relationships include volunteer coalitions and ethnic-specific task forces to ensure culturally appropriate service. EWC is part of a network of regional cancer detection partnerships that provide outreach and support for women, physicians, and health professionals.

Every Woman Counts, Department of Health Services, at
http://www.dhs.ca.gov/ps/cdic/ccb/cds/breastcancer/breastcancer.htm

CARDIOVASCULAR DISEASE PROGRAMS

DHS - CALIFORNIA HEART DISEASE AND STROKE PREVENTION PROGRAM[41]

Structure

The California Heart Disease and Stroke Prevention (CHDSP) Program, under the Chronic Disease and Epidemiology Control Section, is one of several Chronic Disease Control Branch programs (Division of Chronic Disease and Injury Control, in Prevention Services). In 2000, its focus shifted from surveillance to policy, intervention, and secondary prevention of heart disease and stroke; its purpose is to reduce premature death and disability from heart disease and stroke. CHDSP is funded through the CDC Prevention Block Grant.

CHDSP does not have direct oversight over local programs. In order to expand to include program oversight, evaluation and data collection, the program is seeking funding through grant opportunities, specifically CDC grants that focus on cardiovascular health programs.

Responsibilities

CHDSP's responsibilities include:

- Expanding the program and developing grant applications for funding to support that effort
- Providing assistance to local programs
- Aiding in implementing mandatory cardiovascular health guidelines
- Collaborating with DHS programs that address heart disease risk factors

In addition, CHDSP coordinates the California Heart Disease and Stroke Prevention and Treatment Task Force whose members are appointed by the Legislature and the Governor.[*] This Task Force will create the State Master Plan for Heart Disease and Stroke as a foundation for future planning. The Master Plan is expected to increase California's competitiveness for continued CDC funding.

In 2004, CHDSP conducted seven public forums throughout the state to gain perspectives on heart disease prevention needs within various communities. The forums encouraged dialogue about heart disease prevention, created a databank of stakeholders within different communities, and generated ideas for improving cardiovascular health.

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[*] California Health and Safety Code Section 104141 requires that a task force be convened to create a Master Plan for Cardiovascular Health in California by November 2005.

Health disparities was one of the subjects addressed at the forums. The following topics were discussed:

- Providing cultural competency training
- Designing education about cardiovascular health in culturally-appropriate ways
- Ensuring that stakeholders developing cardiovascular health strategies come from diverse backgrounds
- Addressing indirect factors to cardiovascular health and considering solutions in population-specific ways
- Educating various communities on standards of care, patient rights, and necessary questions for patients to ask health providers
- Increasing participation of communities of color in clinical trials
- Developing educational materials that are culturally, linguistically, and reading-level appropriate

Data Collection/Analysis

The Chronic Disease and Epidemiology Control Section conducts data analysis on California heart disease rates using county, race/ethnicity and gender as variables.[42] It does not report language or socio-economic status data.

Data is collected in the following ways:

- The DHS Center for Health Statistics collects mortality data from each county.
- The Office of Statewide Health Planning and Development collects morbidity data from California hospitals.
- Racial and ethnic data is collected using the categories of White, Black, Indian, Asian, and Hispanic. These categories follow federal Office of Management and Budget standards. In the future, the data may allow for more specific breakdowns by racial and ethnic categories, and/or by cities and regional location.

A 2002 surveillance data report is available through the program's website. More recent data about specific counties or ethnic groups may be obtained by contacting the Chronic Disease and Epidemiology Control Section. The program uses data for information distribution purposes and includes data in grant applications as appropriate. Data analysis is not conducted for specific regional or community-administered programs.

California Health Disease and Stroke Prevention Program, Department of Health Services, at http://www.dhs.ca.gov/ps/cdic/chdsp/default.htm

DHS - WISEWOMAN PROGRAM[43]

Structure

The WISEWOMAN (Well-Integrated Screening and Evaluation for Women Across the Nation) Program is housed in the Cancer Detection Section, Cancer Control Branch (Division of Chronic Disease and Injury Control, in Prevention Services). It is a pilot program that provides cardiovascular disease screening and educational services to Latina women, 40-64 years of age, who have elevated cholesterol and/or blood pressure levels, and are enrolled in or eligible for Every Woman Counts (described on page 23).

~~Pilot sites are located at EWC clinic sites in areas with large Latina populations.~~ Participants are randomly divided into control and enhanced intervention groups and are involved in the program for one year. The pilot programs will test the benefits of screening and targeted interventions by comparing women receiving additional services with those who do not. It will also study ways to make the program stronger during statewide expansion.

The CDC funds the program through a collaborative agreement with the state.

Responsibilities

The WISEWOMAN Program emphasizes reducing the risk of illness and death from cardiovascular disease. Its preventive services include:

- Screening for heart disease risk factors
- Education and counseling
- Dietary and physical activity interventions
- Smoking cessation
- Referral and follow-up

Bilingual and bicultural community health workers (CHWs) and a registered nurse (RN) provide screening services and deliver the WISEWOMAN educational curriculum. Women who have additional medical conditions, such as diabetes, are referred to other service providers. Members of the enhanced intervention group receive:

- ***Initial Visit*** – Client receives a Baseline Assessment, including clinical screenings (cholesterol, blood pressure, body mass index reading, height, and weight); is assessed for knowledge, attitude and behavior; is asked demographic information (education level, Latino ethnicity subcategories, and language information); and is provided an individualized plan to meet their goals.
- ***One, Two, Six and Twelve Month Visits*** – Client meets with a CHW for curriculum lessons and with the RN for health screenings. At each visit, the RN takes the client's body mass index, height, weight, and blood pressure. At the six-month visit, the RN also performs a cholesterol test.

The curriculum provides information and activities related to nutrition and physical activity. It has been adapted from an existing program developed in North Carolina to reflect cultural and linguistic differences unique to California Latinas. (The curriculum is available in both English and Spanish; however, the Spanish language curriculum is not a direct translation of the English curriculum. As part of the pilot study, data will be collected via focus groups and personal interviews to evaluate the curricula for further adaptation.

In addition to the curriculum lessons, other components of the program visits include a discussion of client's health goals; a "tool kit" showing portion sizes; cookbooks with heart healthy recipes; incentives such as tennis shoes or pedometers; and supports for transportation, nutrition, and physical activity.

Data Collection/Analysis

Clinics report data findings to the program from each client visit. This data includes clinical measures and assessment of changes in knowledge and behavior. Some of this data is later included in data reports submitted to the CDC. This data will also be used to measure program success and to improve the program. In addition, the program is developing process evaluation tools; these will likely include staff questionnaires, client interview questions, focus group questions, and surveys.

An Advisory Committee comprised of individuals from partnering state and local agencies will also assist in guiding program activities. The WISEWOMAN Program anticipates seeking advice from the committee on issues such as barriers to service and challenges to program implementation.

WISEWOMAN Program, Department of Health Services, at
http://www.dhs.ca.gov/cancerdetection/wisewoman/default.htm

DIABETES PROGRAMS

DHS - CALIFORNIA DIABETES PROGRAM[44]

Structure

The California Diabetes Program is a statewide DHS public health program dedicated to preventing diabetes and its complications in California's diverse communities. It is housed within the Chronic Disease Control Branch (Chronic Disease and Injury Control Division, Prevention Services) and receives funding from the CDC, Division of Diabetes Translation. The University of California, San Francisco, administers the grant. Program staff, many of whom are bilingual, operate out of a state office and in geographic regions throughout the state.

Responsibilities

The California Diabetes Program serves as the coordinating leader for the multiple diabetes prevention and control efforts that exist throughout the state. It is responsible for increasing access to quality diabetes care and treatment, raising public awareness about diabetes, and implementing and evaluating diabetes treatment interventions. It also shares best practices, data, and other resources with local programs.

The California Diabetes Program's framework for achieving state and national objectives – coordinate efforts, fill gaps in service, and strengthen multi-sector local efforts to prevent and control diabetes – is reflected in the following documents:

- ***California's Plan for Diabetes 2003-2007.***[45] This plan is a roadmap for action that stresses the importance of increased data collection and evaluating diabetes control efforts. It highlights the needs of high-risk populations, including ethnic groups.[46]
- ***Diabetes Public Health System Assessment.***[47] The California Diabetes Program convened two day-long forums in 2003, to identify service and treatment gaps, and strengths and weaknesses within the diabetes public health system.
- ***Performance Improvement Plan (PIP).***[48] The PIP translated the *Plan* and *Assessment* (described above) into action for the California Diabetes Program and its partners statewide. Work priorities were drafted at nine community meetings. Priorities focusing on racial and ethnic health disparities called for increased:
  - Collaboration to increase cultural competency
  - Collaboration among diabetes stakeholders to share and expand existing data collection
  - Culturally- and linguistically-appropriate training opportunities
  - Collaboration among diabetes stakeholders to disseminate culturally and linguistically appropriate resources

Following are some of the projects that the Program has developed that specifically address racial and health disparities.[49]

Diabetes Information Resource Center

A web-based interactive Diabetes Information Resource Center (DIRC) enables stakeholders to exchange information, resources, and data. The system:

- Addresses *Assessment* recommendations, including those relating to geographic, population, and resource disparities, evaluations, and quality improvement activities
- ~~Acts as an electronic extension of the work done by the regional staff~~
- Acts as a central depository of information for networking and resources
- Involves design collaboration with diabetes prevention and control partners
- Includes a databank of diabetes organizations and services. Partners may submit profiles about their organizations and the populations they serve, as well as post resources targeting specific groups

Health Resources and Services Administration, Bureau of Primary Health Care-Health Disparities Collaborative

The CDC funds selected states, including California, to participate in a Health Resources and Services Administration, Bureau of Primary Health Care initiative to better understand efforts to reduce health disparities among populations served by federally-funded health centers. The California Diabetes Program is the California representative for this initiative. The Program provides technical assistance, support, and linkages to community resources for health centers in California. Each health center tracks outcome measures to evaluate improvements in care and reductions in health disparities. This data is reported to the state and compiled nationally. Successful models are shared.

Basic Guidelines for Diabetes Care

The *Basic Guidelines for Diabetes Care* is an evidence-based, user-friendly packet of materials to aid health care providers in delivering quality diabetes care. In addition, there are educational tools for patients, community health workers, and medical staff that supplement and reinforce the *Guidelines*. These include:

- *Diabetes Health Record* card (14 languages)
- *Take Charge!* A PowerPoint presentation (14 languages) and video (two languages)
- *Diabetes Consumer Action Groups* – A peer-to-peer education program led by people with diabetes (two languages)
- *Diabetes Care Coordinator Program* – A train-the-trainer program designed to educate the office assistant to be an important member of the diabetes health care team

U.S./Mexico Border Diabetes Project

The California Diabetes Program, along with partners in the U.S. and Mexico, is conducting a bi-national study to reduce the impact of diabetes within the U.S./Mexico border region. Phase One of the U.S. Mexico Border Diabetes Project, completed in 2005, was a prevalence study of diabetes, pre-diabetes, and overweight/obesity in the border region. Phase Two will be a pilot to study the effectiveness of using community health workers to improve diabetes self-management and to prevent or delay the onset of diabetes among those at risk.

Data Collection/Analysis

The Program, consistent with the national diabetes initiatives, promotes data collection efforts to monitor racial and ethnic health disparities. Data includes race/ethnicity, age, gender and diabetes treatment tests and exams.*

The California Diabetes Surveillance System includes:

- National and statewide survey data
- Vital statistics and hospital discharge data
- Health care system data
- Local and community data

In the future, the Program plans to collect community level data (via DIRC) in order to more accurately portray diabetes in California. However this data collection effort will not be mandated, nor will organizations be required to submit results to the California Diabetes Program or any other state agency.

The Program sponsored and funded the diabetes module of the California Behavioral Risk Factor Surveillance System, developed questions on diabetes primary prevention, and prepared a report, *The Burden of Diabetes in California Counties* (2000). The Program participates in the *California Health Interview Survey* user and survey design workgroups and leads the diabetes focus area workgroup. It prepared a county-specific diabetes report, *Diabetes Prevalence and Risk Factors in California*, in 2005. It participates in the State death certificate revision workgroup. The Program also collaborates with statewide partners on California Hospital Discharge and Vital Statistics data and is creating a report, *Diabetes Mortality and Morbidity in California*, using both Hospital Discharge and Vital Statistics data.

California Diabetes Program, Department of Health Services, at
http://www.caldiabetes.org/profile_display.cfm?ProfileID=22

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* Analysis includes all racial and ethnic data available within each data source. Analysis does not include a focus on primary language.

CDE - CHILDHOOD OBESITY AND DIABETES TASK FORCE[50]

Structure

State Superintendent of Public Instruction, Jack O'Connell, established the Childhood Obesity and Diabetes Task Force to examine the complex factors that contribute to these chronic conditions, and to make recommendations on actions that schools and their partners can and should take to address the epidemic trends facing California children. Members of the task force included students, parents, public health experts, physicians, nutritionists, physical education specialists, school nurses, and other educators.

The task force presented recommendations to the Superintendent in December 2004. These recommendations had been incorporated into the Department of Education's efforts to increase fitness and nutrition levels among children. (See CDE – Nutrition, Physical Education, and Healthy Lifestyles, page 61, for details).

The recommendations focused on three main topics: Physical Education and Physical Activity; Health Education; and Nutrition. Recommendations considered the many factors connected to diabetes and obesity such as school location and walking accessibility; coordination between community, parents, educators and health professionals; and the effects of advertising on children's lifestyle choices. None of the recommendations specifically addressed communities of color or health disparities.

California Obesity and Diabetes Task Force, Department of Education, at http://www.cde.ca.gov/ls/he/cd/

HIV/AIDS PROGRAMS

DHS - OFFICE OF AIDS[51]

Structure

The State Office of AIDS (OA), located within Prevention Services, has the lead responsibility for coordinating state programs, services and activities related to HIV/AIDS.* It has four branches:

- AIDS Drug Assistance
- HIV Care
- HIV/AIDS Epidemiology
- HIV Education and Prevention Services

OA oversees and facilitates state and federal CDC funding to local health jurisdiction programs (see footnote on page 10). OA field staff work with local jurisdictions to assess needs and implement the most appropriate services for each community.

Responsibilities

OA develops programs for, and provides resources to, local health jurisdictions. Both OA and local health jurisdictions develop a variety of program models to respond to the diverse and specific needs of target populations; they also adapt existing programs to fit client needs and cultures. Some programs are directed at communities of color, including: The African American Church Outreach Program, The Bridge Project (focusing on gaps between HIV testing and treatment for communities of color), and The Prevention Program for African American and Latino Men who have Sex with Men (MSM) who do not Identify as Gay.

Many OA prevention program models are developed in collaboration with the University of California University-wide AIDS Research Program (UARP). As part of this effort, the Dissemination Project develops program interventions specifically targeted to particular populations. Project studies incorporate perspectives from both direct service providers and academic researchers. They examine a specific program's design, implementation process, and outcome evaluation, as well as providing suggestions for locally adapting the model. Current UARP report titles include:

- *Asian and Pacific Islander MSM: HIV Prevention Study*
- *HIV Prevention Outreach Programs in Santa Barbara (focused on English and Spanish-speaking populations)*
- *Systematic Review of HIV Behavioral Prevention Research Among Heterosexual African Americans*

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* Required by Health and Safety Code Section 100119

- *HIV/AIDS Behavioral Risk Research on African American Gay, Bisexual, and MSM*

The Prevention Branch also performs some outcome evaluations, and conducts process evaluations with each local health jurisdiction. (For example, to evaluate a local program goal of reaching African American MSM men, a process evaluation will determine how many program participants are from that population and what services they use.)

Data Collection/Analysis

OA collects demographic data on program participants to assess program effectiveness in reaching target populations. The Prevention Branch uses self-reported survey data collected on OA-standardized forms that is administered by the local health jurisdictions. Some forms chart individual characteristics and behaviors while others chart the demographic characteristics of the clients served by the program. These forms collect data for OA research purposes and are used to create individual care and prevention plans at the local level. The racial categories on these forms correspond with census racial and ethnic classifications.

The Care Branch also collects demographic data on program participants but uses different forms adapted to specific types of programs. (For example, the AIDS Drug Assistance Program has different reporting forms than the Case Management Program.) Data is collected on the local level and submitted to the Care Branch for analysis. Analysis is used primarily for program monitoring.[52]

Reports

OA produces various reports that monitor use of services and report data. *The State of the State Report* outlines activities of the Office, each branch, and the collaborations with other agencies undertaken during the previous year. Reports are available on the OA website.[53]

The HIV Counseling and Testing Program Annual Report gathers data on both the populations served by OA funded programs and larger trends of HIV contraction in California. Among other data analysis, the 2001 edition of the study included the following information related to communities of color:[54]

- Breakdowns for HIV-risky behaviors by race and sexual orientation
- Percentage of OA- funded HIV-positive tests analyzed by race/ethnicity and gender
- Percentage of total OA- funded HIV-tests analyzed by race/ethnicity and gender
- Percentage of OA-funded counseling and testing participation analyzed by race/ethnicity and gender

The Epidemiology Branch collects and analyzes data to inform Care and Prevention Branch programs and services.[55] This data is not collected on a program-specific basis but is often disaggregated by county, race/ethnicity and gender, and mode of exposure. The surveillance data used to analyze HIV/AIDS trends in California comes primarily from:

- The HIV/AIDS Care Registry: “a confidential, central registry of demographic and clinical information on all reported California AIDS cases”[56][*]
- Targeted surveillance of perinatal cases
- Surveillance with anonymous and blind HIV testing within targeted Sexually Transmitted Disease (STD) clinics
- The HIV Testing Survey that monitors testing patterns in high risk areas (expanded in 2002 to include migrant and seasonal farm workers)
- Testing at blood banks and plasma centers
- Young men behavioral survey
- Various population-targeted studies

Monthly AIDS statistics and other statistical publications are available on the OA website. The website also includes a mechanism for requesting more specific epidemiological information.

Collaboration

The OA collaborates with other organizations and state agencies to provide services and conduct research projects.[57] For example, OA, DHS Office of Multicultural Affairs, and the Drew Center for AIDS Research coordinated the 2003 California Summit on African Americans and HIV. This summit aimed to increase dialogue and coordinate efforts addressing HIV Prevention and Care for the African American community. Regional meetings were held throughout the state to include various stakeholders. The summit resulted in a strategic plan framework specifically focused on services to the African American community.

Another example is the *Urban Migrant Latino Study,* a study based on interviews with the goal of better understanding risk behaviors, migrant patterns and HIV testing activity among urban day laborers. In addition, OA collaborated with its counterpart organization in Mexico to conduct various studies in Mexico and in California. The two organizations assessed various HIV infection and prevention trends. For example, the *Transborder Latina Study* involved interviewing and providing services to Latinas on both sides of the border.

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[*] AIDS Registry Data is currently collected using a coded system instead of patient names. For a discussion of this system, including concerns and potential revisions, see Charles Ornstein, “HIV Tracking System May be Scrapped,” *The Los Angeles Times*, July 25, 2005.

In the *California Statewide Treatment Education Program,* OA contracted with San Francisco's Asian and Pacific Islander Wellness Center to provide HIV treatment education certification classes in English and Spanish throughout California.[58]

OA, along with the Sexually Transmitted Disease Control and the Tuberculosis Control Branches, works with the Department of Alcohol and Drug Programs to address dual diagnosis situations. It also works with Medi-Cal and private insurance companies to increase health care coverage for infected populations, and collaborates with the Department of Housing and Community Development to address issues of homelessness and affordable housing among people with HIV and AIDS.

Office of Aids, Department of Health Services, at
http://www.dhs.ca.gov/ps/ooa/default.htm

DHS - HIV/STD PREVENTION PROGRAM[59]

Structure

The HIV/STD Prevention Program is part of the Sexually Transmitted Disease Control Branch which is located in the Division of Communicable Disease Control, Prevention Services. The Branch's mission is to provide statewide STD consultation, surveillance, education, screening, and services aimed at preventing, treating, and interrupting sexually transmitted diseases.

Responsibilities

The HIV/STD Prevention Program develops curricula, provides resources to local education agencies, and works with other state agencies to support HIV and STD prevention goals.

Curricula

California law mandates that public school students receive HIV/AIDS education once in middle school and once in high school. Counties and school districts select an HIV/AIDS curriculum from a list of state-approved "research validated" curricula posted at the California Healthy Kids Resource Center website.[60] The website lists eight curricula: five target African-American students and three target all populations. None of the curricula are specifically targeted toward any other communities of color.

The *"Positive Prevention"* curriculum meets California HIV/AIDS mandates; it is available only in English. *"Making the Connection between HIV and STDs"* is the most recent curriculum available for California school use. It focuses on addressing HIV in the context of general STD risk, and is based on data collected by the STD Control Branch as well as the results of needs assessment surveys from various California teachers and administrators. It is available only in English.

Program Monitoring

The HIV/AIDS Office monitors schools that rank within the bottom 50 percent* and are located in areas with high HIV/AIDS infection risk. Risk is calculated using DHS/STD county-level data and vital statistics data on teenage pregnancy (because most teenagers have not been tested for HIV/AIDS).

During the monitoring process, HIV/AIDS program staff review a school's compliance with its chosen curriculum and discuss methods for improving HIV/STD prevention efforts. This process sometimes includes a discussion of culturally or community-specific prevention approaches. District-specific information about the underlying causes for HIV/AIDS rates of infection may also be gathered during this review process.

Data Collection/Analysis

The HIV/AIDS program relies on outside data sources to collect California-specific information on HIV, AIDS and STD rates. The primary sources for this data are the DHS/ STD Control Branch electronic database and California Vital Statistics. Research is used to provide "evidence-based" program choices for curricula and to identify disease prevalence and risk factors in each county. Currently, no program-specific or curriculum-specific evaluation or data collection occurs at the state level.

DHS/STD CONTROL BRANCH DATA

DHS/STD performs surveillance data analysis and posts this data electronically by local health jurisdiction. Information includes demographic data on race and ethnicity (in concurrence with U.S. Census designations).

Data is originally collected at the local health jurisdiction level through lab and morbidity reports. It is gathered and analyzed by the DHS/STD Control Branch. The quality and completeness of data varies greatly by county.

Specific data limitations are described on the DHS/STD website. A major limitation involves unreported or inaccurately reported race and ethnicity data. This limitation has consequences for the ways that the CDE Prevention program can identify target populations.

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* The CDE Office of Testing and Accountability ranks school performance.

Collaboration

CDE and DHS established an Adolescent Sexual Health Workgroup in June 2005, to promote an integrated approach to addressing HIV, STDs and teen pregnancy. Participants represented both state departments and community organizations. The workgroup recommended the following:

- Identify strengths, gaps and deficiencies in data and make recommendations for improving consistency and comparability
- Explore methods of sharing and disseminating integrated data for various stakeholders to improve program planning and evaluation
- Develop a comprehensive and appropriate (i.e. gender, age, culturally, sexual orientation, etc.) training program to ensure all educators and instructors are trained in the core competencies
- Identify, develop, and promote the use of culturally-appropriate, youth-focused sexual health curricula

HIV/STD Prevention Program, Department of Health Services, at
http://www.dhs.ca.gov/ps/dcdc/STD/stdindex.htm

MENTAL HEALTH

DEPARTMENT OF MENTAL HEALTH (DMH) - OFFICE OF MULTICULTURAL SERVICES[61]

Racial and ethnic health disparities are manifested differently within mental health than in other physical health areas. Statistically, multicultural communities do not have higher rates of mental illness than White communities. However, multicultural communities in California have low rates of *access* to mental health care and disproportionately experience poor quality of care. In addition, mental health symptoms presented by multicultural clients do not always fit neatly into western psychological theory, making diagnosis and Medi-Cal's "criteria for medical necessity" difficult without culturally appropriate knowledge.

Structure

The mission of the Office of Multicultural Services, housed within the DMH Director's Office, is to strengthen the department's focus and ability to provide culturally and linguistically competent mental health services to the California's diverse population. The Office coordinates departmental efforts to reduce disparities in mental health access and quality for multicultural communities.

The Office was created in December 1997, when DMH established its Specialty Managed Care/Medi-Cal Mental Health Managed Care Plan. The initial plan made limited mention of the needs of multicultural communities for cultural and linguistic competency services. As a result, the DMH Cultural Competency Advisory Committee was formed to establish new cultural competence requirements. Following the completion of these plan requirements, the Office of Multicultural Services was established to support the ongoing development of culturally competent community mental health programs.[*]

Responsibilities

The Office promotes cultural competency in all DMH programming, most recently in relation to the Mental Health Services Act.[**] It also oversees the county cultural competency planning process, ensuring culturally appropriate treatment intervention, services, and assessment in each of California's diverse counties (see description below). Specific responsibilities include:

- Reviewing annually submitted culturally-competent plans

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[*] This history mirrors similar stories within both federal and state mental health efforts where reports on cultural competency were added as addendums to larger reports about mental health that did not originally address this issue.

[**] The Mental Health Services Act of 2004 (also known as Proposition 63) imposes a one percent income tax on personal income in excess of $1 million to provide increased funding to support county mental health programs for children, transition age youth, adults, older adults and families.

- Providing technical assistance for county cultural-competency planning
- Encouraging collaboration between county agencies to ensure that mental health is addressed from a holistic perspective
- Working with state and local quality of care communities
- Coordinating and facilitating trainings on cultural and language competency
- Encouraging strategies to support programs that address the retention and recruitment of bi-cultural service providers
- Providing a web-based list of cultural competency resources
- Developing a cultural competence plan for state hospitals
- Working with the Cultural Competence Committee

County Cultural Competency Plans

Each county must create a Cultural Competency Plan that assesses needs and identifies action steps to reach cultural competency objectives.[62] The plans specifically address Medi-Cal mental health activities. The Office provides technical assistance to counties, reviews all plans and works with the DMH Program Compliance Unit to ensure that the plans are fully implemented.

Needs Assessments

The Office conducts a Population Assessment to compare the demographics of individuals eligible for service with those who actually use mental health services.[*] Data collection involves:

- A county geographic, demographic and socio-economic profile[**]
- A breakdown of service utilization by ethnicity, age, gender, diagnosis and primary language
- Identification of any racial or ethnic service disparities
- Objectives for providing future services and evaluation measurements

The Office also conducts Organizational and Service Provider Assessments to analyze the program's ability to serve diverse populations. This process includes research on:

- How the policies and administration of Mental Health Plan local contracting agencies address the needs of a diverse population.

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[*] Most mental health studies show very similar rates of mental illness among different racial and ethnic populations. As a result, differences in service use identified in this assessment would point to issues of access or cultural appropriateness.

[**] Counties are required to use census data to collect information on five general racial and ethnic categories. They are also encouraged (but not required) to collect more detailed racial category information through other data sources.

- Comparisons between staff and contractor ethnic composition and the populations served. Data analysis includes ethnicity, oral and written language proficiency, and location of staff placements in relation to target population locations.
- Abilities of staff to provide culturally and linguistically appropriate service as measured through evaluations, trainings, and experience with client cultures.
- The existence of a quality assurance process for culturally-specific outcome measures; staff satisfaction, and grievances/complaints procedures.

There are three standard Cultural Competence Plan requirements: Access, Quality of Care and Quality Management. Counties must measure how well they meet these standards by capturing a variety of information on cultural competency. Standard indicators and measurements are listed below.

- Linguistic services must be provided for all threshold languages (languages spoken by at least five percent of the county's Medi-Cal population)
- If clients speak non-threshold languages, accommodations must be made to ensure targeted, language-specific services through referral or individualized linguistic adaptations
- Interpreters must have specific mental health interpretation training
- All written materials must be field tested in all threshold languages
- Client satisfaction surveys must be provided in all threshold languages
- Mental Health Plans must create and implement plans that consider factors such as transportation needs and the comfort of the clinic environment for diverse populations
- Consumers must be provided access to culture-specific community providers through Medi-Cal reimbursements
- Interpreters must have a high level of cultural competency in addition to linguistic knowledge
- The demographics of those using Mental Health Plan services must reflect the demographics of the Medi-Cal community as a whole
- Performance outcomes achieved by communities of color must be as strong as outcomes for the general community

Collaboration

The Office of Multicultural Services collaborates with other DMH divisions. For example, it works with the Office of Statistics and Data Analysis, which collects data for the Client Services Information System (CSIS) and produces surveillance reports on statewide DMH client patterns.[63] The CSIS system charts client services and breaks down the information to grant program-specific levels. The Office collects data on 14 racial and ethnic categories and collapses the information into five racial and ethnic categories for federal reporting requirements.

The Office of Multicultural Services also collaborates with the Performance Outcomes Office, which measures service quality through consumer perception surveys. County cultural competency standards stipulate that these surveys must be made available in all threshold languages. Data collected on race and ethnicity is self-reported, based on federal Uniform Reporting System guidelines.

A recent federal data infrastructure grant for the DMH will provide the department with greater opportunities for data coordination and sharing. This is part of an ongoing federal effort to assist states in data collection efforts. The funding should allow the department to collect more nuanced demographic data, such as tracking more specific racial categories.

The Office of Multicultural Services has an informal relationship with grant-funded programs. Grant administrators within the Department of Mental Health administer funding to local programs. These grant programs focus on specific segments of the mental health client population such as children, older adults, or AIDS patients. Local grantees develop their own programs that include cultural competency efforts (these are most likely documented within each county Cultural Competency Plan).

As noted above, the CSIS system collects client "encounter data" in a program-specific manner. No other racial and ethnic data collection/evaluation is required by DMH for specific grants, but grantees may choose to do this individually. For example, the Early Mental Health Initiative contracts with an outside agency to perform an outcomes evaluation of their program. In this case, demographic data is analyzed to assess the use of specific services by various segments of the population served. This information is disaggregated by race/ethnicity.[64]

Office of Multicultural Services, Department of Mental Health, at
http://www.dmh.ca.gov/multicultural/default.asp

TRAUMA (INTENTIONAL AND UNINTENTIONAL)

DHS - VIOLENCE PREVENTION UNIT[65]

Structure

The Violence Prevention Unit (VPU) is located in the Epidemiology and Prevention for Injury Control (EPIC) Branch in the Division of Chronic Disease and Injury Control, Prevention Services. It provides leadership in applying public health principles and practices to prevent violent (intentional) injuries. The Unit's policies and practices seek to address community violence through shifting cultural norms and values.[*]

Responsibilities

The VPU addresses varied violence prevention issues. Current projects – established through the California 1994 Women's Health Initiative – focus primarily on the prevention of family violence and violence against women. The VPU provides strategic planning and implementation grants for family violence prevention to local health departments. The Unit also provides training on program development and local data collection, and coordinates a *Violence Prevention Network* that offers resource information.

Violence Against Women Statewide Prevention Project

In 2003, VPU received a CDC planning grant to establish and coordinate the Violence Against Women Statewide Prevention Project. VPU staff convened a multidisciplinary group of partners to identify changes in policy and institutional practices that would prevent all forms of violence against women. The 2004 project report outlines priority policy recommendations.[66] The EPIC Branch is facilitating workgroups to implement recommendations that focus on:

- Developing primary prevention campaigns and comprehensive programs
- Instituting improvements in governmental practice, identifying service gaps, and maximizing use of resources through interagency collaboration
- Addressing the needs of diverse populations, especially early action and individualized approaches to victims' needs
- Establishing policies and programs within local school districts

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[*] Other state programs provide services to victims of violence and individuals; these include DHS Maternal, Child and Adolescent Health funded through the state Battered Women's Protection Act, and the Governor's Office of Emergency Services, funded by the federal Violence Against Women Act and the Victims of Crime Act.

Rape Prevention Program

Through an interagency agreement with the Governor's Office of Emergency Services, the Rape Prevention Program funds 84 rape crisis centers to conduct rape prevention activities. Most of the program funding comes from the CDC.

Rape crisis centers customize their programming to meet the needs of their particular community. The VPU facilitates their efforts by providing research resources and training centers on primary prevention methods. These include:

- Developing a social marketing campaign, in collaboration with the California Coalition Against Sexual Assault, to encourage non-violent social norms (the campaign includes billboards and bus placards with models from diverse racial and ethnic backgrounds, and young men's groups)
- Training communities on developing and implementing local social marketing campaigns

Each rape crisis center has a contract with the EPIC Branch Prevention Unit that requires a work plan, timeline and process evaluation. The work plans and goals *may* address targeted efforts for a community of color. The EPIC Branch monitors the contract. While systematic outcome evaluations are not currently conducted, EPIC organizes workshops to promote outcome evaluation, and trains staff in evaluation methods.

The CDC contract requires that basic data be collected. The EPIC Branch collects this data using the same racial categories as the U.S. Census. (The EPIC Branch plans to expand this data collection effort to include more racial categories.) Each rape crisis center has its own data collection system, but EPIC conducts some data analysis for comparison and benchmarking purposes.*

Domestic Violence Training and Education Fund

The Domestic Violence Training and Education Fund was established, and is maintained, with funds received from fees paid by batterers. The purpose of this Fund is to increase public awareness about domestic violence and to improve the quality of services to victims.

The EPIC Branch and VPU provide training and education programs for professionals and organizations that serve families at risk of violence. A current training program links domestic violence advocates with faith leaders, many from communities of color. This "train the trainers" program trains faith leaders, who then train other people in their faith communities about violence prevention. The program makes efforts to include

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* EPIC's goal is to provide state and local-level data analysis in the future. To date, efforts to implement a statewide system have met with strong local opposition due to the potential workload burden on center staff.

representatives from all faith denominations. It tracks the race and ethnicity of trained leaders and collects information about the faith communities that they serve.

Violence Prevention Unit, Department of Health Services, at
http://www.dhs.ca.gov/epic/about/violenceprevention.htm

DHS - TRAFFIC SAFETY PROGRAM[67]

Structure

Motor vehicle crashes remain a leading cause of death and disability for children. The Vehicle Occupant Safety Program (VOSP) is housed in the Epidemiology and Prevention for Injury Control (EPIC) Branch, Division of Chronic Disease and Injury Control, Prevention Services. It strives to prevent injuries and deaths to California children ages 0-6 years by developing and promoting child passenger safety programs (such as increasing the use of child safety seats).

VOSP is funded by the California Office of Traffic Safety. Funding for county health department programs come from vehicle code infractions (such as improper restraining children or leaving them alone in cars). These funds move directly from the state courts to county health departments. Some counties supplement this funding with grants.

Responsibilities

VOSP has developed a statewide child passenger safety infrastructure and network. Via this network, agencies across the state jointly advocate for stronger policies and legislation; work towards changing organizational practices of hospitals, law enforcement, child care, education, and other institutions; develop stronger local coalitions and networks; receive consistent, accurate, and up-to-date information; impart consistent messages and education; and are beginning to conduct evaluations and produce valid statewide data.

VOSP provides resources and technical assistance to local health departments and other community agencies. For example, EPIC's website outlines safe bicycling practices and other organizations partner with CalTrans on multiple projects, including allocations for the Bicycle Transportation Authority funding. The Branch previously administered the Safe Communities Program that helped communities identify specific traffic safety needs; aspects of this program are now folded into VOSP. VOSP works closely with local health departments, hospitals, community agencies, child care providers, law enforcement, municipal court systems, and other state and local agencies on child traffic safety issues.

County Car Seat Training Courses, targeted at underserved populations, provide all participants with car seats at free or reduced prices if they attend a two-hour class on Child Passenger Safety. Some counties also require class enrollment for child passenger safety offenders. VOSP is working to standardize the curriculum to promote consistency statewide. This curriculum is being designed with the input of the State Child Passenger Safety Task Force.

In an effort to further disseminate information about child passenger safety, VOSP facilitates a "train the trainer program." In this model, a bilingual certified child passenger safety technician trains community leaders about safety. These community leaders then pass the information on to members of their community in a variety of languages. Currently, CPS education is provided in Russian, Hmong, Laotian, Spanish, Vietnamese, Punjabi, Arabic and Serbo-Croatian. Pamphlets provided by the National Highway Traffic Safety Administration and other organizations are also available in these languages.

VOSP promotes child passenger safety through public outreach and education efforts that include:

- Educating judges and law enforcement officers about best practices, enforcement and penalty procedures, and identification of child safety seat law infractions.
- Publicizing, supporting and facilitating child passenger safety-certified technician trainings. This nationally certified four-day curriculum, developed by the National Highway Traffic Safety Administration, trains technicians to correctly install child safety seats, and provides them with the skills to teach parents and community leaders about child passenger safety. The training is available in both English and Spanish.
- Facilitating needs assessments for county programs. This involves identifying target populations and monitoring the number of car seats distributed, tallying the number of certified technicians, and identifying existing or desired county resources.
- Monitoring grant funding from the "Kids Plates Program:" 25 percent of funds from these specialty license plates support unintended child injury. This funding is distributed by the Center for Injury Prevention, Policy and Practices to programs targeting rural or other underserved populations.

VOSP acquires annual Department of Motor Vehicles conviction data and California Highway Patrol citation data and provides it to local programs for their program evaluation efforts.

Traffic Safety Program, Department of Health Services, at
http://www.dhs.ca.gov/epic/about/trafficsafety.htm

DHS - INJURY SURVEILLANCE AND EPIDEMIOLOGY SECTION[68]

Structure and Responsibilities

The Injury Surveillance and Epidemiology Section (ISES), is located within the Epidemiology and Prevention for Injury Control (EPIC) Branch, Division of Chronic Disease and Injury Control, Prevention Services. The Section conducts research on violence (intentional) and accidental injury prevention topics. This research provides information on injuries that occur within the state and is used to inform EPIC Branch program decisions.

Data Collection/Analysis

ISES produces short reports on firearms, intimate partner violence, drowning, pedestrian injuries, age-related injury and other trauma occurrences. These reports analyze data based on racial and ethnic categories. Report topics often result from requests or grant funding. Reports include:

- *Data Collection on Injury Occurrence* which lists assaults, bicycle accidents, child abuse, firearms, motor vehicle occupants, pedestrians, sexual violence, self inflicted injuries, and other topics. Information is disaggregated by racial category and divided between fatal and non-fatal injuries. Data is available – and can be customized – through a database on the EPIC website.[69]
- *Violence Against Women from 1992-1999*, an extensive study that looks at female-victim homicides, hospitalized nonfatal violent injuries to women, and self-reported victimization.[70] Data is analyzed using the following racial categories: non-Hispanic white; Hispanic; non-Hispanic black; and Asians or persons of all other races.

Data sources for the surveillance reports include the following:

- Department of Justice Homicide Datafile
- Department of Health Services death certificate data; *California Women's Health Survey*; and *California Health Interview Survey*
- Department of Social Services Child Welfare Services Case Management System
- Office of Statewide Health Planning and Development's hospital discharge database
- Uniform Crime Reports
- County Child Death Review Team Reports
- Child Abuse Central Index
- Statewide Integrated Traffic Records System (vehicle crashes)
- Behavioral Risk Factors Surveillance System

These data sources do not consistently collect demographic data; in addition, they collect information in isolation from each other. EPIC Branch researchers address this lack uniformity through complex data matching processes and through their work with the National Violent Death Reporting System (described below). For example, the surveillance team matches traffic accident reports with hospital records from the same time period. Incorporating both types of data provides a more holistic view of trauma occurrence and outcomes.

The EPIC Branch recently joined a CDC national project – the National Violent Death Reporting System – that focuses on data collection standardization across data sources. This project addresses existing information gaps in various data reporting systems (such as death certificates and homicide reports).

In addition, the EPIC Branch administers the Child Maltreatment Surveillance and Prevention Project. The process involves linking data between organizations, and expanding and revising the EPIC Fatal Child Abuse and Neglect Surveillance program. Data is collected on both intentional and unintentional child injuries.

Injury Surveillance and Epidemiology Section, Department of Health Services, at http://www.applications.dhs.ca.gov/epicdata/default.htm

PROGRAMS ADDRESSING INDIRECT HEALTH FACTORS

DEPARTMENT OF TRANSPORTATION (CALTRANS) - ENVIRONMENTAL JUSTICE PROGRAM[71]

Transportation planning policy and projects affect health outcomes for communities located adjacent to transportation facilities due to impacts on air quality, noise, neighborhood safety, and access to jobs and services. CalTrans addresses these potential impacts by involving communities early in the planning and project development process. The Environmental Analysis and Community Impact Assessment includes an analysis of health impacts and outcomes for transportation projects, primarily addressed as an environmental justice issue.

According to the *CalTrans' Desk Guide,*[72] the concept of environmental justice is defined as: *"...a public policy goal of promoting the fair treatment and meaningful involvement of all people in the decision-making for transportation. Satisfying this goal means ensuring that low-income and minority communities receive an equitable distribution of the benefits of transportation activities without suffering disproportionate adverse impacts."* Incorporating this concept within CalTrans requires a paradigm shift so that all staff view environmental justice and community-driven policy as an integral aspect of their mission.[73]

Structure

The Environmental Justice Program, housed in the Office of Policy Analysis and Research, Division of Transportation Planning, works to create a dialogue between transportation staff and low-income and minority communities. The goal is to improve the levels of trust and communication between these communities and governmental agencies by engaging communities in the planning process.

The Environmental Justice Program was established in 2000, and is funded by federal and state funds. The President's Executive Order 12898 (1994) guides its programmatic actions (see box on following page). The Program identifies opportunities to incorporate environmental justice concepts in the transportation planning process, and provides information to local and county planning agencies about these opportunities.

Responsibilities

The Environmental Justice Program involves community members throughout the State Transportation Improvement Plan planning process. This is the annual "master plan" that brings together the transportation priorities of each region and the state. The plan directs funding to local areas using funds from gas taxes. (Regions often supplement this funding with their own tax revenues.)

LAWS & REGULATIONS RELATED TO ENVIRONMENTAL JUSTICE

- *Title VI of the 1964 Civil Rights Act* prohibits discrimination based on race, ethnicity or national origin. The U.S. Department of Transportation has implemented regulations in compliance with this law that are specific to transportation policy.
- *Presidential Executive Order 12898* (1994) expands Title VI to include all low-income populations. Federal agencies have been instructed to develop strategies, including the following:
    - Identify activities that should be revised to promote enforcement of all health and environmental statutes in areas with minority and low-income populations
    - Improve public participation by minority and low-income populations
    - Improve data collection and research related to the health and environment of minority and low-income populations
    - Identify differential consumption patterns of natural resources by minority and low-income populations
- The *National Environmental Policy Act* (NEPA) requires that agencies evaluate the environmental impacts of major actions and projects. This evaluation occurs through Environmental Impact Assessments. (There is proposed federal legislation to integrate Environmental Justice in the NEPA analysis.)

The Program educates regions about incorporating Title VI and environmental justice practices into their transportation planning processes and policies. It provides guidance to local and regional planners on how to establish Citizen Advisory Committees in order to receive regular input from a diversity of stakeholders.

Involving diverse communities early in the planning process ensures that they can be informed stakeholders in the process and increases the likelihood that any plan reflects their needs and concerns. The Environmental Justice Program, however, has found that many low-income and minority community members are distrustful of government decision-making processes and are hesitant to participate. As a result, it uses planning grants and workshops to promote confidence in the transportation planning process. It is also planning to produce a *Citizen's Primer on Environmental Justice and Planning* to help community members understand and participate in the process.

Within CalTrans, the Environmental Justice Program promotes environmental justice as an integral part of good transportation planning policy. The Program participates in the department's Planners Academy and informs staff about environmental justice issues. It created the *Desk Guide to Environmental Justice in Transportation Planning and Investments* to provide a context and guidance about implementing community-based and environmental justice-driven policy, and is currently working on developing a funding source for training.

In addition, the Environmental Justice Program annually funds ten to fifteen local projects/programs that focus on issues such as health access, affordable housing, and environmental conditions. The Program is especially interested in targeting projects directed at Native American and farm worker communities as it has identified a significant need to overcome the distrust and improve the quality of life for these under-served communities.

Data Collection/Analysis

The Environmental Justice Program collects data on geographic areas with high low-income, minority and Tribal populations in order to provide a basis for evaluating potential impacts of transportation projects and infrastructure. This information is distributed statewide and used when assessing the need of various communities during grant application selection. Regions also use the data to assess the specific needs and trends within their areas.

The Program does not collect data on specific regions because transportation localities are statutorily independent. However, the *Desk Guide* provides information about Environmental Justice performance measures that can be used at the regional level.

Collaboration

The Environmental Justice Program collaborates with other states and participates in the Federal Highway Peer Exchange Program to exchange ideas, resources, and best practices on environmental justice, and to develop a common approach to the issues.

Environmental Justice Program, Department of Transportation, at http://www.dot.ca.gov/hq/tpp/offices/opar/titleVIand_EJ.htm.

CALTRANS - CULTURAL AND COMMUNITY STUDIES OFFICE[74]

Structure

The Cultural and Community Studies Office, housed in the Division of Environmental Analysis, provides guidance and oversight for Community Impact Assessments that are prepared for CalTrans projects. Community Impact Assessments are completed as part of the Environmental Impact Statements mandated by the National Environmental Policy Act for all major infrastructure construction projects.

Responsibilities

The state office reviews the Community Impact Assessments prepared by the district offices. The district office is responsible for implementing the Community Impact Assessment process. CalTrans district staff and their consultants assess whether and how impacts of a project disproportionately affect low-income populations and communities of color; they also assess the positive impacts of the project. Staff complete their research on impacts in a variety of ways, including:

- Public involvement
- Quantitative data collection
- Qualitative data collection
- Consideration of how a neighborhood has been damaged by past projects
- Comparison between the demographic make-up of a community and the demographic characteristics of those who are negatively impacted by a project

If the assessment report findings indicate that there may be significant disproportionate negative impacts on specific members of the community, district office staff must consider ways to revise the project to avoid or minimize such negative impacts or incorporate new aspects within the project that create mitigating for the benefits to those communities to mitigate existing negative impacts.

In 1997, CalTrans became the first state Department of Transportation to develop a handbook for its planners to describe the Community Impact Assessment process. This handbook is available to the public on the CalTrans' website.

Cultural and Community Studies Office, Department of Transportation, at http://www.dot.ca.gov/hq/env/.

NUTRITION AND PHYSICAL ACTIVITY PROGRAMS

DHS - CANCER PREVENTION AND NUTRITION SECTION[75]

Structure

The Cancer Prevention and Nutrition Section (CPNS) is part of the Cancer Branch (Division of Chronic Disease and Injury Control, Prevention Services). Its mission is to reduce cancer deaths in California caused by poor diet, physical inactivity and excess sun exposure, and to help reduce the incidences and costs of other diseases related to diet and physical inactivity (such as obesity, diabetes, and hypertension). The Section leads large-scale public/private social marketing campaigns, conducts regular surveys of adults, teens and children, and oversees various research projects.

CPNS addresses both individual behavior and general social influences affecting nutrition and physical activity. CPNS activities are funded by the United States Department of Agriculture Food Stamp Nutrition Education (through a local/federal funds matching program) and the CDC Block Grant.

Responsibilities

CPNS provides grants to and oversees local programs that focus primarily on low-income neighborhoods and schools, specifically targeting households eligible for the Food Stamp Program. The Section oversees approximately 160 local contractors who implement programs to achieve the following objectives: increase fruit and vegetable intake to recommended levels, increase physical activity to at least 30 minutes per day for adults and 60 minutes per day for children, and promote use of the federal Food Stamp Program and other federal nutrition assistance programs.

The CPNS-developed "5 a Day" health awareness program:

- Works with state and community-based partners to facilitate local Food Stamp nutrition education efforts
- Conducts social marketing media campaigns, including radio/television spots and outdoor advertisements
- Produces retail marketing products such as a recipe book and a CD-rom with advertisements and health tips
- Promotes program objectives at local festivals and farmers markets
- Works with faith leaders and targets specific racial and ethnic populations (such as African-American and Latino) in culturally appropriate ways. Latino 5 a Day materials are available in both English and Spanish. CPNS is currently designing an Asian-Pacific Islander program.

Data Collection/Analysis

The Section conducts formative research[*] when planning programs and media campaigns. For example, the African-American 5 a Day Program conducted festival and church congregation surveys of African-Americans statewide, as well as interviews with pastors, program coordinators and other community leaders. The Program gathered information on fruit and vegetable intake and beliefs, food shopping, physical activity behaviors and beliefs, and preferences for material format, festivals and media outlets. Similar research planned for other campaigns will include focus groups for low-income Latino, Chinese, Vietnamese, and Hmong Californians.

Local contractors submit semi-annual Activity Reports to the state CPNS. The Section analyzes and submits these reports to both federal funders and regional lead agencies. The Activity Reports track program activities and document the amount of exposure that materials specifically designed for target populations receive. However, the reports do not track the racial and ethnic backgrounds of all people exposed to campaign materials. As a result, the Section does not know how many of these people are from communities of color.

In addition, CPNS contractors receiving a specific amount of funds (at least $350,000) conduct outcome evaluations using research methods validated by CPNS. These evaluations look at program participant behavior and/or behavioral determinants of fruit and vegetable consumption. The Section annually produces a composite report of all contractor evaluations for internal evaluation use.

CPNS performs an outcome evaluation on new state programs and campaigns. The Section develops and conducts internal surveys, and uses contractors to evaluate its campaign methodologies, better understand the nutrition and physical activity needs of Californians, and guide program development.

- *California Dietary Practice Survey (CDPS)* collects information on CPNS program exposure as well as nutrition and physical activities, behaviors, and beliefs. The survey uses 1,000 telephone interviews with adults randomly drawn from an all-California listing. This sample is augmented by up to 700 additional low-income African-American, Latino, and other participants.
- *California Teen Eating, Exercise, and Nutrition Survey (CalTeens)* provides general surveillance data on teenage nutrition and physical activity. Data comes from 1,200 telephone interviews with teenagers, drawn from an all-California listing. In 2006, the sample may be limited to Food Stamp recipients.
- *California Children's Healthy Eating and Exercise Practices Survey (CalCHEEPS)* provides both surveillance and CPNS program exposure data. This survey measures behavior through two-day food and physical activity diaries completed by 700-800 children with the help of their parents. Follow-up

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[*] Formative research looks at the community in which a program is created in order to understand the interests, attributes and needs of different populations and individuals in that community.

telephone interviews with the child alone ask about knowledge, attitudes and beliefs. A market research panel aids CPNS in identifying households with children ages 9-11. The parental demographics of the subjects are matched to California population demographics as closely as possible.

- *Communication Benchmark Survey* collects information that is highly program specific. Staff poll 3,000 adults and 400 children about their exposure to CPNS programs as well as their knowledge, attitudes and beliefs. The survey gauges CPNS communications reach and program accessibility and effectiveness.

The *CDPS*, *CalTEENS*, and *CalCHEEPS* are all revised and administered bi-annually. Approximately ten percent of the *CDPS* and *CalTEENS* surveys are conducted in Spanish; the *CalCHEEPS* survey is only conducted in English. All surveys collect demographic data on race and ethnicity using "Hispanic," "African-American," "White," and "Asian/Other" as the categories. Bivariate analyses of dietary and physical activity behavioral factors are correlated with independent variables such as: race/ethnicity, gender, age, age by gender (adults), income, education (adults), overweight status, Food Stamp Program participation, smoking status (teens), and physical activity status. In some years, *CDPS* and *CalTEENS* subjects are asked questions on acculturation.

The surveys also allow the program to analyze data on people exposed to the CPNS campaigns compared to those who are not exposed. Survey results and data analysis are used internally and some analysis is available on the CPNS website. There are no formalized database linkages with other DHS programs.

CPNS also uses external data sources for its analysis, including the *Behavioral Risk Factor Survey, California Health Interview Survey, California Women's Health Survey*, and the Department of Educations' DataQuest System. The Section participates in user and planning groups for the DHS surveys.

Cancer Prevention and Nutrition Section, Department of Health Services, at http://www.dhs.ca.gov/ps/cdic/cpns/

DHS - CALIFORNIA CENTER FOR PHYSICAL ACTIVITY[76]

Structure

The California Center for Physical Activity (CCPA), in the Epidemiology and Health Promotion Section of the Chronic Disease Control Branch (Division of Chronic Disease and Injury Control, Prevention Services) promotes physical activity in order to decrease the prevalence of many chronic diseases. The Center focuses on advocating good community design as a necessary environmental factor for physical activity. A CDC block grant, administered by the University of California San Francisco's Institute for Health, funds the Center's activities.

Responsibilities

The Center connects local communities with training resources. Training sessions are designed for local stakeholders, including land use planners, transportation administrators, and public health professionals. Sessions are entitled: Safe Walk to School; Safe Walk to Transit; Safe Walk for Seniors; and Safe Walk to Healthy Food. In addition, CCPA:

- Tracks workshop success through evaluation summaries from trainers and attendees
- Collects demographic information about the communities that request trainings, including location, socio-economic status, and race/ethnicity – many of these communities are low income, rural, or located in unincorporated areas
- Provides "Walk to School Checklists" – available in 11 languages – for community leaders to assess the next steps for their community
- Educates communities on "HomeZone" that alters traffic patterns to make neighborhoods safer for playing children
- Advocates for health impact assessments to be conducted at the same time that environmental impact assessments are conducted on new infrastructure projects
- Partners with the Governor's Council on Physical Fitness for local walk to school efforts

CCPA designed the *Health Transportation Network*, the first of its kind funded by CalTrans. It provides resources for local community officials on designing walk- and bike-friendly communities. The Center works with various design experts to provide resources that include California-specific case studies, a searchable database of built environment resources, and technical assistance for local officials.

The *California Walk to School Headquarters Project* works with school districts and coordinates "Safe Routes for Kids" trainings. It promotes walking to school throughout the year (instead of focusing on a specific awareness week or month) and advocates safe walks to churches, libraries and other community buildings. The project subcontracts with evaluators who are currently producing a qualitative case study report.

The Center also funds instructor trainings and awareness programs about walking as a great exercise for the elderly. Task forces throughout the state implement community-based physical activity programs for individuals over age 50.

Collaboration

CCPA collaborates with other DHS programs: the California Diabetes Program, the California Obesity Prevention Initiative, California Project LEAN, and the Injury Control Branch.

California Center for Physical Activity, Department of Health Services, at http://www.caphysicalactivity.org/

DHS - CALIFORNIA OBESITY PREVENTION INITIATIVE[77]

Structure

The California Obesity Prevention Initiative (COPI) is located in the Epidemiology and Health Promotion Section of the Chronic Disease Control Branch (Division of Chronic Disease and Injury Control, Prevention Services). This Initiative focuses on reducing the prevalence of obesity and its associated health risks in Californians. It promotes physical activity and healthy eating, and addresses the societal, technological, and environmental influences on obesity. COPI was created in 2000, through a CDC Block Grant targeted to create state infrastructure for obesity prevention, and it continues to receive a small amount of funding from the CDC.

Responsibilities

COPI led DHS efforts to craft a Strategic Plan addressing the challenge of obesity. Several stakeholder groups were included in the planning process, including the COPI Advisory Group – over 90 obesity prevention experts from local government and community-based advocacy organizations – and the DHS COPI State Planning Group, whose members worked within DHS nutrition, physical activity and obesity prevention programs. In addition to key informant interviews, ten community meetings were held with African-American and Latino leaders and residents to better address the disproportionately high rates of obesity in these two groups.

The Strategic Plan recommends a variety of approaches to preventing obesity:[78]

- Improving access to healthy foods, particularly in low-income communities
- Increasing access to physical activity options
- Improving access to culturally and linguistically appropriate nutritional and physical activity information
- Developing community-based prevention strategies

- Implementing research projects and surveillance systems
- Improving implementation of obesity prevention programs, specifically in regards to culturally and linguistically appropriate care

The Plan addresses racial and ethnic health disparities. Based on recommendations from the community meetings, the plan incorporates health disparities issues and includes an addendum report specifically addressing the needs of African American and Latino communities. This report includes detailed information on the following topics:

- Descriptive information about community meeting participants
- Perceptions of obesity
- Contributing factors to obesity
- Barriers and potential barriers to preventing obesity
- Suggested interventions and activities
- Potential partnerships/collaborations

COPI designed a four-part activity module and tool kit to assist after-school programs and youth-serving organizations to reduce excessive use of television, video games and computers among youth age 10-14 years. The tool kit was designed using key informant interviews, focus groups and national data sources. Some focus groups were targeted at Latino populations. The tool kit includes guidance for program administrators, information sheets for youth, and letters for parents. A staff feedback form provides COPI with information to evaluate the program's effectiveness. However, the form does not identify any racial or ethnic information about the populations served.[79] COPI is currently pursuing funding to translate the tool kit into Spanish.

Other COPI activities include:

- Providing resources and technical assistance on obesity issues for other DHS programs
- Serving as co-convener and planning member of the bi-annual Child Obesity Conferences; conference sessions discuss racial and ethnic health disparities and cultural competency
- Creating the California Obesity Surveillance Review with help from the DHS State Planning Group

Obesity Prevention Initiative, Department of Health Services, at http://www.dhs.ca.gov/ps/cdic/copi/default.htm

DHS – CALIFORNIA PROJECT LEAN[80]

Structure

California Project LEAN (Leaders Encouraging Activity and Nutrition) is a joint program of the DHS and the Public Health Institute, an independent, nonprofit organization that promotes health, wellbeing, and quality of life. California Project LEAN (CPL) is organizationally located in the Epidemiology and Health Promotion Section in the Chronic Disease and Control Branch (Division of Chronic Disease and Injury Control, Prevention Services). The Project's mission is to increase healthy eating and physical activity to reduce the prevalence of obesity and chronic diseases (such as heart disease, cancer, stroke, osteoporosis and diabetes).[81]

CPL administers programs implemented in ten regions throughout the state. Regional coordinators are housed within county health departments, universities, or community-based organizations. Activities focus on prevention through policy and environmental change strategies, consumer education, research, and social marketing campaigns. Specific programs vary depending on available grant funds.

CPL receives grant funds from the California Endowment, The California Wellness Foundation, California Department of Justice, Vitamin Case Consumer Settlement Fund, the California Nutrition Network, and the CDC Block Grant.

Responsibilities

CPL staff and contractors undertake a variety of research to frame and plan programs. Research methods include key informant interviews, focus groups, surveys, and pilot studies. The project administers three major programs.

Food on the Run

Food on the Run, one of the three major CPL programs, targets adolescents working to influence high school physical activity and nutrition policies. The program works with parents, teens, community members and school decision-makers to advocate for and develop these policies. Current and/or previous components of the program include:

- A social marketing approach – targeting low-income teenagers – to promote individual behavior change
- Youth leadership in advocacy efforts for school policy change
- On-going training and technical assistance to schools and communities interested in improving youth access to healthy foods and beverages
- Creation and administration of school surveys including the *Fast Food School Survey*, soda contract surveys, and an assessment of food and beverage marketing practices

In 2004, CPL worked with 40 school districts that implemented healthy food and/or physical activity policies. It produced various education materials for parents, students, and community members; much of this material is available in Spanish as well as English.

Successful Students Through Healthy Food Policies

In partnership with the California School Board Association, CPL initiated a campaign targeting school board members to increase their awareness and promote discussion about healthy eating. This project focused on school boards because they have the capacity to enact policies leading to widespread change within school districts. The program conducted special outreach efforts to attract and engage board members representing low-income communities (including low-income communities of color), ~~especially Hispanic communities.~~

Pre- and post-surveys were conducted with a sampling of California school board members for evaluation purposes. The program also collected school policies and monitored changes around physical activity and nutrition by school boards who had participated in the program. Project LEAN state and local staff members continue efforts to influence school board members to enact healthier food and physical activity policies.

Huesos Fuertes, Familia Saludable (Strong Bones, Healthy Family)

The third CPL program, *Huesos Fuertes, Familia Saludable*, is targeted at Latina mothers and their children, and promotes increased consumption of high calcium foods. The program is currently funded in three communities, but was more widespread in previous funding cycles. Elements of the program include:

- Training Latina community workers (promotoras) to lead educational efforts
- Spanish-language television and radio campaigns
- Grocery store taste-tests of calcium rich, culturally-traditional drinks
- Outreach through festivals and community events
- Educational brochures in Spanish and English

Class surveys are used to gauge the program's success. The surveys have shown an increase in low-fat milk consumption.

Collaboration

CPL collaborates with the California Diabetes Program, California Obesity Prevention Initiative, School Health Connections, and the California Center for Physical Activity. It also works closely with other DHS programs, the California Department of Education, and with various physical activity and nutrition organizations outside of state government.

California Project LEAN, Department of Health Services, at
http://www.californiaprojectlean.org

CDE - Nutrition, Physical Education and Healthy Lifestyles[82]

Several Department of Education programs and policy efforts address factors leading to healthy outcomes, including nutrition, health education, obesity-prevention and coordinated health approaches.

The topics of health, nutrition and physical activity have received substantial attention in the Department recently. A 2005 white paper released by the Superintendent's Office – *Healthy Children Ready to Learn* – addresses these topics.[83] It incorporates recommendations from the Superintendent's Task Force on Childhood Obesity, Type 2 Diabetes, and Cardiovascular Disease,[84] and seeks to create a more health-friendly environment in schools, support high-quality instructional programs in health education and physical education, and implement nutrition standards for all food and beverages sold on campus. The paper makes no direct mention of racial or ethnic health disparities; however, it does address socio-economic factors that impact nutrition through its focus on school meal programs.

Nutrition Services Program[85]

The CDE Nutrition Services Program administers federally-funded meal programs to address the nutritional needs of income-eligible children. Ninety percent of school nutrition expenses are funded through the United State Department of Agriculture (USDA). The Program distributes these funds to school districts or service providers at the local level and administers a range of local programs.

Program eligibility is based on family income, enrollment in other income eligible programs (such as Food Stamps), or certification that children live in low-income geographic areas.

There are three types of meal programs. School Nutrition Programs, found in public and non-profit private schools as well as residential childcare agencies (like group homes and correctional facilities), may participate in the free and reduced meal program. These schools have the option of providing breakfast, lunch and/or an after-school snack to eligible students. The Child and Adult Care Food Program provides reimbursement for childcare centers, school programs outside regular hours, daycare home programs, adult day care programs, emergency shelters, and "at risk" snack programs in community centers. In addition, the Summer Service Program provides free meals to children in low-income neighborhoods during school vacations.

The Nutrition Services Program also coordinates the Food Distribution Program that provides school meal programs with ingredients purchased by the USDA from U.S. farmers. In addition, it provides training on ways for providers to meet the cultural needs of a community while also stressing the importance of providing a wide variety of foods for children. However there are no requirements for programs to provide culturally-specific meals, except in cases of religious prescription.

Programs participating in Nutrition Services Programs must follow specific requirements. Program meal menus must be based on USDA federal nutrition guidelines and the USDA food pyramid. California has additional requirements for food nutrition. Some of these restrictions come from the Department of Health Services (DHS) SHAPE CA Project that promotes healthy nutritional environments.[86] New dietary restrictions for school meals are also the focus of current legislative action.

New federal requirements state that all participating districts must have a wellness policy in order to receiving federal meal funds. These policies must promote nutrition, physical activity, and healthy school environments.

~~The Nutrition Services Program limits data collection to protect the anonymity of~~ participating students. The USDA requires that programs receiving meal program funds collect racial and ethnic data on program participants. The Program monitors this data at the local level every three years to ensure that the distribution of services to participants reflects the racial and ethnic makeup of the communities where the program exists.

School Health Connections[87]

School Health Connections takes advantage of the pivotal role schools can play in reaching children and families, by combining health education, health promotion and disease prevention, and access to health-related services in an integrated and systematic manner. The goals and principles of school health are articulated and developed through the Coordinated School Health Work Group, a collaboration between CDE and DHS.

The School Health Connections Office provides resources and technical assistance to school districts on achieving their school health goals, and links the school districts with their public health departments. The Office is funded through a four-year grant from the CDC to implement a coordinated school health model through state education and health agencies. This model involves eight components:

1) Health Education
2) Physical Education
3) Parent/Community Involvement
4) Nutrition Services
5) Health Services
6) Psychological and Counseling Services
7) Safe and Healthy School Environment

There is no funding allocated for program evaluation/data collection. The Nutrition Services Program conducts a limited process evaluation designed by the CDC.

Previously, 17 teams from throughout the state, comprised of school health coordinators, school administrators and public health/community health leaders, developed joint plans to address school health issues in their school or district. Current efforts are more concentrated; they focus on the Los Angeles, San Diego and Orange school districts and their partners.

Building Infrastructure for Coordinated School Health

The report, *Building Infrastructure for Coordinated School Health: California's Blueprint*, identifies six goals and multiple action steps to expand school health in California. The Blueprint reflects input from a diverse group of stakeholders, including a statewide planning body of over 70 individuals.

The *Blueprint* was based on research from the School Health Needs Assessment. The needs assessment consisted of key informant interviews, community focus groups, and written surveys from local health departments and county offices of education. Its goals include:

- Increased collaboration between state agencies, businesses and community organizations
- Resources to support coordinated school health for California's diverse populations[88]
- Personnel capacity in schools to address the needs of a diverse student body

Physical Education[89]

The State Board of Education recently adopted standards that specify what students need to know and should be able to do at each grade level in physical education. These content standards are intended to assist schools in establishing specific learning goals and objectives for physical education. Federal and state mandates related to physical education instruction in local school districts are monitored. Schools that are out of compliance are required to submit a plan outlining the steps they intend to take to meet legal requirements.

The Physical Education Fitnessgram is a battery of tests that assesses student fitness in six physical activity areas. A guide explaining the test is available for parents in both English and Spanish.[90] This test is conducted during grades 5, 7, and 9 by teaching faculty. Information on student performance is collected and submitted to the CDE contracting agency, Education Data System (EDS). EDS then submits results to CDE that provide information at the state, county, district, and school level. The information includes breakdowns of achievement by racial and ethnic categories. The CDE Standards and Assessment Division produces a report for the Governor and Legislature and makes the results available to the public.[91]

Health Education

Recent legislation, AB 689 (Chapter 645, 2005), requires that the State Board of Education adopt content standards for health education based on recommendations from the State Superintendent of Public Instruction by March 2008. However, this requirement is contingent upon sufficient funds being made available.

Health Services and School Nursing

A CDE staff member provides resources and training. Currently none of these training sessions are focused on cultural competence and no funding exists for that express purpose. There are no state mandates regarding health and nursing services.

Workgroup for Interagency School Health

The Workgroup for Interagency School Health (WISH) is a resource roundtable for staff from state agencies that are interested in school health issues. The workgroup hosts a listserv and semi-monthly meetings. Each meeting focuses on a different topic, such as parent involvement. This group provides a venue for linking knowledge and resources from various departments and programs.

California Healthy Kids Survey

The *California Healthy Kids Survey* assesses health behaviors for students in grades 5-12. This *Survey* is designed to meet federal "No Child Left Behind" assessment standards; results are reported at the individual school and district levels. The *Survey* is given in a written, anonymous format with questions on drug use, violence, crime, and physical and mental health. Schools may choose to ask questions about additional topics such as sexual behavior, but participation in the optional components is not widespread.

Versions of the *Survey* exist in both English and Spanish. Students are asked to self-identify as "American Indian or Alaska Native;" White or Caucasian;" "Hispanic or Latino;" "Black or African American;" or "other." Students who identify themselves as "Latino or Hispanic" may further identify with one of six subcategories. Students who identify as either "Asian or Pacific Islander" may further identify with one of ten subcategories.[92] Reports based on the *California Healthy Kids Survey* provide a general respondent breakdown by race and ethnicity, but do not code answers to specific questions by race or ethnicity.[93] For example, there is no information about the percentage of students who self-identified as Asian, and who also said that they ate five servings of fruits or vegetables daily.

Survey data is available for school and district administrators and is available via website for authorized administrators, but is not available to the public. Districts may make these reports available to the public. Comparison data between schools and districts is also available to authorized administrators.

California Student Survey[94]

The *California Student Survey* provides longitudinal statewide data about student risk and health behaviors. The Attorney General's Office publishes the *Survey* with additional funding from the CDE and the Department of Alcohol and Drug Programs. The *California Student Survey* has recently been coordinated with the *California Healthy Kids Survey* in order to make both instruments more valuable (the *California Student Survey* now functions as a statewide version of the local *California Healthy Kids Survey*). The Survey is administered in either English or Spanish. Self-reported racial and ethnic demographic questions are the same as those asked in the *California Healthy Kids Survey*.

In the *9th Biennial California Student Survey 2001-2002 Major Findings Report on Alcohol and Other Drug Use*, racial and ethnic demographic data was used to ensure a representative sample of the California population. However, analysis of student activity was not disaggregated by race or ethnicity.[95]

Nutrition, Physical Education and Healthy Lifestyles, Department of Health Services, at http://www.cde.ca.gov/

TOBACCO AND SUBSTANCE ABUSE

DHS - TOBACCO CONTROL SECTION[96]

Structure

The Tobacco Control Section (TCS) is located in the Cancer Control Branch (Division of Chronic Disease and Injury Control, Prevention Services). Its mission is to improve the health of all Californians by reducing illness and premature death attributable to the use of tobacco products.

TCS receives the majority of its funding from Proposition 99 funds.* It receives a small amount of federal funding from a CDC grant, and from a Substance Abuse Prevention Block Grant that funds the Stop Tobacco Access to Kids Enforcement Act, a federal and state effort directed at combating tobacco sales to underage youth.

Responsibilities

An Oversight Committee, appointed by the Governor and Legislature, administers the program and produces a Master Tobacco Control Plan for California every three years.

TCS focuses its efforts on four priorities:

1. Reduce exposure to environmental tobacco smoke and tolerance to exposure
2. Counter pro-tobacco influences
3. Reduce availability of tobacco from retail and social sources
4. Provide cessation services

The Section administers a competitive local grant program for community-based projects that focus on interventions to address tobacco control planning and intervention efforts. Non-profit agencies that have been funded include community-based organizations, health clinics, ethnic organizations, alcohol and drug centers, labor organizations, youth organizations, and universities.

Twenty-five projects are currently funded. A number of these projects focus their efforts within racial/ethnic communities (such as American Indian, Asian, etc.). In addition, 21 "Priority Population Grants" target specific populations – communities of color; the Lesbian, Gay, Bisexual, and Transgender communities; and low-income communities.

Grantees participate in two phases. In the first phase, the grantee conducts a needs assessment and develops a program plan. A manual provided by TCS explains the needs assessment process in detail, with special focus on targeting programs to population-

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* The DHS Tobacco Control Section receives two thirds of the Proposition 99 funding; the CDE Tobacco Use Prevention Program receives the remaining third.

specific needs. In phase two, the grantee implements the program in conjunction with TCS. The Section provides intensive technical assistance throughout the process.

Local health jurisdictions receive Proposition 99 funding based on a legislatively-mandated formula that takes into account population size and the percentage of indigent residents. They must incorporate community input and design programs around the four tobacco control priorities. Within these parameters, local health jurisdictions may adapt programming to the specific needs of their population.

TCS also funds seven Priority Population Partnerships Projects, each addressing a different targeted community: African American/African Immigrant; Native American/Alaska Native; Asian/Pacific Islander; Hispanic/Latino; Lesbian, Gay, Bi-Sexual, Transgender; and low-income communities. The partnerships include both a paid staff and an advisory committee. These programs provide the following population-specific services:

- Create and conduct advocacy campaigns to change community norms, and train others to implement and replicate successful advocacy campaigns
- Act as spokespersons at press conferences and participating in media interviews, and provide advice and feedback to TCS regarding media.
- Conduct research
- Provide technical assistance and training on how to successfully work with priority populations on tobacco control efforts

TCS conducts paid advertising and public relations smoking-cessation campaigns through various types of media: billboards, radio, television, and posters. Media campaigns are primarily conducted in English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese. In addition, material may be provided in Laotian, Cambodian, Hmong, and Japanese.

TCS has two physical library collections, one primarily for staff and the other a lending library and reference service for TCS-funded projects. The library collection is cataloged in an online library database. The information clearinghouse answers reference questions; houses information on educational curriculums, case studies, program models and other resources; catalogues program evaluations and statewide evaluation data; and facilitates using the CSTATS database system – a one-stop data source for smoking information. The clearinghouse also created and updates a secondhand smoke website providing research and assessment information.

In addition, TCS operates the following projects:

- *The Technical Assistance Legal Center* provides assistance to funded community organizations and city governments about tobacco-related policies and legal issues.
- *The Policy and Community Organization Center,* staffed with community organizers, aids coalitions with community organizing work, resource analysis, stakeholder analysis, and public relations efforts.

- *Smoke-Free California: Where We Live, Work and Play* is a statewide public awareness campaign and web-based resource center that focuses on decreasing exposure to secondhand smoke.
- *The California Youth Advocacy Network* mobilizes high school age youth and young adults to become involved in tobacco control policy and program choices.
- *STAKE Act Program* is a federal program, jointly administered by TCS and the DHS Food and Drug Branch, that targets underage tobacco sales. TCS conducts an annual statewide youth tobacco purchase survey and recruits youth for retail enforcement operations conducted by the Food and Drug Branch.

TCS also operates the Tobacco Quitline. This telephone helpline provides smoking cessation counseling, self-help materials, and referrals to local classes. Tobacco Cessation counseling is provided in English, Spanish, Korean, Cantonese, and Mandarin. Services are also available for the hearing impaired. A critical mass of callers is necessary to support full time employment of bilingual staff members to staff the Quitline. Smoking cessation services in other languages (such as Russian and Vietnamese) are conducted through locally funded TCS projects.

Data Collection/Analysis

TCS requires that programs use at least ten percent of their funding for annual program evaluations. It provides instruction regarding methods and types of data collection to use for measuring outcomes. The evaluation includes demographic information about the populations served in each program. In addition, local health jurisdictions conduct general evaluations and select one or two priorities for which to conduct additional intensive evaluation.

Tobacco usage trends throughout the State are also monitored. This information is used for program development, as well as assessing the effectiveness of large social marketing campaigns. TCS enters into agreements and contracts with universities, research groups, and other DHS units to produce the following surveys and studies:

- *California Tobacco Survey (CTS)* – The University of California, San Diego conducts this tobacco survey every three years. The sample size is large enough that information on tobacco use, knowledge, attitudes, and behavior can be disaggregated by racial sub-categories in addition to the five major demographic categories.
- *California Adult Tobacco Survey (CATS)* and *Behavioral Risk Factor Survey (BRFS)* – The DHS Cancer Surveillance Section conducts these surveys. Data are collected monthly and aggregated annually to provide longitudinal resource data on tobacco use trends. The aggregated *CATS/BRFS* survey illustrates general smoking trends by large racial categories. However, it does not address specific tobacco use prevalence rates by race because sample sizes are too small for some racial/ethnic groups.

- *Special Studies Survey* – In 2003, TCS contracted for five special population studies funded with a one-time appropriation from the Master Settlement Agreement between the State of California and several cigarette companies. These targeted surveys provided statewide tobacco use information about the following populations: Asian Indians; Chinese; Korean; Lesbian, Gay, Bisexual, and Transgender; and active duty military stationed in California. The Asian studies were conducted in multiple languages among first- and second-generation groups and assessed issues of acculturation. For example, the Chinese study allows participants to choose from five different Chinese dialects when identifying their primary language.
- *Special Research Studies* – The evaluation program also conducts non survey-based research projects on specific topics. The program is currently addressing smoking-related cancers within various ethnic communities.

Tobacco Control Section, Department of Health Services, at
http://www.dhs.ca.gov/tobacco/

CDE - SAFE AND HEALTHY KIDS PROGRAM OFFICE[97]

Structure

The Safe and Healthy Kids Program Office (SHKPO) provides leadership to school districts throughout the state and manages the funding sources for programs that support violence prevention in schools, and prevent illegal alcohol, tobacco, and drug use among students. The Office also works with local education agencies to involve parents and communities in the effort to create positive learning environments that support academic achievement.

Local education agencies receive Proposition 99 Tobacco Use Prevention Enforcement entitlement funding through the Consolidated Application for Categorical Aid Programs, a reporting and funding application tool that collects a variety of information on schools such as student eligibility for school lunch and racial/ethnic student demographics. All data is collected at the school level; it is not collected for individual students. All local education agencies and schools that receive this funding must complete an annual report of their activities and expenditures. The Safe and Healthy Kids Annual Reporting Form is designed to elicit information related to these programs and other services that address alcohol, tobacco, other drugs, and violence. The results are made available in a statewide summary report, county summary report, and individual reports for each local education agency.

SHKPO also administers the funding and oversees reporting requirements for the federal Title IV No Child Left Behind and Safe and Drug Free School Community Funds delivered through the Consolidated Application process. These funds support local efforts against substance abuse and violence in schools.

Local education agencies receiving funds through the grant and entitlement processes must annually produce two reports as a condition of funding: *Safe and Healthy Kids Annual Report* and the *California Healthy Kids Survey.*

Data Collection/Analysis

SHKPO does not collect or analyze data on race and ethnicity for use in developing violence and drug abuse prevention programs. Instead, data is categorized using truancy rates, and the frequency, seriousness, and incidence of violence and drug-related offenses resulting in suspensions and expulsions. Using the *California Healthy Kids Survey*, students self-report local health risks, assets, and behaviors. The survey assists districts, counties and SHKPO staff in identifying areas of strength and weakness, and trends based upon social indicators.

The Office is responsible for the *California Healthy Kids Survey.* Information on substance abuse and violence gathered from the survey is not analyzed by race or ethnicity.

SHKPO provides technical assistance regarding prevention curricula. Curricula on the approved list are available in Spanish. The Office is also responsible for data collection and reporting. The Uniform Management and Information Reporting System is federally required to track truancy, expulsion, and school safety indicators for each school. SHKPO also collects data that tracks expulsion records resulting from gun-related infractions, as mandated by the Gun Free Schools Act.

Neither database records individual student data, so racial and ethnic data is not collected. However, the statewide data collection system may be revised in the future from a system based upon district or county statistics to one based upon individual students' information.

Safe and Healthy Kids Program Office, Department of Education, at
http://www.cde.ca.gov/fg/aa/co/capcontacts.asp

CONCLUSION

State programs play an integral role in addressing racial and ethnic health disparities in California. Some programs focus on specific client populations or target health disparities as part of their mission. Others engage in more broad-based educational efforts to change social norms. While health-related programs vary greatly, there are common elements within these programs that impact racial and health disparities. These include:

- Services in different languages
- Research on disease prevalence by race and ethnicity
- "Train-the-trainer" programs designed to reach diverse communities
- Community stakeholders to provide feedback and help with program development
- Grants to community agencies that operate programs designed to meet the needs of the local community
- Targeting low-income populations
- Informal and formal data-sharing (for example, through survey tools such as the *Behavioral Risk Factor Surveillance System* and the *California Healthy Kids Survey*)
- State interagency and intra-agency collaboration

Data Collection, Analysis, and Evaluation

Many initiatives are implemented at the local level with oversight from state programs. This local control has benefits for customizing programs to meet the needs of each community; however, it compounds the difficulty of collecting uniform data on racial and ethnic health disparities at the state level.

Program evaluation and data collection also vary because most health efforts are funded at the federal level. Reporting and program implementation requirements are often mandated by various federal agencies instead of through a centralized state review.

The majority of collected data is surveillance rather than program specific. This is due in large part to the nature of programs that seek to change social norms instead of working with individuals. Some programs have their own surveillance data collection activities, while others use statewide surveys and research from sources such as the DHS Center for Health Statistics.

Data collection often includes the following elements:

- Assessment of knowledge, behavior, attitudes and beliefs. This data is sometimes analyzed by race and ethnicity.
- The five basic racial and ethnic categories outlined in the federal government standards and used by the Census. While many programs express a desire to

collect more detailed data, more specific categories are rarely used. Programs report being limited by funding or by the difficulty of collecting specific information on relatively small populations.

- Primary language and acculturation data are rarely collected.
- When funding cuts occur, different programs adapt in different ways. Some retain data collection and evaluation capacity while others eliminate this aspect of their program.

Because most programs receive their funding from federal sources, reporting requirements relative to evaluation and program-specific data collection are primarily imposed at the federal level. State reporting requirements are limited for a variety of reasons:

- Programs have different data collection needs and designs.
- Programs receive funding from a variety of sources and each source has a different type of data collection and evaluation requirement.
- Almost all funding comes from sources other than state government. Therefore, there are few reporting requirements mandated by state agencies.
- Data sharing across agencies and departments can potentially compromise participant confidentiality.[98]
- The local nature of many programs means that programs are often adapted at the local level to perform community-appropriate interventions. When state programs perform evaluations of grantees, the reviews take into account the community-specific designs made by each grantee.
- If a state reporting system were to be created, it would require flexibility in order to meet the needs of diverse programs.

FURTHER RESEARCH

This report begins to fill the gap in knowledge about state programming and health disparities. The information can be used for both resource sharing among programs and coordination of future efforts and data collection. Further research on this topic would be useful for clearer understanding of how, and to what extent, state agencies address racial and ethnic health disparities. Specifically, research could be expanded to investigate:

- The Primary Care Branch within the Department of Health Services
- The Maternal, Child and Adolescent Health Branch within the Department of Health Services
- Grant-specific programs within the Department of Mental Health
- Additional programs within the Department of Transportation, especially focusing on the Native American Liaison Desk
- Relevant programs within the Department of Social Services

- Relevant programs within the Department of Housing and Community Development

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USEFUL WEBSITES

Following are some useful websites. This list is not exhaustive and there are other good resources on this subject.

American Public Health Association (APHA). http://www.apha.org/.

> The APHA is an association of individuals and organizations working to support public health and achieve equity in health status. It produced the report *Health for All: California's Strategic Approach to Eliminating Racial and Ethnic Health Disparities*, available at http://www.apha.org/legislative/legislative/HealthForAll.pdf.

California Endowment. www.calendow.org.

> The Endowment is a private statewide health foundation whose mission is to expand access to healthcare to underserved individuals and communities, and to promote improved health status. The website provides information and resources on "Community Health and the Elimination of Health Disparities," one of its identified program areas.

California Pan Ethnic Health Network (CPEHN). http://www.cpehn.org.

> The Network works to ensure that all Californians have access to quality health care; its mission is to improve access to health care and eliminate health disparities by advocating for public policies and sufficient resources to address communities' health needs. CPEHN's partner organizations are the Asian and Pacific Islander American Health Forum, the California Black Health Network, the California Rural Indian Health Board, and the Latino Coalition for a Healthy California. The CPEHN website provides issue briefs, data, and other resources.

Centers for Disease Control (CDC), National Center for Chronic Disease Prevention and Health Promotion. http://www.cdc.gov/nccdphp/.

> The CDC, housed in the federal Department of Health and Human Services, provides various reports and statistics, including *Health Disparities: A Selected Bibliography*, available at http://www.cdc.gov/nccdphp/publications/healthdisparities/.

Prevention Institute. http://www.preventioninstitute.org/.

> The Prevention Institute is a non-profit national center dedicated to improving community health and well-being by building momentum for effective primary prevention. The website provides a listing of presentations, publications, and other resources on Health Disparities.

UCLA Center for Health Policy Research. http://www.healthpolicy.ucla.edu.

> Affiliated with the UCLA Schools of Public Health and Public Affairs, the Center is a research institute that supports advances in public health policy, and addresses disparities through research, public service, and education. It provides data on disparities using the *California Health Interview Survey* (CHIS), available at http://www.healthpolicy.ucla.edu/pubs/pubList.asp?topicID=11&subTopicID=38.

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[96] Unless otherwise noted, information in this section derived from personal communication with April Roeseler, Hao Tang, Kelli Berliner, and Shirley Dellenback, Tobacco Control Branch, July 22, 2005.

[97] Unless otherwise noted, information in this section derived from personal communication with Stephanie Papas, Safe and Healthy Kids Program, July 11, 2005.

[98] Ver Ploeg, Michele, and Edward Perrin, eds. *Eliminating Health Disparities Measurement and Data Needs.* National Research Council, Committee on National Statistics, Division of Behavioral and Social Sciences and Education, Panel on DHHS Collection of Race and Ethnicity Data. (Washington, DC: the National Academies Press, 2004). Provides a further discussion of confidentiality issues and ways to share data appropriately.