Love in the Time of Coronavirus: Advancing Anti-Racism, Resiliency, and Climate Action

“Risk Factors are not Predictive Factors because of Protective Factors”

23rd Annual Health Equity Symposium

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Office of Health Equity
November 3, 2021
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Source: Prevention in Mental Health: Lifespan Perspectives, Jeste and Bell, p185
Agenda

• CalHHS and Racism as a Root Cause of Ill Health

• CDPH (California Dept. of Public Health) and Resiliency

• OHE (Office of Health Equity)

• CA COVID-19 Vaccine Equity Goals, 2020 Excess Death, Indirect Health Effects

• Behavioral Health Impacts of COVID-19

• Climate Action for Health Equity Now!

• What you can do today . . .
Native Land Text

1-855-917-5263
Land and Labor
Acknowledgement

We acknowledge that we are all living off the taken ancestral lands of Indigenous peoples for time immemorial. We acknowledge the extraction of brilliance, energy and life for labor forced upon people of African descent for more than 400 years. We celebrate the resilience and strength that all Indigenous people and descendants of Africa have shown in this country and worldwide. We carry our ancestors in us, and we are continually called to be better as we lead this work.
"We envision a nation in which all people live in thriving communities where resources work well; systems are equitable and create no harm nor exacerbate existing harms; where everyone has the power, conditions, resources and opportunities to achieve optimal health; and all physicians are equipped with the consciousness, tools and resources to confront inequities and dismantle white supremacy, racism, and other forms of exclusion and structured oppression, as well as embed racial justice and advance equity within and across all aspects of health systems"
It is critical to address all areas of marginalization and inequity due to sexism, class oppression, homophobia, xenophobia and ableism. Yet conversations about race and racism tend to be some of the most difficult for people in this country to participate in for numerous reasons, including a lack of knowledge or shared analysis of its historical and current underpinnings, as well as outright resistance and denial that racism exists. Given the deep divides that exist between groups in the United States, understanding and empathy can be extremely challenging for many because of an inability to really “walk a mile in another’s shoes” in a racialized sense. Collectively, we have an opportunity and obligation to overcome these fissures and create spaces for understanding and healing.
Let’s Get Humble California

Cultural humility—commitment to personal and institutional transformation by realizing and redressing power, privilege, and prejudice

In 1998, Melanie Tervalon and Jann Murray-García published a groundbreaking article that challenged the concept of “cultural competency” with the concept of “cultural humility” (Tervalon, 1998). Accepting cultural humility means accepting that we can never be fully culturally competent. Cultural humility means

1. committing to *lifelong learning* and *critical self-reflection*;
2. realizing our *power*, *privilege*, and *prejudice* (bias);
3. redressing *power imbalances* for *respectful partnerships*; and
4. promoting *institutional accountability*.

*Humility is the noble choice to forgo your status, and to use your influence for the good of others before yourself. It is to hold your power in service of others.* (Dickson, 2011).
Dr. Radhakrishna Appointed Deputy Director of the Office of Health Equity at California Department of Public Health

written by ECT  |  Feb 26, 2021

15 COMMENTS

RICHARD

Ω  Feb 26, 2021 - 2:25 pm

When my wife was seen by him, I commented after to her that he was the best doctor that I'd ever met, in my 69 years. My wife agreed.

ELIZABETH STERN

Ω  Feb 26, 2021 - 5:21 pm

When will a doctor with a name like SAM JONES be appointed to head such an agency? Why is it always someone with an unpronounceable name — and a foreigner! I don’t care how “good” he is. By the way, a patient really cannot judge a doctor to see whether he’s competent or not. Only another doctor could do that.

 Equity: The position requires Senate confirmation.
Racism is a Public Health Threat: Centers for Disease Control & Prevention

Racism and Health

Source: https://www.cdc.gov/media/releases/2021/s0408-racism-health.html
Declarations of Racism as a Public Health Crisis or Emergency—California: 29+

Sources: [https://www.apha.org/topics-and-issues/health-equity/racism-and-health/racism-declarations](https://www.apha.org/topics-and-issues/health-equity/racism-and-health/racism-declarations)

[http://64.166.146.245/docs/2020/BOS/20201110_1582/43674%5FBO%5FDeclaring%20Racism%20Crisis%20Public%20Health%20Crisis%20Emergency%20Contra%20Costa%20County%20Board%20of%20Supervisors%20Meeting%20-%20November%2010%2C%202020%20-%20D.3%20ACCEPT%20report%20from%20the%20Health%20Services%20Director%20and%20ADOPT%20Resolution%20No.%202020/306%20declaring%20Racism%20as%20a%20Public%20Health%20Crisis%20within%20Contra%20Costa%20County.pdf](http://64.166.146.245/docs/2020/BOS/20201110_1582/43674%5FBO%5FDeclaring%20Racism%20Crisis%20Public%20Health%20Crisis%20Emergency%20Contra%20Costa%20County%20Board%20of%20Supervisors%20Meeting%20-%20November%2010%2C%202020%20-%20D.3%20ACCEPT%20report%20from%20the%20Health%20Services%20Director%20and%20ADOPT%20Resolution%20No.%202020/306%20declaring%20Racism%20as%20a%20Public%20Health%20Crisis%20within%20Contra%20Costa%20County.pdf)
Our North Star

We envision a Healthy California for All where every individual belongs to a strong and thriving community.

Where all our children can play and learn, and where we are confident that we have done all we can to pass to them a state they can lead into the future.

Where older and disabled Californians can live with purpose and dignity, and where they are supported and valued.

Where equity is not just a word or concept but the core value.

Where we constantly pursue social and racial justice by not only lifting all boats but especially those boats that need to be lifted more.

Where health care is affordable, accessible, equitable and high-quality so it drives toward improved health.

Where we prioritize prevention and the upstream factors that impact an individual’s health and well-being.

Where we are committed to tackling the economic inequalities that force many Californians to live on the street.

Where necessities like housing and childcare are complemented by access to physical and behavioral health services.

Where we see the whole person and where programs and services address the social, cultural and linguistic needs of the individuals they serve.

Where climate threats collide with forward leaning health practices and policies that visibly turn the tide toward community resilience.

And where we see our diversity as a strength, and where we embrace a joint responsibility to take care of one another.

Learn more at: https://sgc.ca.gov/meetings/council/2021/docs/20210429-Racial_Equity_Resolution_Staff_Report.pdf
The California Department of Public Health (CDPH) has a vision of a California in which race is no longer a predictor of one’s health outcomes and where all Californians can achieve their highest level of health and well-being.

Racial and Health Equity Vision and Strategy

Normalize
Organize
Operationalize
CDPH Director Dr. Tomás Aragón’s Top 3 Priorities

• Equity & Anti-Racism

• Performance Improvement
  • Efficiency (Improving Process through Lean)
  • Effectiveness (Improving Outcomes through RBA – Results Based Accountability)

• Developing our People
  • Being a Learning Organization
  • Being a Healing Organization
Public health and population health science

- Eco-social perspective
- Life course perspective
- Equity and antiracism\(^a\)
- Primary prevention\(^b\)

\(^a\) Adapted from “health equity”
\(^b\) Adapted from “prevention”

Scientific PDSA problem-solving

1. **Plan:**
   - Problem definition
   - Root cause analysis
   - Consequence (risk) analysis
   - Countermeasure selection

2. **Do:**
   - Countermeasure execution

3. **Study:**
   - Countermeasure evaluation (causal analysis)

4. **Act:**
   - Act on what you learn to improve.

Racism as a root cause framework

Cultural Racism

Structural Racism

Social Determinants of Health

Health and Well-being

Individual and Group Psychology

Discrimination

Prevention

Control

Mitigation

b Steven Roberts. The Psychology of American Racism (http://dx.doi.org/10.1037/amp0000642)
c Jonathan Haidt. The Righteous Mind: Why Good People Are Divided by Politics and Religion
Chronic Stress and Racism: Impacts on Health Equity

- Differential access resources
- Differential living conditions

Racism

Chronic Stress

- Epigenetics
- Increased Allostatic Load

Health Inequities
Cancers, heart disease, high blood pressure, kidney disease, etc.
The World’s Leading Medical Journals Don’t Write About Racism. That’s a Problem

A new study reveals how leading medical journals overlook and ignore racism in publishing research articles. (Photo by Getty Images © David Stock)

BY RHEA BOYD, NANCY KRISGER, FERNANDO DE MAIO, AND ALETHA MAYBANK

April 11, 2021 3:12 PM EDT

A new study reveals how leading medical journals overlook and ignore racism in publishing research articles.

Ignorance is neither neutral nor benign, especially when it cloaks evidence of harm. And when ignorance is produced and entrenched by gatekeeper medical institutions, as has been the case with obfuscation of at least 200 years of knowledge about racism and health, the damage is compounded. The racialized inequities exposed this past year—including COVID-19, police brutality, environmental injustice, attacks on democratic governance, and more—have sparked mainstream awareness of structural racism and heightened scrutiny of the roles of scientific institutions in perpetuating ignorance about how racism harms health.
A dramatic increase in number of articles including the word “racism” in 2020…
Yet for the medical journals, the vast majority of articles were commentaries and viewpoints – not empirical studies

<table>
<thead>
<tr>
<th></th>
<th>AJPH</th>
<th>BMJ</th>
<th>JAMA</th>
<th>NEJM</th>
<th>The Lancet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # of articles (1)</td>
<td>14,192</td>
<td>78,545</td>
<td>40,411</td>
<td>43,378</td>
<td>63,971</td>
</tr>
<tr>
<td>Total # of articles that included the word &quot;racism&quot; anywhere in the text (2)</td>
<td>891</td>
<td>644</td>
<td>145</td>
<td>109</td>
<td>315</td>
</tr>
<tr>
<td>Total # of articles that included the word &quot;racism&quot; anywhere in the text and available for analysis</td>
<td>891</td>
<td>475</td>
<td>141</td>
<td>109</td>
<td>288</td>
</tr>
<tr>
<td>Total # of commentaries / viewpoints / letters (3)</td>
<td>356 (40%)</td>
<td>455 (96%)</td>
<td>130 (92%)</td>
<td>105 (96%)</td>
<td>259 (90%)</td>
</tr>
<tr>
<td>Total # of empirical studies (Intro, Methods, Results, Discussion or review with significant data component) (3)</td>
<td>535 (60%)</td>
<td>20 (4%)</td>
<td>11 (8%)</td>
<td>4 (4%)</td>
<td>29 (10%)</td>
</tr>
</tbody>
</table>

Source: Authors’ analysis. AJPH = American Journal of Public Health; BMJ = British Medical Journal; JAMA = Journal of the American Medical Association; NEJM = New England Journal of Medicine. Notes: (1) PubMed results by journal. (2) Obtained from each journal’s website, searching for “racism” anywhere in the title, abstract, or text. For BMJ, the actual number of pieces (articles, letters, etc.) containing “racism” may be less than the total reported, since some files contain more than one piece and all pieces in the file may turn up in the search, even if not all the individual pieces in the file contain "racism." (3) Primarily for BMJ, we were unable to obtain copies of some articles due to incomplete library coverage and other issues. (4) Manually coded, except for AJPH, which categorizes and displays articles by type on its website.
…if we, as medical and public health professionals cannot name and confront racism as a root cause of racial health inequities, it profoundly affects what the broader public knows and doesn’t know about the racial distribution of health and disease and its social causes.

It is past time for the world’s leading medical journals to name racism, publish evidence on how racism harms health, and articulate how dismantling racism can prevent racial health inequities.
Socio-Ecological (society)

Medical Model (individuals)

PREVENTION

Family & Culture

Exclusionary Narrative
- Race
- Class
- Gender
- Immigration Status
- National Origin
- Sexual Orientation
- Disability

Weak Social Compact
- Corporations & Other Businesses
- Government Agencies
- Schools

Social Vulnerability
- Neighborhood Conditions - Social
- Physical - Residential Segregation
- Workplace Conditions

SOCIAL FACTORS

DRIVERS OF CHANGE
- People Power
- Youth Leadership Development
- Enhanced Collaboration and Policy Innovation
- Leveraging Partnerships
- Changing the Narrative

Individual Health Knowledge

Genetics

TREATMENT

Behavior
- Smoking
- Nutrition
- Physical Activity
- Violences
- Chronic Stress

Disease
- Infectious Disease
- Chronic Disease
- Injury (intentional & unintentional)

Death
- Infant Mortality
- Life Expectancy

HEALTH CARE ACCESS

HEALTH STATUS

Source: The California Endowment adapted from BARHII
Multi-layered structural and contextual factors that influence life course health

https://osg.ca.gov/sg-report/
Center for Healthy Communities
Wellness & Resiliency

Contact Us: CHC@cdph.ca.gov
• **Black Infant Health (BIH) Program:** focuses on empowering Black women to understand and better defend against the daily microaggressions of individual and institutional racism by informing Black women about toxic stress, helping women build social support systems, developing strategies for stress reduction and empowering women to develop essential life skills as well as access high quality prenatal care.

• **California Home Visiting Program (CHVP)** is a voluntary preventive program that pairs trained home visitors with pregnant and/or new parents
  • Home visiting is inherently multi-generational and seeks to address parental stress and readiness, identify and respond to the needs of families and young children, strengthen parent-child relationships, support parent mental health and employment, support child development, and facilitate social support networks for families.

• **Adolescent Family Life Program (AFLP)** is a voluntary case management for expectant and parenting young people 21 years of age and younger
  • Program goal (1 of 4): Increase social and emotional support and build resiliency
  • Program activities are specifically designed to support youth and young families with building resiliency strengths and skills (e.g., emotion regulation, sense of purpose, positive identify, self efficacy, problem solving, healthy relationships)
LIFE COURSE THEORY and HEALTH DISPARITY

Disparity at Birth

Attachment Disorder
Adverse Childhood Events
Exposure to Toxins

Poor Nutrition
Unsafe Neighborhood
Dating Violence
Poor Education
Lack of Health Care
No Family Planning
Tobacco/Alcohol/Drugs

Poverty
No Social Support
Mistimed Pregnancy
Domestic Violence

Disparity in Adulthood

Risk Factors

Optimal Health Outcomes

Resiliency Factors

Poor Health Outcomes

Attachment
Nutrition
Social Support

Education
Health Care
Family Planning
Safe Neighborhood

Healthy Relationships
Financial Security
Planned Pregnancy

Excellent

Poor

Pre-Conception
Birth
Childhood
Puberty
Pregnancy
Delivery
Adulthood

Healthy Relationships
Financial Security
Planned Pregnancy
What more can be done to build resiliency among CA families to support behavioral health?

- Engage in research to further identify and promote modifiable protective factors that build resiliency
- Ensure universal home visiting in California to build family resilience on day one
- Promote policy, practices and resources in communities that focus on:
  - Social - Healthy relationships, connectivity and social supports
  - Developmental – Early bonding, healthy parent/child attachment, positive parenting
  - Physical - Green space, creative space, beautiful space for emotional nourishment
  - Mobility – Active transport modes that are safe, efficient and climate friendly
  - Economic – living wage, economic growth, free community college
  - Interconnectivity - Family advocates to support navigation of complex systems in CA
  - Healing related to:
    - Institutional racism
    - Chronic/toxic stress
    - ACEs, violence and trauma
    - Poverty
“Envisioning a Trauma-Informed, Healing-Centered, and Resilient California: Supporting State Government Efforts to Move toward Recovery”

• **Date/Time:** December 13, 2021, from 1:00 PM – 3:00 PM

• **Purpose/Goals:**
  - Share a draft vision statement for what a more trauma-informed, healing centered, and resilient California could look like, and
  - Engage stakeholders and state government staff in a facilitated an interactive discussion that will shape the draft vision statement and inform efforts to build a proposed roadmap and milestones for how to reach the proposed vision statement that will guide the work of the violence prevention planning efforts

• **Target Audience:** Individuals who work in state and local government, non-profits, and community partners who are interested in addressing resiliency to ACEs through healing centered and trauma-informed practices and approaches in their organizations

• **Zoom Meeting Link:** [https://cdph-ca-gov.zoom.us/j/86213309671?pwd=VUhJMit6eXNxOUhreTVtSktEMDg0Zz09](https://cdph-ca-gov.zoom.us/j/86213309671?pwd=VUhJMit6eXNxOUhreTVtSktEMDg0Zz09)

• **E-mail:** [Elena.Costa@cdph.ca.gov](mailto:Elena.Costa@cdph.ca.gov)
Vision:
Everyone in California has equal opportunities for optimal health, mental health and well-being.

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

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

Statute
Established, as authorized by Section 131019.5 of the California Health and Safety Code, to provide a key leadership role to reduce health and mental health disparities to vulnerable communities.
Health and Safety Code Section 131019.5 A-N

... shall address the following key factors as they relate to health and mental health disparities and inequities:

(A) Income security such as living wage, earned income tax credit, and paid leave.
(B) Food security and nutrition such as food stamp eligibility and enrollment, assessments of food access, and rates of access to unhealthy food and beverages.
(C) Child development, education, and literacy rates, including opportunities for early childhood development and parenting support, rates of graduation compared to dropout rates, college attainment, and adult literacy.
(D) Housing, including access to affordable, safe, and healthy housing, housing near parks and with access to healthy foods, and housing that incorporates universal design and visitability features.
(E) Environmental quality, including exposure to toxins in the air, water, and soil.
(F) Accessible built environments that promote health and safety, including mixed-used land, active transportation such as improved pedestrian, bicycle, and automobile safety, parks and green space, and healthy school siting.
(G) Health care, including accessible disease management programs, access to affordable, quality health and behavioral health care, assessment of the health care workforce, and workforce diversity.
(H) Prevention efforts, including community-based education and availability of preventive services.
(I) Assessing ongoing discrimination and minority stressors against individuals and groups in vulnerable communities based upon race, gender, gender identity, gender expression, ethnicity, marital status, language, sexual orientation, disability, and other factors, such as discrimination that is based upon bias and negative attitudes of health professionals and providers.
(J) Neighborhood safety and collective efficacy, including rates of violence, increases or decreases in community cohesion, and collaborative efforts to improve the health and well-being of the community.
(K) The efforts of the Health in All Policies Task Force, including monitoring and identifying efforts to include health and equity in all sectors.
(L) Culturally appropriate and competent services and training in all sectors, including training to eliminate bias, discrimination, and mistreatment of persons in vulnerable communities.
(M) Linguistically appropriate and competent services and training in all sectors, including the availability of information in alternative formats such as large font, braille, and American Sign Language.
(N) Accessible, affordable, and appropriate mental health services.

Consult regularly with representatives of vulnerable communities, including diverse racial, ethnic, cultural, and LGBTQQ communities, women’s health advocates, mental health advocates, health and mental health providers, community-based organizations and advocates, academic institutions, local public health departments, local government entities, and low-income and vulnerable consumers.
Office of Health Equity

Health Research & Statistics

Climate Change & Health Equity

Gender Health Equity

Advancing Community Equity COVID-19

Community Development & Engagement

Health in All Policies & Racial Health Equity Initiative

Business Operations

Advisory Committee

https://www.cdph.ca.gov/Programs/OHE/Pages/OfficeHealthEquity.aspx
CRDP: California Reducing Disparities Project
Phase II Extension & Expansion Planning

• CRDP Phase II (2016-2022): First of its kind, $60 Million investment in developing and evaluating community defined evidence–based practices (CDEP’s) in mental health prevention & early interventions to reduce disparities. Funding for 35 CBO’s in 5 Priority Populations.

• CRDP Phase II Extension (4 more years) & Phase III Expansion Planning: $63.1 Million in 2021 Budget Act:

  • Through work with the County Behavioral Health Departments, California Department of Health Care Services, and the Mental Health Service Oversight & Accountability Commission, integrate community defined and led practices into the mainstream public mental health programming to achieve equity.

  • To conduct research, community engagement, and planning for a CRDP Phase III which would expand the CRDP to include additional Community-Based Organizations, priority populations, and the reach of the CRDP to other communities across California.
Covid deaths by vaccination status

From September 28, 2021 to October 4, 2021, unvaccinated people were 15.0 times more likely to die from COVID-19 than fully vaccinated people.

Source: https://covid19.ca.gov/state-dashboard, accessed November 2, 2021
Total vaccinations by HPI (Healthy Places Index) quartile over time

HPI quartile data as reported by State vaccination dashboard

~90% HPI Q4 population
Of HPI Q4 12+ population is vaccinated 1+ dose as of 10/26, compared to 71% of HPI Q4 12+ population as of 5/1 (increase of 19%)¹

~80% HPI Q3 population
Of HPI Q3 12+ population is vaccinated 1+ dose as of 10/26, compared to 60% of HPI Q3 12+ population as of 5/1 (increase of 20%)¹

~78% HPI Q2 population
Of HPI Q2 12+ population is vaccinated 1+ dose as of 10/26, compared to 54% of HPI Q2 12+ population as of 5/1 (increase of 24%)¹

~75% HPI Q1 population
Of HPI Q1 12+ population is vaccinated 1+ dose as of 10/26, compared to 47% of HPI Q1 12+ population as of 5/1 (increase of 28%)¹

¹ Equity Ops team deployed 5/3
Source: https://covid19.ca.gov/vaccination-progress-data/ accessed on 11/02/2021, 11:00am PT
Total vaccinations by race/ethnicity over time

Race/ethnicity data as reported by State vaccination dashboard

1+ dose by race/ethnicity over time

- ~72% White population
  - Of white 12+ population is vaccinated 1+ dose as of 10/26, compared to 56% as of 5/1 (increase of 16%)\(^2\)

- ~62% LatinX population
  - Of LatinX 12+ population is vaccinated 1+ dose as of 10/26, compared to 38% as of 5/1 (increase of 24%)\(^2\)

- ~60% Black population
  - Of Black 12+ population is vaccinated 1+ dose as of 10/26, compared to 37% as of 5/1 (increase of 23%)\(^2\)

- ~97% Asian population
  - Of Asian 12+ population is vaccinated 1+ dose as of 10/26, compared to 76% as of 5/1 (increase of 21%)\(^2\)

- ~64% American Indian or Alaska Native population
  - Of AI/AN 12+ population is vaccinated 1+ dose as of 10/26, compared to 43% as of 5/1 (increase of 21%)\(^2\)

- ~2.40M vaccinations attributed to “other” race
- ~1.27M attributed to “unknown” race

1. Data for Native Hawaiian & other Pacific Islander and Multi-Race categories may not reflect actual vaccination rates due to some misclassifications in vaccine administrations among these groups
2. Equity Ops team deployed 5/3

Source: [https://covid19.ca.gov/vaccination-progress-data/](https://covid19.ca.gov/vaccination-progress-data/) accessed on 11/02/2021, 11:00am PT
Total vaccinations by insurance type

Vaccination rate by insurance type
As of 10/19/2021; 12+ population in Millions

- **~90% Non-Medi-Cal population**
  Of non-Medi-Cal 12+ population is vaccinated 1+ dose as of 10/19

- **~56% Medi-Cal population**
  Of Medi-Cal 12+ population is vaccinated 1+ dose as of 10/19

Overview of California’s COVID-19 Vaccine Equity Goals

Why?
- The State, in partnership with counties, community-based organizations, and other local partners, has administered over 53M vaccine doses, with nearly 80% of eligible Californians at least partially vaccinated, but more needs to be done.
- In Sept. 2021, the State achieved its initial equity goal of vaccinating > 70% of eligible people (1+ dose) living in the most vulnerable areas (Healthy Places Index Quartile 1), but more work is needed to ensure ALL eligible Californians are vaccinated.
- The State is focusing its efforts on preventing a winter surge and decreasing inequities in vaccine administration.

What?
- Ensure 75% of eligible individuals across all races/ethnicities have received at least 1 dose of the COVID-19 vaccine by Jan 1, 2022.
- Decrease inequities in COVID-19 1+ dose vaccination rates across place-based (HPI Quartile 1 vs. Quartile 4) and insurance type groups (Medi-Cal vs. Non Medi-Cal) to less than 10 percentage points by Jan 1, 2022.

How?
- Identifying communities and neighborhoods most impacted by COVID-19 and focusing on increasing vaccination.
- Partnering with and providing technical assistance to Local Health Jurisdictions (LHJs) to support local vaccination efforts.
- Partnering with Medi-Cal managed care plans to increase vaccination rates among Medi-Cal beneficiaries.
- Deepening partnerships with community-based organizations to build upon our network of trusted messengers.
- Conducting public education communications campaigns to reach individuals in targeted communities.

California’s equity goals

Planned activities
- Identifying communities and neighborhoods most impacted by COVID-19 and focusing on increasing vaccination.
- Partnering with and providing technical assistance to Local Health Jurisdictions (LHJs) to support local vaccination efforts.
- Partnering with Medi-Cal managed care plans to increase vaccination rates among Medi-Cal beneficiaries.
- Deepening partnerships with community-based organizations to build upon our network of trusted messengers.
- Conducting public education communications campaigns to reach individuals in targeted communities.

FALL FLU SHOTS

I got my Flu Shot for her.
Speak to a
Our Effort in Practice

- Social and cultural factors are critical for messaging
- People want to see others who look like them
- Peer-to-peer engagement is the most effective means to motivate our hard-to-reach communities
- Creating a space to encourage collaboration is essential
- Translated materials assist in reaching all communities
CA Built a Geospatial Collaboration Tool to Inform Decision Making and Increase Effectiveness

CORD
COVID-19 Outreach Rapid Deployment

**INCLUDES:**
- VEM (Vaccine Equity Metric) Q1 (Quartile) and Q2
- Hard to Count Index
- Vaccination rates
- Vaccination clinics
- State funded CBO activities
- Paid media buys
- Trusted community locations (e.g. churches, schools)

**USES:**
- Planning
- Resource allocation
- Coordination
- Reports
- CBO contract management
- Rapid response
Health Equity Playbook

- 70+ pages
- Released in December 2020
- 6-month updates (informed by the Equity Playbook Bulletin)
- Equity resources, best practices, and strategies

Health Equity Playbook Bulletins

- 3-4 pages
- Released in February, March, April, June, and July
- New equity resources, best practices, and strategies within the categories of the Equity Playbook framework
- Addition of population-specific resources
• All-cause age-adjusted mortality rate is extremely closely related, in inverse, to life expectancy at birth, which is a more intuitive measure for many people to grasp.
• Life expectancy at birth (LE) decreased among all groups in California in 2020
• Latino LE decreased 3.6 years from 2019 to 2020
• Black LE, as key overall measure of disparity, was 73.2 in 2020, 11.6 years less than Asians
• LE estimates available for all counties on CCB: https://skylab.cdph.ca.gov/communityBurden/

### Trend in Life Expectancy, CALIFORNIA, 2010-2020

![Graph showing life expectancy trends over years](https://skylab.cdph.ca.gov/communityBurden/_w_cd512e4c/xMDA/2020_Excess_Mortality.html)
Leading causes of death, CA 2017-2020

Quarterly Trend in Selected Causes of Death 2017-2020

Trend in Age-Adjusted Death Rate of Ischemic heart disease in California, 2010-2020

Trend in Age-Adjusted Death Rate of Drug overdose in California, 2010-2020

Produced by CDPH Fusion Center – 8/2021
Trends in Death Rates by Race/Ethnicity by Quarter, 2020 and 2017-2019 Average
The **mortality ratio** is 4.18 higher for **Latinos** and 2.75 higher for **African Americans** than the **COVID-19 death rate** for Whites.

The **mortality ratio for foreign-born Latinos 20-64 years old with high school or less** is **10.73 times the COVID-19 death rate** for Whites.

The authors highlight some of the **structural factors such as workplace exposure**.

• Excess mortality calculated as the percent increase in a rate from 2019 to 2020.
• Latinos have the highest excess mortality based on percent increase.
• The “conclusions” from the two methods differ because of the different ways the methods take into account the rate in the baseline period and the population size.
• These methods are both reasonable and provide different insights.

• Excess mortality calculated as the increase in the number of deaths divided by the population size.
• Blacks have the highest excess mortality based on this “excess mortality rate”; followed by Native Hawaiian/Pacific Islanders and American Indian/Alaska Natives.

"Excess Mortality Rate"

2020 Rate − 2019 Rate
2019 Rate × 100

Percent Increase in Age-Adjusted Death Rate

2020 Deaths − 2019 Deaths
2020 Population × 100,000
• Most increase in older age groups due to COVID-19
• Large percent increases in young Blacks and 35-44 year old AI/AN, mostly not due to COVID-19
  • homicide, road injury, drug overdose
• Number, rate and percent detailed in Appendix
"For each person who dies of Covid-19, experts say there are at least nine newly bereaved."
Global Prevalence of (A) Major Depressive Disorder and (B) Anxiety Disorders Before and During the COVID-19 pandemic, by age and sex, 2020

Major depressive disorder cases increased by 27.6% (53·2 million additional cases) due to the COVID-19 pandemic.

Anxiety disorder cases increased by 25.6% (76·2 million additional cases) due to the COVID-19 pandemic.

For both disorders, females were affected more than males, and younger age groups were affected more than older age groups.

Source: “Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic.” The Lancet. Published October 8, 2021. DOI: 10.1016/S0140-6736(21)02143-7
94% of Hispanics 18+ received NO TREATMENT for Co-Ocurring Mental Illnesses.
Racial and Ethnic Disparities in the Prevalence of Stress and Worry, Mental Health Conditions, and Increased Substance Use Among Adults During the COVID-19 Pandemic — United States, April and May 2020

Lela R. McKnight-Eily, PhD1; Catherine A. Okoro, PhD2; Tara W. Strine, PhD1; Jorge Verlenden, PhD1; Natasha D. Hollis, PhD2; Rashid Njai, PhD3; Elizabeth W. Mitchell, PhD3; Amy Board, DrPH3; Richard Puddy, PhD3; Craig Thomas, PhD1

TABLE. Weighted prevalence estimates of current depression,* suicidal thoughts/ideation,† and substance use increase or initiation§ among adults aged ≥18 years, by race/ethnicity — Porter Novelli View 360 survey, United States, April and May 2020

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Unweighted no. of persons</th>
<th>Current depression</th>
<th>Suicidal thoughts/ideation</th>
<th>Substance use increase or initiation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>1,004</td>
<td>28.6 (25.6–31.5)</td>
<td>8.4 (6.6–10.2)</td>
<td>18.2 (15.7–20.7)</td>
</tr>
<tr>
<td>White, NH</td>
<td>657</td>
<td>25.3 (21.9–28.7)</td>
<td>5.3 (3.6–6.9)</td>
<td>14.3 (11.6–17.0)</td>
</tr>
<tr>
<td>Black, NH</td>
<td>100</td>
<td>27.7 (18.7–36.7)</td>
<td>5.2 (0.7–9.7)</td>
<td>15.6 (8.4–22.7)</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>118</td>
<td>40.3 (31.3–49.3)</td>
<td>22.9 (15.2–30.6)</td>
<td>36.9 (28.1–45.7)</td>
</tr>
<tr>
<td>Other, NH</td>
<td>129</td>
<td>31.4 (22.8–40.0)</td>
<td>8.9 (3.6–14.1)</td>
<td>15.1 (8.4–21.7)</td>
</tr>
</tbody>
</table>

Abbreviations: CI = confidence interval; DSM-IV = Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition; NH = non-Hispanic/Latino.
* Defined as a score of ≥10 on the eight-item Patient Health Questionnaire (PHQ-8). The PHQ-8 is adapted from the nine-item PHQ (PHQ-9), which is based on the nine criteria for diagnosis of depressive disorders in the DSM-IV.
† Defined as an affirmative response to the question “At any time in the past 30 days, did you seriously think about trying to kill yourself?”
§ Defined as an affirmative response to the question “Have you started or increased using substances to help you cope with stress or emotions during the COVID-19 pandemic? Substance use includes alcohol, legal or illegal drugs, or prescriptions drugs that are taken in a way not recommended by your doctor.”
¶ Includes participants who identified as Native American/Alaska Native, Asian, multiracial, or another race/ethnicity.
RAPID PROJECT PURPOSE & FRAMEWORK
Indirect Negative Health Effects of COVID-19 Pandemic

COVID-19 PANDEMIC

Economic Stressors
- Unemployment
- Housing insecurity
- Food insecurity
- Others

Psycho-emotional Stressors
- Fear of infection
- Stigma
- Loneliness
- Grief and loss

Access to Medical Care Disruptions
(e.g., deferred medical procedures, loss of health insurance)

Biological impacts of the toxic stress response**

Disruptions in Healthy Lifestyle & Buffers
(e.g., school closure, reduced recreational opportunities)

Mental & Behavioral Health Outcomes
(e.g., depression, substance use, violence)

Risk Factors & Risk Behaviors
(e.g., Hypertension, drinking)

Physical Health Outcomes
(e.g., Cardiovascular diseases)

COVID Health Outcomes
(e.g., Death, Hospitalization)

Direct Impact

Source: Rapid Assessment of Pandemic Indirect impacts and mitigating interventions for Decision-making (RAPID) by UCSF/CA Office of Surgeon General Oct 2021
• Substantial human & economic costs for six health conditions during the pandemic:
  - Adult depression
  - Intimate partner violence
  - Homelessness
  - Excessive alcohol use
  - Opioid use disorder
  - Stroke mortality

• Health harms result in large part from ACEs – both in the offspring of adults today and in adults with a history of childhood adversity

• Mitigation strategies for all six health conditions will save quality-adjusted life years and will also save costs.
# The Human Toll:
## Increased Indirect Health Harms due to the COVID-19 Pandemic

<table>
<thead>
<tr>
<th>Priority Public Health Condition Indirectly Affected by COVID-19</th>
<th>Relative Risk: Change Under COVID-19</th>
<th>Excess Quality-Adjusted Life Years (QALYs) Lost Due to COVID-19 per Million Population*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>QALYs Lost in Affected Adults</td>
</tr>
<tr>
<td>Depressive symptoms</td>
<td>1.37</td>
<td>69,000</td>
</tr>
<tr>
<td>Intimate partner violence</td>
<td>1.11</td>
<td>52,000</td>
</tr>
<tr>
<td>Homelessness</td>
<td>6.67</td>
<td>17,000</td>
</tr>
<tr>
<td>Excessive alcohol use</td>
<td>1.19</td>
<td>26,000</td>
</tr>
<tr>
<td>Opioid use disorder</td>
<td>1.63</td>
<td>28,000</td>
</tr>
<tr>
<td>Stroke mortality</td>
<td>1.53</td>
<td>1,200</td>
</tr>
</tbody>
</table>

*Values in each column are the sum of 1-2 years and longer-term outcomes
## Costs of Doing Nothing: Estimated Societal Costs (Medical + non-Medical) from Indirect Health Harms of Pandemic

<table>
<thead>
<tr>
<th>Priority Public Health Condition Indirectly Affected by COVID-19</th>
<th>Excess Societal Costs Due to COVID-19 (Per Million Total Population)*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Societal Costs Incurred by Affected Adults</td>
</tr>
<tr>
<td>Depressive symptoms</td>
<td>$2,231M</td>
</tr>
<tr>
<td>Intimate partner violence</td>
<td>$699M</td>
</tr>
<tr>
<td>Homelessness</td>
<td>$2,154M</td>
</tr>
<tr>
<td>Excessive alcohol use</td>
<td>$11,000M</td>
</tr>
<tr>
<td>Opioid use disorder</td>
<td>$551M</td>
</tr>
<tr>
<td>Stroke mortality</td>
<td>$1M</td>
</tr>
</tbody>
</table>

*Values in each column are the sum of 1-2 years and longer-term outcomes*
## Health & Cost Effects of Interventions

<table>
<thead>
<tr>
<th>Health Condition</th>
<th>Intervention Cost</th>
<th>Outcomes if Reaching 20% of Affected Adults (Per 1M Total Pop)*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>QALYs Gained</td>
</tr>
<tr>
<td><strong>Depressive symptoms</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBT + anti-depressant</td>
<td>$878</td>
<td>14,481</td>
</tr>
<tr>
<td>Mindfulness meditation</td>
<td>$200</td>
<td>1,207</td>
</tr>
<tr>
<td><strong>Intimate partner violence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse-family partnership</td>
<td>$13,489**</td>
<td>24,208</td>
</tr>
<tr>
<td><strong>Homelessness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rent subsidies</td>
<td>$9,282</td>
<td>3,171</td>
</tr>
<tr>
<td><strong>Excessive alcohol use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening + brief interven.</td>
<td>$452</td>
<td>5,625</td>
</tr>
<tr>
<td><strong>Opioid use disorder</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication-assisted tx</td>
<td>$15,669</td>
<td>6,284</td>
</tr>
<tr>
<td><strong>Stroke mortality</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public awareness campaign</td>
<td>$98***</td>
<td>388</td>
</tr>
</tbody>
</table>

*Except for stroke, which assumes 100% coverage of those at risk for stroke, **Cost per family, ***Cost per person at risk of stroke*
## Scaling up Interventions: Projected Economic Savings across 3 Time Periods

<table>
<thead>
<tr>
<th>Priority Public Health Condition Indirectly Affected by COVID-19</th>
<th>Economic Outcomes from Intervention Programs that Reach 20% of Affected Adults (Per Million Total Population)*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Net Savings Over 1 Year</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td><strong>Depressive symptoms</strong></td>
<td></td>
</tr>
<tr>
<td>CBT + antidepressants</td>
<td>$61.5M</td>
</tr>
<tr>
<td>Mindfulness meditation</td>
<td>- $10.1M</td>
</tr>
<tr>
<td><strong>Intimate partner violence</strong></td>
<td></td>
</tr>
<tr>
<td>Nurse-family partnership</td>
<td>- $69.8M</td>
</tr>
<tr>
<td><strong>Homelessness</strong></td>
<td></td>
</tr>
<tr>
<td>Rent subsidies</td>
<td>- $4.2M</td>
</tr>
<tr>
<td><strong>Excessive alcohol use</strong></td>
<td></td>
</tr>
<tr>
<td>Screening and brief intervention</td>
<td>$9.0M</td>
</tr>
<tr>
<td><strong>Opioid use disorder</strong></td>
<td></td>
</tr>
<tr>
<td>Medication-assisted treatment</td>
<td>- $36.0M</td>
</tr>
<tr>
<td><strong>Stroke mortality</strong></td>
<td></td>
</tr>
<tr>
<td>Public awareness campaign</td>
<td>$147,500</td>
</tr>
</tbody>
</table>

*Except for stroke, which assumes 100% coverage of those at risk for stroke.
Take Away Messages...

Increases in adult depression and IPV during the pandemic are likely to have particularly pernicious health impacts on children.

Increases in interpersonal violence and excessive alcohol use are particularly costly for adults with a history of childhood adversity.

The long-term economic costs for children exposed to increased interpersonal violence and excessive alcohol use by adults are likely to be high.

Using recommended strategies now to mitigate any of the six conditions will save life years and economic costs.

Mitigating increases in adult depression and interpersonal violence now would pay off substantially, both in life years saved and economic costs.

Source: Rapid Assessment of Pandemic Indirect impacts and mitigating interventions for Decision-making (RAPID) by UCSF/CA Office of Surgeon General Oct 2021
History will repeat itself unless we address the root causes of inequity

Disparities in influenza mortality and transmission related to sociodemographic factors within Chicago in the pandemic of 1918

Kyra H. Grantz\textsuperscript{a,b,1}, Madhura S. Rane\textsuperscript{c,1}, Henrik Salje\textsuperscript{d,1}, Gregory E. Glass\textsuperscript{b,2}, Stephen E. Schachterle\textsuperscript{a}, and Derek A. T. Cummings\textsuperscript{a,b,2,3}

\textsuperscript{a}Department of Biology, University of Florida, Gainesville, FL 32611; \textsuperscript{b}Emerging Pathogens Institute, University of Florida, Gainesville, FL 32611; \textsuperscript{c}Department of Epidemiology, University of Washington, Seattle, WA 98195; \textsuperscript{d}Department of Epidemiology, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD 21205; \textsuperscript{2}Mathematical Modelling Unit, Institut Pasteur, Paris 75015, France; \textsuperscript{3}Department of Geography, University of Florida, Gainesville, FL 32611; and \textsuperscript{3}Epidemiology, Worldwide Safety & Regulatory, Pfizer Inc., New York, NY 10017

Edited by Burton H. Singer, University of Florida, Gainesville, FL, and approved September 29, 2016 (received for review August 10, 2016)

Social factors have been shown to create differential burden of influenza across different geographic areas. We explored the relationship between increased case fatality rates, and also, they were unable to detect variation in excess mortality within countries or even finer spatial scales.

Differential Burden in Neighborhoods with:
- lower literacy
- higher population density
- higher unemployment

Title 17 Section 1276 CCR
"The health department shall offer …
(i) Services directed to the social factors affecting health …"
- Excess mortality is associated with Social Drivers of Health, including Poverty, Crowding, and Limited English Proficiency
- SDOH are based on the community level (census tract) not individual level, using the Krieger/Harvard Public health Disparities Geocoding approach
- Both SDOH and race/ethnicity are independently associated with excess mortality. The patterns of SDOH and excess mortality differed across race/ethnicity groups. These interrelationships are complex, difficult to measure, and important.
WE’RE ALREADY BARRELING TOWARD THE NEXT PANDEMIC
This one is far from over, but the window to prepare for future threats is closing fast.

“[We have] a Sisyphean cycle of panic and neglect that is now spinning in its third century. Progress is always undone; promise, always unfulfilled. It might seem ridiculous to think about future pandemics now . . . But America must do both together, precisely because of the cycle . . . Today’s actions are already writing the opening chapters of the next pandemic’s history.

“Inequity reduction is not a side quest of pandemic preparedness. It is arguably the central pillar—if not for moral reasons, then for basic epidemiological ones. Infectious diseases can spread, from the vulnerable to the privileged. Our inequality makes me vulnerable.”

“To be ready for the next pandemic, we need to make sure that there’s an even footing in our societal structures. It means measuring preparedness not just in terms of syringes, sequencers, and supply chains but also in terms of paid sick leave, safe public housing, eviction moratoriums, decarceration, food assistance, and universal health care.”

“The president has told many of us privately, and said publicly, that equity has to be at the heart of what we do in this pandemic.”
-Vivek Murthy US Surgeon General

Source: The Atlantic by Ed Yong 9/29/21
Climate Action for Health Equity Now!

Rohan Radhakrishna, MD, MPH, MS (he/him)
Deputy Director, Office of Health Equity
California Department of Public Health

November 3, 2021
The IPCC’s latest climate report is dire. But it also included some prospects for hope.” (The Guardian, 8/13/21)

Climate Change Is The Greatest Threat To Public Health, Top Medical Journals Warn

Inaction on climate change imperils millions of lives, doctors say

Top medical journal warns that rising temperatures will worsen heat and respiratory illness and spread infectious disease

The 2021 report of the Lancet Countdown on health and climate change: code red for a healthy future

https://www.lancetcountdown.org/2021-report/

In October, more than 500 organizations representing 46 million health professionals worldwide, about 2/3 of the global health workforce, signed an open letter to the 197 Heads of State around the world as well as every nation’s lead climate negotiator, calling for urgent climate action to protect people’s health. #HealthyClimatePrescription

Human Health Impacts of Climate Change

**Environmental Degradation**
- Forced migration, civil conflict, mental health impacts, loss of jobs and income

**Extreme Heat**
- Heat-related illness and death, cardiovascular failure

**Wildfires & Severe Weather**
- Injuries, fatalities, loss of homes

**Water & Food Supply Impacts**
- Malnutrition, diarrheal disease

**Degraded Living Conditions & Social Inequities**
- Exacerbation of existing social and health inequities and vulnerabilities

**Changes In Vector Ecology**
- Malaria, dengue, encephalitis, hantavirus, Rift Valley fever, Lyme disease, chikungunya, West Nile virus

**Air Pollution & Increasing Allergens**
- Asthma, cardiovascular disease, respiratory allergies

**Water Quality Impacts**
- Cholera, cryptosporidiosis, Campylobacter, leptospirosis, harmful algal blooms

Adapted from CDC, J. Patz
Human Health Impacts of Climate Change

Behavioral Health Impacts:
Stress, anxiety, depression, sense of loss; strains on social relationships; substance abuse; post-traumatic stress disorder

Environmental Degradation
Forced migration, civil conflict, mental health impacts, loss of jobs and income

Extreme Heat
Heat-related illness and death, cardiovascular failure

Wildfires & Severe Weather
Injuries, fatalities, loss of homes

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Asthma, cardiovascular disease, respiratory allergies

Water Quality Impacts
Cholera, cryptosporidiosis, Campylobacter, leptospirosis, harmful algal blooms

Adapted from CDC, J. Patz, USGCRP
It’s not just you: Everyone is Googling ‘climate anxiety’

Searches for the phrase have soared 565 percent over the past year.

Wildfires and smoke are affecting our mental health

By Julie Sabatier (OPB)

Eco-anxiety: 75% of young people say ‘the future is frightening’

September 28, 2021

More disease, more suicide: Study shows human cost of climate change

“There is no safe temperature rise from a health standpoint.”

By Dr. Yalda Safai
October 22, 2021, 8:37 AM • 8 min read

Climate Anxiety Takes a Growing Toll on Farmers

Extreme weather is bringing anguish and grief to an already precarious way of life.

By Gosia Wozniacka • October 5, 2021
People with mental health challenges are more likely to be harmed in extreme weather events, and more likely to have their mental health impacted for extended periods.

Extreme weather events can trigger PTSD, anxiety, depression, complicated grief, survivor guilt, vicarious trauma, substance misuse, and suicidal ideation (~20-65% of survivors experience mental health impacts).

Incremental climatic changes (temp, sea level rise, drought) lead to financial stress, anxiety, increased aggression, and displacement.

Higher temperatures increase ER visits for mental health outcomes.

1°C increase in temp leads to 0.7% increase in suicide rate in US: additional 14,000 suicides by 2050.
**Climate Change Impacts and Behavioral Health**

- Mental health impacts **increasing with more frequent climate-related disasters**
- Since 2000 the frequency of climate change-related weather disasters has **increased by 46%**.
- **47 million** Americans now impacted by disasters/year; **this will double by 2050**

**Vulnerable populations:**
- first responders
- migrants, especially undocumented
- elderly and children
- people with physical disability, a mental health challenge, or SUD
- pregnant people
- Institutionalized individuals
- farmworkers
- low-income
- people experiencing homelessness

- Climate anxiety due to **existential threat** and **loss to known world** ("solastalgia")
- Can lead to ‘**Post Traumatic Growth’ (PTG)**, empathy, compassion, altruism, and emotional resilience
CLIMATE CHANGE IS ALREADY HARMING HUMAN HEALTH.

PEOPLE FACING INEQUITIES HURT FIRST AND WORST.
Vulnerability

Visualize California Counties based on levels of both an exposure variable and a population sensitivity variable.

The plot illustrates the intersection of hazard (from an aspect of climate change) and sensitivity (from circumstances of the population or place that tend to increase susceptibility to the hazards of climate change). Counties are assigned to the bottom (least), middle, or top (most) tier for both exposure and sensitivity. The most vulnerable counties appear in top- and right-most portions of the figure. Points are sized according to the population living in that county. Hover over points for the county name, population, and indicator values.

Some examples of important combinations to consider are:
- Heat + elderly / outdoor workers / health insurance / air conditioning / tree canopy / impervious surfaces
- Ozone + children
- PM2.5 + children
- Wildfire + elderly / disability

Combined Vulnerability from Exposure (Projected number of extreme heat days) and Sensitivity (Percent of population aged 65 years or older)

Download the data in this figure

https://skylab.cdph.ca.gov/CCHVIz/
Health Professionals are Trusted Messengers and Want to Address Climate Change

• **Protecting health is the top reason** Americans select for supporting climate solutions (EcoAmerica):
  - 76% motivated by health
  - 71% motivated by good paying jobs

• **68% of Americans trust health professionals** for information on climate change

• **LHD (local health departments) are eager to participate in climate change planning** to simultaneously reduce emissions and increase health and equity

• CCLHO chose climate change as a top 3 priority in 2019, 2020, and 2022

• **70% of California public health officers** said they do not have adequate information to respond to climate change

• 94% perceived it to be a health threat

• **Only 2 LHDs** have full-time climate change staff
Integrate Climate Change into Existing Health Services & Integrate Health Services into Climate Change Planning

• Integrate climate change into mental health first aid and health services

• Ensure mental health service availability in shelters and assistance centers, delivering trauma-informed therapy and crisis counseling

• Ensure access to adequate supplies of medication to last through disasters

• Educate patients on impacts of medications on temperature regulation

• Provide culturally responsive health services in languages spoken by community members, by trusted providers from racial and ethnic communities

• Assess clients for climate-induced anxiety, depression, etc.

• Be a spokesperson on health and climate mitigation, adaptation, and resiliency
California For All: Racial Equity Lens and Equity Frame for Climate Resiliency

Equity mechanisms:

- Prioritized financial incentives, investments, or resources
- Higher levels of service
- Facilities
- Capacity building or training
- Jobs
- Decision-making power

“Cash, capacity, control”
Support Community-Based Psychosocial Support Systems, Build Social Cohesion

- Racial and health equity frame
- Support mutual aid and community-based peer led efforts, and services and structures that build social cohesion
- Enhance skills, strengths, and resources to prevent and heal from trauma
- Provide community members will tools and skills to regulate and calm mind, body, emotions, increase linkages to social networks
- Use hardships as transformational catalyst to find new source of meaning, purpose, and hope (”presencing” and “purposing”)
Community Response and Solutions: Lessons from COVID-19 for the Climate Crisis

We invite you to join a virtual meeting of the Public Health Workgroup of the California Climate Action Team (CAT-PHWG) on Tuesday, November 30, 2021 from 10:00 AM to 12:00 PM PT.

This meeting will focus on the lessons learned from COVID-19 equity actions and how they can be leveraged to strengthen climate action planning and community resilience to the health impacts of the changing climate.

DATE: November 30, 2021
TIME: 10:00 AM to 12:00 PM PT
LOCATION: Virtual Zoom Meeting (Register below)

https://ww2arb.ca.gov/resources/documents/climate-action-team-public-health-workgroup-meetings
Email climatechange@cdph.ca.gov to be notified of future CAT-PHWG meetings
What can I do today to promote Anti-racism?

- **Structural:** talk about it at work and at home, weekly then daily (Normalize, Organize, Operationalize)

- **Institutional:**
  - suggest or get involved in a JEDI / DEI Committee
  - suggest or connect with your Chief Equity Officer
  - request or lead an Organizational Assessment
  - request or lead a REAP: Racial Equity Action Plan

- **Interpersonal:**
  - observe your daily thoughts, words, actions with clients, patients, and co-workers
  - start a 21 day Racial Equity Challenge [https://21dayequitychallenge.com/](https://21dayequitychallenge.com/)
  - take the AMA module on Historical Foundations of Racism in Medicine

- **Internalized:**
  - Read *How to Be An Antiracist* by Ibram X. Kendi
  - Ask yourself when brushing your teeth: how did I practice and promote anti-racism today?
Continuum on Becoming an Anti-Racist Multicultural Organization

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>An Exclusionary Institution</td>
<td>A &quot;Club&quot; Institution</td>
<td>A Compliance Organization</td>
<td>An Affirming Institution</td>
<td>A Transforming Institution</td>
<td>Anti-Racist Multicultural Organization in a Transformed Society</td>
</tr>
</tbody>
</table>

- **Exclusive**
  - Intentionally and publicly excludes or segregates African Americans, Native Americans, Latinos, and Asian Americans.
  - Intentionally and publicly enforces the status quo throughout the institution.
  - Institutionalization of racism includes formal policies and practices, teachings, and decision making on all levels.
  - Usually has similar intentional policies and practices toward other socially oppressed groups such as women, gays, and lesbians, Third World citizens, etc.
  - Openly maintains the dominant group’s power and privilege.

- **2. Passive**
  - Tolerant of a limited number of "token" People of Color and members from other social identity groups allowed in with "proper" perspective and credentials.
  - May still secretly limit or exclude People of Color in contradiction to public policies.
  - Continues to intentionally maintain white power and privilege through its formal policies and practices, teachings, and decision making on all levels of institutional life.
  - Often declares, "We don’t have a problem."
  - Monocultural norms, policies and procedures of dominant culture viewed as the "right" way to business as usual.
  - Engages issues of diversity and social justice only on a club member’s terms and within their comfort zone.

- **3. Symbolic Change**
  - Makes official policy pronouncements regarding multicultural diversity.
  - Sees itself as "non-racist" institution with open doors to People of Color.
  - Carries out intentional inclusiveness efforts, recruiting "someone of color" on committees or office staff.
  - Expanding view of diversity includes other socially oppressed groups.

- **4. Identity Change**
  - Growing understanding of racism as barrier to diversity.
  - Develops analysis of systemic racism.
  - Sponsors programs of anti-racist training.
  - New consciousness of institutionalized white power and privilege.
  - Develops intentional identity as an "anti-racist" institution.
  - Begins to develop accountability to racially oppressed communities.
  - Increasing commitment to dismantle racism and eliminate inherent white advantage.
  - Actively recruits and promotes members of groups that have been historically denied access and opportunity.

- **5. Structural Change**
  - Institutional structures and curriculum that maintain white power and privilege still intact and relatively untouched.
  - Token placements in staff positions: must assimilate into organizational culture.
  - Commits to process of intentional institutional restructuring, based upon anti-racist analysis and identity.
  - Audits and structures all aspects of institutional life to ensure full participation of People of Color, including their worldview, culture and lifestyles.
  - Implements structures, policies and practices with inclusive decision making and other forms of power sharing on all levels of the institutions and work.
  - Commits to struggle to dismantle racism in the wider community, and builds clear lines of accountability to racially oppressed communities.
  - Anti-racist multicultural diversity becomes an institutionalized asset.
  - Redefines and rebuilds all relationships and activities in society, based on anti-racist commitments.

- **6. Fully Inclusive**
  - Future vision of an institution and wider community that has overcome systemic racism and all other forms of oppression.
  - Institution’s life reflects full participation and shared power with diverse racial, cultural, and economic groups in determining its mission, structure, constituency, policies and practices.
  - Members across all identity groups are full participants in decisions that shape the institution, and inclusion of diverse cultures, lifestyles, and interest.
  - A sense of restored community and mutual caring.
  - Allies with others in combating all forms of social oppression.
  - Actively works in larger communities (regional, national, global) to eliminate all forms of oppression and to create multicultural organizations.

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Source: https://philanos.org/resources/Documents/Conference%202020/Pre-Read%20PDFs/Continuum_AntiRacist.pdf
Inspired by Dr. Monica Sharma, Former Director of United Nations Leadership Development

Radical transformational leadership is leading change from the universal values of dignity, equity, compassion and humility to transform self, people, systems and cultures towards equity, antiracism, and sustainable results.

Universal values are values that apply to everyone, everywhere, and leaves no one behind, including your worst enemy. Core universal values include dignity, equity, compassion, and humility. Universal values enable us to transcend differences, to find common ground, and to solve problems together. We strive to embody and promote universal values in every interaction and in every conversation.

https://www.radicallytransform.org/
“risk factors are not predictive factors because of protective factors”