



Alameda County Public Health Department

Chronic Disease Prevention: *A Community Vision*

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ALAMEDA COUNTY PUBLIC HEALTH DEPARTMENT

Message from the Director

Alameda County is one of the most diverse counties in the country and faces tremendous challenges and opportunities in ensuring health, social and racial equity for our communities. Our residents are passionate and have creative ideas for how to create healthier communities. Our leaders have on-the-ground knowledge and years of experience in advocating for a just and equitable society where all people can thrive and be healthy. We share a commitment to improve conditions for all residents, especially in neighborhoods historically under-resourced and overexposed to unhealthy conditions. It is against this backdrop that I share with you the *Alameda County Chronic Disease Prevention: A Community Vision Report*.

Chronic disease is the most frequent cause of death in Alameda County—with cancer, heart disease and stroke accounting for more than half of all mortality. While disease rates are declining, significant disparities persist and are concentrated in certain communities. Local data shows that people are more likely to suffer from almost any disease if they live in conditions of poverty. We see disturbing differences in life expectancy based on race, with African Americans dying, on average, 12 years earlier than Asians, 9.5 years earlier than Latinos, and 6.5 years earlier than Whites. Violence is one of the starkest indicators of inequity—African Americans have a homicide rate more than 20 times higher than Asians and Whites. Among children, the rates of those diagnosed with asthma are highest among Hispanics and African Americans (30% each). Stroke mortality is highest among Pacific Islanders (75.2), over twice the Hispanic rate of 33.6.

This report is a call to action. We must aggressively address health disparities and the social, economic, and racial inequities that perpetuate them. No one should be condemned to a shorter, more unhealthy life due to skin color, neighborhood of residence or income. Chronic diseases are preventable, as are the social, economic, and environmental conditions that lead to them. We must ensure that all our communities have the conditions, opportunities, and support that they need to be healthy.

Congratulations to all the residents, organizations, and agencies who contributed to this report and ensured that it reflects the community's experiences. I am proud to see that it highlights the principles of *primary prevention, health equity, and social and racial justice*. Our community reminds us that we must address the root causes of health inequities and advance policies and institutions that reverse these legacies of discrimination.

We cannot do this work alone. We must actively engage with partners—elected officials and other public agencies, private organizations, medical providers, and clinics, and with community residents. Many of the strategies described in this report are inspired by the good work that is already happening. Together, we will ensure that everyone in our County can live a life that is not only free of disease but full of prosperity, opportunity, and fulfillment. Thank you for your ongoing partnership and support in building a healthier Alameda County for all.

Yours in health,

Dr. Muntu Davis, MD, MPH
Public Health Director and County Health Officer

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Executive Summary

PURPOSE OF COMMUNITY INPUT PROCESS

This report summarizes the effort undertaken in 2012-13 to gather input from a broad range of community stakeholders on how Alameda County Public Health Department should approach chronic disease prevention and achieve health equity for all. Many organizations and a diverse group of residents were engaged to share their community health concerns, desires, and possible solutions.

SCOPE OF THE PROBLEM: CHRONIC DISEASE IN ALAMEDA COUNTY

Chronic diseases are those “non-communicable illnesses that are prolonged in duration, do not resolve spontaneously and are rarely cured completely.” More than half (52.4%) of all deaths in Alameda County result from just three chronic diseases—cancer, heart disease, and stroke. While life expectancy has increased for every group and all-cause mortality has declined, low income and people of color continue to experience a persistently higher burden of chronic disease and premature death. Local data shows that people are more likely to suffer from almost any disease

if they live in a poor neighborhood. Certain ethnic groups are more likely to develop chronic diseases, regardless of the neighborhood they live in. Pacific Islanders have the highest rate of heart disease and death due to stroke of all ethnic and racial groups. Thirty-six percent of the county’s American Indians have diabetes, more than three times the rate for African Americans, the second most impacted ethnic group. Among children, the rates of those diagnosed with asthma are highest among Hispanics and African Americans (30% each). African American residents are particularly hard hit: they live an average of *9 years less* than Latinos, and *7 years less* than Whites; die from cancer, stroke, and diabetes at a rate *twice* that of Asians; and are hospitalized for hypertension at a rate *more than three times* that of Asian/Pacific Islanders. These stark disparities in health outcomes are the result of preventable differences in exposure, access to resources, and life conditions related to the social determinants of health.



REPORT THEMES

The report emphasizes the connections between poverty, lack of education, exposure to violence and stress, and the development of disease. It highlights the community's concern that the long-term impacts of discrimination and racism still play a prominent role in determining all aspects of health and well-being. It describes the impact of unhealthy conditions and chronic disease on Alameda County residents. The report aligns the participants' input on what constitutes a healthy community with five broad public health frameworks that can help shift the social, economic, educational, and institutional environments that increase the risk of chronic disease and poor health.

In responding to these complex and inter-related community factors, our community members strongly advocated for a prevention approach that explicitly addresses the important social and community inequities that lead to such different health outcomes for low income and communities of color. The report prioritizes efforts to change the larger systems, policies and institutional practices that lead to poor health and chronic disease.

PRIORITY AREAS OF FOCUS AND RECOMMENDED STRATEGIES

Building on the vision of a healthy, productive and fulfilling life for all, the report outlines four priority areas to focus on to effectively reducing chronic disease and health inequities. Using the Public Health Department's results-based accountability framework, each area is defined in terms of the result that will indicate improved community health:

- #1 All residents have access to healthy food that is readily available, and reduced access to unhealthy food and products**
- #2 All residents have healthy, safe, accessible places to live**
- #3 All residents live in safe, caring, and strong communities**
- #4 Educational and economic success is achieved for all residents**

Samples of strategies to achieve each result through policies, systems, institutional and environmental change approaches are outlined, along with community and health indicators to measure both short and long term success.

ALAMEDA COUNTY PUBLIC HEALTH DEPARTMENT ROLE IN SUPPORTING COMMUNITY RECOMMENDATIONS

The legacy of racism is a key factor influencing health across every issue in Alameda County. Institutional policies and practices play a critical role in creating and perpetuating conditions and patterns of opportunity and resource access that can ultimately lead to racial inequities in social and health outcomes. The Public Health Department is working to ensure that its decision-making processes analyze potential equity impacts to prioritize efforts most likely to reverse this trend. We are investing in improving the systems, institutions and practices that have perpetuated inequities by championing the effort to embed an "Equity in All Policies" approach within all county level decision making processes. The report also describes key Public Health Department roles in supporting community-driven efforts, and gives examples of how that work is currently being carried out. It explains how the community feedback informed our long-range planning and is being incorporated into our Community Health Improvement Plan (CHIP) that will ultimately result in optimal health and well-being for all.

CONCLUSION

Strategic partnerships between public agencies, institutions, elected officials, and community based organizations are essential to move this comprehensive prevention initiative forward. The Health Department will continue to help convene and actively engage multiple cross-sector partners and systems to raise awareness, and to support and help mobilize resources to achieve this broad vision of a healthy, equitable Alameda County. We will continue to support our community's interest in achieving health and social equity by using public health and other data to illustrate the links between policy issues and health.

Introduction: Purpose and Intent

ALAMEDA COUNTY PUBLIC HEALTH DEPARTMENT VISION AND MISSION

The Alameda County Public Health Department envisions that everyone in Alameda County, no matter where you live, how much money you make, or the color of your skin, leads a healthy, fulfilling and productive life. Our mission is to work in partnership with the community to ensure the optimal health and well-being of all people.

PURPOSE OF REPORT AND OVERVIEW OF COMMUNITY INPUT PROCESS

This report summarizes the effort undertaken in 2012–13 to gather input from a broad range of community stakeholders on how the Public Health Department, stakeholders and the community should work to prevent chronic disease, close the gaps in health disparities, and achieve health equity for all. A diverse group of organizations and residents shared their community health concerns, desires, and possible solutions.

In the spring of 2012, the Health Department convened a steering committee of stakeholders from the public health, health care, economic development, education, and criminal justice sectors. The committee was tasked with developing a vision and key principles for chronic disease prevention and making critical decisions throughout the process. Twenty-six individuals from community organizations, non-profits, and other public agencies attended a planning retreat in fall of 2012 to review that vision and brainstorm approaches for reducing chronic

disease. Four work groups were formed: healthy people, healthy schools, healthy neighborhoods, and healthy policies and systems. They fleshed out strategies in their respective areas which were further refined by the steering committee. The steering committee, work group members, and key stakeholders reviewed and finalized the findings at a retreat held in November 2012. This report documents those findings and outlines how we collectively can contribute to realizing the community's vision to eliminate health inequities, close the gaps and achieve maximum health for all residents.

REPORT CONTENTS OVERVIEW

The report describes the impact of chronic disease and unhealthy conditions on Alameda County residents. It illustrates the inequities experienced by specific communities, most prominently due to the long-term impacts of institutional and systemic racism. It defines a vision for a healthy community and aligns that vision with broad public health prevention frameworks that can help address the social, economic, educational, and institutional conditions that increase the risk of chronic disease, particularly in low income and communities of color. It outlines the conditions of well-being or “results” that will indicate improved community health, and recommends strategies to achieve them through policies, systems, institutional and environmental change. Finally, the report explains how the community perspective, values, priorities, and recommendations are being incorporated into the Health Department’s planning through its County Health Improvement Plan (CHIP).

Setting the Local Context: Chronic Disease in Alameda County

DEFINITION OF CHRONIC DISEASE AND SCOPE OF THE PROBLEM

Chronic diseases are largely preventable “non-communicable illnesses that are prolonged in duration, do not resolve spontaneously and are rarely cured completely.”¹ Although they are among the most common and costly of all health problems, they are also among the most preventable. Heart disease, cancer, diabetes, and asthma are examples of these preventable chronic diseases.

Chronic diseases cause the vast majority of deaths and disability in Alameda County, causing 7 out of 10 deaths.² In fact, 52.4% of deaths result from just three chronic diseases- cancer, heart disease, and stroke.³ Chronic diseases are more common in older adults, but affect people of all ages. Nearly half of adults live with at least one chronic illness, and about one-fourth of these experience significant limitations in daily activities as a result.

The cost to the medical system of managing chronic diseases is enormous. In 2002, approximately eighty percent of the State of California’s health care expenditures—about \$70 billion—was spent on people with chronic conditions.⁴ We must work simultaneously on preventing more people from developing these diseases as well as providing optimal care to help those already diagnosed to effectively control and prevent complications from their disease.

INEQUITIES IN ALAMEDA COUNTY ARE PLACE- AND RACE-BASED

Living in poor neighborhoods is a key predictor of an individual’s health. In Alameda County, African American and Hispanic communities are more likely to live in these neighborhoods than their counterparts.⁵ Comparisons of neighborhoods by poverty level indicate that affluent neighborhoods

are disproportionately comprised of Whites and Asians (60% of the county, but 71% of residents in affluent neighborhoods). High-poverty neighborhoods are largely comprised of Hispanics and African Americans (34% of the county population, but 63% of residents in high-poverty neighborhoods). Ninety-one percent of residents in **very** high-poverty neighborhoods are people of color.⁶ These residential patterns were established by a longstanding system of structural racism—where intentional public policies and institutional practices were adopted, and cultural norms enforced in ways that perpetuate inequities, which impact health and well-being on both individuals and neighborhoods.

Specific ethnic and racial groups in Alameda County are not only more likely to live in poverty, but to attend under-resourced, poorly performing schools, experience violence, and end up in the criminal justice system, when compared to other groups.⁷ Local indicators include:

- ✓ Forty-three percent of the African American, 39% Latino and 28% of Pacific Islander children attend high-poverty schools, while only 4% of white children do. Less experienced teachers, more unstable enrollment, and lower student achievement and graduation rates characterize these schools.
- ✓ Seventy-three percent of children in affluent neighborhoods score at the proficient level in English-Language-Arts tests, but only 30% in very high poverty neighborhoods do.⁸
- ✓ Latino children meet third grade reading level standards at a rate *less than half*, or 45%, the rate of Asian/Pacific Islanders.⁹
- ✓ American Indian/Alaska Native students graduate at 30% the rate of Asian/Pacific Islanders.¹⁰
- ✓ African Americans go to the emergency department for assault at a rate *15 times* that of Asian/Pacific Islanders or Whites.¹¹

- ✓ Homicide rates in very low income neighborhoods are *eight times* higher than in affluent ones.¹²
- ✓ Youth Incarceration rates—for overwhelmingly non-violent offenses—are *five times* higher in economically low income neighborhoods than in affluent ones.¹³

IMPLICATIONS FOR COMMUNITY HEALTH AND CHRONIC DISEASE PREVENTION

While life expectancy has increased for every racial and ethnic group and all-cause mortality has declined, low income and people of color experience a persistently higher burden of disease relative to white populations.¹⁴ Local data indicates that people are more likely to suffer from almost any disease if they live in a poor neighborhood. Communities of color living in Alameda County face inequitable rates of illness and premature death from many preventable chronic diseases:

- ✓ Pacific Islanders have the highest rate of heart disease and death due to stroke of all ethnic and racial groups.
- ✓ Thirty-six percent of American Indians have diabetes, which is three times the rate for African Americans, the second most impacted group (36.1% vs. 11%). By comparison, the prevalence rate for Whites is 4.3%.
- ✓ Obesity rates are highest for African Americans, followed by Hispanic (28.9% vs. 26.6%).
- ✓ *Among children, the rates of asthma diagnoses are highest among Hispanics and African Americans (almost 30% for each).*

African American residents are particularly hard hit compared to other groups, with key indicators showing that they:

- ✓ Experience the greatest burden of premature death (deaths occurring before the age of 75), with homicide as the leading cause followed closely by cancer and heart disease.
- ✓ Live an average of 12 years less than Asian/Pacific Islanders, 9.5 years less than Latinos, and 6.5 years less than Whites
- ✓ Die from cancer, stroke, and diabetes at twice

the rate of Asians

- ✓ Die from homicide at a rate *twenty times* that of Whites or Asians.
- ✓ Are hospitalized for hypertension at a rate *three times* that of Asian/Pacific Islanders and for stroke at a rate *more than two times* that of American Indian/Alaska Natives.

The stark differences in health outcomes by race/ethnicity are the result of preventable variations in environmental exposures, access to resources and opportunities, and other life conditions that strongly influence health and well-being. Four common, health-damaging, but modifiable behaviors—excessive alcohol use, tobacco use, poor eating habits, and insufficient physical activity—are responsible for much of the illness, disability, and premature death related to chronic diseases. All of these behaviors are influenced by the conditions in which people live, learn, work and play and by the options readily available to them.

Some of the most troubling trends are seen among adolescents from specific racial and ethnic groups in Alameda County:¹⁵

- ✓ Hispanic and Pacific Islander youth had the highest reported rates of ever smoking a cigarette among all groups (17.5% and 17.0%, respectively).
- ✓ Hispanic and African American adolescents are more likely to report not engaging in regular physical activity (62.5% and 50.6%, respectively) compared to Whites and Asians (35% and 44.6%).
- ✓ Hispanic and African American youth are more likely to report daily consumption of soda/sugar sweetened beverages (63.5% and 57.9%, respectively) compared to Asians and Whites (47.0% and 51.0%, respectively).
- ✓ Ninety-one percent of Hispanic and 82% of African American youth report eating less than five servings of fruit and vegetables a day, compared to 75% of adolescents overall.

This report outlines the community recommendations for a more comprehensive and coordinated approach to tackle the root causes of social inequities that lead to inequalities in health.

Aligning Community Input With Public Health

Participants generated many ideas about what constitutes a healthy community. These were grouped into broad themes: healthy people, healthy schools, healthy neighborhoods, and healthy policies and systems. The Steering Committee and Public Health Department staff aligned the themes with key public health frameworks that formed the foundation for the strategic discussions that followed:

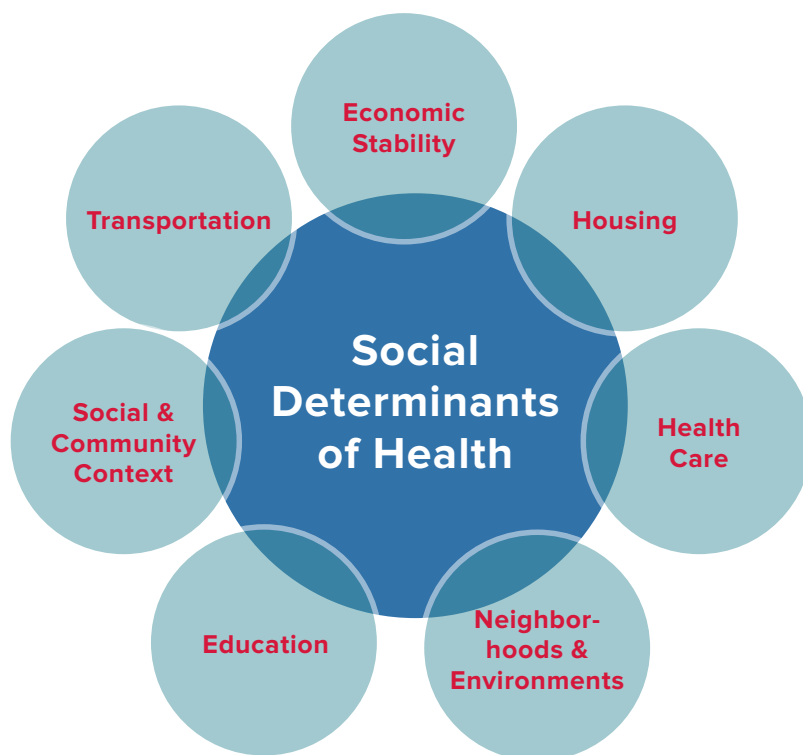
- ✓ Social Determinants of Health
- ✓ Health, Social and Racial Equity
- ✓ Institutional and Systemic Practices Influence Community Health
- ✓ Primary Prevention
- ✓ Life Course Perspective

SOCIAL DETERMINANTS OF HEALTH

The **social determinants of health (SDOH)** are the interrelated social, economic, and environmental factors and conditions that impact people's ability to access resources and opportunities that influence and shape their lives. These determinants include: education, housing, income, job opportunities and working conditions, physical environment, child development, transportation, access to health care services, food security, exposure to violence, discrimination and stigma, racism, culture, social support, and ease of democratic participation. Research has increasingly shown that the SDOH play a critical role in establishing and perpetuating health disparities, and contribute to a pattern of higher rates of chronic disease in certain communities.^{16, 17}

HEALTH, SOCIAL AND RACIAL EQUITY

A growing body of literature demonstrates that health is intrinsically entwined with the social, cultural, economic, and environmental conditions in which people are born, live, study and work.¹⁸ Patterns of poor health in some neighborhoods are rooted in persistent social and racial injustices shaped by a legacy of segregation, widespread disinvestment in communities of color, and exclusion of them from decision-making venues. The cumulative impact of these conditions and practices—most of which are beyond an individual's control—can lead to chronic stress, physiologic effects and a greater risk of chronic diseases and health disparities.¹⁹ A comprehensive chronic disease prevention approach needs to address the social inequities—the preventable and unjust differences—that lead to such different health outcomes between communities.



INSTITUTIONAL AND SYSTEMIC PRACTICES INFLUENCE COMMUNITY HEALTH

This report prioritizes efforts to improve the larger systems that establish and institutionalize the conditions that lead to poor health and chronic disease. Inequitable land use and policy decisions have concentrated environmental hazards and burdens, such as freeways, polluting industries, liquor stores, and dilapidated infrastructure in certain communities, while healthy food outlets, safe parks and open spaces, and high quality schools, are concentrated in others. Historically, banks and government agencies withheld home loans from residents in low-income communities of color while approving loans in predominantly white neighborhoods. People of color were trapped in rental housing in under-resourced, inner city neighborhoods while white residents moved from these neighborhoods (“white flight”) and purchased homes. These policies and practices led to segregation and the unequal distribution of resources in our County²⁰. Such policies and practices must shift to reverse the patterns that profoundly impact community health for low income communities and communities of color.

PRIMARY PREVENTION

Efforts to control chronic disease by clinical interventions alone have had limited effectiveness, particularly in communities where the environment does not make healthy choices the easy choices. The success of California’s tobacco control movement clearly demonstrated the effectiveness of a comprehensive and coordinated community-focused, primary prevention approach. This initiative worked across a spectrum of strategies to address the multiple factors that were contributing to the unhealthy choices people made about smoking. The combination of changing community norms, reducing environmental exposures, and advancing policies to restrict sales and advertising led to one of public health’s greatest successes in curbing a key chronic disease risk factor.²¹



LIFE COURSE MODEL PERSPECTIVE

The Life Course Model focuses on broad social, economic, and environmental factors as underlying causes of persistent inequities for a wide range of diseases across population groups.²² It is based on the concept that today’s experiences and exposures influence tomorrow’s health, and that health trajectories are particularly vulnerable to stress and unhealthy experiences at key critical periods, including prenatally and during early childhood and adolescence. The life course perspective complements the other frameworks by considering the impact of social and environmental conditions and experiences at all stages of life and across generations.

Priorities for Eliminating Chronic Disease Inequities and Achieving Healthy Communities

Community members felt strongly that this report must emphasize all the elements of a community's experience that influence health. Building on the vision of a healthy, productive and fulfilling life for every resident, the planning team and steering committee prioritized four focus areas to address to effectively reduce chronic disease and health inequities. Using the Public Health Department's results based accountability framework, they developed a "result" statement for each area to measure progress toward improved community health:

#1: ALL RESIDENTS HAVE ACCESS TO HEALTHY FOOD THAT IS READILY AVAILABLE, AND REDUCED ACCESS TO UNHEALTHY FOOD AND PRODUCTS

- ✓ Making the "healthy food choice the easy choice" is the most consistent way to ensure that people make purchases that will positively influence their health. Having a variety of fresh produce available, even at the local corner store, encourages shoppers to buy and consume them. When unhealthy food and products (like alcohol, tobacco, and sugary beverages) are easily accessible, residents are more likely to purchase them and suffer major health consequences over time (such as obesity, hypertension, and heart disease). Many neighborhoods in Alameda County do not have easy access to affordable, healthy food. These neighborhoods are known as **food deserts**—defined as those communities without a grocery store within a mile. Often these same neighborhoods have an over-saturation of liquor, corner convenience stores, and fast food restaurants offering mostly unhealthy food options.²³



#2: ALL RESIDENTS HAVE HEALTHY, SAFE, ACCESSIBLE PLACES TO LIVE, WORK AND PLAY

- ✓ A healthy physical environment or place can be defined as one that is safe and free from violence, promotes daily physical activity, provides the basic goods, opportunities, and services needed to live a healthy life, and has air, water, and soil that are toxic-free. Each of these characteristics alone has a direct impact on people's health; often the factors interact. For example, research has shown that street designs and infrastructures like sidewalks and lighting not only increase safety, but encourage regular physical activity like walking and biking—which can help prevent obesity and heart disease.²⁴ Conversely, physical activity is hindered in communities where the neighborhood streets, parks and open spaces are inaccessible, unsafe or deteriorated.
- ✓ Air quality is another key environmental influence on health, and directly affects asthma and cancer rates. Many parts of our County have poor air quality because of land use decisions that concentrated freeways and polluting industries in certain communities. Strategies to promote affordable, reliable, and safe public transportation can mitigate some of these exposures by reducing the amount of pollution from cars, while at the same time improving access to important services and resources, particularly for geographically isolated communities. Policy and systems strategies can have a broad impact on multiple levels to create safe, appealing and connected physical environments that will improve both individual and community health.



#3: ALL RESIDENTS LIVE IN SAFE, CARING, AND STRONG COMMUNITIES

- ✓ Strong, safe, and caring communities are those where residents feel connected not just to their neighbors, but to the larger society. The strong relationships and social support networks found in these neighborhoods buffer the effect of negative environments and stressful situations that can affect health and increase the risk of disease and premature death.²⁵ Residents in these communities believe that they have some control and influence over their environment. They understand how policies are made and they have the networks, knowledge, and skills to organize and advocate for change. Young people have hope for their futures, and have opportunities to develop civic engagement and leadership skills to influence policy decisions that impact their lives.
- ✓ Many communities in Alameda County are deeply troubled by violence.



Exposure to crime and violence directly and indirectly affect health and life expectancy-not just due to actual violence or homicide- but also through pathways such as anxiety and stress, effects on physical activity levels, and impacts on school performance.²⁶ The fear of violence can result in every day decisions that compromise health. Young people who don't expect to live to adulthood because of violence in their community are less likely to prioritize eating healthy, getting exercise, and finishing school. People don't spend time outside, limiting their opportunities to socialize, connect with neighbors, and to be physically active. Social cohesion, or the sense of connection and trust that binds a community together, has been linked to lower rates of violent crime and mortality.²⁷ When neighbors trust each other, they are more likely to help each other, share information and resources, and intervene in negative situations. They can more easily advocate collectively for their needs.

- ✓ Violence is a complex issue that requires comprehensive interventions at a structural, societal level to prevent it from happening. Affected communities need to be supported to heal and rebuild, and those involved in the cycle of violence must be included in these processes.

#4: EDUCATIONAL AND ECONOMIC SUCCESS FOR ALL RESIDENTS

- ✓ Educational attainment and income are inter-related and are two of the strongest social determinants of health.²⁸ People who complete higher levels of education have better social and cognitive abilities such as problem solving skills, and get practice with teamwork, dependability, and structure, making them better prepared to compete for higher paying jobs.²⁹ These jobs allow workers reliable access to the goods and services that are necessary for a healthy life. This includes medical care, healthy food, quality housing, and education that help provide opportunities for the future.³⁰
- ✓ Homeownership is the single largest source of wealth creation for Americans, and has traditionally been an especially important wealth building strategy for people of color.³¹ Historically, opportunities to build and retain wealth in this manner were withheld from communities of color through racial redlining and other forms of targeted discriminatory mortgage and loan practices. This robbed families of the chance to garner and transfer generational assets to their children through property ownership. Many of these same communities lacked high quality financial institutions and banks, but were over-populated with predatory lenders, such as payday loan centers. These centers offer high interest rates to people who need cash but may have little ability to repay the loans.³² This combination of factors and conditions continue today, perpetuating the educational and economic inequities that contribute to poor health.



Community Recommendations

Strategies to Prevent Chronic Disease

Indicators to Measure Progress

Multiple interventions are needed to address the social and environmental conditions that either promote or prevent healthy communities. The work group and steering committee developed a set of recommended strategies for each result area and identified community and health indicators that could measure both short (within 1–2 years) and long term success (several years). Community participants recognized that the Public Health Department has an important function in providing the health data that can illustrate changing health trends (see Appendix B for potential result indicator data presented to the group). Other agencies or sectors will need to be tapped as partners to help quantify the community and quality of life indicators described below.

RESULT #1: EASY ACCESS TO HEALTHY FOOD AND REDUCED ACCESS TO UNHEALTHY FOOD AND OTHER UNHEALTHY PRODUCTS

SAMPLE STRATEGIES

1. Establish healthy retail outlets in every community

- ✓ Educate on and encourage zoning codes limiting the concentration of retail outlets offering unhealthy products such as tobacco and alcohol
- ✓ Create incentives (including financing, marketing, and technical assistance) for existing store owners to adopt healthy store strategies to increase availability of fresh produce, restrict advertising of unhealthy products, and promote acceptance of WIC and CalFRESH food vouchers
- ✓ Partner with mobile vendors who sell near schools to adjust their business model to include healthy food options

2. Increase healthy food options at schools, workplaces, healthcare facilities and institutional residential settings

- ✓ Implement healthy food strategies at schools, including universal free breakfast for qualifying districts, on-site community kitchens, and experiential learning garden and cooking programs
- ✓ Adopt and implement healthy, local food

purchasing policies at all government sponsored meetings and events³³

- ✓ Support healthcare facilities, transitional homes, shelters, and board and care facilities, and all county workplaces in establishing and implementing healthy food guidelines

3. Enact policies and programs to limit consumption of sugar-sweetened beverages

- ✓ Implement recommendations on sugar-sweetened beverages from the “Health and Economic Impact of Obesity and Contributing Factors” report commissioned by the Board of Supervisors’ Health Committee

POTENTIAL INDICATORS OF SUCCESS

Community-Level Indicators—Short Term:

- ✓ Rate of soda, fast food, and fresh produce consumption

Health Indicators—Long Term:

- ✓ Rate of obesity in adults, children, and adolescents
- ✓ Hypertension, coronary heart disease, stroke and diabetes hospitalization rates

RESULT #2: HEALTHY, SAFE, ACCESSIBLE SPACES FOR PEOPLE TO LIVE, WORK AND PLAY

SAMPLE STRATEGIES

1. Create safe, accessible outdoor spaces for recreation and wellbeing

- ✓ Advocate for space designs that will discourage crime and encourage frequent community use, using Crime Prevention Through Environmental Design (CPTED) principles
- ✓ Establish joint agreements with schools, institutions, and government for expanded use access for after business hours

2. Ensure that homes and workplaces are free from environmental hazards and air pollution

- ✓ Enact indoor air quality standards for multi-unit housing to reduce exposure to mold, secondhand smoke, and particulate matter from outdoor pollution sources
- ✓ Support regular inspections of multi-family rental housing to identify and fix unhealthy housing conditions
- ✓ Prioritize high risk workplaces such as nail salons, for intervention
- ✓ Promote a comprehensive goods movement plan to determine appropriate truck routes throughout the County

3. Increase access and use of safe, alternative active public transportation, especially in communities with few cars

- ✓ Expand Paratransit services
- ✓ Preserve affordable transit fares



4. Encourage street designs that accommodate all transportation modes and improve mobility and safety for everyone

- ✓ Promote “complete streets” designs that enable safe, convenient, and comfortable travel and access for users of all ages and abilities regardless of their mode of transportation
- ✓ Expand existing programs to ensure children and youth have safe ways of walking and biking to school, e.g. Safe Routes to Schools

POTENTIAL INDICATORS OF SUCCESS

Community-Level Indicators—Long Term:

- ✓ Rate of property crimes
- ✓ Homicide and violent crime rates

Health Indicators—Short Term:

- ✓ Rate of adolescents who exercise and adults who are sedentary
- ✓ Rate of those in healthy fitness zone for aerobic capacity
- ✓ Asthma Emergency Room visits

RESULT #3: SAFE, CARING, AND STRONG COMMUNITIES

SAMPLE STRATEGIES

1. Re-frame violence as a public health issue and support multi-sector prevention efforts

- ✓ Compile regular report data on county rates of violence
- ✓ Improve coordination and access to information about local resources and programs that address/ prevent injury, violence, and trauma

2. Support community-level programs that build resilience, wellness, and healing

- ✓ Support “restorative justice” and trauma support services
- ✓ Incorporate public health resources such as nutrition education, chronic disease prevention, and information about public benefits programs like Nutrition programs, into these services

3. Develop resident capacity to organize for healthy neighborhood change

- ✓ Support existing leadership development programs for youth and adults to enhance understanding of role of government and how to influence planning and policy decisions

4. Address the inequitable criminal justice system practices that target communities of color, and particularly African Americans

- ✓ Promote stronger and more effective partnerships between law enforcement and low income communities and communities of color
- ✓ Encourage new or ongoing efforts that support men/boys of color
- ✓ Support the re-integration of formerly incarcerated residents back into community life



POTENTIAL INDICATORS OF SUCCESS

Community Indicators—Long Term

- ✓ Violent crime rates
- ✓ Level of social cohesion/% of social isolation in population
- ✓ Sense of spiritual connectedness (Percent of population that is guided by spiritual/ purposeful or service oriented principles)
- ✓ % of people reporting experience of discrimination

Health Indicators—Short and Long Term

- ✓ Child abuse rates and rates of children receiving protective services
- ✓ Mental health/anxiety/depression rates
- ✓ Drug/alcohol hospitalization rates
- ✓ Divorce rate

RESULT #4: EDUCATIONAL AND ECONOMIC SUCCESS FOR ALL COUNTY RESIDENTS

SAMPLE STRATEGIES

1. Promote policies/programs to enhance educational success at all levels of schooling

- ✓ Continue support for Head Start and Kindergarten Transition programs
- ✓ Promote full-service community schools, vocational education or linked-learning programs for livable wage jobs

2. Promote policies that build economic opportunity and wealth for residents, particularly low income, and communities of color

- ✓ Living wage policies
- ✓ Job development, training, and job readiness programs in emerging growth industries

3. Create a thriving local business community

- ✓ Support the adoption of institutional purchasing policies that direct funding to local cooperative businesses and resident-owned businesses
- ✓ Encourage the use of under-developed and/or vacant land for sustainable community businesses, including urban agriculture and other micro-enterprises



POTENTIAL INDICATORS OF SUCCESS

Community Indicators—Short Term:

- ✓ 3rd grade reading level proficiency rate

Community Indicators—Long Term:

- ✓ Rate of high school graduation
- ✓ Unemployment rates
- ✓ Percent of population at or below poverty level
- ✓ Percent of residents earning a “living wage”
- ✓ Percent of renting households paying 50% or more of income on rent

Public Health Department's Role in Supporting Community Recommendations

In developing this report, the Public Health Department and our partners committed to the following shared values:

1. Ongoing community participation
2. Building on existing efforts that have demonstrated a positive impact
3. Working across sectors to create healthy places, policies, and systems
4. Addressing the social factors that affect health
5. Using data that reflects community health and wellbeing
6. Inspiring political support and strong leadership from decision-makers
7. Striving for significant and sustainable improvement in community health
8. Pro-actively focusing on reducing health disparities and achieving health equity by creating opportunities for all to live a healthy, fulfilling, productive life
9. Promoting policy change as a tool to create healthier environments

SHIFTS IN INTERNAL, INSTITUTIONAL PRACTICE: SOCIAL AND RACIAL EQUITY IN COUNTY DECISION-MAKING

The long-term impact of racism is a key factor influencing health across every issue in Alameda County. Institutional policies and practices play a critical role in creating and perpetuating conditions and patterns of opportunity and resource access that can ultimately lead to racial inequities in social and health outcomes. These equity considerations must be incorporated into decision-making processes, policies, and practices.³⁴ They must be actively and explicitly addressed in all county and city policies and practices to guide funding and resource allocation and determine priorities for designing and implementing programs and interventions. The Public Health Department is working to ensure that its decision-making



processes analyze potential equity impacts to prioritize efforts most likely to improve social and racial equity. We are investing in improving the systems, institutions, policies and practices that have perpetuated inequities by championing the effort to embed an “Equity in All Policies” approach within all county-level decision making processes.

ALAMEDA COUNTY'S RACIAL EQUITY INITIATIVE

Despite a long history of working towards racial and health equity, significant social and health disparities remain deeply entrenched—many along racial lines. When other government jurisdictions across the country started to develop racial equity initiatives, our Public Health Department launched a similar effort to move a racial equity initiative forward. In 2014, the Public Health Department joined the Government Alliance on Race and Equity (GARE), a national network of government jurisdictions working together to achieve racial equity. In 2016, we sponsored the county to join a GARE Northern California cohort. The Alameda County team includes representatives from Health Care Services Agency, Office of Diversity Programs, Probation Department, Social Services Agency, Sheriff's Office, Human Resources Department, and the District Attorney and Public Defender's Offices. We are collaborating on the development of a plan to expand the initiative throughout the county.

STRATEGIC PARTNERSHIPS WITH COMMUNITIES AND OTHER SECTORS

Partnerships between public agencies, local elected officials, residents, the business community and community based organizations are essential to move comprehensive prevention initiatives forward. Multiple sectors have responsibility and authority to implement the strategies outlined in this report. The Public Health Department will continue to actively engage multiple cross-sector partners to raise support and awareness, and to help mobilize resources to carry out our vision of a healthy, equitable Alameda County. The Public Health Department plays several key roles in participating in strategic partnerships that support community-driven efforts to improve health, as described with examples below:

1. Convene and manage coalitions comprised of staff and a full range of partners across sectors to engage in collaborative work.

- ✓ The Building Blocks Collaborative (BBC) works to implement comprehensive solutions to address the complex problems and improve health in our most challenged neighborhoods. The Health Department's Maternal, Paternal, Child and Adolescent Health unit staffs the collaborative, whose partners include local economic development agencies, food access projects, city and county government, community clinics, housing, and parks and recreation. The Best Babies Zone is one key initiative being carried out in an East Oakland neighborhood where BBC is working hand-in hand with the organizations and residents to ensure that every child can lead a healthy life.



2. Educate Alameda County residents and officials on the health-related impacts of policies and practices, through health research, data analysis, testimony, presentations, and reports produced in response to emergent issues and requests.

- ✓ Place Matters works with multiple sectors to advance health equity through community-centered local policy focused on economics, education, housing, criminal justice, land use and transportation policy. Coordinated by the Health Department, Place Matters frames key policy issues through a health equity perspective, and provides analysis to emerging policy areas where this perspective is absent. It responds to community partners and supports their efforts to achieve health and social equity by studying the links between policy issues and health, providing health data and testimony as requested.

3. Collect input and incorporate community recommendations into relevant Public Health Department planning

- ✓ The community input process undertaken to produce the *Chronic Disease Prevention: A Community Vision Report* is an example of how we actively seek community input to help guide our work, and to inform the work of other sectors and local government. Many of the community members that participated in the process are currently actively supporting the development of the Department's Community Health Improvement Plan (CHIP). The values, principles and models outlined here are being incorporated into that planning process.

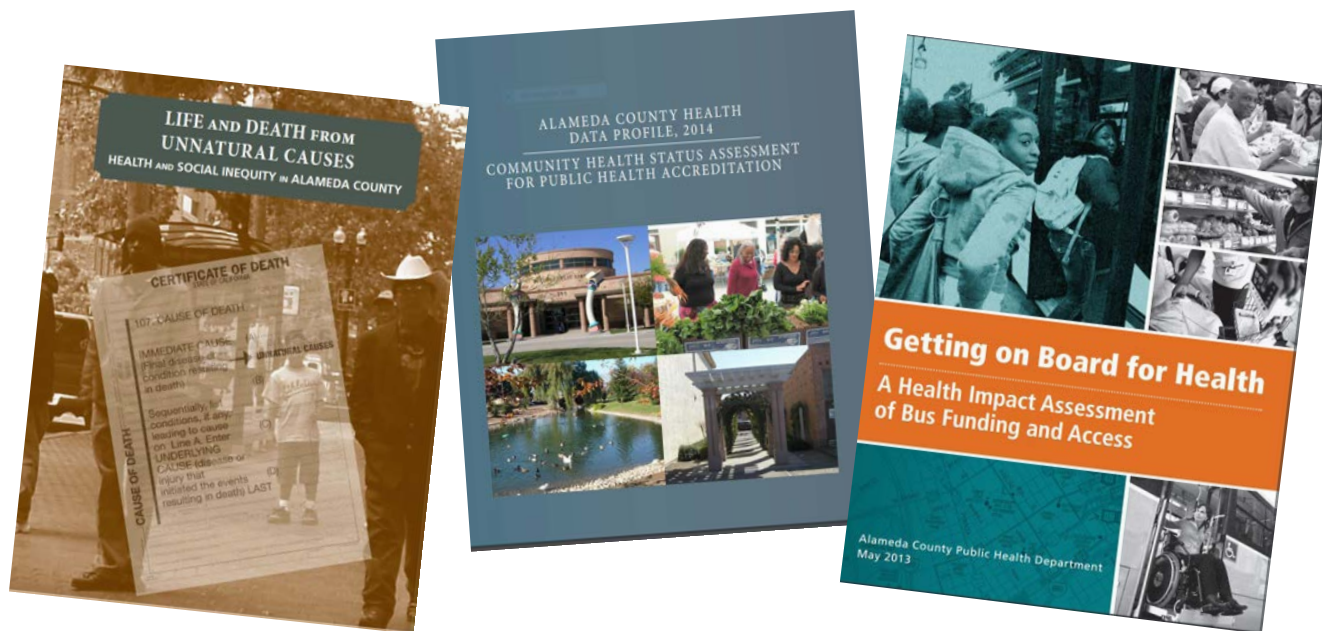
4. Work cross-programmatically within the Health Department and with other county agencies and institutions to create inter-connections across sectors

- ✓ The Health Care Services Agency and Social Services Agency are working together to develop a Countywide Plan for Seniors. The HCSA Internal Agency Workgroup undertook a comprehensive public planning process to update the inventory and better understand current services for older adults. This effort involved multiple departments, including the Social Services and Health Care Services

Agencies, Public Health Department, Behavioral Health Care Services, and others. The planning process was steered by a committee that included community-based organizations, representatives from cities, consumers, academics, and other stakeholders. The information produced was included in the 2017–2020 Alameda County Plan for Older Adults.

5. Produce annual or on-request reports on disease areas and health and wellness, including health data, and local trends

- ✓ The Community, Assessment, Planning, and Evaluation (CAPE) unit works to achieve the Health Department's mission and vision by monitoring the latest data on social and health issues affecting the county and producing periodic reports and presentations on overall health status of County residents. CAPE frames and analyzes the issues and trends using a health, racism, and poverty lens. It produces information to help educate and inform policy makers, non-profit organizations, community educators, city planners, local service providers, residents, and students on health trends on a wide range of topics. Their reports are intentionally structured to be accessible to communities so that they can understand and benefit from the information.





“I can do things you cannot,
you can do things I cannot;
together we can do great things.”

—MOTHER THERESA



Conclusion

The Alameda County Public Health Department shares the community’s broad vision of a healthy, prosperous and fulfilled life for every resident. We are committed to addressing the persistent health disparities in Alameda County, and the social, economic, and racial inequities that perpetuate them. This work cannot be done alone or in isolation. Internally, we will continue to champion the effort to incorporate an “Equity in All Policies” approach within all county-level decision making processes and to expand the Government Alliance on Race and Equity principles throughout the county. The Health Department will maintain its efforts to engage with external partners across systems, sectors and institutions, to raise awareness and to advocate for initiatives, policies and programs that comprehensively address the

social determinants of health. We will continue to be an ally to our community partners and will support their efforts to achieve health and social equity by studying and sharing the links between policy issues and health, providing public health data and trend updates (such as those outlined in Appendix A for this planning process), and offering testimony as requested. The findings in this report continue to inform our work—many community members that participated in the process are currently actively supporting the development of the Department’s long-range Community Health Improvement Plan (CHIP). Together, we will make a difference in Alameda County.

Glossary of Terms

The below definitions come from a mix of sources—including the Bay Area Regional Health Inequities Initiative (BARHII), the World Health Organization (WHO), and the Centers for Disease Control and Prevention (CDC). Some of these have been modified by ACPHD to describe the way we use them in this Plan.

Chronic Disease is a long-lasting health condition that can be controlled and managed, but not cured. Chronic disease is preventable and is also the leading cause of death in the U.S., disproportionately affecting low-income people and people of color.

Healthy Equity is achieving the highest level of health for all people, as indicated by the health status of the most socially advantaged group. Health equity involves focused societal efforts to address avoidable inequalities by equalizing the conditions for health for all groups, especially for those who have experienced socioeconomic disadvantage or historical injustices. It also requires comparing health and its social determinants between more and less advantaged social groups.

Health Inequities are differences in health by population groups, also known as disparities, that are systemic, preventable, and avoidable—and therefore considered unfair or unjust.

Risk Factors are any characteristics or experiences which make an individual more likely to develop a disease or injury. Risk factors can include behaviors—such as smoking, physical inactivity, and unhealthy diet—as well as social and environmental conditions, such as living in unhealthy housing, breathing polluted air, and having limited access to education.

Social Determinants of Health are the interrelated social, economic, and environmental conditions in which people are born, grow, live, work and age that influence their health. These determinants include, but are not limited to: income and socio-economic status, discrimination, physical environment, housing, food security, child development, transportation, access to health care services, working conditions, culture, social

support, education, and democratic participation.

Structural Racism. The word “racism” is commonly understood as referring to instances in which one individual intentionally or unintentionally targets others for negative treatment because of their skin color. This individual focus is too limited, as racialized outcomes do not require racist individuals. Structural racism refers to a system of social structures—including public policies, institutions like prisons, schools, and government agencies, and societal norms and values—which have produced long-standing race-based inequalities. Structural racism is also a method of understanding and analyzing how historical legacies and contemporary structures work together to distribute privileges and disadvantages along racial lines.

Access is the ability of an individual or community to make use of a resources or opportunity. In this Plan, we use access to mean the physical presence of a resource, as well as its affordability and cultural relevance. For example, having access to healthy food means that stores selling healthy food must be in the neighborhood and the healthy food options must also be affordable.

Mobility refers to how easily a person can move from one place to another, either due to physical constraints, safety, money, or availability of transportation.

Appendix A

Chronic Disease Trends in Alameda County: Risk and Protective Factors and Disease Incidence by County vs. Racial/Ethnic Group

NOTE ON DATA SOURCES: Data in this table were compiled from several data sources by the Community Assessment, Planning, and Evaluation (CAPE Unit) of the Alameda County Public Health Department. Data sources reflect the years 2010–2012. This information was subsequently published in the report entitled Alameda County Health Data Profile, 2014.

UNDERSTANDING THE CHART COLUMNS: The “Trend” column shows whether overall rates are increasing or decreasing, and the “inequity ratio” column shows the magnitude of difference between the highest and lowest rates of disease for specific groups. For each indicator, the numbers in **red** show the highest/worst rate compared with other groups, and numbers in **green** show the lowest/best rate compared with other groups.

HEALTHY LIFE										
Indicator	Measure	Alameda County Rate	A C Trend	African American	American Indian/ Native Alaskan	Pacific Islander	Asian or **Asian/ Pacific Islander	Latino	White	Inequity Ratio
SMOKING										
Current Smoking, Adults	Prevalence Rate	11.7%	↓	21.8%	n/a	n/a	6.2%	12.4%	10.7	3.5
Lifetime Smoking, Adolescents	Prevalence Rate	14.1%	n/a	16.0%	23.5%	18.4%	6.3%	19.0%	13.3%	3.7
DIET										
Soda, Adolescents	Prevalence Rate, 2+ Sodas Consumed/ Day	23.4%	↑	55%	n/a	n/a	15.5%	30.5%	16.1%	3.5
Fast Food, Adults	Prevalence Rate, Consumed 3+ days/ week	16.6%	↑	25.4%	n/a	n/a	13.7%	23.8%	12.1%	2.1
Fruits and Vegetables, Adolescents	Prevalence Rate, not received 5-a-day	75.2%	–	82.7%	n/a	n/a	61.4%	91.1%	66.4%	1.5
PHYSICAL ACTIVITY										
Aerobic Capacity, Adolescents	Prevalence Rate, Not in Healthy Fitness Zone	35.4%	↑	48.5%	n/a	n/a	19.9%	46.7%	26.4%	2.4
Physical Activity, Adolescents	Prevalence Rate, < 4 days/ week of 1 hr.+ P.A.	49.2%	–	50.6%	n/a	n/a	44.6%	62.5%	34.8%	1.8

HEALTHY LIFE										
Indicator	Measure	Alameda County Rate	A C Trend	African American	American Indian/ Native Alaskan	Pacific Islander	Asian or **Asian/ Pacific Islander	Latino	White	Inequity Ratio
Sedentary, Adults	Prevalence Rate	11.1%	–	13.1%	n/a	n/a	7.6%	8.7%	14.6%	1.7
Some Physical Activity, Adults	Prevalence Rate		–	48.0%	n/a	n/a	64.4%	40.6%	40.1%	1.6
OBESITY										
Obesity, Adults	Prevalence Rate	18.2%	↑	28.9%	n/a	n/a	5.5%	**26.6%	21.3%	5.2
Obesity, Teens	Prevalence Rate	17.4%	–	23.0%	19.7%	16.9%	8.2%	25.9%	11.4%	1.9
Obesity, All Ages	Hospitalization Rate	338.3	↑	769.7	338.0	n/a	**84.9	326.2	366.6	9.1
HEART DISEASE										
Coronary Heart Disease, All Ages	Hospitalization Rate	314.1	↓	379.4	343.7	n/a	**248.9	256.6	306.7	1.5
Hypertension, All Ages	Hospitalization Rate	1,353.3	↓	2,614.4	n/a	n/a	**901.8	1,096.8	1,293.7	3.2
STROKE										
Stroke, All Ages	Hospitalization Rate	229.1	↓	430.2	165.7	n/a	**166.0	187.5	214.5	2.6
DIABETES										
Diabetes, All Ages	Hospitalization Rate	978.5	↓	1,946.3	859.5		748.2	1,170.6	834.9	2.6
ASTHMA										
Asthma, All Ages	ED visit Rate	476.9	↓	1,622.2	n/a	n/a	**266.0	416.6	364.3	6.0
Asthma, < 5 Yrs. Old	ED visit Rate	1,030.2	↓	2,942.8	n/a	n/a	**972.2	977.1	558.6	5.2

PRODUCTIVE LIFE										
Indicator	Measure	Alameda County Rate	A C Trend	African American	American Indian/ Native Alaskan	Pacific Islander	Asian or **Asian/ Pacific Islander	Latino	White	Inequity Ratio
EDUCATION										
High School Graduation	Prevalence Rate, Percent Graduated	79.4%	↓	62.0%	61.4%	75.4%	90.4%	69.2%	89.1%	1.5
3rd Grade Reading	Prevalence Rate, Percent Proficient or Advanced	54.0%	↑	36.0%	54.0%	34.0%	76.0%	31.0%	73.0%	2.5
POVERTY										
Federal Poverty Level (FPL)	Prevalence Rate, Population with Income < FPL	13.1%	↑	24.3%	16.8%	16.5%	9.6%	18.6%	10.7%	2.5
UNEMPLOYMENT										
Unemployment	Prevalence Rate	10.9%	↑	19.5%	16.2%	22.1%	8.4%	12.9%	9.2%	2.4

FULFILLING LIFE										
Indicator	Measure	Alameda County Rate	A C Trend	African American	American Indian/ Native Alaskan	Pacific Islander	Asian or **Asian/ Pacific Islander	Latino	White	Inequity Ratio
VIOLENT CRIME										
All Violent Crime	Prevalence Rate	713.2	↑	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Homicide	Prevalence Rate	8.8	↑	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Assault	Emergency Department Visit Rate	388.9	n/a	1,398.4	469.0	179.5	90.4	313.7	279.3	15.5
COST OF LIVING										
Rent Burden	Prevalence Rate, HHs Paying > 50% Income on Rent	27.1%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
SOCIAL COHESION										
Indicators being explored.										
SPIRITUAL CONNECTEDNESS										
Indicators being explored.										
FULFILLMENT										
Indicators being explored.										

Appendix B:

Community Identified Indicators and Availability

Indicator	Available to ACPHD; frequency	Collected elsewhere	Level at which data is collected	Not available (N/A)
RESULT #1: ACCESS TO HEALTHY FOOD AND PRODUCTS				
COMMUNITY-LEVEL INDICATORS				
Children living in food insecure households	2014 is latest	Kidsdata.org		
Rate of soda, fast food, and vegetable consumption (Short term Community-Level)	Available in CHIS but maybe not every cycle or asked in the same way	CHIS		
HEALTH INDICATORS				
Rate of obesity in adults (Long term, health indicator)	Yes: annually from CHIS	CHIS		
Rate of obesity in children and adolescents	Yes: annually	FitnessGram (physical fitness testing (PFT) in grades 5, 7, 9)		
Coronary heart disease, stroke and diabetes hospitalization rate	Annually			
Rate of hypertension hospitalizations	Annually			
RESULT #2: HEALTHY, SAFE, ACCESSIBLE PLACES TO LIVE, WORK, PLAY				
COMMUNITY-LEVEL INDICATORS				
LONG TERM				
Rate of property crimes	Yes: annually		Dept. of Justice	
Homicide rates	Same as above		Dept. of Justice	
Rate of violent crimes	Yes: annually		Dept. of Justice	
Student perception of safety at school by middle and high school students	Yes: annually	Kidsdata.org		
HEALTH INDICATORS				
SHORT TERM				
Rate of those in healthy fitness zone for aerobic capacity			Fitness Gram (children only)	
Rate of adolescents who exercised and adults who are sedentary				N/A

Indicator	Available to ACPHD; frequency	Collected elsewhere	Level at which data is collected	Not available (N/A)
RESULT #3: SAFE, CARING AND STRONG COMMUNITIES				
COMMUNITY-LEVEL INDICATORS				
Level of social cohesion	No			N/A
Spiritual connectedness	No			N/A
% of residents who report discriminatory treatment	No			N/A
Divorce Rates	No			N/A
Child abuse rates	Maybe # of substantiated cases of child abuse in AC and by type of abuse	Social Services/Child Protective Services Kidsdata.org		
HEALTH INDICATORS				
Mental health, anxiety/ depression rates	Rate of hospitalization for 5–19 y.os for MH issues, annually Some, for adults and teens	Kidsdata.org ASK CHIS/AC CHIS		
Depression related feelings among youth, by race (last reported 2013)		Kidsdata.org		
Drug/Alcohol Hospitalizations	By race/ethnicity, male/female, for select years			
Divorce Rates	NO			N/A
RESULT #4: EDUCATIONAL AND EMPLOYMENT SUCCESS				
Rate of high school graduation	Yes	California Dept. of Education		
3rd grade reading proficiency	?	Dept. of Ed		
% of residents receiving a “Living wage”	No, only poverty levels are available to Health Dept.			
Percent of renting households paying 50% or more of income on rent	Yes, annually	American Community Survey		

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