

RECOMMENDATIONS ON PREVENTION

CALIFORNIA WORKING FAMILIES POLICY SUMMIT JANUARY 13, 2009

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INTRODUCTION

Some communities have parks for physical activity, sidewalks for walking, and easy access to healthy foods. Other communities do not. These public environment conditions have an impact on our health—more than 50% of our health is determined by where we live. With the increase in chronic diseases such as heart disease, diabetes, and asthma, and skyrocketing health care costs, we need to provide all Californians, regardless of where they live, with the opportunity to breathe healthy air, engage in physical activity safely in their neighborhoods, and get nutritious foods easily. The majority (53%) of Californians are people of color, and yet communities of color are more likely to suffer from chronic and debilitating disease, and to live in neighborhoods that do not provide them with systems that promote good health. Our political leaders in Sacramento must commit to addressing these health disparities.

In 2000, California spent approximately \$500 million in hospitalizations due to asthma alone. Every time a child can't go to school due to an asthma attack, the child misses a learning opportunity, parents miss work, the business loses productivity, and the school loses money.ⁱ The estimated annual medical care costs of the consequences of obesity and overweight are \$21.7 billion in California.ⁱⁱ It has been estimated that a 5% reduction in heart disease prevalence in California would save the state \$974,078,000 annually.ⁱⁱⁱ Loss of productivity results in loss of time and money for our businesses, and prevents California from maintaining a robust, competitive workforce.

California must begin to look at health more broadly than access to health care services. We must look at each policy decision through a lens of how the change would impact our health. We must be mindful to the possibility that closing school playgrounds after hours to keep down maintenance costs actually increases the odds our children will become obese from lack of physical activity. Will a new infrastructure enhancement create more pollution, or will it expand sidewalks to allow for more walking in the community? If a grocery store closes down in downtown San Jose, will there be other opportunities for the community to buy affordable produce and other nutritious foods?

Finally, communities of color are much more likely to suffer health problems—not only because of the communities in which they live, but also because health care systems deliver poorer outcomes for people of color. We must collect data on race and ethnicity to ensure we are identifying disparities and tracking our progress in eliminating them. We must also ensure our health care system is addressing the unique needs of our communities. One clear, immediate way that can be done is to take advantage of the state's ability to draw down more federal dollars to fund interpreter services in the Medi-Cal program.

POLICY OBJECTIVE #1

Open up school facilities for use by the community for physical activity.

Background

One of the primary challenges to reducing obesity and diabetes is that low-income communities of color lack safe neighborhoods, parks, sidewalks, and other venues that are necessary for engaging in increased physical activity on a daily basis. One solution is to create new—or open up existing—school facilities for use by the community. Such a policy change allows the playgrounds and other school recreation facilities to be “jointly used”—by students during school hours, and by members of the community during non-school hours, providing members of the community with increased opportunities to improve their health through regular physical activity.

The state has an established funding mechanism to develop and improve facilities that can be used for joint-use. To obtain joint-use funding from the state, the projects require partnerships between school districts and nonprofit organizations or government agencies. These resources can then be used to build or modernize facilities for the community and the school, such as libraries, gymnasiums, health clinics, athletic and recreational fields, and child care centers.¹ Funds from previous bonds are largely depleted, so there must be efforts to place new bonds on the ballot to fund new joint-use facilities. Another problem is that the funds from prior bonds could not be used by schools to pay the costs associated with maintenance, to support recreational activities, or simply to expand the use of existing facilities (as opposed to building to new ones).

New facilities are part of the answer, but existing schools also need to open their doors to the community. Under the state Civic Center Act every school is designated as a Civic Center and can be used for supervised recreational activities. When no other location is available, schools must allow their facilities to be used by organizations promoting youth and school activities. However, there have been serious problems with implementation: Most communities and schools are unaware of the Act; there is no enforcement mechanism in the Act; and schools lack the resources to absorb increased maintenance costs.

Recommended Actions

- A. The Legislature must initiate the process of issuing new bonds for school construction that contain funding streams for joint-use facilities. Funds should be available for indoor and outdoor recreational facilities to support recreational activities for children and others in the community, to build new facilities as well as renovate existing ones, and to pay for maintenance.
- B. The Legislature should create incentives or requirements for schools to enter into joint-use agreements or open their facilities for community recreation. One way to do this is to amend the Civic Center Act to include stronger enforcement provisions.

POLICY OBJECTIVE #2

Expand the use of Health Impact Assessment (HIA).

Background

Research shows that how neighborhoods and cities are designed affects numerous health conditions such as heart disease, asthma, diabetes, obesity, osteoporosis, depression, injuries, and some cancers. According to the Institute of Medicine, improving health in the 21st century will require new approaches to environmental health, including strategies to deal with unhealthy buildings, urban congestion, poor housing, poor nutrition, and environmentally-related stress.

¹ Description adapted from New Schools for Better Neighborhoods, an organization working on joint-use projects and policies. www.nsbnn.org.

Health Impact Assessments (HIA) are exciting new tools being developed to evaluate and improve policies and projects based on predicted health outcomes. HIAs are routine in other countries, where health departments provide advice on policy decisions that impact health. The World Health Organization defined HIA as a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population. An HIA can be conducted by a government agency, researcher, or community group.

HIAs can provide important evidence to support community positions and concerns. These assessments also give communities a direct role in asking and getting answers to questions important to healthy growth, whether those questions come from an environmental justice, environmental health, economic justice or other community perspective. Overall, HIAs support a stronger community voice in planning decisions and help policymakers better understand how seemingly unconnected policy decisions can affect the health of our communities.

Recommended Actions

- A. The Legislature and Administration must provide sufficient funding to the California Department of Public Health (CDPH) to implement an HIA program.
- B. As part of this program, CDPH must conduct HIAs on how policy decisions in Sacramento are impacting our health. CDPH must also provide local public health departments and community organizations with guidance on how to conduct their own HIAs.

POLICY OBJECTIVE #3

As part of broader prevention efforts, the state must prioritize the elimination of racial and ethnic health disparities by ensuring that data on race, ethnicity, and primary language—and other important characteristics, such as gender—is collected and analyzed.

Background

Health care experts agree that there are significant disparities and differences in treatment, disease patterns, and risk behaviors among different racial and ethnic groups that persist even when we look at groups that are from the same socio-economic status. Public health officials, advocates, health services providers, health plans, and even individuals managing their own health risks benefit from having a complete picture of community health.

The collection of race and ethnicity data is essential to develop sound public policies, ensure the most efficient use of scarce resources, and address the needs of diverse communities. Health care experts use health data on race and ethnicity to understand who is most affected by certain diseases and health threats, to create prevention programs appropriate for different communities and cultures, and to determine when our medical system fails to reach and treat a particular community.

The programs in the CDPH and the California Department of Health Care Services (CDHCS) are particularly vital to ensuring that disparities are addressed. These two departments must have policies that ensure all their programs are collecting and utilizing this data. In particular, California's Medi-Cal program provides health care access to 6.45 million beneficiaries. Of this population, about eighty percent are people of color, and almost half speak a language other than English. Medi-Cal must ensure its data collection is accurate and that quality data in the program is analyzed by race, ethnicity, and primary language. In addition, the Healthy Families Program, operated by the independent Managed Risk Medical Insurance Board (MRMIB), is a program that is also relied upon by communities of color and is even more diverse—with its enrollment of nearly ninety-percent people of color and over half speaking a language other than English. The Healthy Families Program must also collect data needed to assess health disparities.

Recommended Actions

- A. All CDHCS and CDPH programs must collect and analyze race, ethnicity, and language data. The Medi-Cal program is the first priority.
- B. MRMIB must ensure the Healthy Families Program is collecting and analyzing race, ethnicity, and language data.

POLICY OBJECTIVE #4

Seek federal matching funds to support language assistance services in the Medi-Cal program.

One opportunity to immediately improve services in Medi-Cal for the nearly half of beneficiaries who speak a language other than English is to increase the capacity of providers in the program to provide language services. When patients who are limited-English proficient (LEP) attempt to access the health care system, they are likely to confront language and cultural barriers. In many cases, LEP patients are expected to bring their own interpreters, perhaps using minors, despite federal and state laws requiring the availability of qualified language assistance services. Lack of language services impacts access to health services and preventive care, can result in greater emergency room use, impedes patients from comprehending diagnoses, and increases the likelihood of patients missing appointments.

Providers cite the high cost of providing language assistance services as a primary reason for not providing interpreters and translated materials. While costs are certainly an important factor, they need not create an insurmountable barrier to language services. Federal law allows states to offset the costs of language services for Medicaid and State Children's Health Insurance Program (SCHIP) enrollees by providing federal matching funds. Although California is the most diverse state in the country, it has not taken advantage of these federal matching funds.

The CDHCS Medi-Cal Language Access Services Taskforce was formed in 2006 to explore options for the state to draw down federal funds to provide language services to patients who need them. Adopting the recommendations of this Taskforce would enhance the future health and economic well-being of the state.

- A. The Legislature must fund, and the CDHCS must implement, a program to draw down federal reimbursement dollars for language access services in the Medi-Cal program.

For more information on these recommendations, contact:

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ⁱ *California Asthma Facts*. California Department of Health Services, Vol. 1, Iss. 1, May 2003.

ⁱⁱ Chenoweth, David. The Economic Costs of Physical Inactivity, Obesity, and Overweight in California Adults: Health Care, Workers' Compensation, and Lost Productivity. Topline Report, April 2005.

ⁱⁱⁱ Prevention Institute and The California Endowment, Reducing Health Care Costs through Prevention, accessed January 15, 2008 at http://preventioninstitute.org/documents/HE_HealthCareReformPolicyDraft_091507.pdf