CALIFORNIA
BLACK HEALTH NETWORK

California Black Health Agenda 2019

California Black Health Agenda

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Building Healthy Families in Healthy Communities Throughout California

California Black Health Network
520 Ninth Street, Suite 100
Sacramento, CA 95814
CaBlackHealthNetwork.org
(916) 333-0613

California Black Health Agenda

Executive Summary

OVERALL FINDINGS — "Like Black Lives and Black Minds, Black Life Matters"

For the African-Americans who participated in the seven town hall meetings that the California Black Health Network conducted in 2017, four themes mattered most:

(1) Our health must be our first priority.

(2) Our health must be a movement, requiring systemic change in our communities, institutions, organizations and in public policy.

(3) All African-American organizations must reinvent themselves with health as our first priority.

(4) Health policy, economic development, oral health, and community and mental health are four topics on which our discussion as a community should begin.

This document serves as a conversation starter for community members, advocates and stakeholders. This is an evolving document that will continue to be enhanced through input from the 2018 Policy Summit; from ongoing contributions by workgroup members committed to advancing the issues raised in this document; and through validation and input from future town halls, researchers and policy advocates. This is the first step in the construction of a "Black Health Agenda." The process to build this agenda commenced in 2017 with seven town hall meetings, described herein.

THE TOWN HALL PROCESS

In 2017, the California Black Health Network (CBHN) conducted town hall meetings throughout the state, specifically in Perris (near Riverside), Fresno, Sacramento, Oakland, San Bernardino, San Diego and Los Angeles. The purpose of these meetings was to obtain input from the community about their health and health care concerns, priorities for policy advocacy, and strategies they believe would help to improve their health outcomes. This document represents the clearest aggregate of the recommendations collected during the town hall meetings in the seven California cities visited in 2017, which more than 320 individuals attended.

Each town hall meeting included presentations from local experts on a variety of issues facing the local community. These community advocates included representatives from the health and public health departments, local universities, mental health professionals, prevention specialists and health care providers as well as community advocates. Experts presented local data about conditions believed to be detrimental to the health and well-being of the African-American community in their area. The audience was then given an opportunity to respond to the presentations and add their perceptions of the needs for their specific communities.

Town hall participants also were asked to identify behaviors, services and strategies they believe are ineffective in promoting their health and well-being. The same questions were posed regarding behaviors, services and strategies they would continue as well as others they would start in order to improve or sustain their health and well-being. The results from these conversations were analyzed and aggregated into specific themes and strategies. These themes and strategies were shared with statewide policy advocates, consultants and community activists, who added information and suggested strategies for creating the agenda.

TOWN HALL RESULTS: The results of the town halls form the foundation of the California Black Health Agenda. The creation of the agenda is an evolving process, meant to be informed by

and refined by community input and consensus over the next year. The input collected to date has been organized into four general categories described below in brief and in greater detail within this document:

• **Health policy** — Under this area respondents expressed a desire for a reconceptualization of health navigators and service enhancements to Medi-Cal. Suggested Medi-Cal enhancements include improvements in the enrollment process, continuity of eligibility status, and remedies for perceived stigma. Other topics presented that could be addressed through policy advocacy include: high rates of infant mortality that reportedly are influenced by adverse childhood experiences but are not included in funding formulas when allocating resources to improve the health outcomes of Black babies; and the environment and financial stability, identified as "upstream" issues that impede the ability of Black people to prevent detrimental conditions related to health and community vitality. Social and political determinants that influence chronic exposure to toxic stress, poverty, homelessness and other problems should be braided into policy changes intended to improve health outcomes and vice versa.

• **Economic development** — The ability to financially sustain community services and the people who perform those services was a major topic in every town hall. Economic instability is the root cause for impediments that individuals and communities encounter in pursuing beneficial change, in complying with treatment regimens, in seeking to reduce stress, and in overcoming obstacles to attain a positive outlook for future improvements. Suggestions and strategies discussed to improve the financial condition of Black people included for-profit business development training, tax revenue from cannabis sales that Proposition 64 authorized, community-serving co-ops, collaboration among nonprofit organizations, and funder collaboratives focused on the social determinants of health.

• **Oral health** — Highlighted in this area are concerns regarding the prevalence of periodontal disease within Black communities, trends related to oral cancer within African-American men, fluoridation of water, oral cancer, limitations of insurance, the inability to afford out-of-pocket copayments, and limitations in access to dentists and dental care. In addition to a focus on dental care, participants focused on the need to increase the number of dental professionals at every level.

• **Community and mental health** — This category encompasses a vast number of concerns related to challenges and strategies for improving African-American health and well-being. Topics include violence and domestic violence, social injustices, impact of racial trauma, the need for a new paradigm for Black unity, community empowerment, the need for a centralized clearinghouse for community information and advocacy, homelessness, and advocacy for more prevention related to a variety of health indicators associated with poor health outcomes. Many of the health advocates who attended the town halls raised awareness regarding the prevention of a variety of health conditions that have become the primary indicator for inequities in health outcomes with the Black community. They include: diabetes, sexually transmitted diseases, cardiovascular disease, HIV/AIDS, premature death, obesity and poor nutrition. Primary prevention of health problems remains a principal strategy of community-based organizations for addressing the health needs of community members.

ADDITIONAL INFORMATION

BLACK PEOPLE ARE ON THE MOVE

— In addition to the recommendations, our travel reinforced the demographic changes in California's African-American population

originally reported in Dr. Robert Teranishi's study "Black Residential Migration in California." The largest increases in African-American populations have occurred in cities, including Sacramento, Stockton and Fresno, whereas the largest percentage change continues to occur in smaller rural communities. African-Americans are now concentrated in both suburban and rural communities, a fact that continues to transform traditional power centers, representation, collaboration and services provided.

BLACK PEOPLE HAVE ISSUES TO ADDRESS — Black people are interested in sharing their concerns about challenges but also what's working in their communities. Although 320 people attended, 780 people had signed up to participate in the town halls, suggesting a need for more face-to-face conversations.

FOCUS ON SOLIDARITY, COOPERATION and IMPACT — The members of the California Black Health Network are conveners. The goal of building a Black Health Agenda is not to "reinvent the wheel." Instead, the intention is to strengthen the spokes on a community of wheels already rolling. Many organizations serving Black communities have existing agendas and priorities, and new members of the community have a vision and desire to share in the work.

The California Black Health Network stands in solidarity with these long-standing and new ventures. Through strategic collaboration and cooperation a larger impact can be achieved, if these various organizations collectively support one another. This is a consequential time for many reasons; the California Black Health Network participants hope that African-Americans emerge more unified and focused on the most consequential issue in our community: life.

IN SUMMARY

CBHN hopes that this document will serve as a conversation starter and an avenue to begin to support like efforts and a community agenda. Input gathered from this day forward will help create the Black Health Agenda. Our hope is that the Black Health Agenda will be used by individuals and organizations seeking to promote the health and well-being of Black people. CBHN developed this document for use at the local level, to serve as talking points at community meetings or with policy makers. We hope it will be used by organizations and advocates seeking change in venues that affect the lives of African-Americans. This is a community effort, owned by the community.

California Black Health Agenda

Health Policy

Town hall participants identified multiple issues that have been organized into five topics for conversation.

1. Universal Navigation Services — Participants believe that the current health care system is complex beyond reason. People need more support to access care, implement the treatment regimens that physicians prescribe, and sustain behavior changes required for full recovery. Specifically, participants want health plans across the insurance industry to cover enhanced navigation services that accountability partners, care coordinators and/or cultural brokers perform. For people living with chronic conditions, enhanced navigation services will help them access, implement and sustain behavior changes that will improve their condition. Navigation and education services are needed specifically in the following areas: patient benefits and education, physician visits, home visits, and assessments and treatment related to breast cancer and diabetes care.

RESEARCH SHOWS: **Universal Navigation Services —** One of the most important overall health indicators of the federal government's Healthy People 2020 initiative is access to high-quality health care services. In 2011 about 17 percent of African-American (23 percent of Americans) did not have a regular primary care provider for preventive care or advice. The Implementation of the federal Affordable Care Act (ACA) has expanded access to health insurance for most people; but this does not ensure that everyone receives appropriate or high-quality care at the right time. The ACA provides several avenues to address the health disparities linked to cultural and linguistic barriers. This includes expanded research on health and health care disparities and a Patient-Centered Outcomes Research Institute that oversees studies that examine differences in patient outcomes among racial and ethnic minorities. ACA also has expanded grant programs to attract and retain health professionals from diverse backgrounds and it directs funding to encourage services in underserved areas ("Health Care Access and Quality of Care," 2015, pp. 48–51). For example, in Sacramento, some health care providers employ health navigators to help patients use their new coverage, understand how to navigate the health care system, and avoid inappropriate use of emergency departments (Wishner & Burton, 2017).

Sources:

California Department of Public Health, Office of Health Equity. (2015). Health care access and quality of care: Narrowing the gaps. In *Portrait of Promise: The California Statewide Plan to Promote Health and Mental Health Equity* (pp. 48–51). Retrieved from https://www.cdph.ca.gov/Programs/OHE/CDPH%20Document%20Library/Accessible-CDPH_OHE_Disparity_Report_Final%20(2).pdf

Chi, J., & Handcock, M. (2014). Identifying sources of health care underutilization among California's immigrants. *Journal of Racial And Ethnic Health Disparities*, *1*(3), 207–218. doi:10.1007/s40615-014-0028-0

Derose, K., Escarce, J., & Lurie, N. (2007). Immigrants and health care: Sources of vulnerability. *Health Affairs*, *26*(5), 1258–1268. doi:10.1377/hlthaff.26.5.1258

Wishner, J., & Burton, R. (2017). How have providers responded to the increased demand for health care under the Affordable Care Act? Retrieved from https://www.urban.org/sites/default/files/publication/94396/2001576-how-have-providers-responded-to-the-increased-

demand-for-health-care-under-the-affordble-care-act_0.pdf

2. Medi-Cal Stigma and Medi-Cal Reform — Participants from the town halls support strategies that result in easier access to high-quality care. However, they believe that Medi-Cal needs a comprehensive overhaul, and that stigma attached to Medi-Cal is a cause for low enrollment and low service utilization. Perceptions that Medi-Cal recipients receive substandard care appear to be influenced by several factors: inability to access the more popular and highly rated doctors or hospitals when assigned Medi-Cal status; physicians' unwillingness to accept Medi-Cal; front office medical staff reaction when told the patient has Medi-Cal; and the loss of eligibility when communication with the county is disrupted. Some participants want Medi-Cal renamed, "like [the] Food Stamps [program] was renamed CalFresh." The experience of Medi-Cal across the state is different depending on the county in which the recipient lives. This different and its branding influences the perceptions of this valuable resource. In some counties Medi-Cal is publicly marketed as insurance for the indigent; in others, it blends into the insurance market like employer-supported insurance, reducing the impact of stigma.

RESEARCH SHOWS: **Medi-Cal Stigma and Medi-Cal Reform —** The enrollment data that was included in the Medi-Cal Eligibility Data System (MEDS) represent only certified eligible counts. The "certified eligible" designation indicates beneficiaries deemed qualified for Medi-Cal by a valid eligibility determination, and who have enrolled into the program. As of February 2018, 1 million out of the 13.2 million certified eligible people enrolled were African-American, which equates to 8 percent of the total population eligible (1,004,716 of 13,290,899 total of eligible population). MEDS also reported that African-American adults have the highest rate of

reporting medical care discrimination due to race or ethnicity, 14.2 percent, in comparison to rates for other racial groups (Whites, 2.6 percent; Asians, 5 percent; Latinos, 6.4 percent).

Source:

California Department of Health Care Services, Research and Analytic Studies Division. (June 2018). *Medi-Cal Monthly Enrollment Fast Facts, February 2018 as of the MEDS Cut-off for May 2018*.

3. Reframing Infant Mortality — Participants want to re-focus the conversation of infant mortality to include adverse childhood experiences (ACE) utilizing the ACE score model, as a means of identifying at-risk individuals, and they want to link that discussion to policies that reduce violence, stress, poverty and family disruption. Participants also want to implement a model of care that starts at pre-conception. Many of them strongly support elimination of barriers to breast-feeding, and express the need for pre-conception health services for women throughout their lifetime. Participants referenced two findings from recent studies as a need to re-think infant mortality: (1) Black women are more likely than women of other races to die during childbirth. (2) Black boys are four times more likely than Whites to be born at low birthweight in Oakland.

RESEARCH SHOWS**: Reframing Infant Mortality —** Research has revealed that the risk of morbidity and mortality rises with increased

exposure to adverse childhood experiences (ACEs). The widespread prevalence of ACEs demonstrates that they constitute a major public health problem. Despite great interest, only limited research has been conducted on racial and ethnic differences in the prevalence of ACEs (Mersky & Janczewski, 2018). Prior research in the United States suggests that the prevalence of ACEs varies along socioeconomic lines, but is inconclusive about whether racial and ethnic differences in ACE rates occur among low-income populations.

Racial disparity in infant mortality — Significant racial and ethnic disparities existed across a variety of maternal quality measures in California, from prenatal visits to preterm births to maternal and infant mortality rates. For many of these measures, African-Americans performed worse than their peers in other racial and ethnic

groups. In 2014, 11.5 percent of African-American babies were born with low birthweight in comparison to 5.8 percent for White babies (Joynt, 2016). Infant mortality rate (IMR) is more than an indicator of maternal and child health; it is a symbolic benchmark of a society's overall health. In the United States, African-American infants have significantly higher mortality than White infants. African-American infants have a 2.2-fold greater mortality rate than White infants, in comparison to a rate of 1.6. (Matoba & Collins, 2017).

Race and geographic ancestry — Race has been viewed as a proxy for geographic ancestry, and some investigators have argued that disparities in birth outcomes result from genetic differences between African-American and White women because statistical adjustment for socioeconomic factors did not fully eliminate racial disparities in infant mortality. Rather than a traditional genetic concept, race should be viewed as a social construct. As such, social, economic, and cultural processes across the life-course are hypothesized to adversely impact historically disadvantaged populations in a multilayered manner (Matoba & Collins, 2017).

Stress and exposure to racism — Racial discrimination is a social construct that African-American women must navigate throughout their lives. An expanding literature suggests that African-American women's exposure to interpersonal racial discrimination is a risk factor for poor pregnancy outcomes. The underlying mechanism appears to be related to stress; physiologic responses to chronic exposure to stress can accumulate over time, leading to an enhanced inflammatory response, compromised fetal development and adverse pregnancy outcomes (Matoba & Collins, 2017).

Scholarly discussions of the role of racism in health disparities have led to awareness of the need for public health interventions to combat the environmental, economic and cultural stressors specific to the African-American community's experience. Undoubtedly, interventions to reduce racial health disparities in this country will require such innovative community-based efforts, in addition to ongoing clinical, scientific and legislative efforts.

Studies suggest that African-American infants have significantly worse infant mortality than White infants. Looking at individual risk factors alone does not explain this persistent gap. Recent studies in social determinants provide

insight into the contribution of community and environmental factors to the racial disparity. Select community-level factors are potential, but partial, determinants of the racial disparity (Matoba & Collins, 2017). Interpersonal and institutionalized racism is an important, and increasingly recognized, stressor for African-American women with damaging consequences to maternal and child health.

The main objective is to eliminate racial disparity in infant mortality, by addressing early life disadvantages, in addition to lifelong exposure to social determinants ranging from neighborhood poverty, community factors such as crime, segregation and built-in environment, and racial discrimination.

Sources:

Bhatt, C., & Beck-Sagué, C. (2018). Medicaid expansion and infant mortality in the United States. *American Journal Of Public Health*, *108*(4), 565–567. doi:10.2105/ajph.2017.304218

Joynt, J. (2016). Maternity care in California: Delivering the data. Retrieved from https://www.chcf.org/wp-content/uploads/2017/12/PDF-MaternityCareCalifornia2016.pdf

Matoba, N., & Collins, J. (2017). Racial disparity in infant mortality. *Seminars In Perinatology*, *41*(6), 354–359. doi:10.1053/j.semperi.2017.07.003

Mersky, J., & Janczewski, C. (2018). Racial and ethnic differences in the prevalence of adverse childhood experiences: Findings from a low-income sample of U.S. women. *Child Abuse & Neglect*, *76*, 480–487. doi:10.1016/j.chiabu.2017.12.012

4. Merging Environmental Protection Policies with a Black Health Agenda — Participants identified multiple "green" legislative initiatives that must be leveraged to transform the health and well-being of African-Americans. They included legislation focused on greenhouse gas emissions and cap and trade, bond measures for park restoration, building urban forests, and elimination of toxic consumer products. Participants identified green policy opportunities to strengthen Black health, including legislation to fund projects in high-pollution communities to reduce greenhouse gas emissions and new legislation to increase employment training for clean energy careers for youth and people who formerly were incarcerated.

California Black Health Agenda

Economic Development

Town hall participants identified multiple issues organized into five topics for continued conversation.

For-Profit Business Development — Participants support current and future Black-owned businesses focused on health. Employment and business ownership is a key social determinant of health. Participants identified the double bottom line (making money, promoting health) for African-American entrepreneurs who are focused on health and health care for the Black community. Participants are interested in capacity building, technical assistance, education and investments to address issues related to African-American health.

Tax Revenue From Cannabis Sales That Proposition 64 Authorized — Participants identified the potential for economic opportunity related to the millions of dollars that may be generated from the tax on cannabis consumption in California. The proposition authorizes funds to be earmarked for community reinvestment and youth. Advocates are currently working on an "equity' formula for the distribution of funds. Those funds could be used for prevention and education activities as well as for funding related to local and or community pop-up health clinics and initiatives.

Community Serving Co-Ops — Participants focused on building more economic opportunities through co-ops and the history of co-ops as the backbone for the Civil Rights Movement. Participants focused on creating community cooperatives ranging from community gardens and healthy eating restaurants to manufacturing, distribution, job training and job creation. The Cooperation Jackson model working now in Jackson, Mississippi, is important to review with its focus on organizing at the municipal level for economic self-determination. These co-ops would also include internships and paid positions for African-American youth as well as community governance councils to ensure a community voice and attentiveness to needs in all decisions.

Nonprofit Collaboration — Participants want to create nonprofit collaborative organizations focused on health and well-being, with a specific emphasis on African-American populations and issues. In many cities nonprofit collaboratives have begun working together to approach funders as a collective body that pursues diverse but unified approaches to create the conditions for health and well-being in African-American communities statewide.

Funder Collaborative Focused on the Social Determinants of Health — Participants requested that national, regional and local funders combine forces and co-sponsor strategic initiatives together to focus on the social determinants of health that affect African-Americans communities in California. Sentiments reflected a funder shift in priorities to other communities, just as African-American communities were starting to strengthen their capacity to provide services. The result was a lapse in services along with a loss of culturally appropriate services and Black service providers. Participants want more input into the initiatives that funders place in their communities. They also want national, regional and local funders to convene and create a unified strategy for maximum impact.

California Black Health Agenda

Oral Health

Inequities related to oral health and the African-American community have reached alarming proportions over the past decade.

Recently published news and peer-reviewed research articles establish a set of broad facts ripe for both advocacy and action at the community and public policy levels.

Overview — African-American adults are more likely than other racial or ethnic minorities and Whites to have periodontal disease and to develop oral cancer, are less likely to have an early diagnosis of oral cancer and other oral health problems, and are more likely to be uninsured and have low-quality dental care or poor access to any dental care.

Insurance — In nearly every age cohort (children to adults) African-Americans experience oral health problems that are exacerbated by low-quality insurance or lack of insurance. Even when African-Americans have insurance they are more likely to receive lower quality dental care than White Americans and report insufficient coverage for needed treatments.

Access and Prevention — African-Americans often encounter difficulty in finding a dentist who accepts their insurance, and care often is delayed due to slow response for coverage authorization. Those are among key issues inhibiting proper oral health care. Participants seek improved availability of dentists and dental care, and access to early prevention and environments where prevention is supported. African-American children are more likely than their White or Hispanic counterparts to have untreated tooth decay at every age level.

Oral Cancer — In California, African-American adults, especially African-American

men, have a higher prevalence of tooth extraction due to decay or gum disease, and oral cancer mortality rates that are higher than those of adults in other racial and ethnic groups.

Careers — Participants identified careers and an education pipeline in oral health care and dentistry as important to the overall health and well-being of African-Americans.

RESEARCH SHOWS**: Oral Health** — The report titled "Status of Oral Health in California: Oral Disease Burden and Prevention 2017" (California Department of Public Health, April 2017) is a comprehensive review of oral health and disease in the state. It is intended to serve as a foundation for the Oral Health Program in the California Department of Public Health and the establishment of a new statewide oral health plan for California. In many cases the most recent California-specific data are more than 10 years old or non-existent.

Oral health is an essential and integral component of overall health throughout life, and it is about much more than just healthy teeth. Oral health refers to the health of the entire mouth, including the teeth, gums, hard and soft palates, linings of the mouth and throat, tongue, lips, salivary glands, chewing muscles, and upper and lower jaws. Good oral health means not only being free

of tooth decay and gum disease, but also being free of chronic oral pain, oral cancer, birth defects such as cleft lip and palate, and other conditions that affect the mouth and throat (Rogers, 2017). African-American adults in California have a higher prevalence of tooth extraction due to decay or gum disease, and higher mortality rates from oral cancers, in comparison to adults of other racial and ethnic groups. Among U.S. adults, African-Americans are twice as likely as non-Hispanic Whites (39.7 percent vs. 19.3 percent) to have untreated tooth decay. No state data are available to evaluate this measure for California adults (Rogers, 2017). A strong link exists between smoking and oral disease, yet only 1 in 10 smokers report that their dental providers advised them to quit.

Sources:

Cabezas, M. (n.d.). Identifying dental deserts in the Los Angeles County Safety Net using GIS maps. Retrieved from http://www.nationaloralhealthconference.com/docs/presentations/2016/04-19/Maritza Cabezas-Dental Deserts of the Los Angeles County Safety-Net Dental Clinics Using GIS Maps.pdf

Rodgers, M. N. (Ed.). (2017, April). Status of oral health in California: Oral disease burden and prevention 2017. Sacramento: California Department of Public Health. Retrieved from https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH Document Library/Oral Health Program/Status of Oral Health in California_FINAL_04.20.2017_ADA.pdf

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Community + Mental Health

Town hall participants identified multiple issues that we have organized into five topics for conversation.

1. Violence and Domestic Violence — Participants identified violence and, specifically, domestic violence, as a crucial issue for community mental health and well-being. Violence perpetrated against the community by both internal and external forces was seen as a particularly lethal force that tears the community apart. Participants felt that the issue of domestic violence has decreased in community awareness and concern, but it has increased in occurrence —specifically among the millennial generation. Participants, particularly advocates against domestic violence, would like to elevate awareness and concern regarding the horizontal violence that exists within families and among community members, commensurate with concerns regarding violence perpetrated against Black people (men) by external forces, such as the police.

RESEARCH SHOWS: **Violence and Domestic Violence** — Some research also indicates that compared to White women, Black (and American Indian) women are at an increased risk of being victims of domestic violence (Mersky & Janczewski, 2018). This study assesses lifetime prevalence and socio-demographic correlates of police violence among women, and investigates potential associations between intimate partner violence (IPV), sexual violence (SV), and police violence (Fedina et al., 2018). Police violence has been identified as a public health concern in the U.S., yet few studies have assessed the prevalence and nature of police violence among women. Furthermore, increasing evidence suggests that women reporting IPV and SV to police are often met with harmful or neglectful police responses and thus, women's exposures to police violence may be associated with experiences of IPV and SV; however, this has not yet been empirically tested. Physical, sexual and psychological police victimization and neglect by police were assessed. Lifetime prevalence of physical (4 percent), sexual (3.3 percent) and psychological (14.4 percent) police violence and neglect (17.2 percent) (Fedina et al., 2018), show that a notable proportion of women experience police victimization, with significantly higher rates among racial and ethnic minority women.

Findings suggest the need for gender-inclusive community-centered policing initiatives and other preventive efforts aimed at eliminating police violence. Police violence and victimization among women also should be considered in IPV and SV intervention and treatment responses.

Source:

Fedina, L., Backes, B., Jun, H., Shah, R., Nam, B., Link, B., & DeVylder, J. (2018). Police violence among women in four U.S. cities. *Preventive Medicine*, *106*, 150–156. doi:10.1016/j.ypmed.2017.10.037

2. A New Paradigm for Black Unity — Participants overwhelmingly focused on the need for a new paradigm for Black unity and cross-organizational collaboration. Suggestions about how to attain that goal ranged from a re-articulation of ethnic and racial solidarity, to a resurgence of a common cultural identity, to an examination of issues-based solidarity. Health was a common theme of an issues-based solidarity approach. In light of increased migration of Black people from urban centers where most culturally oriented services are rendered and political organizing is most robust, an overwhelming sense of isolation and helplessness was reflected in every one of the town halls. Participants were open to the idea of re-thinking strategies for organizing "the Black community."

3. DIY (Do It Yourself) Infrastructure for Community Empowerment — Participants want and need targeted technical assistance to expand the reach of their nonprofit organizations and individual initiatives. Suggestions and requests included structured workshops and assistance to find grant opportunities, and exposure to models that will help create for-profit entities that focus on African-Americans. Participants desire to build their missing infrastructure and provide meaningful services in their communities. Ideas include:

- Community-based health clinics (most frequently mentioned)
- Community-based re-entry education and support system for ex-offenders, their families and communities, another needed structure that could be built and sustained by the community
- Community gardening and restaurants that promote plant-based diets and healthy eating
- A Black Churches Health Network, another DIY structure that could be built to improve African-American health

Clearinghouse of Community Information and Advocacy — Participants requested a city and statewide clearinghouse of information on health issues and the common activities of similar organizations. While the focus on information and events was important, participants suggested that the clearinghouse could be used to educate our children and to promote health advocacy for African-Americans statewide. Participants suggested statewide talking points for multiple organizations to focus their advocacy efforts.

Homelessness as a Public Health Issue — Participants expressed a need for culturally appropriate strategies to address the homeless crisis. African-Americans are disproportionally represented among homeless populations in large urban cities like Los Angeles and Oakland and transitionally housed at high rates through out the state. Participants believe that future strategies to reduce the risk of homelessness should seek to link housing to issues that influence the likelihood of becoming homeless, such as domestic violence, formerly incarcerated and recently released African-American men, post-high school student housing, former foster youth, veterans, mental illness and people living with disabilities. Black people comprise up to 40 percent of America's homeless population. In California's largest urban centers the problem is overwhelming. In Los Angeles County, 39,396 people were identified as homeless. 34 percent of those individuals were Black (17,825).

RESEARCH SHOWS: **Impact of Mental Health on Well-being** — A 2018 article describing the impact of mental illness on the Black community revealed that Black Californians are more likely to experience mental health problems than other ethnic groups, but are far less likely to seek and receive the care they need to live a fulfilling life. The article cited a study conducted by the RAND Corporation that highlighted a connection between untreated mental health problems and multiple absences from work, which can take an economic toll on persons and families in the form of lost pay or lost jobs. This dynamic, researchers found, disproportionately affects communities of color. The data also revealed that mental health problems were causing 12 percent of Black Californians to miss four or more work days per year, compared with 6.1 percent for Asians, 7.9 percent for Whites, and 9.4 percent for Latinos (Hayes, 2018). African-Americans are three times as likely as Asians and nearly twice as prone as Whites to suffer from severe psychological distress. Study showed that African-American women are more likely than African-American men to face even more daunting mental health struggles. African-Americans — particularly those residing in America's inner cities — are

reportedly more likely to experience certain factors that increase the risk for developing a mental health condition. These factors include, but are not limited to, homelessness because these individuals are at a greater risk of developing a mental health condition. With the current state of mental health and the stigma that surrounds it in African-American communities, ethnic -specific programs could be innovated in present time and utilized to bridge the gaps and the stigma surrounding mental health issues in the African-American communities.

Sources:

Chiland, E. (2018, May 31). LA's homeless population is finally falling. Curbed Los Angeles. Retrieved from https://la.curbed.com/2018/5/31/17411054/los-angeles-homeless-count-2018-how-many

Hayes, M. (2018). Mental illness remains hidden shame within Black community; African Americans suffer more from psychological distress. Retrieved from http://ourweekly.com/news/2018/may/11/mental-illness-remains-hidden-shame-within-black-c/

Los Angeles Homeless Services Authority. (n.d.). Homelessness in Los Angeles County. Los Angeles Almanac. Retrieved from http://www.laalmanac.com/social/so14.php

Takeuchi, D., Sue, S., & Yeh, M. (1995). Return rates and outcomes from ethnicity-specific mental health programs in Los Angeles. *American Journal Of Public Health*, *85*(5), 638-643. doi:10.2105/ajph.85.5.638

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Appendix

Recommendations for Medi-Cal (Notes for Medi-Cal reform from an enrollment specialist)

1. Enrollment specialists should receive ongoing training on how to help people make the transition on and off of Covered California, as well as how the entire health insurance system works. Just understanding their job is not enough to provide great service.
2. Workers need to fully understand MAGI (modified adjusted gross income). Consumers' benefits are being terminated because the worker does not understand the new way of determining income eligibility.
3. Medi-Cal needs to overhaul the way it does business. Medi-Cal administrators need to make sure that workers are able and empowered to do multiple jobs. The agency needs to recognize that its client base has grown and the "DMV" model of doing business is no longer appropriate. In other words, a sick person does not want to stand in one line to get a ticket to stand in another line and then wait 48 hours for an answer.
4. A Medi-Cal case can be renewed in any of several ways, yet consumers are still confused on how to renew. Consumers should be reminded multiple times that they can renew using the county's website, a paper application, through Covered California, or over the phone. Also, people may have difficulty determining when they are required to renew. Is it on the anniversary of when you signed up, the first of the year, or during the Covered California open enrollment period?
5. Medi-Cal needs to do a better job of sending letters requesting additional information or notifications of termination. The agency often mails letters requesting information after the due date indicated in the letter. It also sends termination letters months after a case has been terminated, if sent at all.
6. Medi-Cal needs to increase its call center capacity. Waiting 30 minutes to an hour to speak to a representative is not uncommon. A staff of only 45 call center representatives for all of Alameda County is unacceptably inadequate.
7. Medi-Cal needs to update its computer systems. The worker should not have to go to multiple systems to activate or deactivate an account. A consumer can end up being denied medical attention or medicine due to being active in one system but not in the other, which may not become apparent if a worker does not do a task in multiple systems correctly.
8. Medi-Cal needs to follow the law and inform people within 45 days if their application has been accepted or rejected. However, 48 business hours should really be the standard.

California Black Health Network
520 Ninth Street, Suite 100
Sacramento, CA 95814
CaBlackHealthNetwork.org
(916) 333-0613