SAVING OUR LEGACY

African Americans for Smoke-Free Safe Places

Strategies to Improve Health Equity Where African Americans Live, Work, Learn, Worship & Play

Community Action Plan, Sacramento, California

This document was developed by the SOL Project: Saving Our Legacy, African Americans for Smoke-Free Safe Places, a project of Public Health Foundation Enterprises, funded by the California Department of Public Health, Tobacco Control Program, contract number 10-10217 © 2015

FORWARD

Educators trained in public health and practitioners in health care focus on influencing individuals' knowledge, attitudes, behavior, and community norm change to improve health and reduce disease. The public health community has come to realize that health is not just about individual behavior choices; it is also about the social conditions of where people live, work, learn, play and worship.

Saving Our Legacy, African Americans for Smoke Free Safe Places (SOL Project), and a Social Determinants of Health Planning Committee comprised of health educators, public servants, health care practitioners, and non-profits came together to develop a community action plan that addresses social determinants of health among African Americans in Sacramento California.

The SOL Project is funded by the California Tobacco Control Program (CTCP), who understands the importance of advancing health equity to improve tobacco control and prevention efforts. Partners such as the SOL Project are collaborating with non-traditional partners to refocus attention from individual behaviors like smoking to a broader focus on social determinants of health that influence disparate tobacco usage and disproportionate rates of illness and mortality for African Americans.

As a first step toward improving health equity among African Americans living in Sacramento County, the **Strategies to Improve Health Equity Where African Americans Live, Work, Learn, Worship and Play in Sacramento, California A Community Action Plan** (also known as The CAP or CAP) will explore disparities related to: heart disease and type 2 diabetes; tobacco use and obesity as two risk factors for these disparities; and educational attainment, economic development, and racial discrimination/social justice as three social determinants of health that when improved can greatly impact and eventually eliminate health inequities in this population.

The CAP examines heart disease and type 2 diabetes as critical health issues where disparities are exhibited among African Americans. The CAP contains a fraction of obtainable promising practices that influence health disparities and inequalities faced by African Americans. It is our hope that the CAP will spark a movement among organizations, medical providers, businesses, community advocates, and residents to implement more strategic and synchronized efforts around social determinants of health. More collaborative efforts are needed to positively change historical, institutional, and policy practices that affect the health outcomes of African American residents.

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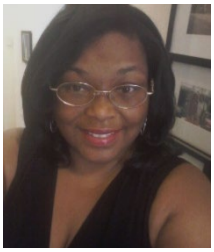

Valarie Scruggs
Community Advocate

ACKNOWLEDGEMENTS

In 2014, the SOL Project brought together a committed group of thought leaders with experience in education, health, economics and policy with strong ties in the African American community. This group was formed as the Social Determinants of Health Planning Committee and convened with the purpose of creating a Community Action Plan that: 1) identifies achievable, population-specific outcome measures; 2) shares strategic directions that guide tobacco control and other chronic disease efforts to achieve health equity; and 3) strengthens partnerships and encourages collaboration that supports an integrated approach to correcting health inequities.

The SOL Project acknowledges the Social Determinants of Health Planning Committee for their contributions toward the development of the **Strategies to Improve Health Equity Where African Americans Live, Work, Learn, Play & Worship in Sacramento California Community Action Plan.**

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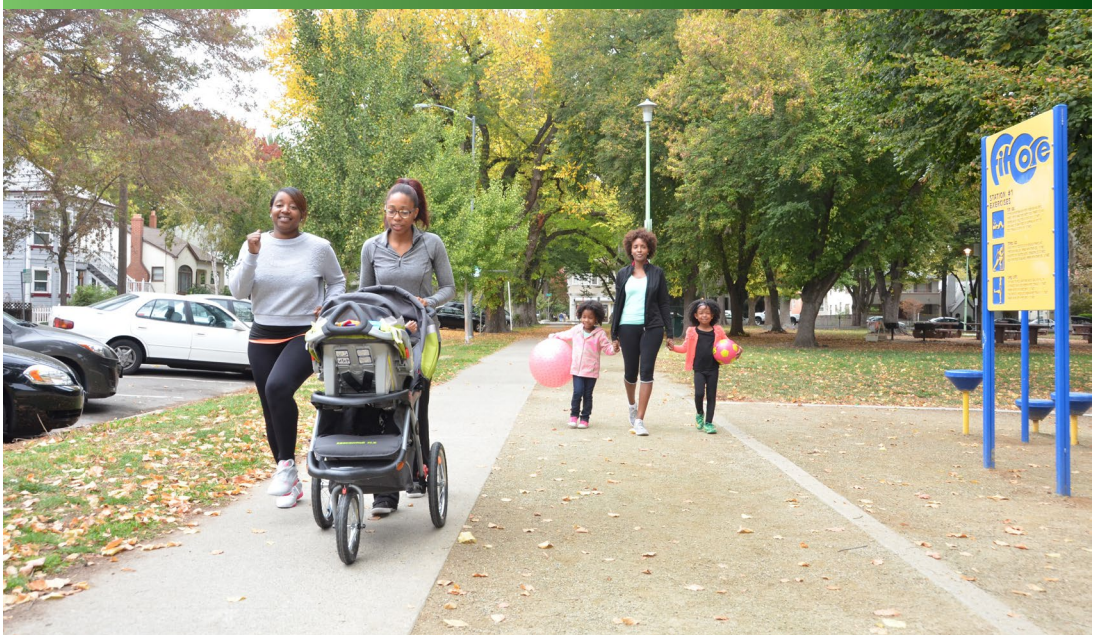
EXECUTIVE SUMMARY



SOL
SAVING OUR LEGACY
African Americans for Smoke-Free Safe Places

EXECUTIVE SUMMARY

The public health community has come to realize that health is not just about individual behavior choices, it is also about the social conditions of where people live, work, learn, worship and play. Saving Our Legacy, African Americans for Smoke Free Safe Places (SOL Project) and a Social Determinants of Health Planning Committee of health educators, public servants, health care practitioners, and non-profits came together to develop a community action plan that addresses social determinants of health among African Americans in Sacramento County.

The resulting *Strategies to Improve Health Equity Where African Americans Live, Work, Learn, Worship and Play in Sacramento, California A Community Action Plan* is a guide to reducing and eventually eliminate disparate conditions in Sacramento County among African American residents. The Community Action Plan (CAP) outlines health disparities related to Heart Disease and Diabetes, outlines Tobacco Use and Obesity as two risk factors of health disparities, and reviews promising practice examples in areas of Educational Attainment, Economic Development and Racial Discrimination/ Social Justice as three of the five major areas of Social Determinants of Health recognized by the World Health Organization. This plan, when implemented by organizations that have the capacity, can improve the health and wellbeing of African American community members with measurable results.

The Community Action Plan is intended to be the first of many, where diverse sectors of non-traditional partners collaborate to engage in efforts to reduce racial and ethnic disparities in health outcomes for African Americans in Sacramento County. The CAP development was based on an understanding that there is no one strategy, individual, nor organization that would be or can be the trailblazer to eliminate health disparities and improve all inequities related to social determinants of health. However, these efforts can be improved by collective expertise, commitment and determination from organizations and individuals to developing and executing short and long term plans with measurable outcomes. It is our hope that this project will spark a movement to implement more strategic and synchronized efforts in the greater Sacramento area addressing the many social determinants of health to improve health outcomes of all residents.

SOCIAL DETERMINANTS OF HEALTH

Where we live, work, learn, play and worship provide strong indicators of how long we will live and the quality of that life while we are alive. The social determinants of health describe the health behaviors, clinical care, social & economic factors, and physical environments under which we live that are directly linked to health outcomes. Public health professionals have long focused on the elements of individual health behaviors and access to clinical care as methods for improving population health. However, there is a growing body of evidence that indicates factors such as educational attainment, economic opportunities and wealth, and racial and social discrimination have a greater impact on health outcomes. These three factors were selected by the Social Determinants of Health Committee to take a closer look at how they affect the lives of African Americans in the greater Sacramento area. Priorities and activities were identified to advance these factors for African American communities. Stakeholders are encouraged to adopt these priorities, integrate them into their current efforts to improve the health of communities and collaborate with like-minded individuals to facilitate greater impact.

Educational attainment

The number of years a person goes to school and their level of education such as securing a high school diploma or college degree effects health in a number of ways and has implications on the social, economic, and environmental opportunities that will be available to them over the course of their life.

EXECUTIVE SUMMARY

Priority: Increase the number of African Americans graduating from high school and college.

- *Increase the number of African American children attending pre-school.*
- *Increase the number of African American youth obtaining high school, college and post graduate education.*

Economic Development

Longer life expectancy, lower rates of chronic disease, greater food security and more physical activity all have a strong correlation with income and wealth. A higher level of financial resources allows individuals and families to make different choices about education, employment, food purchases, consistency in taking medications, safety and exposure to health hazards (e.g. poor air quality, power lines, fast food, etc.) in their neighborhoods, and many other factors that have positive health effects.

Priority: Increase the Income of African Americans.

- *Increase minimum wage to a livable wage.*
- *Build wealth in the African American community.*

Racial Discrimination and Social Justice

Racial discrimination plays a significant role in increased levels of unemployment, high levels of stress, residential segregation, reduced access to goods and services, lower educational attainment and low socioeconomic status, All of which have been shown to be linked to poor health outcomes.

Priority: Eliminate Racial Discrimination and Social Injustices that Affect Health.

- *Reduce racial bias in healthcare systems.*
- *Expose industry target marketing (I.e., tobacco, sweetened beverage and fast food companies) to African Americans.*

Health policies and evidence-based programs that address multiple social determinants of health simultaneously are needed to reduce disparities and improve health outcomes among African Americans.

MECHANISMS OF CHANGE

Effective public health, health promotion, and chronic disease management programs help people maintain and improve health, reduce disease risks, and manage chronic illness. They can improve the well-being and self-sufficiency of individuals, families, organizations, and communities. Usually, such successes require behavior change at many levels, (e.g., individual, environmental or systems, and community policy change). It is important for organizations and collaborations that set out to improve the health of African Americans to identify, design and implement interventions at multiple levels in order to produce positive change within their communities.

Individual Behavior Change

Individual Behavior Change focuses on the individual, changing their knowledge, beliefs or attitude in order to change their behavior towards a particular health condition.

Environmental/Systems Change

Contemporary health promotion involves efforts to change organizational behavior, as well as the physical and social environment of communities. It is also about developing and advocating for policies that create opportunities for people to make healthy choices.

EXECUTIVE SUMMARY

Public Policy

Public policy changes respond to how social systems function and change. They offer longer-term strategies that work in a variety of settings, such as health care institutions, schools, worksites, community groups, and government agencies.

Understanding and creating local networks that support change at the individual, environmental/systems, and public policy levels may garner greater impact overall in improving the lives of African Americans.

REDUCING DISPARITIES AMONG AFRICAN AMERICANS IN SACRAMENTO COUNTY

African Americans suffer disproportionately from inequalities. The information below looks at how African Americans in Sacramento County fair with respect to other ethnic groups related to key social determinants of health.

Educational attainment

An education gap exists among the different racial and ethnic groups in Sacramento. For African Americans, the highest level of education most completed is grade 12 at 33.2%, compared to Asians whose highest level of education most completed is a bachelors' degree at 32.9%. [1]

Income

The average household size is two people and the median income is $55,846. For Blacks, the median income is $39,471 (2008-2012).[2]

Health status of African Americans

- 29.9% currently smoke.[1]
- 67.7% are overweight or obese.[1]
- 11% have diabetes.[1]

Life Expectancy

Life expectancy for African Americans is lowest among all racial and ethnic groups in the county at 73.8 years compared to Hispanics at 87.7 years, Asian/Pacific Islanders at 84.1 years and Caucasians at 78.6 years.[3]

GOAL: ELIMINATE HEART DISEASE AND TYPE 2 DIABETES AMONG AFRICAN AMERICANS

The CAP provides strategies and promising practices that were identified from a variety of resources and entities who have successfully implemented programs to improve Social Determinants of Health for the African American community. Coordinated efforts among stakeholders in Sacramento County to implement the recommended strategies will increase evidence-based improvements in the health of African Americans.

Eliminate Heart Disease

Strategy #1: Raise awareness of symptoms and signs of heart attack and stroke through cultural, linguistic, and gender education initiatives.

Strategy #2: Increase primary prevention efforts to avoid Heart Disease among African Americans through: smoking cessation, management of blood pressure (BP), weight control, and dietary and physical activity counseling.

Strategy #3: Comprehensive management of risk factors in those with established Heart Disease.

Eliminate Diabetes

Strategy #1: Increase implementation of evidenced-based diabetes prevention and management programs in underserved African American communities.

Strategy #2: Improve access to supermarkets in underserved areas and incentivize the sale of healthier foods and beverages in underserved areas.

Strategy #3: Increase access to outdoor recreational facilities and enhance walkability and bike-ability in neigbhorhoods.

Strategy #4: Reduce barriers to healthy meal planning and preparation by increasing resources and social support for a healthy diet.

Eliminate New and Emerging Tobacco Product Use

Strategy #1: Foster collaboration between community-based organizations (CBOs) serving African Americans and those organizations working in the tobacco control movement to broaden their efforts to reduce use.

Strategy #2: Work jointly on policy or systems change with local, state and national entities to eliminate the use and targeting of flavored tobacco, including menthol and other candy flavorings towards African Americans and youth in particular.

Strategy #3: Increase understanding of community perspective and needs for development of effective community interventions.

Eliminate Obesity

Strategy #1: Ensure state-level leadership and coordination of statewide obesity prevention efforts to create active living and healthy eating environments and work toward the elimination of health inequities.

Strategy #2: Collaborate with existing programs local and statewide to implement joint public education campaigns that promote healthy eating and active living.

Strategy #3: Work with government, worksites, health care providers, and schools to improve access to healthy eating and physical activity.

Summary

The Social Determinants of Health Planning Committee elected to explore the impact of social and economic factors on the health of African Americans. Developing priorities, strategies and promoting promising practices that can be implemented in a coordinated and synergistic effort between community-based organizations, private business, and local, state, and national government endeavors is necessary to improve social and economic factors. Understanding how educational attainment, economic opportunities and wealth, and racial and social discrimination contribute to health outcomes among African Americans is critical to making improvements in the health of this population. Successful strategies employed to improve the health of African Americans have included increasing job training, connecting youth and formerly incarcerated with jobs, creating access to healthier foods, building safe and open green spaces for physical activity, policies that support early and low-cost health screenings, revitalizing neighborhoods, and investing in education.

This Community Action Plan will be shared with key thought and opinion leaders and those who want to move from dialogue towards action. It is intended to inspire more plans that lead a movement of addressing other social determinants of health and other health issues in order for the African American community to live well and prosper *by not only reducing, but eliminating disparities for African Americans in Sacramento California.*

INTRODUCTION

SAVING OUR LEGACY
African Americans for Smoke-Free Safe Places

INTRODUCTION

Saving Our Legacy, African Americans for Smoke Free Safe Places (The SOL Project) is a partner of the California Tobacco Control Program (CTCP) advocating for healthy, smoke-free communities in the greater Sacramento valley. The SOL Project forms cross-sectorial partnerships to reduce exposure to second hand tobacco smoke in outdoor areas such as dining patios, bus stops and light rail stations; counters tobacco industry targeting and marketing of mentholated tobacco towards African Americans and provides resources to people who use tobacco and want to quit. The SOL Project also concentrates on social determinants of health as it relates to tobacco use and illness.

The World Health Organization defines social determinants of health as the conditions in which people are born, grow, live, work, and age.[4] These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. A CTCP California Health Equity Summit Proceeding[5] document stated strong evidence suggesting that factors such as economic structures, lack of access to jobs, unhealthy housing conditions, discrimination, and oppression underlie common causes of illness, injury and disease; whether they are tobacco-related, food-related, inactivity-related illnesses, or violence-related. This document further suggests that California Tobacco Control Prevention Programs form more collaborative partnerships with organizations addressing other community problems that impact a community's health. The unified work can help to ensure that it will no longer be possible to predict a person's life expectancy based on their zip code.

Consequently, the SOL Project and the Social Determinants of Health Planning Committee developed the Strategies to Improve Health Equity Where African Americans Live, Work, Learn, Worship and Play in Sacramento, California A Community Action Plan to reduce and eventually eliminate disparate conditions among African American residents. The CAP summarizes health disparities related to Heart Disease and Type 2 diabetes and outlines Tobacco Use and Obesity as two risk factors of health disparities. The CAP also reviews promising practice examples in areas of Educational Attainment, Economic Development, and Racial Discrimination/Social Justice as three of the five major areas of Social Determinants of Health identified by the World Health Organization.

This plan, when implemented by organizations that have the capacity, can improve the health and wellbeing of African American community members with measurable results. The SOL Project seeks to create more non-traditional collaborative partnerships to implement policies and programs profiled in the CAP to improve social determinants of health among African Americans. Sharing the CAP with additional stakeholders in the area is also intended to provide direction and inspiration to others to concentrate on social determinants of health to raise the quality and quantity of life for all residents.

The CAP provides an overview and framework to identify issues, priorities, strategies, and methods which stakeholders can become involved in moving social determinants of health forward for African American communities. The process of connecting with likeminded people who want to work on a specific issue will be addressed through a future symposium and online resources as stakeholders take steps toward implementing the CAP.

This CAP is intended to be the first of many efforts where diverse sectors of non-traditional partners collaborate to reduce racial and ethnic disparities in health outcomes for African Americans. The CAP development was based on an understanding that there is no one strategy, individual, nor organization that would be or can be the trailblazer to eliminate health disparities and improve all inequities related to social determinants of health. However, these efforts can be improved by collective expertise, commitment, and determination from organizations and individuals dedicated to developing and executing short and long term plans with measurable outcomes.

SOCIAL DETERMINANTS OF HEALTH

SOL
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HEALTHY PEOPLE 2020 SOCIAL DETERMINANTS OF HEALTH:

Economic Stability

Educational Attainment

Social and Community Context

Health and Health Care

Neighborhood and Built Environment

SOCIAL DETERMINANTS OF HEALTH

Where individuals live, work, learn, play and worship provide strong indicators of mortality and quality of life. The social determinants of health describe the health behaviors, clinical care, social and economic factors, and physical environments that are directly linked to health disparities and inequity outcomes.

Healthy People 2020 developed a framework around five key social determinants of health areas and provided a breakdown of elements that influence each area.[6] The list below provides a common understanding of the social determinants of health the CAP seeks to influence. Organizations, coalitions, and stakeholders working on public health issues are encouraged to utilize this framework along with the priorities, strategies and promising practices laid out in the CAP to work toward creating significant and sustainable change. Integrating these elements into the scope of work of each initiative will help leverage resources and strengthen the impact and coordination of work in our community.

5 KEY SOCIAL DETERMINANTS OF HEALTH AREAS AND ELEMENTS

ECONOMIC STABILITY
- Poverty
- Employment
- Food Security
- Housing Stability

EDUCATIONAL ATTAINMENT
- Language and Literacy
- Early Childhood Education and Development
- High School Graduation
- Enrollment in Higher Education

SOCIAL AND COMMUNITY CONTEXT
- Social Cohesion
- Civic Participation
- Perceptions of Discrimination and Equity
- Incarceration/Institutionalization

HEALTH AND HEALTHCARE
- Access to Health Care
- Access to Primary Care
- Health Literacy

NEIGHBORHOOD AND BUILT ENVIRONMENT
- Access to Healthy Foods
- Quality of Housing
- Crime and Violence
- Environmental Conditions

Public health professionals have long focused on the elements of individual health behaviors and access to clinical care as methods to improve population health, rather than other factors such as social conditions that lead to health inequities and disparities. Access to health care and quality health care continue to be important aspects of improving the health outcomes of African Americans. However, when African Americans face unequal treatment, exposure to toxic agents from poor housing, or limited numbers of trained African American medical providers, these patterns must also be recognized as social determinants of health and corrected in order to minimize the negative impact on the health of African American communities.

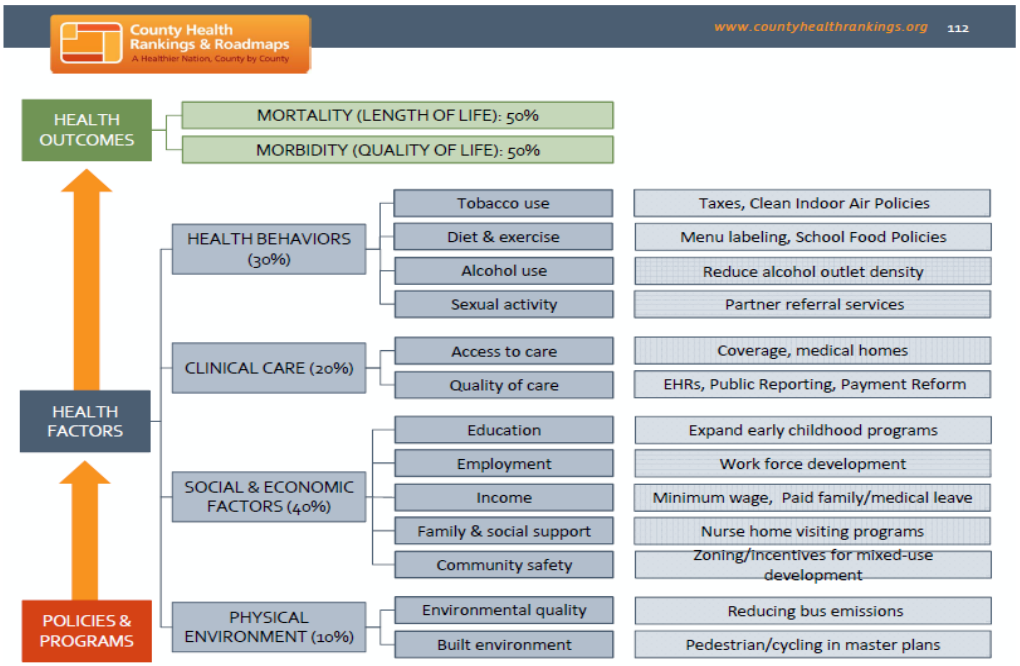
Medical and public health provider partners are instrumental in reducing the disparities in care experienced by African Americans.

SOCIAL DETERMINANTS OF HEALTH

Providers may also lend their expertise outside of influencing direct patient care by actively working on projects that affect social determinants of health. Provider involvement in integrating the medical evidence necessary to demonstrate the success of joint medical care and upstream social and economic interventions is vital to gaining support for policies, systems and environmental changes that improve the health of African Americans.

The Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute developed County Health Rankings & Roadmaps[7] to build a culture of health, county by county. As part of that effort the chart in Figure 1 clearly outlines health behaviors, clinical care, social & economic factors and physical environment as health factors that influence health outcomes and ultimately contribute to mortality and morbidity. Policies and programs are interventions that focus on the health factors and drive health outcomes. For example, a policy that raises minimum wage is an approach that improves social and economic factors. The increased income to families from this policy would give a family more options when choosing where to live, healthier food outlets, and access to better schools, all of which correlate to longer life expectancy.

Figure 1: County Health Rankings & Roadmaps.



Source: www.countyhealthrankings.org

There is a growing body of evidence that points to social and economic factors or indicators such as educational attainment, economic opportunities, wealth, and racial/social discrimination as having a greater impact on health outcomes than other factors such as health behaviors, clinical care, and physical environments. These three factors (educational attainment, economic development, and racial discrimination/social justice) were selected by the Social Determinants of Health Committee because they are not currently being addressed in Sacramento. Therefore, the CAP examines how these factors affect the lives of African Americans. As a result, goals, strategies and promising practices have been identified for each factor where available.

Understanding how these social determinants contribute to health outcomes among African Americans is critical to making improvements in the health of this population.

EDUCATIONAL ATTAINMENT

The number of years a person attends school and the level of education attained (high school or college degree; or trade school certification) effects health in a number of ways and has implications

Loss of businesses decreases jobs.

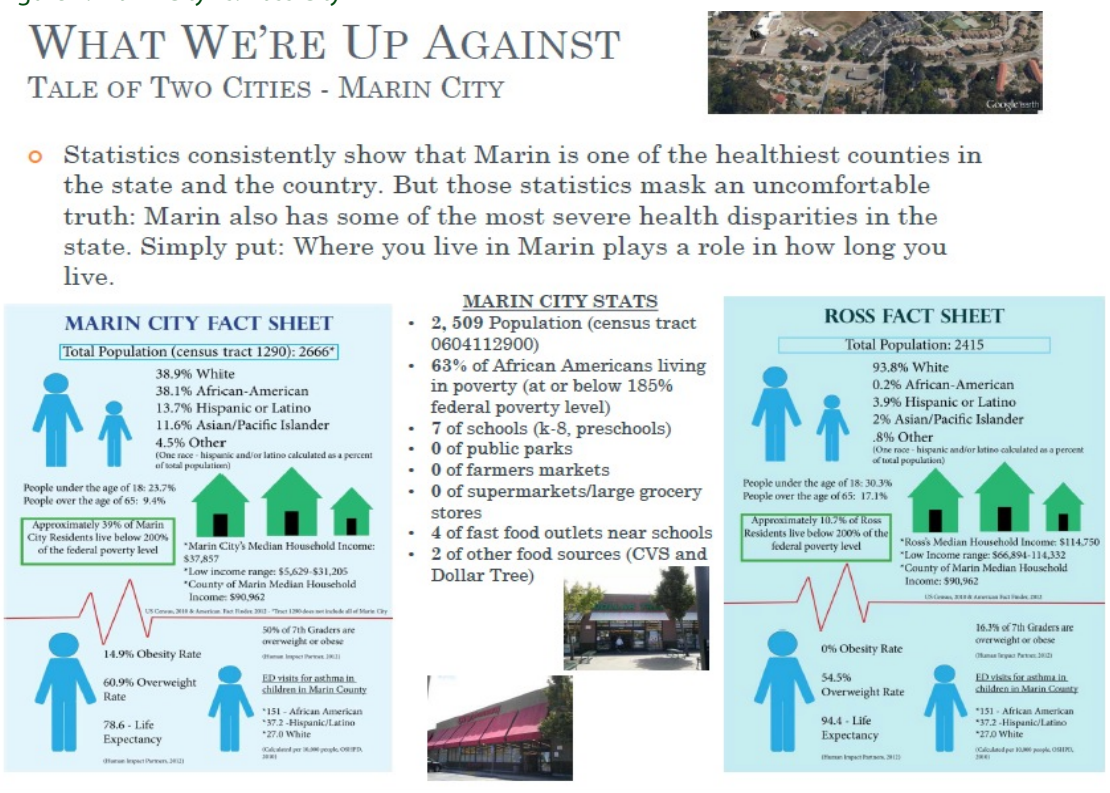
on the social, economic, and environmental opportunities that will be available over the course of life. Among adults 25 years of age or older, an additional 4 years of education lowers 5-year mortality by 1.8 percentage points (from 11% to 9.2%); it also reduces the risk of heart disease by 2.2 percentage points (from 31% to 28.8%) and the risk of type 2 diabetes by 1.3 percentage points (from 7% to 5.7%).[8] Higher education has a positive effect on health outcomes allowing these individuals access to jobs paying higher incomes, homes in healthier neighborhoods, and resources to better manage their health such as social influencers and medical care. Investment in evidence-based programs that lead to higher educational attainment among African Americans is one strategy that can lead to better health outcomes among this group. For example, early education programs such as Healthy Start have been shown to lead to increased knowledge and beliefs that support healthy behaviors and greater retention in school. Healthy Start reaches out to pregnant women and new mothers and connects them with health care and other resources they need to nurture their children.[9]

ECONOMIC DEVELOPMENT

Longer life expectancy, lower rates of chronic disease, greater food security and more physical activity all have a strong correlation with income and wealth. The more diverse and greater number of job opportunities in an area affects the number and quality of services available. The more money a person or family has from well-paying jobs the better health and well-being they experience. An example of this can be seen in a comparison of an impoverished neighborhood (residents live 15.8 fewer years) vs wealthier neighborhoods (residents live 15.8 years longer) in Marin County (figure 2).

The Marin County example was used as it provides more comprehensive data than what was available for Sacramento. The graphic below shows two cities in Marin County and the disparities that exist relative to life expectancy, income, and demographics.[10] In the city of Ross the life expectancy is 94.4 years, overweight & obesity rate is 54.5%, median household income is $114,750, and the population is 93.8% White, 3.9% Latino, 2% Asian, 0.2% African American and 0.8% Other. In comparison, Marin City residents who live within the same county have a life expectancy of 78.6 years, overweight & obesity rate is 75.8%, median household income is $37,857, and the population is 38.9% White, 13.7% Latino, 11.6% Asian, 38.1% African American and 4.5% Other.[10]

Figure 2: Marin City vs. Ross City



Source: California Department of Public Health, Office of Health Equity

SOCIAL DETERMINANTS OF HEALTH

These disparities also affect issues such as walk ability and health status. In Sacramento, we see differences in the demographic profiles of East Sacramento zip code of 95819 vs Oak Park zip code of 95817 in the graphic below. In Oak Park, photos show lower level of walk ability due to smaller sidewalks, trash, and fencing (Figure 3). We also found that residents from Oak Park visit emergency rooms at three times the rate for asthma, diabetes, and high blood pressure.

Figure 3: Differences between East Sacramento and Oak Park.

Source: California Department of Public Health, Office of Health Equity

Income has a direct effect on the decisions and opportunities available to different groups. A higher level of financial resources allows individuals and families to make different choices about education, employment, food purchases, medical care, consistency in taking medications, safety and exposure to health hazards (e.g. poor air quality, power lines, fast food, etc.) in their neighborhoods, and many other factors that have positive health effects.

RACIAL DISCRIMINATION/SOCIAL JUSTICE

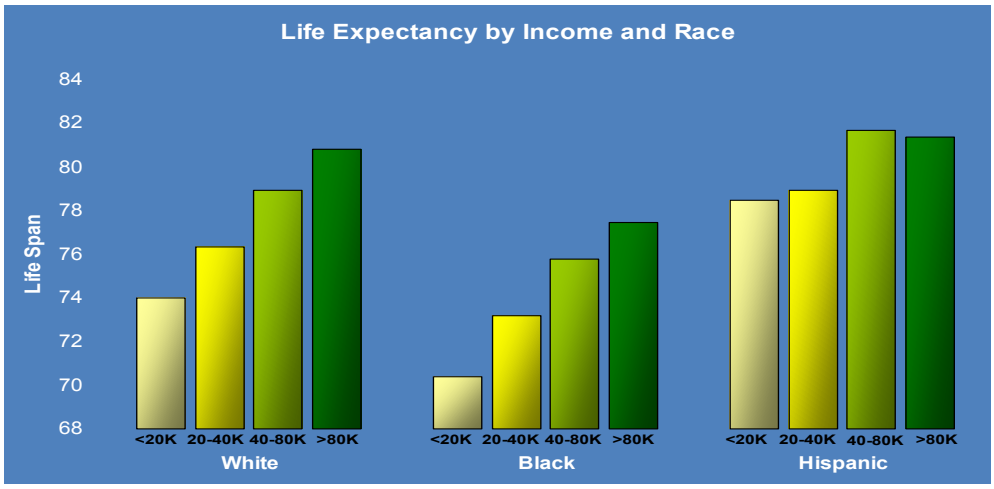
According to Dr. David Williams, Professor of Public Health and African and African American Studies and Sociology at Harvard University, "Everyday discrimination is positively associated with coronary calcification, blood pressure, lower birth weight, cognitive impairment, poor sleep, mortality, and visceral fat. In addition, racial discrimination plays a significant role in increased levels of unemployment, high levels of stress, residential segregation, reduced access to goods and services, lower educational attainment and low socioeconomic status, all of which have been shown to be linked to poor health outcomes."[11] In "Unnatural Causes: Is Inequality Making Us Sick?" it was demonstrated that high levels of stress largely due to persistent exposure to racial discrimination resulting in poor living conditions over the life of African American women, led to lower birth weight babies.[12]

Another example of racial discrimination at work was found in a review of tobacco advertising around public schools. According to a Henricksen et al 2011 study, African Americans are more likely to utilize menthol and candy flavored tobacco products such as Newport cigarettes. The researchers found that for each 10% increase in the proportion of African American student enrollment in schools, the proportion of menthol advertising increased by 5.9%, Newport cigarette promotion was 42% higher, and the cost of Newport cigarettes were 12 cents lower. [13]

SOCIAL DETERMINANTS OF HEALTH

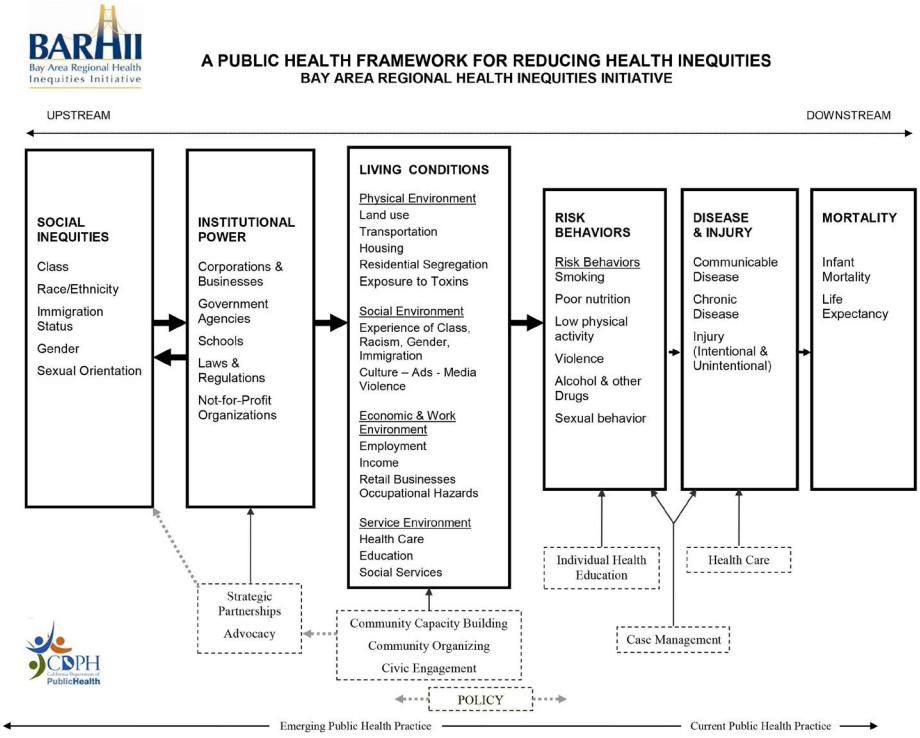
The links between education, income and race become easier to see looking at the effects of income and life expectancy across races as well as within the African American community. If poor health outcomes were solely linked to available resources and income, we would expect to see higher income African Americans achieving the same health status as whites and other groups at comparable levels. Unfortunately, the data shows us a different picture. Health status by income level data used in "Unnatural Causes: Is Inequality Making Us Sick?" (Figure 4) shows that even when we look at the life span of African Americans at varying income levels, we continue to see grave disparities compared to other ethnic groups. Low-income whites live about three years longer than low-income blacks do and middle-income whites live nearly 10 years longer than middle-income blacks do. [12]

Figure 4: Life Expectancy by Income and Race. Unnatural Causes: Is Inequality Making Us Sick?



Source: Unnatural Causes: Is Inequality Making Us Sick?

Figure 5: Bay Area Regional Health Inequities Initiative Framework



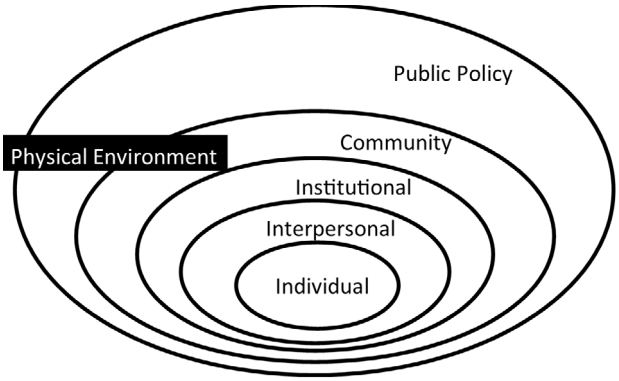
Source: Bay Area Regional Health Inequities Initiative

SOCIAL DETERMINANTS OF HEALTH

The Bay Area Regional Health Inequities Framework (Figure 5)[14] provides a good illustration of how social determinants of health play a significant role in influencing individual behaviors, disease and injury outcomes and ultimately mortality. Plans for initiatives targeting social determinants of health may use this model and take into consideration how they will impact one or more of the social determinants of health as listed above under "Living Conditions." These areas include concentrating on the physical environment, social environment, economic and work environment or service environment.

Strategic partnership that include nontraditional partners will need to be identified and cultivated to facilitate change to institutional practices that impact the living conditions directly related to the desired change. Strategies that involve increasing community capacity building, community organizing and civic engagement will be needed to prepare and promote change for the target community. For example, passing a policy to bring a healthy food outlet to a low resource community may involve work on several levels. Opportunities may be sought to work with business redevelopment districts and city planners to craft a plan to revitalize the communities' economic base by bringing in a healthy grocery store. Community organizing would need to occur to educate and engage government officials around land use policies in their district. Information on the prevalence of unhealthy food outlets vs healthy food outlets in neighborhoods and the link between poor nutrition and causation of chronic disease among African Americans may be shared with both policy makers and community members. Medical providers would share the economic impact of chronic disease in the community and offer perspectives on how healthier food options contribute to disease prevention and management. Evaluation consultants could then document increases in sales of healthy produce and decreases in emergency room visits due to chronic disease crisis.

Health policies and evidence-based programs that attend to multiple social determinants of health simultaneously are needed to reduce disparities and improve health outcomes among African Americans. Successful strategies employed to improve the health of African Americans have included increasing job training, connecting youth and the formerly incarcerated with jobs, and creating access to healthier foods. In addition, building safe and open green spaces for physical activity, policies that support early and low-cost health screenings, revitalizing neighborhoods, and investing in education are also proven strategies. These policies and programs are joint efforts accomplished by individuals, organizations and communities.



Social Ecological Model. Image courtesy of American Journal of Preventive Medicine.

MECHANISMS OF CHANGE

SAVING OUR LEGACY
African Americans for Smoke-Free Safe Places

MECHANISMS OF CHANGE

Effective public health campaigns, health promotion, and chronic disease management programs help people maintain and improve health, reduce disease risks, and manage chronic illness. They can improve the well-being and self-sufficiency of individuals, families, organizations, and communities. Usually, such successes require behavior change at many levels, (e.g., individual, environmental or systems, community and policy change). [10]

INDIVIDUAL BEHAVIOR CHANGE

Individual Behavior Change focuses on the individual—changing their knowledge, beliefs, or attitude in order to change their behavior towards a particular health condition. For example, increasing a person's knowledge about how Human Immunodeficiency Virus (HIV) is transmitted sexually through unprotected sex or the sharing of needles and syringes among intravenous drug users and then encouraging the use of condoms and clean needles is directed at changing individual behavior. Also, addressing the need for regular blood glucose testing, eye exams, and foot exams to detect and manage diabetes or overcoming attitudes related to the difficulty of exercising, are all examples of dealing with health through individual behavior change.

Individual behavior change is one of the most frequently used levels in the Social Ecological Model[15] for health prevention practice. Planners must be able to explain and influence the behavior of individuals. Many health practitioners spend most of their work time in one-on-one activities such as counseling or patient education, and individuals are often the primary target audience for interventions and health education materials.

ENVIRONMENTAL/SYSTEMS CHANGE

Contemporary health promotion involves more than simply educating individuals about healthy practices. It includes efforts to change organizational behavior, as well as the physical and social environment of communities. It is also about developing and advocating for policies that create opportunities for people to make healthy choices.

For example, a man with high cholesterol may find it hard to follow the diet his doctor has prescribed because his company cafeteria does not offer healthy food choices. A systems change approach may be that the company administration establishes a policy that requires the cafeteria to offer healthy choices and label food items with nutritional content so employees can make informed decisions.

PUBLIC POLICY

Initiatives serving communities and populations, not just individuals, are at the heart of public health approaches to preventing and controlling disease. Community-level models explore how social systems function and change; and how to mobilize and organize community members and organizations. They offer strategies that work in a variety of settings, such as health care institutions, schools, worksites, community groups, and government agencies. Embodying an ecological perspective, community-level models address individual, group, institutional, and community issues.

Before making any changes at this level, it is important to understand and get input from the community. Conducting a community needs assessment, conducting focus groups of key opinion leaders or those who will be impacted by the systems change are crucial for buy-in and successful change.

Community organizing is a process through which community groups are helped to identify common problems, mobilize resources, and develop and implement strategies to reach collective goals. Strict definitions of community organizing assume that the community itself identifies the problems (not an outside change agent). Public health professionals often adapt the methods of community organizing to launch programs that reflect the priorities of community members, but may not be initiated by them.

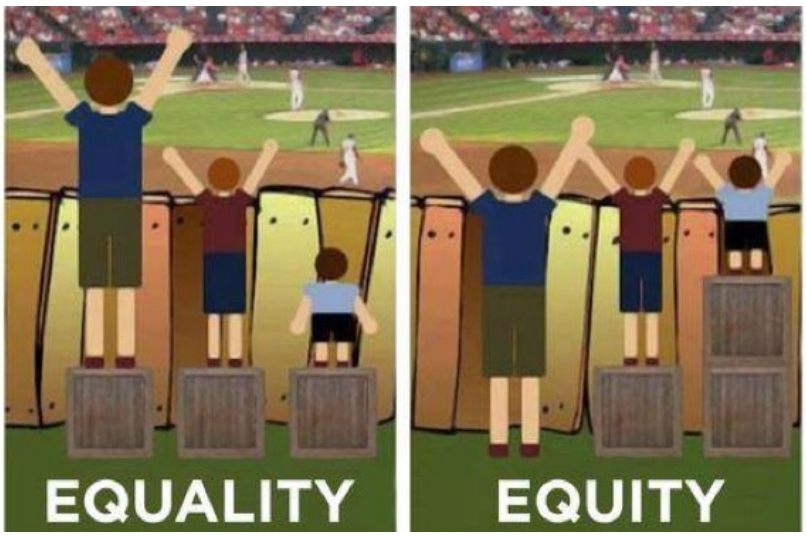
Community organizing projects that start with the community's priorities, rather than an externally imposed agenda, are more likely to succeed. An example of this process is from The California (Lesbian, Gay, Bisexual, Transgender (LGBT) Tobacco Education Partnership (the Partnership)

whose goal was to decrease the widespread availability of tobacco products in pharmacies. The Partnership focused on San Francisco's Castro District, where smoking rates within the LGBT population are high. The Partnership engaged pharmacies that were already tobacco-free and educated community stakeholders on the benefits of tobacco-free pharmacies to build support. To ensure that every San Franciscan had access to tobacco-free pharmacies, the Partnership also worked to implement a citywide strategy by making a compelling, research-supported argument that pharmacies should be hubs for health— not dispensaries for tobacco. As a result, San Francisco became the first U.S. city to eliminate the sale of tobacco products in all its pharmacies in 2008.

Changing social norms is vital to achieving any sustained change and improvement in the health of African Americans. Community changes can often have a more immediate impact on community members and their environment. An example would be churches that have voluntarily adopted healthy eating policies for their congregation and church. An example of this is churches participating in the Body & Soul Program that adopted church policies to remove sodas and soda machines from their premises and to serve healthy food options to increase fruits and vegetables offered at church meals. While these changes were not implemented through city, county, state or national public policy, they resulted in immediate impact on the attitudes, habits, and health of congregations members.

Before health disparities, inequities and possible goals and strategies can be fixed, it is important to understand the community intended for impact, which is the African American community in the County of Sacramento.

Figure 6: Equality vs. Equity)



Source: United Way of the Columbia-Willamette

Health disparities are defined as differences in physical health and mental health status among distinct segments of the population, including differences that occur by gender, age, race or ethnicity, sexual orientation, gender identity, education or income, disability or functional impairment, or geographic location, or the combination of any of these factors. Disparities are often looked at through a lens of how they affect vulnerable populations who have experienced institutionalized challenges based on these characteristics.[16]

Health equity is defined as employing efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives, and not just having the same access. In contrast, as illustrated in Figure 6: Equality vs. Equity; health inequities are disparities in health or mental health; or the factors that shape health, that are systemic and avoidable; therefore, considered unjust or unfair.[17]

THE STORY OF OUR COMMUNITY

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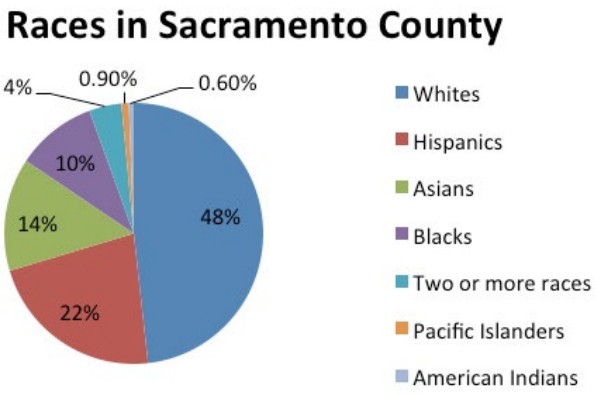
THE STORY OF OUR COMMUNITY

Sacramento County (Figure 7) is home to the capitol of California. The county consists of both urban and rural communities and is home to more than 1.4 million people as of 2012, which grew by 15.9% since 2000. Sacramento County is included in the Sacramento-Roseville-Arden-Arcade, CA Metropolitan Statistical Area. It encompasses about 994 square miles in the northern portion of the Northern California Central Valley on into Gold Country. Sacramento County extends from the low delta lands between the Sacramento and San Joaquin Rivers north to about ten miles beyond the State Capitol and east into the foothills of the Sierra Nevada Mountains. The southernmost portion of Sacramento County has direct access to the San Francisco Bay.[18]

Figure 7: County of Sacramento

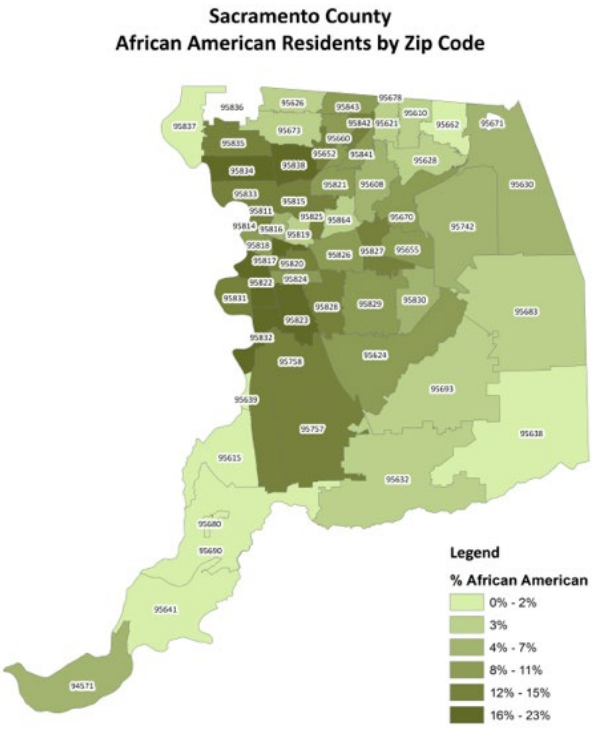
Whites make up 48% of the population, followed by Hispanics at 22%, Asians at 14%, Blacks at 10%, two or more races at 4%, Native Hawaiian/Pacific Islanders at 0.9% and American Indians at 0.6% (Figure 8). The median resident age is 34 years, 42% of the population are male and 58% female.[18]

Figure 8: Races in Sacramento County



Of the estimated 145,000 African Americans living in the 58 zip codes in the county, the six zip codes with the highest percentages (darkest green) of African Americans include 95838, 95834, 95832, 95823, 95822, and 95817 (Figure 9).[18]

Figure 9: African American Residents by Zip Code



Source: LPC Consulting Associates, Inc.

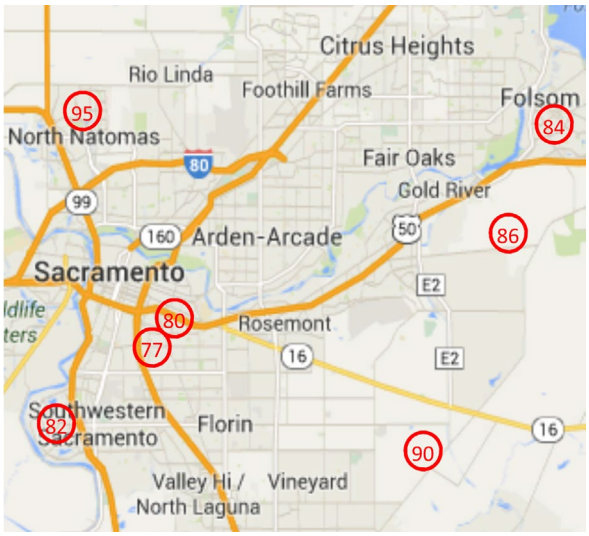
HEALTH STATUS OF AFRICAN AMERICANS

- 29.9% currently smoke[1]
- 67.7% are overweight or obese.
- 11% have diabetes.[1]
- 59.9% eat less than 5 servings of fruit and vegetables daily.[1]
- *13.4% get vigorous activity at least 20 minutes/day for 3 days/week (*not stable estimates).[1]

LIFE EXPECTANCY OF AFRICAN AMERICANS

Life Expectancy is a measure that summarizes health over the entire lifespan. It is the average number of years a newborn can expect to live, assuming he or she experiences the currently prevailing rates of death throughout his or her life span.[3]

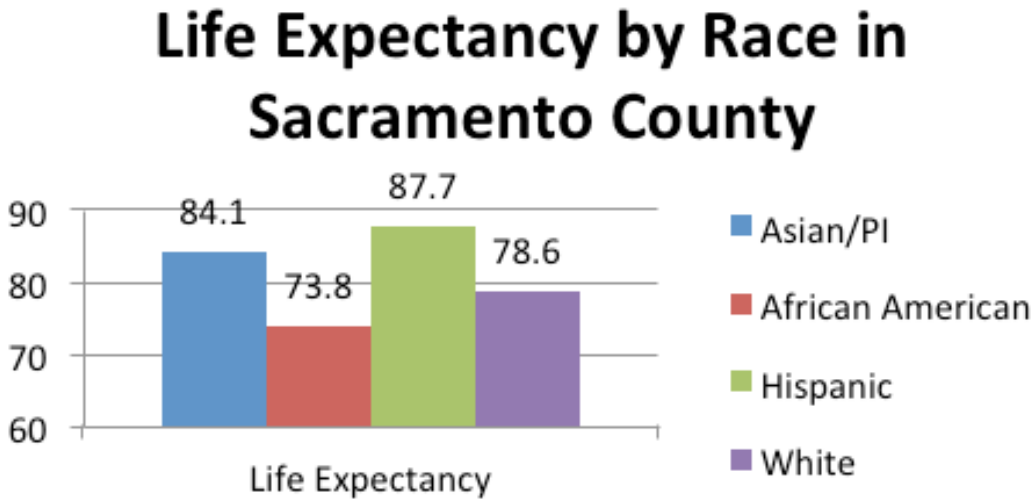
Figure 10: Life Expectancy in Sacramento County



Source: Sacramento County Health Status Report, 2014

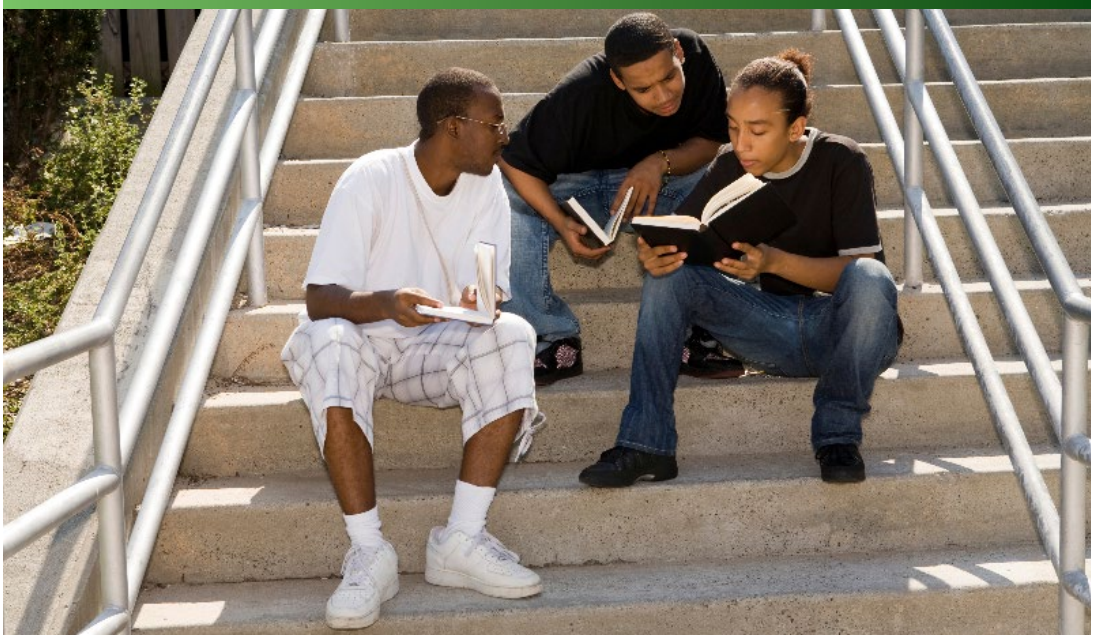
The range of life expectancy in the 58 zip codes for all residents in the county ranges from 70 years to 95 years (Figure 10). The highest life expectancy of 91-95 years of age are in two zip codes, 95834 and 95835 (North Natomas) and the lowest life expectancy of 70-77 years of age can be found in 16 zip codes, including 95817 (south Sacramento). Life expectancy increased for all racial and ethnic groups from 2002 to 2011; however, life expectancy for African Americans is lowest among all racial and ethnic groups in the county at 73.8 years compared to Hispanics at 87.7 years, Asian/Pacific Islanders at 84.1 years and Caucasians at 78.6 years (Figure 11). [3]

Figure 11: Life Expectancy by Race in Sacramento County



Source: Sacramento County Health Status Report, 2014

SOCIAL DETERMINANTS OF HEALTH PRIORITIES



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SOCIAL DETERMINANTS OF HEALTH PRIORITIES

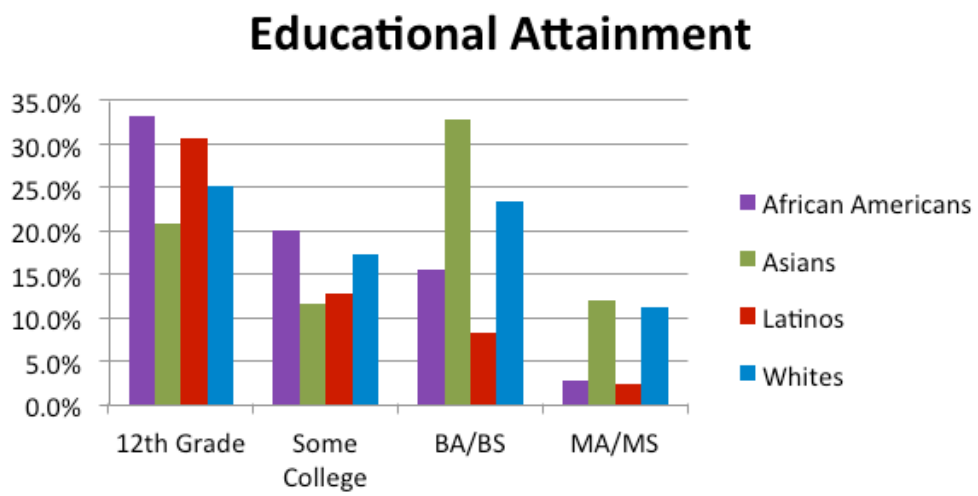
The Social Determinants of Health Committee elected to focus on social and economic factors influencing the health of African Americans because of their significant impact and ability to eliminate health disparities. Goals and strategies that seek to improve educational attainment, economic development, and racial discrimination/social justice within communities in general will improve life expectancy, reduce disparities, and uplift quality of life for everyone. Developing strategies and promoting promising practices that can be implemented in a coordinated and synergistic effort between community-based organizations, private business, and local, state, and national government endeavors is necessary to improve social and economic factors.

Priorities have been identified for each area to assist groups working to improve their communities with examples for their scope of work. Although activities to support some of the examples are provided to address the social determinants only a few promising practices examples are listed. As new examples are identified and evaluated they will be recorded in addendums to the CAP.

EDUCATIONAL ATTAINMENT

Education gaps exist among the different racial and ethnic groups in Sacramento (Figure 12). For African Americans, the highest level of education most completed is grade 12 at 33.2%, compared to Asians whose highest level most completed is a bachelors' degree at 32.9%. Latinos completed grade 12 the most, yet have some of the lowest rates of completing higher education.[1]

Figure 12 - Educational Attainment in Sacramento County



Source: California Health Interview Survey, 2011-2012

Priority: Increase the number of African Americans graduating from high school and college.

Activities:

Increase the number of African American children attending pre-school.

- Advocate for legislation for early childhood development.
- Ensure children have access to affordable or free quality preschool.

Increase the number of African American youth obtaining high school, college and post graduate education.

- Provide access to tutoring and other resources to improve literacy and math skills.
- Develop alternatives to suspension and expulsion.
- Encourage mentorship opportunities and internship programs for African American students.
- Provide assistance to African Americans applying to post graduate education (medical, engineering, sciences, mathematics, law, etc.).
- Encourage African American professionals to teach in community colleges.

For African Americans, the highest level of education most completed is grade 12.

SOCIAL DETERMINANTS OF HEALTH PRIORITIES

ECONOMIC DEVELOPMENT

The average household size is two people and the median income is $55,846. For Blacks, the median income is $39,471 (2008-2012).[19]

Priority: Increase income of African Americans.

Activities:Increase minimum wage to a livable wage.

- Advocate for laws to increase minimum wage.

Promising Practice Examples

Mechanism of Change: Public Policy

In the City of Sacramento, much like other cities around the state, the Mayor is putting together a taskforce to look at raising the minimum wage from $9 to $11. Similar proposals have been attempted at the state level; yet have failed to pass committees. Cities such as Oakland, San Francisco, San Jose and Los Angeles have already increased minimum wage to as much as $15 per hour for some employees.

Build wealth in the African American community.

- Teach money management.
- Provide access to business opportunities.
- Help with acquiring and maintaining home ownership.
- Build capacity among African Americans to seek higher paying jobs through job/career training and education.

Promising Practice Examples

Mechanism of Change: Public Policy

Ubuntu Green is a non-profit organization committed to promoting healthy, sustainable and equitable communities through advocacy, education, and community empowerment. They create policy systems change at the local, regional, state, and federal levels through direct advocacy, empowerment of communities, policy development, and implementation. As a result of their advocacy work through a collaboration of like-minded non-profits, they were successful in advocating for an ordinance in the City of Sacramento that allows residents to grow and sell produce.

RACIAL DISCRIMINATION AND SOCIAL INJUSTICES

Priority: Eliminate Racial Discrimination and Social Injustices that Affect Health.

ACTIVITIES

Reduce racial bias in healthcare systems.

- Increase the number of Health Care providers who cultivate interest, mentor and encourage medical students throughout post graduate education
- Increase the number of African American health care providers in underserved communities
- Advocate for policies in pay for performance that are based on improving and prevention of health disparities specific to African Americans

Promising Practice Examples

Mechanism of Change:

Kaiser Permanente has developed handbooks for providers that describe population characteristics, health beliefs, risk factors, and specific health needs of Hispanics, African Americans and Asian Americans. The goal of the Provider Handbooks is to provide clinicians with an overview of the cultural and epidemiological differences that characterize major cultural groups represented among patients.[20]

SOCIAL DETERMINANTS OF HEALTH PRIORITIES

Expose industry target marketing (I.e., tobacco, sweetened beverage and fast food companies) to African Americans.

- Educate the African American community of marketing practices by tobacco, sweetened beverage, and fast food industries.
- Restrict price, placement, and promotion of un-healthy foods and products.

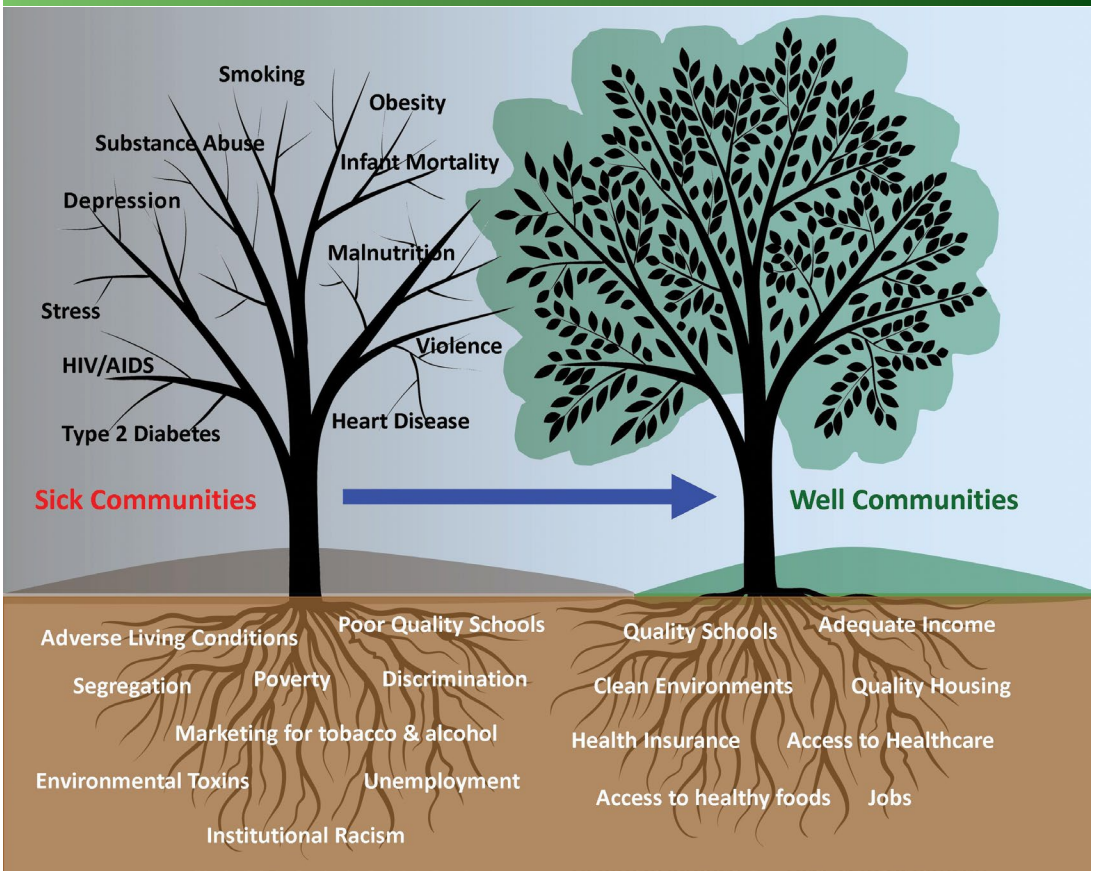
Promising Practice Examples

Mechanism of Change: Environmental/Systems & Individual Behavior

The California Endowment is finding innovative new ways to help educate the public. They provide grants to organizations that work in taking on "Big Soda" and working closely with partners in California and across the country. Canzilla is an anti-soda campaign that is part of a collaborative project of Youth Speaks and UCSF Center for Vulnerable Populations. Working with youth, the purpose of the campaign is to raise awareness on the dangers of consuming sugary drinks through marketing that parodies how the soda industry targets youth. They also make fresh potable water available as alternatives to sugary beverages.

Type 2 diabetes is the 4th leading cause of death for African Americans.

ELIMINATE HEART DISEASE, TYPE 2 DIABETES, EXISTING AND EMERGING TOBACCO PRODUCT USE, AND OBESITY



Credit: Adapted from Anderson et al, 2003; Marmoetal, 1999; and Wilkinson et al, 2003.

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ELIMINATE HEART DISEASE, TYPE 2 DIABETES, EXISTING AND EMERGING TOBACCO PRODUCT USE, AND OBESITY

The Social Determinants of Health Committee conducted a review of the health issues faced by African Americans and discussed options for narrowing the scope of the CAP in order to have a more concentrated impact. Key factors that influenced the committee's decision to focus first on two important health conditions - heart disease and type 2 diabetes and two significant contributing risk factors - tobacco use and obesity include:

- The leading cause of death for African Americans in the United States is cardiovascular disease and is the second leading cause of death for African Americans in Sacramento, second to cancer. Cardiovascular Disease claims 36% of the more than 290,000 who die each year.[3]

- The fourth leading cause of death for African Americans in the US, California, and the County of Sacramento is type 2 diabetes. Blacks are 1.7 times as likely to develop type 2 diabetes as Whites and the death rates for Blacks with type 2 diabetes are 27 percent higher than for whites.[3]

Figure 13: Top 10 leading causes of death for African Americans

Rank	United States	California	Sacramento (2011)
1	Heart disease	Heart disease	Cancer
2	Cancer	Cancer	Heart disease
3	Stroke	Stroke	Stroke
4	Diabetes	Diabetes	Diabetes
5	Unintended injuries	Unintended injuries	Unintended injuries
6	Kidney diseases	Chronic lower respiratory disease	Chronic lower respiratory disease
7	Chronic lower respira-tory disease	Alzheimer's Disease	Hypertension
8	Homicide	Influenza and pneumonia	Alzheimer's Disease
9	Septicemia (healthcare associated infections)	Hypertension	Homicide
10	Alzheimer's Disease	Kidney diseases	Influenza and pneumonia

Since tobacco use and obesity are two risk factors for these disparities, promising practices have been identified that address the risk factors as well as focusing on the health indicators of educational attainment, economic development and/or racial discrimination/social justice as three social determinants of health that when improved can greatly impact and eventually eliminate health inequities for African Americans.

Promising practices are interventions that have the potential to effectively speak to issues of concern in the community. The promising practices listed are from organizations that have been working well nationally, statewide, or locally with improvement to the well-being of the African American population in that vicinity.

The strategies and promising practices on heart disease, diabetes, tobacco, and obesity were identified from a variety of resources and entities who have successfully implemented programs to improve Social Determinants of Health for the African American community. Strategies and practices may not always align which shows gaps and further enforces the need for more community action plans. Unfortunately, promising practices did not exist or were not found for all strategies, which further indicate the need for communities to collaboratively develop and implement programs to tackle these determinants and reach our local Sacramento community.

Frequent assessment of social determinants of health indicators through a lens of how they impact the African American community is needed for all areas. The assessment results would be used to guide research, health care services, business and policy practices, public health campaigns, and

CVD is the 2nd leading cause of death for African Americans in Sacramento County.

ELIMINATE HEART DISEASE, TYPE 2 DIABETES, EXISTING AND EMERGING TOBACCO PRODUCT USE, AND OBESITY

resources towards meeting systemic needs in the African American community. Stakeholders can build on the current successful evidence-based strategies and have a coordinated plan to identify areas that are left unmet. Tools such as the Robert Wood Johnson Foundations County Health Rankings & Reports are available to be used by stakeholders to track the impact of implemented strategies against any improvements in the social determinants of health outcome measures for each county compared to the overall state. They can also produce reports specific to Sacramento County similar to the Bay Area Regional Health Inequities Initiative report which provides data on social determinants of health for African Americans in the Bay area.

Specifically, looking at social determinants of health as they impact African Americans will help to remove blinding issues derived from general campaigns that may touch African Americans but don't drive the change needed because they lack cultural competency and meaningful outreach to African Americans. While it is important to note that the benefits of making these changes to improve the African Americans community may benefit other people of color, low-income, and disadvantaged communities, this approach has a high likelihood of preventing African Americans from being left out or behind in building healthier communities.

The breadth of need to improve the health of African Americans is great and must be advanced thoroughly. The overarching vision of this CAP is to implement activities that eventually eliminate disparities related to heart disease and type 2 diabetes among the African American community

GOAL: Eliminate Heart Disease and Type 2 Diabetes Among African Americans.

The definition of health is to be free of disease. The World Health Organization defines health this way-- Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.[21] While it may be difficult to think of eliminating heart disease and type 2 diabetes altogether (similar to the belief smoking could not be eliminated in restaurants and bars), concentrating on them from the aspect of social determinants of health is a more global and end-game approach.

Eliminating heart disease and type 2 diabetes can only be accomplished through the collaborative efforts of health care professionals, educators, government officials, public health departments, and local communities—including faith-based organizations, community organizations, local businesses, and individual community members. Public health and healthcare professionals must understand the community's dynamics and develop preventive education strategies that are culturally relevant, easily understood, affordable and appropriate.

ELIMINATE HEART DISEASE

Cardiovascular disease (CVD), commonly called heart disease is the leading cause of death among all Americans. CVD encompasses conditions that affect the heart and blood vessels throughout the body including coronary artery disease, hypertension, stroke, heart failure, heart attack, atherosclerosis, and other vascular diseases. African Americans have high incidences of cardiovascular disease and high risk conditions that contribute to heart disease such as hypertension, diabetes, smoking, and obesity.

Although CVD usually manifests itself in middle age, it is a condition with a long incubation period. Changes in blood vessels begin in early childhood and gradually progress to manifest as heart attacks and strokes in later life. Socioeconomic status can influence cardiovascular health differentially along the life course.

In childhood, poor living conditions and social class have a strong impact on cardiovascular health status. In middle age, risk factors such as smoking, physical inactivity, unhealthy diet, obesity, hypertension, raised cholesterol, and diabetes increase the risk of CVD.

ELIMINATE HEART DISEASE, TYPE 2 DIABETES, EXISTING AND EMERGING TOBACCO PRODUCT USE, AND OBESITY

This may be counteracted by living conditions that make healthy behaviors affordable and facilitate health information seeking, and education. As adults, access to medical care, social and family support, a sense of control over life and health has an impact on cardiovascular health. In middle-income societies where basic material needs are available, the psychosocial components of the socioeconomic status framework (including perceived status in social hierarchy) are likely to be relatively more important for cardiovascular health than living conditions."

Quick Facts[1]:

Prevalence of heart disease in California Adults (2009)[1]

- African Americans: 5.8%
- Latino/Hispanics: 4.5%
- Caucasians: 7.4%

Adults diagnosed with heart disease in Sacramento County (2009)[1]

- African Americans: 4.9%
- Latino/Hispanics: 8.6%
- Caucasians: 6.6%

Death rate per 100,000 (California)[1]

- African Americans: 552
- Latino/Hispanics: 287
- Caucasians: 403

Strategies for Heart Disease Prevention

Strategy #1: Raise awareness of symptoms and signs of heart attack and stroke through cultural, linguistic, and gender education initiatives.

Studies show that African Americans often have limited knowledge about hypertension and stroke. In some cases, cultural barriers may contribute to these knowledge gaps. Studies also show that education is needed according to gender as female symptoms for heart attacks and stroke can be different from male symptoms. Some African Americans, especially those from older generations, continue to resist health education because of long-standing distrust of the medical system.

Methods to raise awareness of symptoms and signs of heart attack and stroke include:

- Teaching heart healthy behaviors.
- Conducting media campaigns with united messaging specifically for the African American Community.
- Collaborating to train and implement interventions with the use of culturally competent community-based health educators on a large scale.
- Partner with community based organizations and businesses such as barber shops and beauty salons owned by and serving African. Americans to distribute educational messages and change social norms
- Conduct focus groups or surveys to develop and evaluate health media campaigns.

ELIMINATE HEART DISEASE, TYPE 2 DIABETES, EXISTING AND EMERGING TOBACCO PRODUCT USE, AND OBESITY

Promising Practice Examples
SDOH addressed: Racial Discrimination/Social Justice
Mechanism of Change: Environmental/Systems & Individual Behavior Change
California WISEWOMAN Program helps underserved women reduce the risk of cardiovascular disease (CVD) through timely, high quality screening, education, and intervention for elevated cholesterol, glucose, and high blood pressure, as well as, education on the signs and symptoms of heart attack and stroke and when to call 911.

SDOH addressed: Racial Discrimination/Social Justice
Mechanism of Change: Environmental/Systems Change
California Department of Public Health Master Plan for Heart Disease and Stroke Model Program: Lumetra, California's federally-designated Quality Improvement Organization (QIO), has a Cultural Competency Initiative that offers physicians no-cost tools and resources, including a self-paced online course called "A Physician's guide to Culturally Competent Care."

Strategy #2: Increase primary prevention efforts to avoid Heart Disease among African Americans through: smoking cessation, management of blood pressure (BP), weight control, and dietary and physical activity counseling.

Achieving CVD risk reduction and ultimately reducing death and disability from cardiovascular diseases require specific strategies for lifestyle change and adherence to medical therapies across all racial/ethnic populations. Although considerable published data support the effectiveness of primary and secondary prevention of CVD risk factors on reducing all-cause cardiovascular morbidity and mortality across all racial/ethnic populations, more needs to be done to achieve risk reduction.

- Interventions that make smoking less desirable, prohibitive in public or shared places, and increasing smoking cessation
- Behavioral Strategies to Improve Physical Activity and Heart-Healthy Nutrition
- Strategies to manage stress as a risk factor for high blood pressure and obesity
- Increase physician and health care provider advocacy efforts to support local, statewide and national policy that improve health services or outcomes for African Americans

Promising Practice Example
SDOH addressed: Racial Discrimination/Social justice
Mechanism of Change: Environmental/Systems Change
Kaiser Permanente has developed handbooks for providers that describe population characteristics, health beliefs, risk factors, and specific health needs of Hispanics, African Americans, and Asian Americans.

Strategy #3: Comprehensive management of risk factors in those with established Heart Disease.

African-Americans often have less access to health care, are less likely to visit a doctor and get routine screenings, and are less likely to be referred to specialists. Community education programs are needed to teach African Americans how to advocate for the best care possible and how to request or demand referrals to specialists when needed, and to request preventive care and wellness for hypertension and cholesterol management, counseling on lifestyle modifications, and medication management.

Methods for comprehensive management of risk factors include:

- Safe exercise
- Heart healthy eating options
- No-to-low cost cardiac rehabilitation programs

ELIMINATE HEART DISEASE, TYPE 2 DIABETES, EXISTING AND EMERGING TOBACCO PRODUCT USE, AND OBESITY

Promising Practice Example
SDOH addressed: Racial Discrimination/Social justice
Mechanism of Change: Public Policy
South Carolina Taking Local Action in African American Communities: South Carolina worked in collaboration with local community partners to promote heart health in African American communities. Several faith organizations implemented specific policy and environmental strategies appropriate to their needs that deal with high blood pressure, high cholesterol, and tobacco use prevention.

ELIMINATE TYPE 2 DIABETES

Type 2 diabetes is a serious health issue that has long lasting implications for African Americans. Type 2 diabetes is a chronic disease in which the body does not produce or properly use insulin. About 90 percent to 95 percent of all diagnosed cases are Type 2 diabetes, otherwise known as adult-onset type 2 diabetes. Serious long-term complications include heart disease, stroke, kidney disease, blindness, and limb amputation. Risk factors include older age, family history, obesity, physical inactivity, race, and ethnicity.

Type 2 diabetes is one of the leading causes of illness and death for African Americans and people of African descent throughout the United States and in the County of Sacramento, California. The involvement of families and communities in developing prevention strategies can increase the likelihood that behavioral changes will be sustained.[22] Strategies that speak to lifestyle behaviors such as regular health screenings, healthy eating, and physical activity are key to the prevention and management of type 2 diabetes.

Quick Facts:

Type 2 diabetes is a major risk factor for CVD. Complications from diabetes due to high sugar levels in the blood include increased risk for heart disease, stroke, angina and coronary artery disease.[23]

About 65 percent of people with diabetes die from heart disease and stroke.[23]

Adults with diabetes are two to four times more likely to have heart disease or suffer a stroke than people without diabetes.[23]

Type 2 diabetes cost the U.S. $174 billion in 2007. In 2008, there were 3.7 million Californians with type 2 diabetes. Of these numbers:[23]

- 2.3 million (8.5%) were aware (diagnosed)
- 1.4 million (5%) were unaware (undiagnosed)

In Sacramento County African Americans, Latinos, and American Indians suffer the highest rates of Type 2 diabetes.[1]

- American Indian: 27%
- Latino/Hispanics: 18.7%
- African Americans: 11.1%

Strategies for Type 2 Diabetes Prevention

Strategy #1: Increase implementation of evidenced-based prevention and management programs serving African American communities.

ELIMINATE HEART DISEASE, TYPE 2 DIABETES, EXISTING AND EMERGING TOBACCO PRODUCT USE, AND OBESITY

Although the importance of addressing type 2 diabetes is well recognized, implementing evidence-based type 2 diabetes prevention and management programs in underserved African American communities has been limited. Decision makers often award grants based on accountability for achieving results.

Methods to implement evidence-based prevention and management programs include:

- Provide sustainable funding for community-led type 2 diabetes intervention programs on a state and local level.
- Collaborate with hospitals and other health care providers to conduct regular health screenings known to promote early detection of and support management of type 2 diabetes such as blood glucose testing, A1C testing, eye exams, and foot exams.
- Train medical providers on methods to create more positive experiences within the medical system for minority communities.
- Increase awareness and knowledge of the seriousness of type 2 diabetes, its risk factors, and effective strategies for preventing complications associated with type 2 diabetes and preventing type 2 diabetes.
- Increase the number of people who live well with type 2 diabetes and effectively manage their disease to prevent or delay complications and improve quality of life.
- Decrease the number of Americans with undiagnosed type 2 diabetes.
- Among people at risk for type 2 diabetes (e.g. insulin resistant, pre-diabetic, or family history), increase the number who make and sustain effective lifestyle changes to prevent type 2 diabetes.
- Promote increased awareness of people with pre-diabetes through screenings, clinic referrals to recognized diabetes self-care management education programs and lifestyle intervention programs to prevent the development of type 2 diabetes.
- Advocate for provider reimbursement for community-based diabetes management education and lifestyle intervention programs for people with pre-diabetes and type 2 diabetes. Increase the number of these programs available in low resource communities.
- Facilitate efforts to improve type 2 diabetes-related health care and education, as well as systems for delivering care. Engage culturally competent community-based health care workers to support self-care management among African Americans.
- Identify, disseminate, and support the adoption of evidence-based, culturally and linguistically appropriate tools and resources that support behavior change, improved quality of life, and better type 2 diabetes outcomes.

Promising Practice Example
SDOH addressed: Educational Attainment
Mechanism of Change: Individual Behavior Change
The National Diabetes Prevention Program teaches participants strategies for incorporating physical activity into daily life and eating healthy. Lifestyle coaches work with participants to identify emotions and situations that can sabotage their success, and the group process encourages participants to share strategies for dealing with challenging situations. The CDC-led National Diabetes Prevention Program is an evidence-based lifestyle change program for preventing type 2 diabetes. It can help people cut their risk of developing type 2 diabetes in half. The Diabetes Prevention Program research study showed that making modest behavior changes helped participants lose 5% to 7% of their body weight—that is 10 to 14 pounds for a 200-pound person. These lifestyle changes reduced the risk of developing type 2 diabetes by 58% in people with pre-diabetes. Participants work with a lifestyle coach in a group setting to receive a 1-year lifestyle change program that includes 16 core sessions (usually 1 per week) and 6 post-core sessions (1 per month).

Strategy #2: Improve access to supermarkets in underserved areas and incentivize the sale of healthier foods and beverages in underserved areas

ELIMINATE HEART DISEASE, TYPE 2 DIABETES, EXISTING AND EMERGING TOBACCO PRODUCT USE, AND OBESITY

Research indicates an association between increased access to supermarkets and healthy eating behaviors. Although full-service grocery stores have a wider selection of healthy foods at lower prices, many low-income, minority and rural communities tend to have fewer supermarkets and more corner or convenience stores. A year study by the Reinvestment Fund found that increasing the number of supermarkets in underserved neighborhoods led to an increase in real estate values, economic activity and employment, and a decrease in food process.

Methods for attracting supermarkets to underserved areas or persuading convenience stores to sell healthier items include:

- Pricing benefits and discounts
- Loan guarantees or grants to cover start-up and investment costs
- Supportive zoning and technical assistance to small business on how to start and maintain sales of healthier items

Promising Practice Example
SDOH addressed: Educational Attainment/Economic Development
Mechanism of Change: Environmental/Systems and Individual Behavior Change
In South Los Angeles, four convenience stores have undergone a community-driven conversion process through the Community Market Conversion Program. The Program creates healthy hubs for residents with limited access to healthy food by introducing fresh produce for sale and limiting access to unhealthy products. They also created tobacco control guidelines, which include steps such as moving cigarillos and other cigarette products away from counters; and posting signs to promote smoking cessation. Community participation was key to the project with residents selecting the stores and providing outreach and education in the neighborhoods surrounding them.

Strategy #3: Increase access to outdoor recreational facilities and enhance walkability and bike-ability in neighborhoods.

Providing and maintaining public parks, fields, pools and playgrounds, bike lanes and creating an infrastructure that supports walking, such as sidewalks, trails, crosswalks, street lighting, and shared use paths, are important elements of the built environment that encourages physical activity.

Methods for increasing access include:

- Improve personal and traffic safety in the community so people can be physically active
- Identify and creating opportunities for safe, enjoyable, and low-impact physical activities for community members.
- Collaborate with police enforcement to ensure that safety is a priority in outdoor recreational areas.
- Develop city and local area walking programs

Promising Practice Example
SDOH addressed: Economic Development
Mechanism of Change: Environmental/Systems and Public Policy Change
WALKSacramento works with transportation and land use planners, elected officials and community groups to create safe, walkable environments for all citizens and particularly for children, seniors, the disabled and low-income individuals. WALKSacramento works to incorporate pedestrian access into transportation and development decisions, to increase funding for pedestrian infrastructure, and to adopt and implement pedestrian master plans for local communities.

ELIMINATE HEART DISEASE, TYPE 2 DIABETES, EXISTING AND EMERGING TOBACCO PRODUCT USE, AND OBESITY

Promising Practice ExampleSDOH addressed: Economic Development
Mechanism of Change: Environmental/Systems and Public Policy Change
Sacramento Area Bicycle Advocates (SABA) helps make it safe and convenient for more people to ride a bike more often and makes the Sacramento region a cleaner, healthier, happier place to live and work. SABA focuses on two broad areas: public agencies and private entities that influence where and how people can ride bikes. SABA meets with developers and public agencies and provides impact reports, makes recommendations for improvements and advocates that bike-riders' needs are met for new and re-development projects in the Sacramento area.

Strategy #4: Reduce barriers to healthy eating such as the number of fast food outlets in low-income communities, assure healthy menu options are priced competitively in restaurants and increase resources and social support for a healthy diet.

Eating well to maintain a healthy weight is one of the most important things African Americans can do to lower risk for type 2. The right meal plan will help improve blood glucose, blood pressure, and cholesterol numbers and also help keep weight on track.

Methods to reduce barriers include:

- Healthy meal preparation classes
- Encouraging developers to donate land for community garden projects
- Increasing the number of organizations who provide social support for healthy diet practices
- Connect with low resource schools to ensure healthy menu choices are being offered through all school meal programs
- Work with organizations and government officials to limit the number of fast food outlets placed in low-income communities.
- Increase the number of healthy food in low-income communities.

Promising Practice Examples
SDOH addressed: Educational Attainment
Mechanism of Change: Individual Behavior Change
The African American Leadership Coalition (AALC) collaborated with UC Davis to involve families and communities in developing prevention strategies for diabetes to increase the likelihood that behavioral changes will be sustained; and to engage families in developing a process to identify barriers to diabetes and obesity prevention and reduction, exchange strategies, and create action plans for prevention.

SDOH addressed: Educational Attainment
Mechanism of Change: Individual Behavior Change
The African American Women's Health Legacy empowers African American women to better protect their families through monthly education workshops that increases social support; and initiatives that assist them in making healthy meal plans to prevent the development of type 2 diabetes.

SDOH addressed: Economic Development
Mechanism of Change: Environmental and Systems Change
The Alliance for a Healthier Generation has worked with industry partners to make school meals healthier for America's children. Agreements are made with food manufacturers to ensure healthier food items are priced at rates no higher than comparable "classic" items; marketed products meet certain nutritional guidelines; and increased sales metrics are established for a healthier school food menu. The joint goal is to achieve at least 50 percent of all school sales among nutritionally healthy food products.

ELIMINATE HEART DISEASE, TYPE 2 DIABETES, EXISTING AND EMERGING TOBACCO PRODUCT USE, AND OBESITY

SDOH addressed: Economic Development
Mechanism of Change: Individual Behavior Change, Environmental and Systems Change, and Public Policy
The Network for a Healthy California – Gold Country Region has "been able to empower individuals towards a healthy life by 1) Providing communities with increased access to fresh fruits and vegetables, 2) Educating community residents about eating the recommended amounts of fruits and vegetables, and being physically active every day, 3) Creating opportunities for parents, youth, and community residents to advocate for their personal health and the health of their families, and 4) Developing trainings that provide the tools necessary for Promotoras, teachers, after-school site leaders, retailers, employers, faith leaders, health practitioners, and youth to engage others in making health a priority.

The program:

- Reached over 275,000 youth.
- Reached approximately 1.5 million adults.
- Assisted in the development of 15 farmers' markets or produce stands.
- Assisted in the development of 10 school or community gardens.
- Assisted schools in developing their School Wellness Policies.
- Worked with afterschool to create new policies promoting healthy behaviors. https://healthedcouncil.org/our-impact/network-for-healthy-california/

ELIMINATE EXISTING AND EMERGING TOBACCO PRODUCT USE

California's tobacco prevention and control efforts over the last twenty-five years has demonstrated the power of policy, organizational practice, and social norms change in improving health outcomes and morbidity rates for all. Despite overall declines in adult and youth smoking prevalence in California, African Americans continue to smoke or use tobacco products at elevated rates. Each year, approximately 45,000 African Americans die from smoking related disease. [24] Smoking is responsible for 80% of all lung cancer deaths and is also a major cause of heart disease.

Tobacco use is the single largest preventable cause of death and chronic disease in the world today, causing 5.4 million deaths in 2005. [25] It is a risk factor for six of the eight leading causes of death in African Americans, including heart disease and several cancers and lung diseases. Tobacco use disproportionately affects African Americans, males and lower socioeconomic groups in developed and developing countries, and is increasingly prevalent in poorer parts of the world.

Quick Facts:

Current smokers in California* [1]

- All adults: 14.4%
- African Americans: 21.9%
- Latino/Hispanics: 12.9%
- Whites: 14.9%

Current smokers in Sacramento County*) [1]

- All adults: 15.9%
- African Americans: 30.3%
- Latino/Hispanics: 11.7%
- Whites: 15.7%

*most recent statistically stable data.

ELIMINATE HEART DISEASE, TYPE 2 DIABETES, EXISTING AND EMERGING TOBACCO PRODUCT USE, AND OBESITY

Strategies for Tobacco Prevention

Strategy #1: Increase collaboration between community-based organizations (CBOs) serving African Americans and those organizations working in the tobacco control movement to broaden their efforts to reduce use.

Often there are several organizations working toward eliminating health disparities or other issues in the African American community. Because of lack of knowledge, communication, or the habitual redundancy of working in silos; cross sector collaboration and idea sharing does not occur. Organizations can prevent re-invention of the wheel when roundtable discussions are held with a wide variety of representatives who serve the African American population.

Methods to improve collaboration and reduce redundancies include:

- Host a roundtable brainstorming session to identify key partners and collaborative opportunities.
- Seek non-traditional partnerships (business owners, non-health government entities, education systems, faith-based, healthcare providers, etc.) to broaden outreach and education efforts.
- Conduct assessments to identify similar programs, current legislation, and those instrumental in implementation.
- Include joint objectives and activities in work plans.

Promising Practice Example
SDOH addressed: Educational Attainment
Mechanism of Change: Environmental/Systems Change
The SOL Project serves as an Advisory Board member for the Sacramento Community Cancer Coalition (SCCC). The SCCC hosts annual prostate, breast, and vision screenings at medical student operated community clinics. These clinics provide care to underserved community members (African Americans, homeless, veterans, etc.). The SOL Project's participation on the board has encouraged medical students to become trained to provide motivational interviewing for their patients seeking assistance in quitting tobacco. Providing tobacco cessation quit kits and referral to the Medical Incentive to Quit Smoking California Smokers Helpline is now a standard practice for medical students providing cessation counseling kits.

Strategy #2: Eliminate the use of flavored tobacco including menthol and target marketing of African Americans and youth.

Methods to eliminate the use and targeting of flavored tobacco include:

- Work jointly on policy or systems change with local, state and national organizations that eliminate the sale of flavored tobacco (i.e., menthol and candy) products (E.g., electronic smoking devices, little cigars and cigarillos and blunt wrappers).
- Identify collaborative partners who are willing to commit resources to implement and complete deliverables toward this strategy.
- Develop educational messaging especially messages reflective of the voices of young African American males that raise awareness of tobacco industry targeting of African Americans.
- Develop culturally appropriate tobacco cessation interventions materials specifically for African Americans.

Promising Practice Examples
SDOH addressed: Racial Discrimination/Social JusticeMechanism of Change: Public Policy Change
The African American Tobacco Control Leadership Council (AATCLC) worked jointly with Chicago Department of Public Health and Mayor Rahm Emanuel's office to provide technical assistance on adoption for tobacco control legislation to regulate where menthol and other flavored tobacco products can be sold. The ordinance created a flavored tobacco buffer zone and prohibited the sale of menthol and other flavored tobacco products within 500 feet of Chicago schools.

SDOH addressed: Racial Discrimination/Social Justice
Mechanism of Change: Environmental/Systems Change
California's Tobacco Control and Prevention Program became a national model for success through their Joint Ethnic Networks. The Joint Ethnic Networks consisted of agencies that concentrated on tobacco concerns among racial and ethnic groups such as African Americans, Asian/Pacific Islanders, Hispanic/Latinos, and Native Americans. These ethnically diverse programs and staff were considered experts in cultural and linguistic outreach and education for their respective communities. They collaborated jointly to implement community based projects and legislation to reduce secondhand smoke and tobacco industry targeting toward minorities, youth and young adults. Projects included cultural competency trainings, multi-ethnic conferences, annual visits to the California legislature, and development of an advocacy platform guide.

Strategy #3: Increase understanding of community perspective and needs for development of effective community interventions.

Public health practitioners frequently develop messages for the community without asking those who live in the community what they think the problem or solution might be.

Methods to include and obtain buy-in from the community include:

- Monetarily incentivize and/or provide jobs to community members to participate in program interventions, particularly youth.
- Recruit key community members to participate on advisory committees and relay campaign messaging.
- Conduct community led assessments to determine policy and education priorities.

Promising Practice Example
SDOH addressed: Educational Attainment
Mechanism of Change: Policy Change
The SOL Project worked with the Sacramento Regional Transit District (SRTD) and community youth to adopt a 100% smoke-free policy for all bus stops and light rail stations. The SOL Project engaged community youth serving on a youth task force to help make the case for the importance of smoke-free policies in the community. The SOL Project's youth volunteers, called the "SOLdiers," held cigarette litter pick-up events to demonstrate the need for a smoke-free policy. They collected over 5,600 pieces of tobacco litter at 75 bus stops and light rail stations in only four hours' time. The research and information developed with the help of the youth volunteers set the stage for policy action and played an important role in affecting change. SRTD's new policy will protect thousands of passengers from secondhand smoke and reduce the number of cigarette butts and paraphernalia that litter transit stations across Sacramento.

ELIMINATE HEART DISEASE, TYPE 2 DIABETES, EXISTING AND EMERGING TOBACCO PRODUCT USE, AND OBESITY

ELIMINATE OBESITY

Obesity is a risk factor for heart disease. Obese people have higher levels of fat in the blood which can lead to coronary atherosclerosis. They are also at risk for heart failure a condition when your heart is not able to pump enough blood. Being overweight and obese is also related to increased prevalence of hypertension, high cholesterol, and diabetes, which all contribute damage to blood vessels and the heart muscle resulting in heart disease. Obese people may also suffer from osteoarthritis and sleep apnea. Maintaining a healthy weight is important for overall health. Normal weight is considered a Body Mass Index (BMI) of 18.6-24.9. Overweight is defined as BMI 25-29.9 and obesity is defined as a BMI of 30+. BMI is defined as weight in kilograms divided by height in meters squared (kg/m).[26]

California and the nation face a growing obesity epidemic that threatens the life expectancy gains of past decades and portends greater increases in health care costs. Where people live, work, and play impacts obesity. One in every nine California children, one in three teens, and over half of adults are already overweight or obese. This epidemic affects virtually all age, income, educational, ethnic, and disability groups, although rates are highest among Californians of Latino, American Indian, African American, and Pacific Islander descent, from lower-income households, and those with disabilities. [27]

Obesity and being diagnosed as overweight is a significant health problem. For children ages 2-11 years old, 12.8% are overweight and children ages 12-17 years old, 5.7% are overweight. For teens, 12 to 17 years old, 16.7% are considered at risk of being overweight. For adults, 1 in 3 is overweight and 1 in 4 is obese. Adult males had higher overweight rates compared to females across the 5-year time span.[28]

Following a healthy lifestyle that includes a healthy diet and being physically active can help prevent becoming diagnosed as overweight or obese. In California, 23% of African Americans reported that they did not participate in any leisure time physical activity in the past month, which was the same as the rate for all adults statewide. Nearly half (48%) of African Americans reported that they did not participate in the recommended levels of physical activity (30 minutes of moderate physical activity, 5 days a week, or 20 minutes of vigorous physical activity 3 days a week), which was very similar to the 49 percent for all adults statewide. [29]

Obesity rates are higher and dietary patterns are worst for those living in low income neighborhoods. Among African Americans who think they should eat more fruits and vegetables, over 75% listed difficulty buying fruits and vegetables at fast food places as the leading barrier to eating more fruits and vegetables. Other barriers were that fruits and vegetables are hard to get at work (64%), hard to buy in restaurants (32%), and too expensive (32%). And forty two percent of low-income African American adults in California were not able to afford enough food. Seventeen percent of food stamp recipients or approximately 350,000 people, were African American, although 29% of African Americans were income-eligible for food stamps.[30]

Obesity is associated with factors such as food insecurity, low-income, poor nutrition and physical inactivity. Many African Americans live in neighborhoods with an abundance of cheap, low-nutrient, high-calorie food, but with limited access to affordable fresh food. Low-income families must often travel miles from where they live to purchase healthy foods at reasonable prices. Rural, low-income, and minority communities generally have less access to supermarkets[31]; and predominantly Black neighborhoods may have up to 50 percent less access to chain supermarkets than White neighborhoods. High quality fruits and vegetables are often less available and more costly than calorie-dense foods of lower nutritional quality.[32]

ELIMINATE HEART DISEASE, TYPE 2 DIABETES, EXISTING AND EMERGING TOBACCO PRODUCT USE, AND OBESITY

Quick Facts

Overweight and obesity rates in California[1]
- African Americans: 28.9% overweight, 37.6% obese
- Latinos/Hispanics: 37.7% overweight, 32.1% obese
- Whites: 34.9% overweight, 22.8% obese

Overweight and obesity rates in Sacramento County[1]
- African Americans: 51.3% overweight, 26.6% obese
- Latinos/Hispanics: 24.9% overweight, 45.4% obese
- Whites: 37.2% overweight, 24.7% obese

Strategies for Obesity Prevention

Strategy #1: Increase support among state-level leadership and coordination of statewide obesity prevention efforts to create active living and healthy eating environments and work toward the elimination of health inequities.

African American representation on advisory boards and committees that influence funding and program implementation is imperative to ensure that priority populations and those of low socio economic status are considered early in the planning process.

Methods that lead to obesity prevention efforts include:

- Providing culturally specific recommendations for policy priorities and strategies to the Governor and Legislature.
- Bringing local partners together through meetings to review best practices.
- Having African American representation on the Strategic Growth Council's Health in All Policies Task Force, established by the Governor's Executive Order.
- Ensure local new development and re-development includes active living and healthy eating options in the design plans.

Promising Practice Example
SDOH addressed: Racial Discrimination/Social Justice
Mechanism of Change: Public Policy
Los Angeles City Council voted to place a one-year moratorium on building new fast food restaurants in some of the city's poorest neighborhoods, primarily in south and southeast Los Angeles. An analysis by the Los Angeles Times showed that of the city's 8,200 restaurants, South Los Angeles had the highest concentration of fast-food eateries at 45%. According to the Department of Health, 29% of children in South Los Angeles were obese compared with 23.3% throughout Los Angeles County.

Strategy #2: Collaborate with existing programs local and statewide to implement joint public education campaigns that promote healthy eating and active living.

ELIMINATE HEART DISEASE, TYPE 2 DIABETES, EXISTING AND EMERGING TOBACCO PRODUCT USE, AND OBESITY

To create a healthier African American community, it will take collaborative efforts between community based organizations, providers, health educators, decision makers, and funders. No entity can reduce health inequities alone. The ability to collaborate effectively with other individuals and organizations is essential to doing the work of building healthy African American communities.

- Host African American focus groups to develop and test culturally and linguistically appropriate messages.
- Collaborate with the California Obesity Prevention Program (COPP) to partner in local campaigns and ensure that new campaigns are not duplicative.
- Conduct focus groups with neighborhood market owners to determine what they need in order to provide more healthy options for customers.
- Position organizations to build capacity to ensure their eligibility for funding opportunities.

Promising Practice Examples
SDOH addressed: Economic Development
Mechanism of Change: Individual Behavior Change
Blue Shield of California's Healthy Lifestyle Rewards program helps its members adopt and maintain healthy lifestyle habits. Using online tools and resources supporting healthy eating, regular physical activity, stress management, and smoking cessation, members can earn up to $200 annually.

SDOH addressed: Educational Attainment
Mechanism of Change: Systems Change
The California Obesity Prevention Program (COPP) plans to convene partners to collaborate on common goals, share resources, and best practices that support active living and healthy eating environments. COPP currently has an objective to disseminate funding statewide permitting healthy eating and active living messages through state-level nutrition, obesity prevention, and physical activity programs.

Strategy #3: Work with government, worksites, health care providers, and schools to improve access to healthy eating and physical activity.

Obesity, which may be focused on through proper nutrition and physical activity, is a major risk factor for many chronic diseases, and has become a major health risk for Sacramento African Americans. Government, worksites, health care providers, and schools can improve this disparity by doing more to promote, support, and maintain systemic and sustainable changes needed to make healthy eating and physical activity easy for everyone.

Methods working with local organizations include:

- Foster collaboration among organizations that serve African Americans.
- Develop or adapt applicable toolkits, marketing, trainings, and educational materials that are culturally sensitive, appropriate, and competent.
- Adopt more local policies that limit access to sugar-sweetened beverages and increase access to school facilities for safe places for children and families to play.
- Provide local grants aimed at decreasing or eliminating obesity-related health inequities.

ELIMINATE HEART DISEASE, TYPE 2 DIABETES, EXISTING AND EMERGING TOBACCO PRODUCT USE, AND OBESITY

Promising Practice Example
SDOH addressed: Educational Attainment
Mechanism of Change: Environmental/Systems and Individual Behavior Change
The California WIC Program implemented and evaluated a statewide, year-long Healthy Habits education campaign to support major changes for healthier WIC foods. The innovative campaign collaborated with Sesame Street Workshop, whose characters are universally recognized. Using a wellness approach the campaign helped over 3,500 WIC staff become powerful health advocates for WIC families. The participant education component included five key health messages and reached nearly one million WIC families. Each family received a Sesame Street Workshop's Get Healthy Now mini-kit. The kit included active living and healthy eating messages in a booklet and on a CD. For the first time ever, all 675 WIC clinics gave the same nutrition education messages at the same time. These messages were also coordinated with external partners such as community stakeholders, state-level nutrition, obesity prevention, and physical activity programs. As a result, WIC achieved a major nutrition milestone, coordinating nutrition messages across numerous channels (direct mailing, signage, workshops) and providing healthier foods to over 1.5 million Californians. Evaluation results found that WIC families remembered campaign messages, increased their consumption of fruits, vegetables, and whole grains, and replaced whole milk with lower fat milk. This success highlights the critical importance of linking communications strategies to systems and environmental changes that make it easier for people to act on healthy eating messages.

RECOMMENDATIONS & NEXT STEPS

SOL
SAVING OUR LEGACY
African Americans for Smoke-Free Safe Places

RECOMMENDATION & NEXT STEPS

Developing this action plan is the first step toward collaborative efforts to implement programs that decrease disparities affecting African Americans through the lens of social determinants of health. The SOL Project is committed to ensuring that the goals, strategies, and promising practices in this document are made available to organizations that have the capacity and desire to implement them.

The CAP is intended to encourage cooperation among like-minded individuals. The collective would then prioritize strategies, identify roles and delegate responsibilities. This would help to increase success by leveraging the collective's assets so that not just any one individual, group or organization would be responsible for the overall outcomes in Sacramento. It should lead to a movement that encourages individuals and agencies to network, join coalitions, commissions, or other bodies that can significantly influence social change.

The SOL Project will host an implementation symposium to achieve the following:

- Identify organizations with the capacity to implement portions of the CAP
- Prioritize by consensus goals, strategies and promising practices
- Identify and prioritize practical and attainable work plans for the collective
- Increase partnerships among individuals and institutions interested in working collectively
- Identify CAP implementation timeline and next steps

The symposium will focus participants on implementing tangible strategies of the CAP and breakdown 'silo systems.' Interested individuals, organizations and institutions will agree to work collectively to improve health outcomes of African Americans.

The SOL Project will compile a list of organizations that provide or have provided operational or grant resources for those interested in the social determinants of health program implementation. This resource will be made available at the symposium and online and will be open for updates as more current opportunities avail themselves.

This Community Action Plan will be shared with key thought and opinion leaders and those who want to move from dialogue towards action. It is intended to inspire more community action plans that lead a movement of tackling other social determinants of health and other health issues. A continuum of these efforts is needed in order for the African American community to live well and prosper—by not only reducing, but eliminating disparities for African Americans in Sacramento California.

RESOURCES

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African Americans for Smoke-Free Safe Places

RESOURCES

World Health Organization: Social Determinants of Health
www.who.int/social_determinants/sdh_definition/en/

California Tobacco Control Section Health Equity Proceedings
www.cdph.ca.gov/programs/tobacco/documents

Healthy People 2020
www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health

Office of Health Equity Webinars
http://www.cdph.ca.gov/programs/Documents/Webinar%20v4.pdf

Youth Speaks and UCSF Center for Vulnerable Populations
The Bigger Picture Campaign
http://youthspeaks.org/thebiggerpicture/home/

California WISEWOMAN Program
http://www.cdph.ca.gov/programs/WISEWOMAN/Pages/Default.aspx

California Department of Public Health Master Plan for Heart Disease and Stroke Model Program
http://www.cdph.ca.gov/programs/cvd/Documents/CHDSP-MasterPlan-LowRes.pdf

South Carolina Taking Local Action in African American Communities Heart Health Project
http://www.cdc.gov/dhdsp/docs/prevention_works.pdf

CDC National Diabetes Program & Curriculum
http://www.cdc.gov/diabetes/prevention/about.htm

Go Red for Women Campaign
https://www.goredforwomen.org/home/about-heart-disease-in-women/symptoms-of-heart-disease/

Community Market Conversion Program – South Los Angeles
http://communitymarketconversion.org/

WALKSacramento
WalkSacramento.org

Sacramento Area Bicycle Advocates (SABA)
Sacbike.org

The African American Leadership Coalition (AALC)
http://www.ucdmc.ucdavis.edu/medicalcenter/features/2011-2012/05/20120517_Partnership-in-Action.html

The African American Women's Health Legacy (AAWHL)
http://aawhl.com/

The Alliance for a Healthier Generation
https://www.healthiergeneration.org/

The Network for a Healthy California – Gold Country Region
https://healthedcouncil.org/our-impact/network-for-healthy-california

RESOURCES

Sacramento Community Cancer Coalition (SCCC)
http://www.imaniclinic.org/sacramento-community-cancer-coalition.html

Minority Medical Association of Pre-Medical Students UC Davis (MAP)
http://www.mapsatucd.com/dr.-hunter-foundation.html

The African American Tobacco Control Leadership Council (AATCLC)
http://www.savingblacklives.org/

The SOL Project
Thesolproject.com

Blue Shield of California's Healthy Lifestyle Rewards program
https://www.blueshieldca.com/bsca/about-blue-shield/newsroom/healthy-living-dividend.sp

The California Obesity Prevention Program (COPP)
http://www.cdph.ca.gov/programs/COPP/Documents/COPP-ObesityPreventionPlan-2010.pdf.pdf

Unnatural Causes
http://www.unnaturalcauses.org/media_and_documents_charts_and_graphs.php

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