2018
Black/African-American Health Report

BLACK/AFRICAN-AMERICAN HEALTH INITIATIVE

San Francisco
Department of Public Health

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The charge of the San Francisco Department of Public Health (SFDPH) is to protect and promote the health and well-being of all San Francisco. In many ways, San Franciscans are healthier than Americans in many other parts of the country. This cannot be said of Black/African American (B/AA) San Franciscans, who have persistently had poorer health than their fellow residents in a wide array of measures [Figure 1]. This **Black/ African American Health Report** was developed to present the data supporting the need for urgent intervention to address Black/African American (B/AA) health disparities; and to describe the work within SFDPH to improve the health of B/AA residents. The report is structured in 2 sections: **Section 1** – An overview of data about the health environments and health status of B/AA residents of San Francisco; and **Section 2** – The history, goals and accomplishments of the first three years of the Black/African American Health Initiative within SFDPH, as well as examples of other complementary work to improve B/AA health from various areas of SFDPH.

Our hope is that the data and examples here will persuade the broader community that widespread coordinated efforts to improve B/AA health are urgently needed. We also hope the example of our efforts will inspir e partnerships and collaborations with others seeking to correct the inequities that cause the B/AA members of our community to suffer worse health and to die sooner than their fellow r esidents. We believe that this report can inspire hope that these gaps can be closed. The work is difficult and complex, but also worthwhile and achievable. Lastly, increasing the ability to discuss issues of inequity openly is a necessary precursor to acknowledging inequity in our work, and changing the practices and policies that have created it. As James Baldwin said, "Not everything that is faced can be changed, but nothing can be changed until it is faced."

- Dr. Ayanna Bennett
  Director of Interdivisional Initiatives
  San Francisco Department of Public Health

FIGURE 1

Unevenly distributed obstacles to health

Variable	White	B/AA
No prenatal care in first trimester	5%	36%
Children 0-18 living in poverty*	2%	48%
Not exclusively breastfeed in the first weeks of life	9%	33%
Child neglect or abuse, age 0-18	3/1,000	36/1,000
Not proficient in English language standardized test in 3rd grade	19%	76%
Did not meet 5th grade Fitness standards	26%	48%
Did not graduate from high school	16%	63%
Unemployed	4%	18%
Homelessness	39%	36%

All data from San Francisco, see SF Community Health Needs Assessment 2016[4]
"poverty" = household income < 100% FPL

As James Baldwin said, "Not everything that is faced can be changed, but nothing can be changed until it is faced."

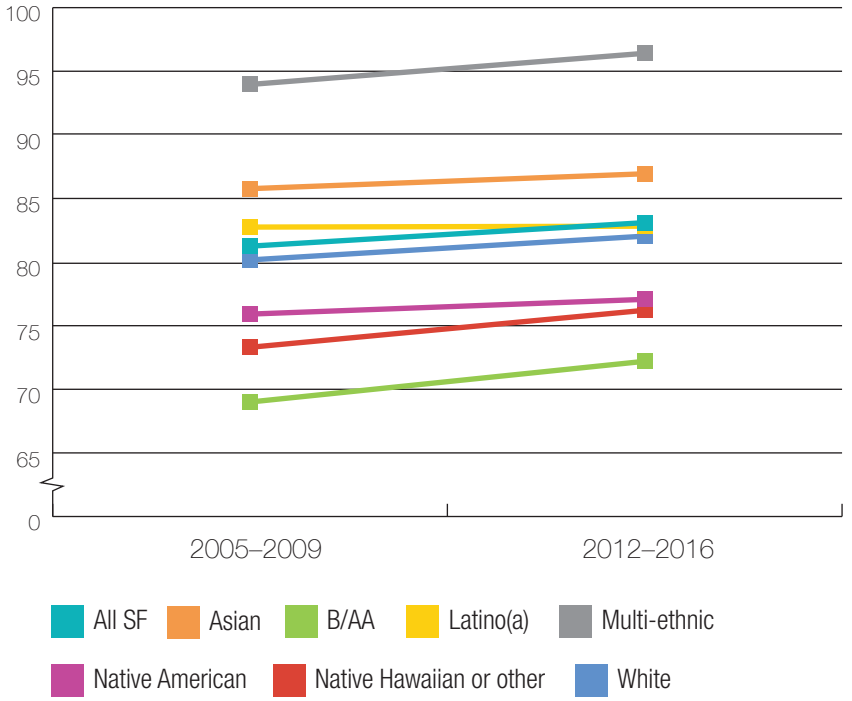
BACKGROUND

It has long been understood in public health that Blacks/African Americans (B/AA) experience disproportionate social, economic, and environmental burdens that impact their living conditions and constrain their life choices. We now are beginning to truly grasp the outsized role that these social factors play in health, the so-called social determinants of health. It is now clear that any community faced with these socioeconomic disparities would also have health disparities. The ultimate disparity, premature death, starkly illustrates the gap between B/AA residents and their neighbors. Life expectancy for Black/African Americans is the lowest of all race/ethnicities in San Francisco. Based on the most recent data from 2012-2016, a B/AA resident could expect to live 72 years (a bit less for men vs. women), nearly 10 years less than White, Asian, and Latino residents who can expect to live into their 80s [Figure 2]. On the other end of the life-course, B/AA infants are five times more likely than White infants to die before their first birthday.

These numbers are stark, but not without hope. In the last 10 years the life expectancy of Black/African Americans has increased by over 3 years, as opposed to the 1-2 year increase in other ethnic groups. This has allowed the life expectancy gap between White and Black San Franciscans to narrow from 11.17 years to just under 9.8 years. This matches a national trend reported by the Centers for Disease Control and Prevention in 2017 showing a 25% drop in mortality for Black/African Americans between 1999 and 2015.[1] This drop was most dramatically seen in heart disease deaths where the national racial gap between Black/African Americans and Whites closed over that time. Locally, we see the same type of movement with a larger drop in ischemic heart disease deaths for Black/African Americans than Whites in the last 10 years, closing the gap from 50% to 5%.[2]

FIGURE 2

Life Expectancy at Birth by Race and Ethnicity (San Francisco, CA)



Data Source: Life Expectancy at Birth: State of California, California Department of Public Health, VRBIS Death Statistical Master File Plus 2005-2017.

We know that even with a decrease in deaths, B/AA patients have more severe disease that starts at a younger age. Still, the improvement is encouraging and suggests that change is possible.

In 2014, the Director of Health, Barbara Garcia, recognized that in order to significantly and sustainably improve the health of B/AA residents in San Francisco, the department needed to commit to focused and deliberate work on these issues. A cross-divisional group convened and established the Black/African American Health Initiative (BAAHI) to focus on correcting these disparities. The group chose four indicators spanning the life course as a place to start the long process of committed work. The four health indicators were:

Heart health:
reduce the percentage of Blacks/African Americans with heart disease

Women's health:
reduce the mortality rate of B/AA women with breast cancer

Behavioral Health:
reduce the mortality rate among B/AA men due to alcohol

Sexual Health:
reduce the rate of Chlamydia among teenage and transitional age young B/AA women

The group of public health and medical staff that established BAAHI decided early on that focusing on medical conditions would not be sufficient to create lasting change. Racial health disparities are in part due to inequities in the availability and quality of healthcare delivered to racial minorities. Those differences in care stem from often unconscious bias among healthcare staff and from unexamined policies and practices that have inequitable impacts on B/AA people. Mitigating the impact of bias and inequitable policy requires support and prioritization from leadership to both provide training for staff, and to enable changes in policies and practices that perpetuate racism. To address these issues, a workgroup was established to consider how **Cultural Humility** education and practices might be promoted across the department. Another tool for improving equity of care for B/AA patients and community members is providing concordant, culturally aware staff members to deliver services and create policy. The SFDPH workforce is 11% B/AA, higher than the 6% of Black/African Americans in the city. However, the proportion of B/AA clients and patients among those receiving various SFDPH services is much higher. A **Workforce Diversity** workgroup was formed to examine how to improve diversity, advancement and inclusion of B/AA staff in light of this gap.

The following sections expand on the B/AA health data and specific SFDPH efforts to make change.

SECTION 1: A PICTURE OF BLACK/ AFRICAN AMERICAN HEALTH IN SAN FRANCISCO

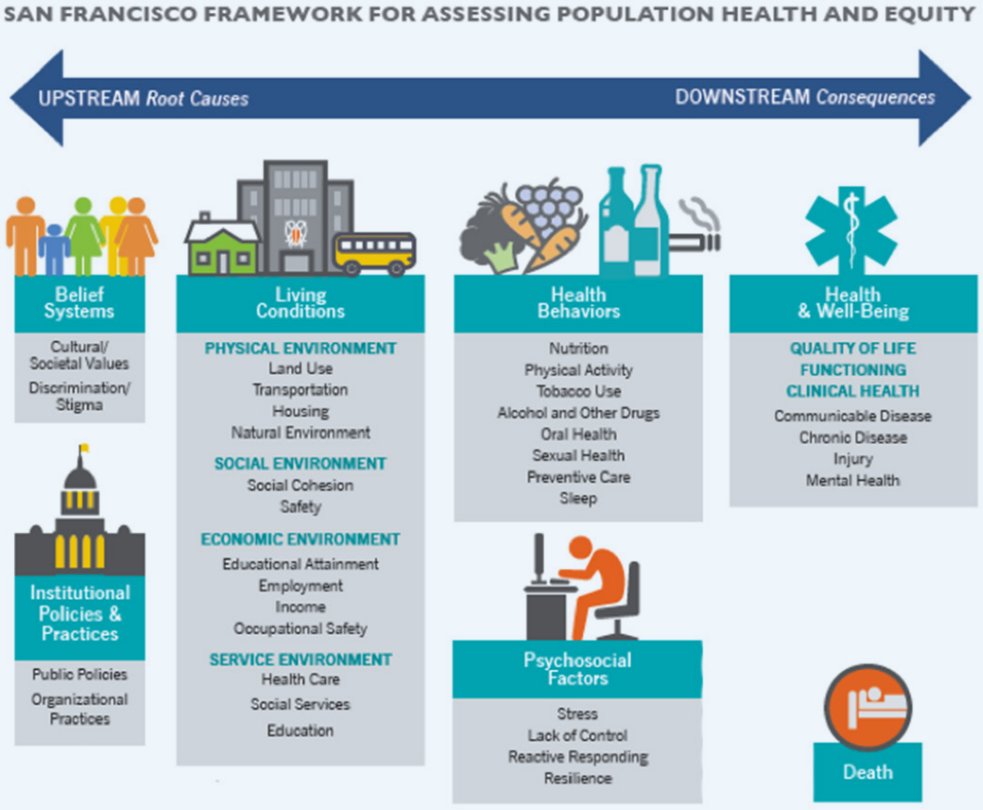
THE HEALTH ENVIRONMENT: Challenges to living a healthy life

The social and economic environments in which people live determine the state of their health in many ways. The World Health Organization (WHO) defines social determinants of health (SDOH) as the "conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life".[3] Based on the Public Health Framework for Reducing Health Inequities diagram, the simplified diagram to the right represents the various social determinants of health [Figure 3]. Upstream determinants (root causes) include belief systems, institutional policies and practices, and living conditions, while the downstream determinants (outcomes) represent the actual health disparities we see in the community. Health behaviors and psychosocial factors sit between these causes and outcomes. In the following section we first share data related to upstream living conditions and then to the downstream health conditions that result. The following data comes primarily from the San Francisco Community Health Needs Assessment, available online.[4]

SEGREGATION AND DISPLACEMENT

Segregation, exacerbated by displacement, is a known cause of health disparities. According to

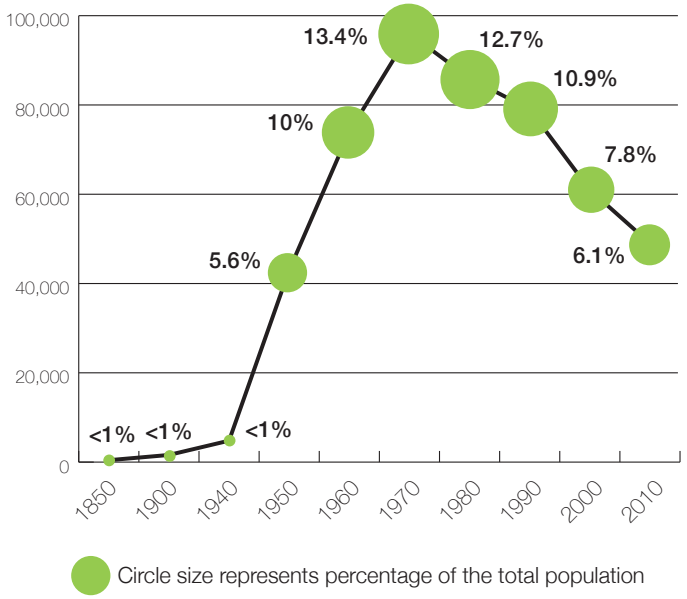
FIGURE 3



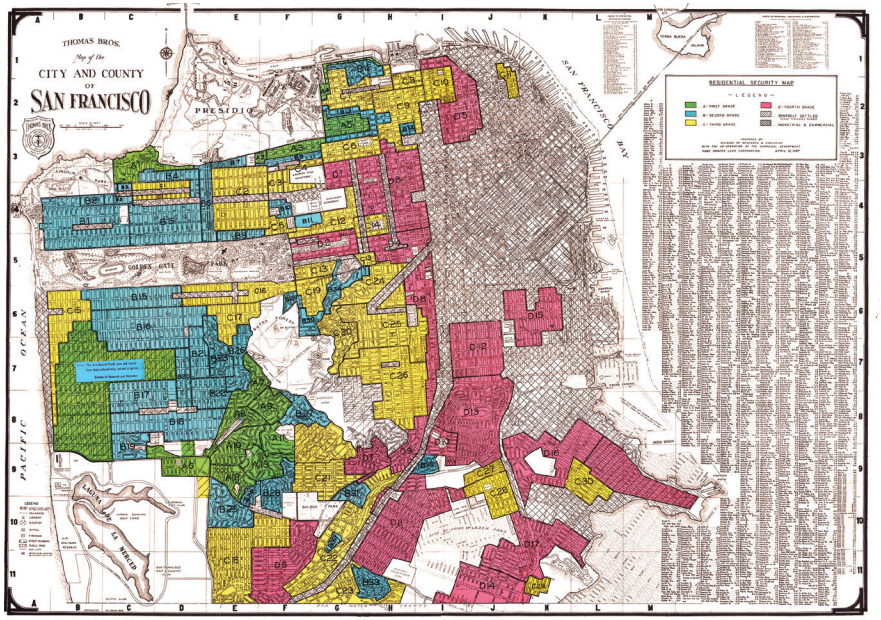
SFHIP, Community Health Needs Assessment Page 48

FIGURE 4

Black / African American Population (San Francisco, CA)



Map 1: Redlining map of San Francisco



Green= “Best”, Blue = “Still Desirable”, Yellow= “Definitely Declining”, Red= “Hazardous”

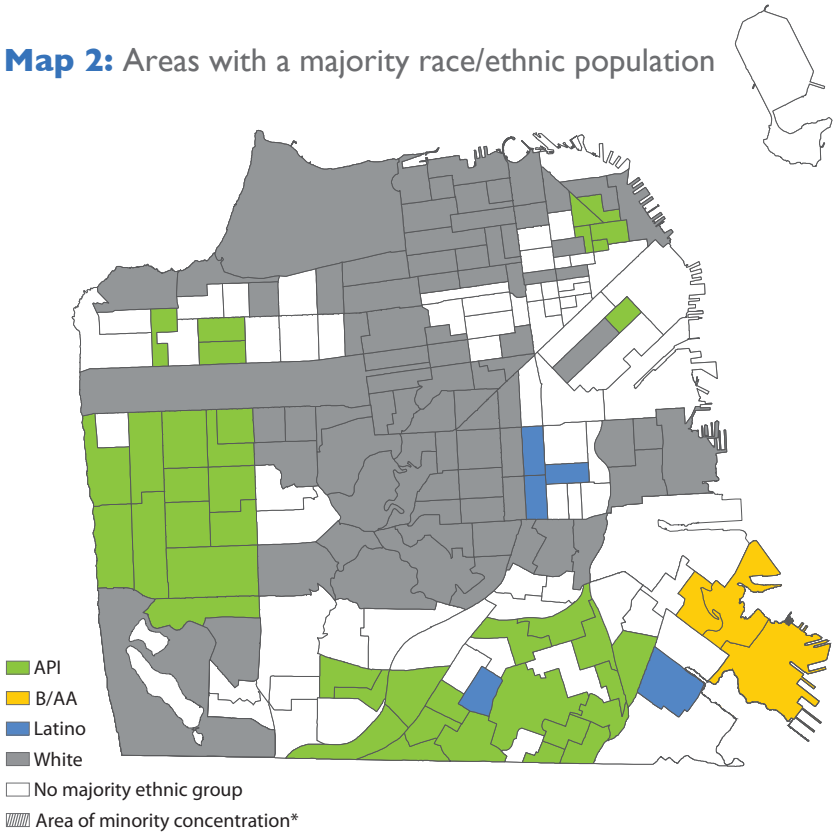
Mapping Inequality: Redlining in New Deal America.

the Robert Wood Johnson Foundation, “Blacks and Hispanics who live in highly segregated and isolated neighborhoods have lower housing quality, higher concentrations of poverty, and less access to good jobs and education. As a consequence, they experience greater stress and have a higher risk of illness and death.”[5]

Small numbers of Black/African Americans arrived to San Francisco during the Gold Rush years and the population surged in the 1940’s as shipyard workers arrived during the war [Figure 4]. Redlining and restrictive covenants segregated these new arriving B/AA residents to the Fillmore and Bayview-Hunters Point neighborhoods. Mortgages lenders used federal maps which marked “hazardous” areas red(defined as those with “undesirable racial infiltration”) [Map 1]. Mortgages were denied “red” areas, leading white borrowers to stay in the eastern parts of the city and oppose the inclusion of new B/AA residents there who might lower the grade of their neighborhood. Later, redistricting public works projects in the 40s and 50s demolished most of the B/AA housing and businesses in the Fillmore area and many residents moved into public housing developments in Sunnydale, Potrero Hill, and Bayview-Hunters Point. Those concentrations of B/AA communities remain today.

There are relatively small areas in San Francisco with higher concentrations of B/AA residents and a much larger area with very few B/AA residents. Between 2009 and 2013, Black/African American residents made up 6% of the population generally but were 33% of the residents in Bayview-Hunters Point, 23% of residents on Treasure Island, and 20% in the Western Addition [Map 2]. This contrasts with the 8 of 41 neighborhoods where B/AA residents were 2% or less of the total population. Increased

Map 2: Areas with a majority race/ethnic population



Data source: ACS 2009 –13.

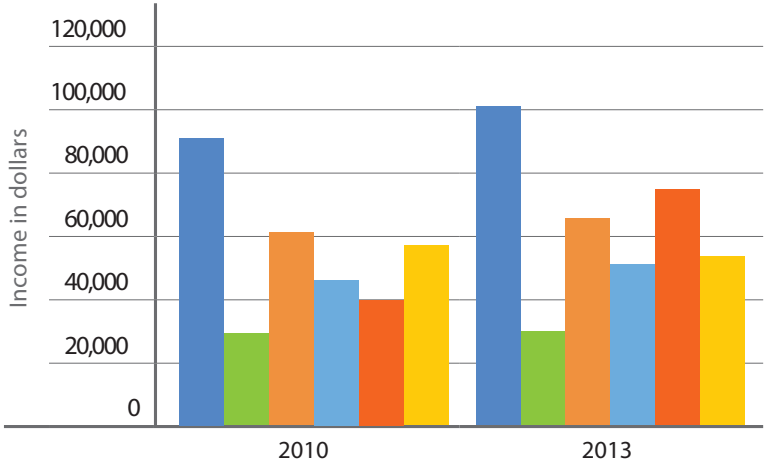
*San F rancisco defines an area of minority concentration as any census tract with a non-White population that is 20 percent greater than that of the City's total Non-White percentage.

According to the 2009 –13 ACS, 58.3 percent of the City's population identifies as being Non-White. Therefore any census tract in which 78.3% of the population is classified as minority would qualify as an area of minority concentration.

outmigration since 1973, primarily of middle class families, has decreased the presence of Black/African Americans in their historic communities, with vacancies filled by other racial/ethnic groups. Housing losses in the recession beginning in 2008 disproportionately impacted home owners in the Bayview neighborhood. In 2009, Bayview had the highest rate of concentrated foreclosures and homes at risk for foreclosure of any San Francisco neighborhood.[6] Families who lost their homes to foreclosure and working class residents confronted high rental costs, further fueling displacement.

FIGURE 5

Median household income, by race and ethnicity, 2010 and 2013



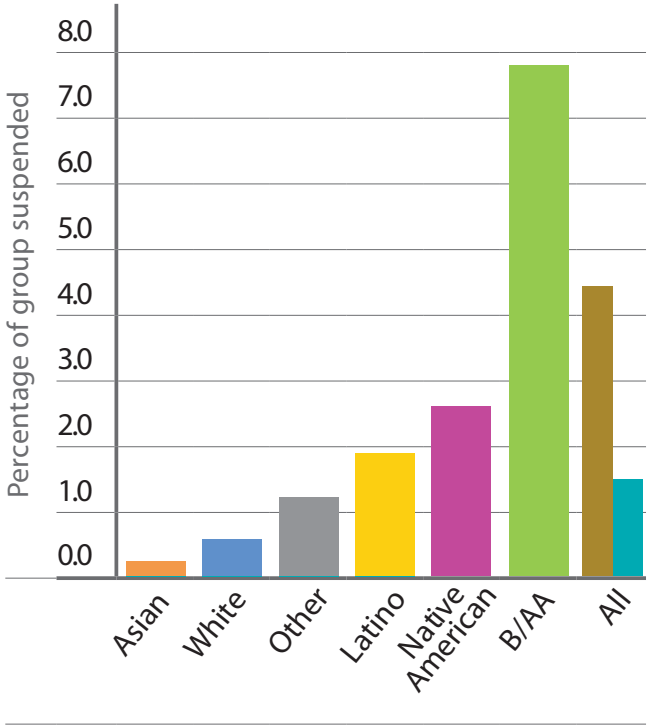
*Some groups not included due to unstable data. White, B/AA, Asian, Other, Multi-ethnic, Latino. Data source: ACS.

INCOME

Black/African American households in San Francisco are persistently poor in a city where the average household income is among the highest in the nation. This pattern is seen in many economic indicators; Black/African American families do not generally benefit from the prosperity of San Francisco. For example, as the Great Recession began to fade between 2010 and 2013, Black/African Americans were the only racial/ethnic group that did not see a rise in median household income [Figure 5]; essentially, they were left out of the recovery. Unemployment followed a similar pattern. A recent study by the Brookings Institute puts the Black-White employment gap in San Francisco among the highest in the nation.[7] This results in families with very different resources: 47% of B/AA children in San Francisco live below the federal poverty level, in comparison to only 3% of White children.

FIGURE 6

Student suspension rates in San Francisco Unified School District



California, San Francisco Unified School District. Data source: OCOFC, SFUSD.

47% of B/AA children in San Francisco live below the federal poverty level, in comparison to only 3% of White children.

EDUCATION

The greatest hope for correcting economic disparity is generally accepted to be educational achievement. Unfortunately, the disparities in educational attainment in San Francisco mirror the economic disparity. B/AA residents are less than half as likely as their fellow San Franciscans to have a bachelor's degree. B/AA 3rd graders are only about half as likely to be proficient in math and English as other students. Graduation rates are also lowest for B/AA students among all students in San Francisco. Finally, elevated suspension rates suggest that B/AA youth have additional barriers to the engagement with school needed to improve these numbers. Historically, low educational attainment has correlated with future poverty, meaning that current school data suggests the current students in SFUSD will have difficulty improving the economic health of their families.

HOMELESSNESS

The number of homeless Black/African Americans is far disproportionate to the number of B/AA people in the community. The 2017 Homeless Count in San Francisco B/AAs are 36% of the homeless population, despite being less than 6% of the population.[8] The substantial history of inequity in housing policy and criminal justice enforcement helps explain this disparity. In particular, the mass incarceration of B/AA men and women means that a significant number of Black/African Americans have been legally barred from access to public housing as well as a myriad of other supportive services. In addition, B/AA families have an increased foreclosure risk related to lack of family wealth and limited credit access.

POLLUTION

Environmental pollution has historically been a concern for residents of the Bayview Hunters Point Neighborhood. Indoor hazards related to poor housing condition are a known trigger for asthma and allergies. These conditions have been a problem in San Francisco public housing in the past. Outdoor air pollution is also an issue. Much of the Bayview-Hunters Point neighborhood sits near either of the two major city freeways. A review of research by the Health

Effects Institute in 2010 reported significant health impacts within 500 feet and some impact up to 1,000 feet (1-3 blocks) from a busy road or highway.[9]

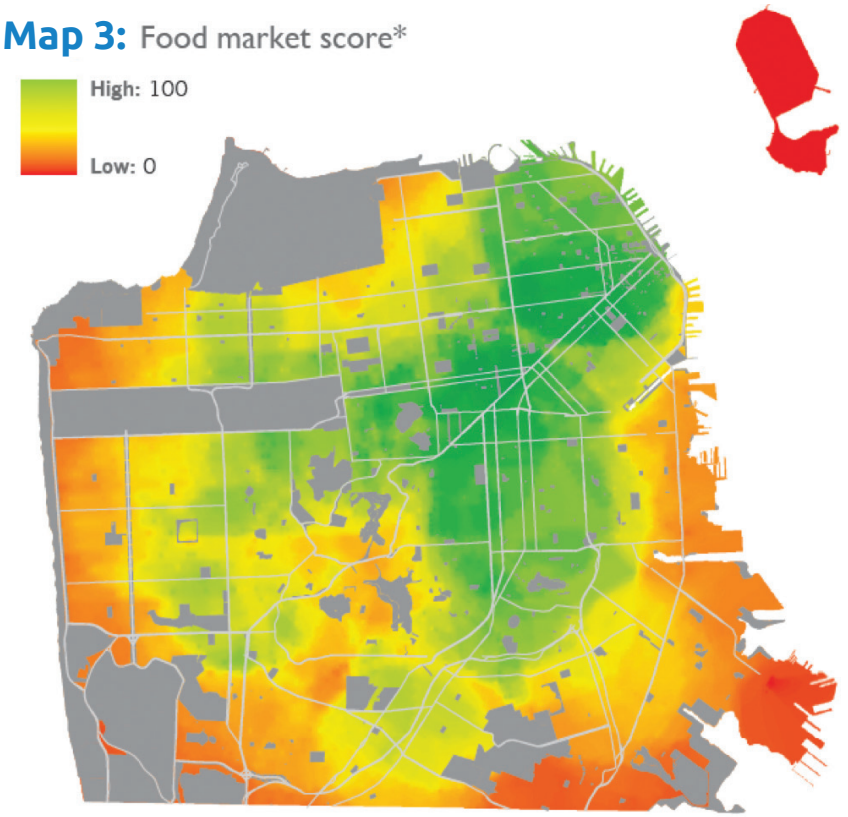
RECREATIONAL SPACE

In 2011, SFDPH gathered data on the usability of recreational space across neighborhoods in San Francisco called the distance-weighted 2 mile recreational area resource score. The score was meant to account for the accessibility of recreational spaces. Bayview Hunters Point, the neighborhood with the highest concentration of B/AA residents, received one of the lowest scores for adequate open spaces. Efforts are ongoing by the Parks and Recreation Department to make these spaces more usable for community members.

FOOD ACCESS

Residents in the Bayview Hunters Point district have less access to fresh and affordable produce than residents in San Francisco's other neighborhoods, as evidenced by its food market score [Map 3]. In Bayview, access points for fresh produce are outnumbered by fast food chains, convenience stores, and liquor stores selling a variety of unhealthy sugary and salty snacks. The impact of this unequal access can be seen in the prevalence of diet-related diseases such as diabetes and heart disease in the B/AA community. The SFDPH Healthy Retail program was established to help small retail outlets offer produce in neighborhoods where sources are scarce.

Map 3: Food market score*



*A relative measure of the number and variety of retail resources within one mile, weighed by food offerings and distance. **Data source:** Dun and Bradstreet, SFIP, 2011.

HEALTH STATUS: The health of the community

Black/African Americans have the highest mortality rate for 9 of the top 10 causes of death in San Francisco. Mortality is the common endpoint for a number of chronic and serious health conditions that B/AA residents experience at disproportionate rates. Below is a brief overview of some of these conditions. The Community Health Needs Assessment (CHNA) for San Francisco, last released in 2016, includes appendices that offers a fuller picture of the breadth of conditions that show a racial disparity. All data, unless otherwise noted, comes from the appendices of the CHNA report.[10]

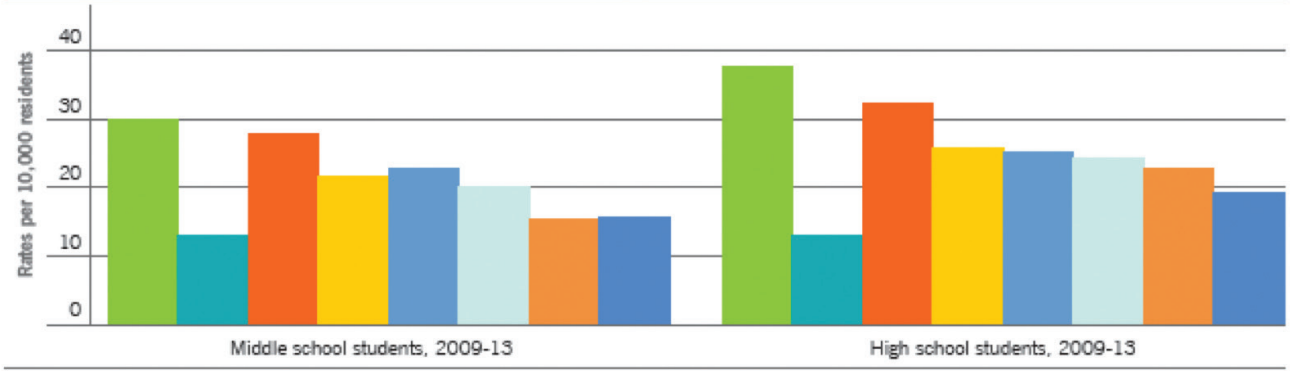
ASTHMA

Asthma and chronic obstructive pulmonary disease (COPD) are chronic conditions affecting the airways. Both conditions are exacerbated by exposures to indoor and outdoor pollution including tobacco smoke or allergens, like mold. These are all impacted by housing conditions that are known to be poorer for B/AA families in San Francisco. Asthma is also exacerbated by stress, which is again worse for poor families, and for those experiencing racism. The prevalence of asthma among B/AA adults (13.9%) in San Francisco is more than twice that for Whites (5.0%). Black/ African American middle school students (29.9%) and high school students (37.6%) students were more likely than their classmates to have asthma [Figure 7]. Filipino middle and high school students (24.8% and 32.2% respectively) had the second highest prevalence of asthma, while Chinese students (13.2% and 13.1%, respectively) had the lowest. Consistent with higher prevalence, rates of asthma hospitalizations are highest for Black/ African Americans and are almost 9 times higher than for Whites.

Black/African Americans have the highest mortality rate for nine of the top ten causes of death in San Francisco.

FIGURE 7

Asthma rates for San Francisco students, by ethnicity, 2010–13



Data source: YRBS 2009–13.

CANCER

Cancer is a term for more than 100 conditions characterized by the uncontrolled growth and spread of abnormal cells. Cancer is caused by both external factors (tobacco use, infectious organisms, chemicals, radiation, etc.) and internal factors (genetics, hormones, immune system conditions, etc.). Incidence rates for liver cancer and lung and airway cancers are elevated among B/AA women. Among men, Black/African Americans have the highest incidence rates of prostate, colorectal, liver, and lung and airway cancers, myeloma, and

Hodgkin lymphoma. In addition to a high incidence of some cancers, B/AA men and women also have higher than average mortality rates for many cancer types (even when their incidence is not relatively high). For both women and men, death rates for most common cancers are significantly higher for B/AA residents than they are for residents citywide [Figure 8 and Figure 9].

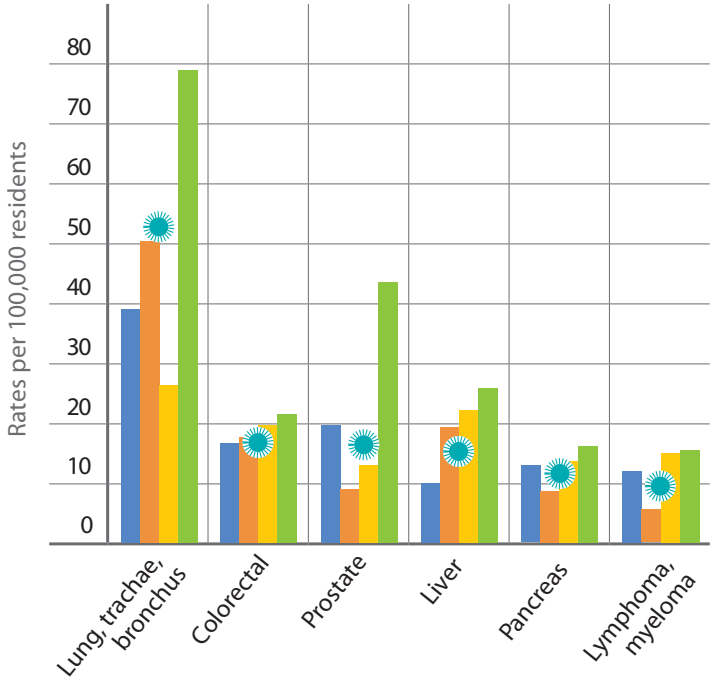
The reason for the large disparity in rates is unclear. However, tobacco use (related to access and marketing) is one known factor. Black/African Americans and American Indian/Alaska Natives have a higher adult smoking prevalence rate compared to other racial/ethnic groups in San Francisco. The California B/AA male smoking rate was 20.0% in 2014, compared with a 14.8% White male smoking rate. Meanwhile the B/AA female smoking rate was 14.7% compared with a 13.1% White female smoking rate that same year. Low income B/AA adults have an even higher rate of smoking.

CARDIOVASCULAR HEALTH

Cardiovascular disease is an umbrella term for the many conditions that affect the health of the blood vessels and heart. Some of the more prevalent conditions include hypertension, stroke, heart attack and heart

FIGURE 8

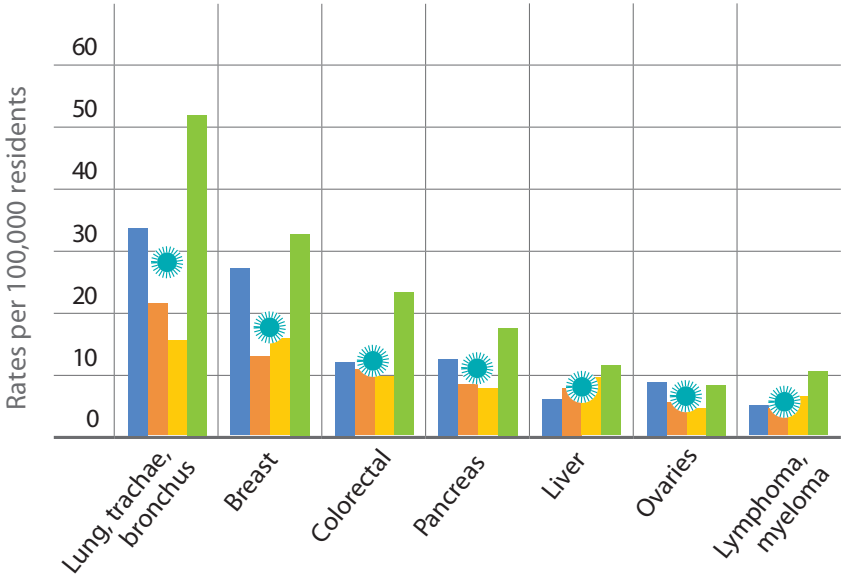
Age-adjusted mortality rate for males by cancer site, 2009–12



San Francisco, White, API, Latino, B/AA.
Data source: CDPH Death Statistical Master Files .

FIGURE 9

Age-adjusted mortality rate for females by cancer site, 2009–12



San Francisco, White, API, Latina, B/AA. Data source: CDPH Death Statistical Master Files

failure. Like most chronic diseases, the origins of these conditions trace back to lifestyle factors like a high-fat diet, cigarette smoking, and stress, and co-morbid conditions such as diabetes. These lifestyle factors and conditions can themselves be traced back to socio-economic factors discussed earlier, including housing, economic conditions, food access and lack of recreational space. This explains why from 2012-14, B/AA residents of San Francisco were 5.5 times more likely to become hospitalized from hypertension, at a rate of 11 per 10,000 residents [Figure 10]. The next closest group, Latinos, had a rate of hospitalization due to hypertension of 2.65 per 10,000 residents.

Research has shown that chronic stress is a major contributor to cardiovascular disease, with those reporting higher stress having higher disease rates and worse outcomes. In recent research, the experience of racism has been noted as a definable risk factor for cardiovascular disease (perhaps mediated through stress).[11,12]

FIGURE 10

Age Adjusted Rates of Hospitalizations for hypertension (per 10,000 residents)

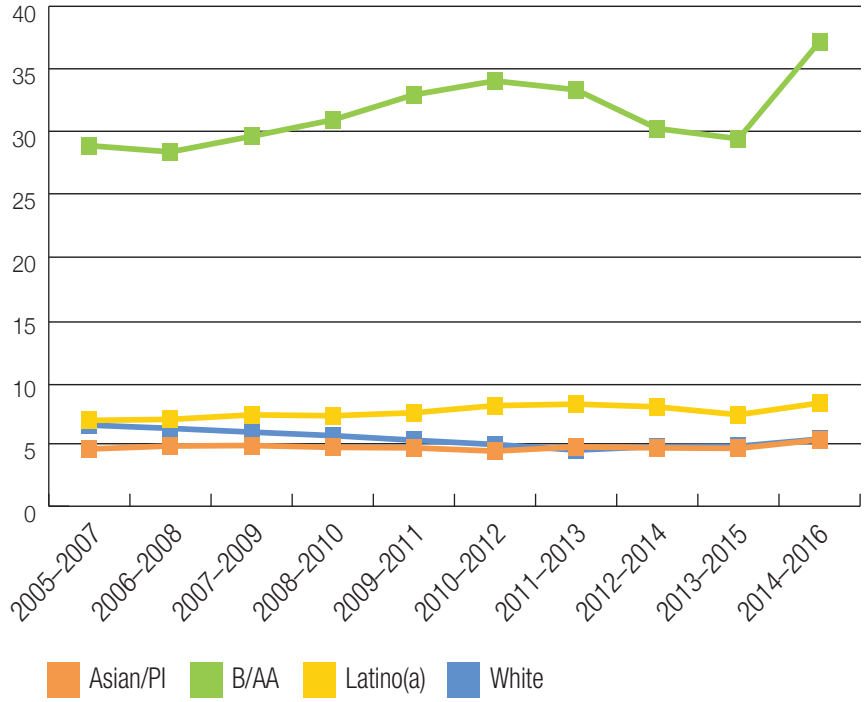
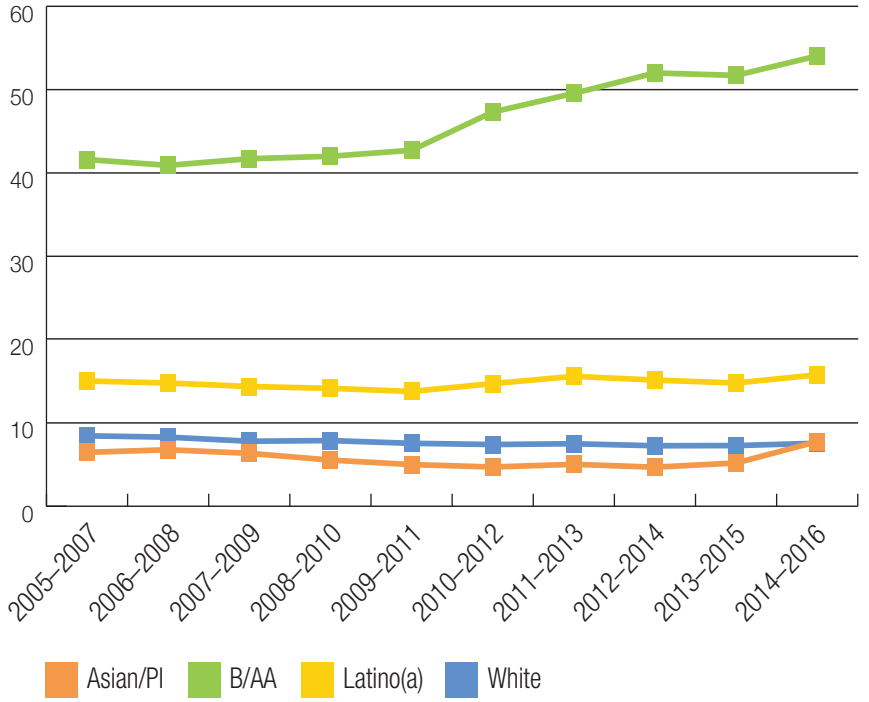


FIGURE 11

Age Adjusted Rates of Hospitalizations for Diabetes (per 10,000 residents)



DIABETES

Diabetes is a disease in which the body loses the ability to manage blood sugar levels. There are three types; Type 1 (usually juvenile onset), Type 2 (adult onset), and gestational or pregnancy-related diabetes. Diabetes can lead to heart disease, kidney failure, blindness and lower-extremity amputations. Babies born to mothers with gestational diabetes may suffer from excessive birth weight, preterm birth, respiratory distress syndrome, low blood sugar, and type 2 diabetes later in life.

Risk factors for diabetes include cardiovascular disease or obesity, or lifestyle factors such as consumption of sugary drinks and exercising fewer than three times a week. Other environmental and social factors have also been associated; for example, San Francisco residents living in households earning less than 300% of the Federal Poverty Level (FPL), or living in the eastern (historically B/AA) sections of the city, are more likely to be hospitalized due to diabetes than those with higher incomes or living elsewhere in San Francisco.

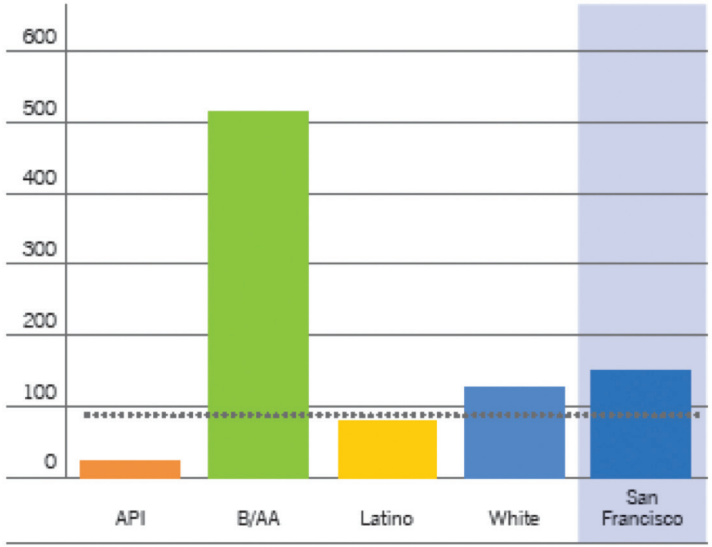
All of these factors contribute to the unequal distribution of this disease, with Black/African Americans and Latinos at higher risk for diabetes. Diabetes hospitalization rates were significantly higher among Black/African Americans (40.31 per 10,000 residents) and Latinos (12.55) than Whites (6.04) and Asian Pacific Islanders (API) (3.71) [Figure 11]. Notably, hospitalization rates for diabetes among Black/African Americans increased between 2005 and 2014 while rates for other ethnicities have remained relatively constant or declined.

HEPATITIS C

Hepatitis C (HCV) is a common infection which can lead to liver cancer, and is the leading reason for liver transplants in the United States. Death from HCV is actually more common than from HIV in the last decade. In San Francisco, as in the United States generally, HCV is more common among Black/African Americans than others in San Francisco. There are also more newly reported cases of HCV infection in Black/African Americans per 100,000 residents than any other race/ethnicity [Figure 12].

FIGURE 12

Newly reported past or present Hepatitis C cases in San Francisco per 100,000 people, 2013



•••• California (2011). Data source: SFDPH, CDPH.[7]

MATERNAL/INFANT HEALTH

Healthy birth is less assured for B/AA women than for other women in San Francisco. Though San Francisco had only 10 maternal deaths in 10 years (2005-2016), 5 of them were B/AA women, despite the fact that B/AA women account for only 4% of all births.[13] Similarly, preterm births are nearly twice as likely to occur for B/AA women as white women in San Francisco (12.7% vs. 7.%1 of live births, Figure 13). Preterm births are those that occur before the 37th week of pregnancy, and these infants are likely to have some level of poor health related to underdevelopment. Preterm birth is also a leading cause of infant deaths; the rate of infant deaths is 5 times higher for Black/African Americans than Whites.

FIGURE 13

Live Births That Occurred before 37 Weeks Gestation, by Ethnicity (San Francisco, CA)

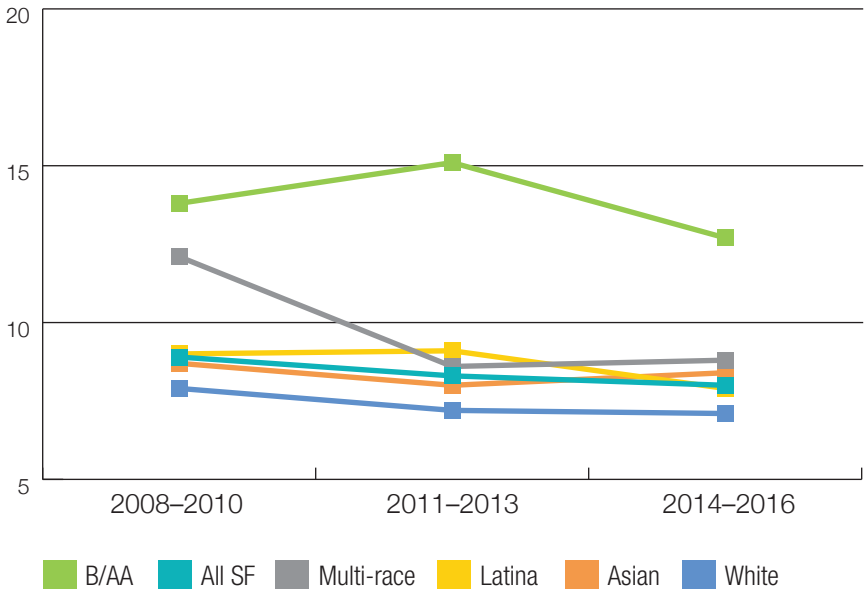
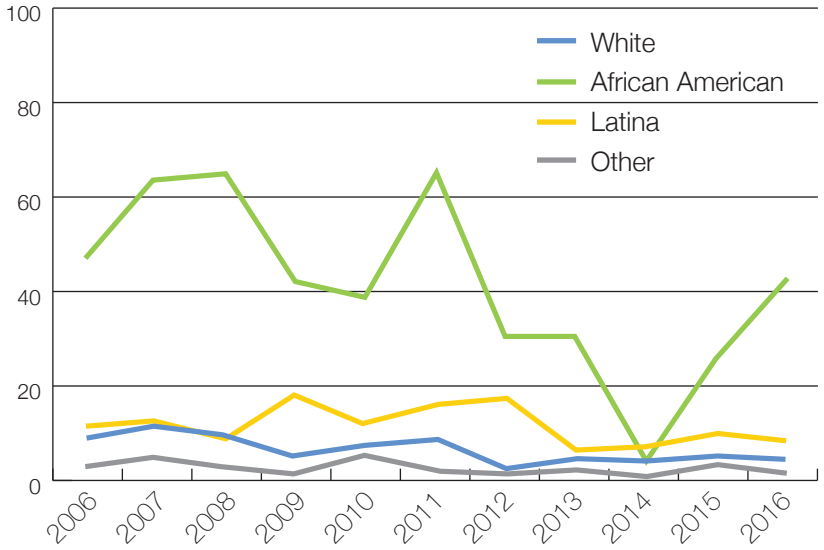


FIGURE 14

Rate of HIV Infections per 100,000 by Year of Diagnosis



Although San Francisco meets the targets for preterm birth set by Healthy People 2020, B/AA mothers and babies are still suffering disproportionally from this burden. There has been some improvement in this indicator over recent years. In 2008-10, 13.8% of B/AA live births were preterm, and in 2014-16 only 12.7% were preterm. However, this is still substantially higher than the national Healthy People 2020 Target of 9.4%.

The risk factors that contribute to preterm birth are physical and psychosocial. Medical risk factors include hypertension, diabetes, sexually transmitted infections and other conditions. Social factors include use of tobacco, alcohol or drug use, living in low income neighborhoods, lack of education and other signs of lower socioeconomic status. Many of these risk factors are more common among B/AA women, however even when they are not present B/AA women still have higher rates of preterm birth; for example, even though education is known as a protective factor, a college educated B/AA woman has essentially the same risk of preterm birth as a white woman without a high school diploma (10.5 per 100 births vs. 10.4 per 100 births).[14] Evidence is growing that experiences of racism are a risk factor for preterm birth, which may explain the persistence of this disparity despite other protective factors.

SEXUAL HEALTH

Sexual health includes both sexually transmitted infections (STIs) as well as conditions impacting reproduction. Chlamydia and gonorrhea are the most common bacterial STIs, and both can lead to serious complications in women including infertility, ectopic pregnancy and pelvic inflammatory disease. HIV is the most serious of the sexually transmitted viral infections and can lead to serious illness and death. These infections are all treatable and many are curable.

Many of the sexually transmitted infections, including chlamydia, gonorrhea and HIV, occur at higher rates in B/AA residents in San Francisco and nationally. In 2014, rates of chlamydia, gonorrhea, and early latent syphilis were 6, 13, and 7 times higher among Black/African Americans, respectively, than among Asians, who experience the lowest rates of STIs in San Francisco. HIV infections are also higher among B/AA San Francisco residents [Figure 14]. In 2016, newly diagnosed persons with HIV were more likely B/AA than any other group, with smaller disparities seen for Latinos and Asian/ Pacific Islanders. Pre-exposure prophylaxis (PrEP) use is also lower for B/AA than other San Franciscans. However, all groups have increased use in the last 5 years, though without decreasing the disparity gap.[15]

SECTION 2: THE BLACK/AFRICAN-AMERICAN HEALTH INITIATIVE (BAAHI)

BAAHI Workgroups and Goals

HEART HEALTH: reduce the percentage of Blacks/ African Americans with heart disease
Co-leads Dr. Ellen Chen and Jacque McCright

WOMEN'S HEALTH: reduce the mortality rate of B/AA women with breast cancer (focus shifted to preterm birth)
Initial co-leads Barbara Cicerelli and Veronica Shepard

BEHAVIORAL HEALTH:
reduce the mortality rate among B/AA men due to alcohol
Co-leads Dr. Judith Martin and Israel Nieves

SEXUAL HEALTH: reduce the rate of Chlamydia among teenage and transitional age young B/AA women.
Co-leads Shivaun Nestor, Dr. Susan Philip

CULTURAL HUMILITY: increase cultural humility practices in the department.
Co-leads John Grimes, Michelle Long

WORKFORCE DEVELOPMENT: increase recruitment, retention and advancement of B/AA staff in the department. (role shifted to human resources)
Lead Rhonda Simmons.

In 2014, members of both divisions of SFDPH convened to address B/AA health disparities; the Population Health Division which holds the public health functions of health promotion and health education, epidemiology, disease surveillance and environmental health; and the San Francisco Health Network, the group of hospitals and clinics operated by the health department. The Black/African American Health Initiative (BAAHI) was chartered by this group in 2014 as a collaboration across SFPDH divisions and branches. The intention was to develop activities that would impact a specific set of B/ AA health indicators. The first indicators the group intended to improve were in 4 areas chosen to span the life-course [see next section].

A collective impact work group was formed to identify ways for the SFDPH to improve these indicators. Two additional workgroups were established to support activities intended to improve care for Black/African Americans more generally; Cultural Humility, focused on training staff to understand structural and institutional racism and implicit bias that impact Black/African Americans and other marginalized groups; and Workforce Development, focused on improving workforce diversity, inclusion, and mobility for underrepresented staff to better reflect the communities we serve.

The first 3 years of the initiative invested heavily in creating infrastructure; creating a governance structure, establishing cross-divisional working groups, planning/piloting activities, and hiring backbone staff. In the following pages, each workgroup is outlined in more detail.

BAAHI Staff :

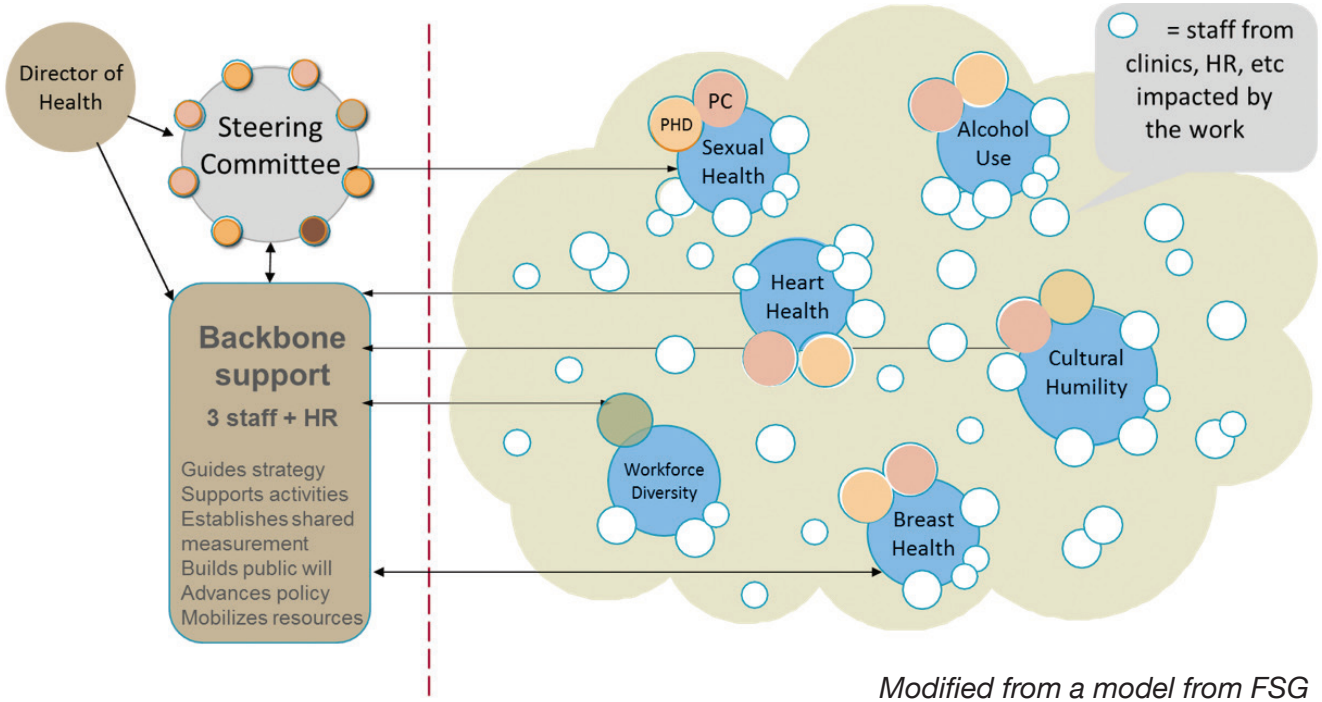
Dr. Ayanna Bennett, Director of Interdivisional Initiatives
Gavin Morrow-Hall, Collective Impact Coordinator
Vincent Fuqua, Health Program Coordinator
Tracy Shaw Senigar, Health Worker 2

BAAHI structure

BAAHI is modeled as a collective impact project, in line with the model articulated by Kania and Kramer in 2011.[16] The initial structure and its subsequent evolution are described in the pages that follow. [Figure16]. The initial six workgroups are described in the pages that follow.

Initially, oversight was provided by a small group called the Design Team, made up of selected management, executive, and front-line staff from various areas of the department. In late 2016 that group was restructured as the BAAHI Steering Committee to include leaders from all major units and divisions, significantly increasing the participation of clinical units. The Steering Committee, over the course of 2017, re-chartered the initiative to recognize the transition from infrastructure building to implementation. That new charter outlines a system of ***watch metrics*** that create a broader picture of B/AA health impacted by various programs across the department; and a focused list of ***active metrics*** that define the goals of the shared improvement work overseen by the committee [Figure 17].

FIGURE 16



Modified from a model from FSG

FIGURE 17

Area	Population Indicator
Cardiovascular Health	Hypertension hospitalization
Sexual Health	Chlamydia incidence
Infant and Maternal Health	Premature Birth
Behavioral Health	Alcohol related deaths
Cancer	Breast Cancer mortality rate Lung Cancer Rate
Diabetes	Adult Diabetes Hospitalizations due to long term complications
Asthma	Pediatric Asthma hospitalization Adult Asthma hospitalization
Communicable Disease	New HIV infections Hep C incidence
Violence	Violent injury Incidence

see CHNA 2016 Appendices for data in these areas[4]

BAAHI Workgroups

HEART HEALTH

Goal: eliminate hypertension control disparity

Primary Care leadership, came together with the leadership from the Community Health Equity and Promotion branch of Population Health to co-chair the BAAHI Heart Health Workgroup. The San Francisco Health Network clinics set an equity goal of eliminating the disparity in hypertension control for B/AA patients soon after the start of BAAHI. This connected well with a Population Health project called Healthy Hearts SF—a CDC Million Hearts Initiative that focuses on primary prevention and management.

Accomplishments: Increased hypertension control among B/AA patients from 53% to 62%

In the San Francisco Health Network (SFHN), blood pressure (BP) control rates for patients diagnosed with hypertension from January 2015 to December 2017 have increased from 61% to 70% for the overall population and 53% to 62% for the Black/African-American population [Figure 18]. This is a substantial improvement for all groups. However, the disparity gap in BP control between the overall population and B/AA patients remains at 8%. This is a common occurrence in clinical improvement projects where new efforts bring benefits to all patients, and disparities persist. The goal of the group is to specifically work against this problem, focusing efforts to increase the rate of BP control among B/AA hypertensive patients to narrow the disparity gap between B/AA patients and the overall population to just 2% in the next year.

Future Plans: focus on quality improvement and patient communication in clinics, continue food pharmacy roll-out, raise community awareness of heart health

The workgroup plan for the next year includes several expansions of these programs:

1. Provide focused support for four clinics with the highest populations of B/AA patients with hypertension
2. Integrate disparity data into daily management activities to message equity to clinicians as a priority
3. Develop tailored outreach materials to strengthen patient engagement and collect data
4. Incorporate communication tools for discussing disparities in nurse and doctor chronic care visits
5. Iterate the strategies for Food Pharmacy and nurse/doctor chronic care visits
6. Partner with Zuckerberg San Francisco General Hospital's (ZSFG) Million Hearts campaign to raise awareness with focus on B/AA patients

FIGURE 18

Blood Pressure Control Rates (San Francisco, CA)

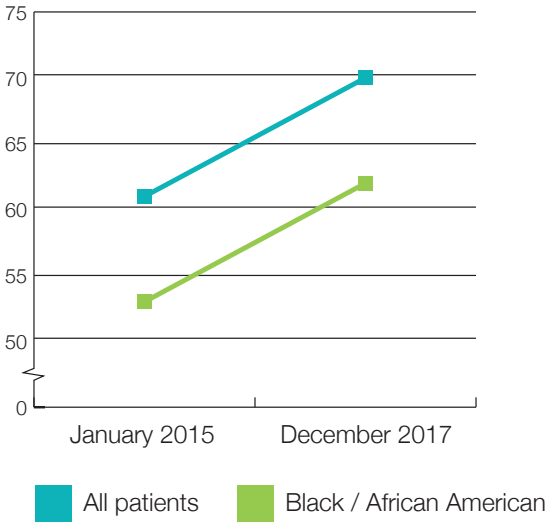
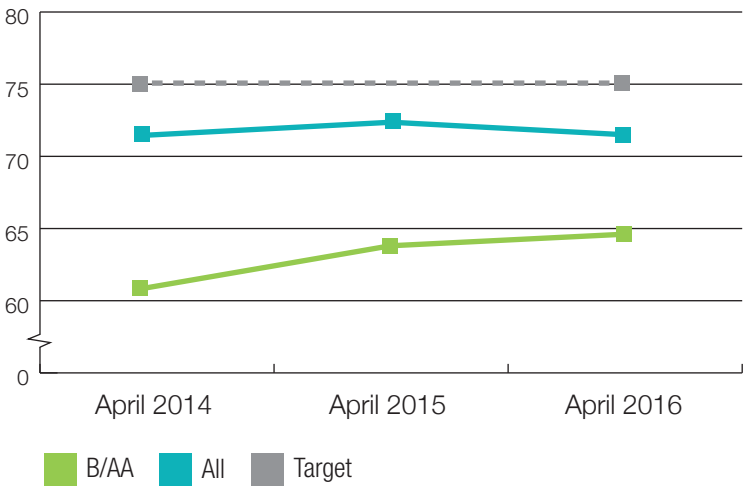


FIGURE 19

SFHN Mammogram screening



WOMEN'S HEALTH

Goal: Breast Cancer – eliminating the gap in mammography screening for B/AA women

The women's health workgroup initially focused on **breast cancer**. The mortality rate of B/AA women diagnosed with breast cancer is twice that of other women in San Francisco. Conversely, the screening rate for B/AA women was less than that of other women. The initial work of the group centered on improving screening rates for B/AA women, educating staff of the need for focused work and clarifying gaps in the system.

Accomplishments: Breast Cancer

The breast cancer workgroup had an initial focus on screening mammogram rates which were known to have a disparity of 10% between B/AA and all SFHN women patients. The rate of screening did increase from a baseline of 60% to 64% in the first two years then decreased to 58%. Breast cancer screening recommendations changed during course of this activity changing the expectations for patients. Clinics are currently working within the new standards to monitor breast cancer screening rates internally.

Future Plans: Shifting active work to Preterm Birth with plans in development.

In early 2018, the Steering Committee recommended shifting the focus of active BAAHII work on women's health to efforts to reduce **preterm birth** among B/AA women, who have the highest rate of any group locally (13.9% of B/AA births in 2015 vs 7.3% of white births in SF). There are large concerted efforts to decrease the preterm birth disparity for B/AA women and infants. The Preterm Birth Initiative (PTBi) is a multi-national, multi-faceted intervention to prevent preterm birth outcomes based at UCSF, and funded by the Benioff Foundation. The Maternal Child and Adolescent Health branch of the San Francisco Health Network, along with the Center for Learning Innovation branch of Population Health co-administer a collective impact community-based arm of the initiative. BAAHI staff are currently investigating how centralized support from SFDPH leadership and collaboration across divisions might expand or enrich the work of the current program.

SEXUAL HEALTH

Goal: increase Chlamydia screening in SFPDH clinics to 90% in youth clinics, >60% in primary care clinics

This workgroup brings together the Disease Prevention and Control and Community Health Equity and Promotion branches of Population Health, the Family Planning program in Maternal Child Adolescent Health within SFHN, and the clinical sites offering sexual health services. The group is focused on decreasing Chlamydia rates for B/AA young women in San Francisco, which are 5.5 times higher than for White San Francisco young women. The initial focus has been on increasing clinic screening rates at SFHN clinics that serve the highest numbers of B/AA youth, beginning with the youth clinics (Community Health Programs for Youth, CHPY), Children's Health Center at ZSFG, Potrero Hill Health Center, and Maxine Hall Health Center.

Accomplishments: raised Chlamydia screening rates from 61% to 95% in SFDPH youth clinics

Efforts began in 2015 with training and quality improvements efforts in the CHPY clinics, raising the collective testing rate across these clinics from 61% to 95% [Figure 20]. Efforts in the primary care clinics are in the early stages.

Future Plans: improve sexual health care in the clinics, educate young B/AA women on healthy communication about sex, host a community summit on reproductive justice

The larger goal of the group is to ensure good reproductive and sexual health care and education for B/AA young women, with the goal of improving communication about sex, increasing rates of condom use, and improving the culturally-appropriate sexual health programs and services. Over the next year the group plans to achieve this through several steps:

1. Discussion groups with B/AA youth and other community members, service providers, and staff from Black Infant Health and Community Health Programs for Youth to generate shared understanding of the relevant barriers and opportunities.
2. Collaboration between the Family Planning program and a SFDPH peer-education program called Youth United Through Health Education. The group is creating a community education initiative to increase STI awareness in key communities.
3. Holding a reproductive health summit in 2019 focused on reproductive justice.
4. Continued training for providers on the value and skills of sexual health history for all patients at all visits.

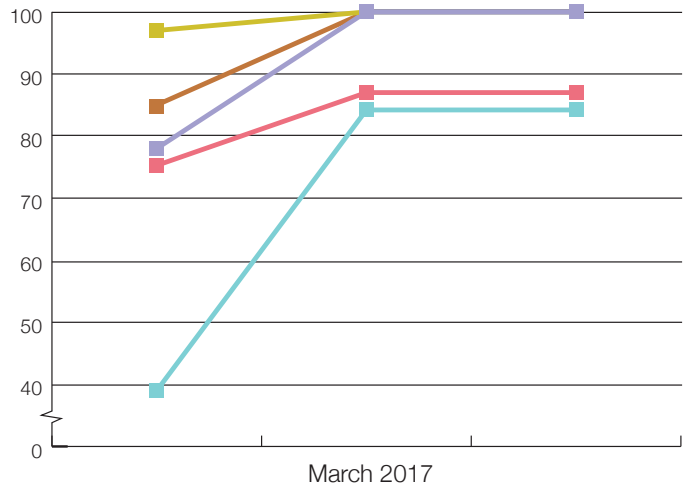
BEHAVIORAL HEALTH

Goal: Eliminate the disparity in alcohol use disorder treatment medication use for B/AA men

The behavioral health workgroup is focused on **alcohol use** in B/AA men. Despite having lower rates of alcohol use disorder, B/AA men have nearly double the rate of death from cirrhosis of the liver as white men. The workgroup did an analysis of the data, as well as focus groups with patients and staff, to develop an understanding of differences in care for B/AA men in the SFDPH substance abuse (SA) clinics. The data analysis showed that B/AA men were prescribed medication for treatment for alcohol use disorder much less than white men. Focus groups clarified that this difference was due to fewer offers of medication from substance abuse clinic providers. The patient and staff focus groups also noted differences in the welcome offered to B/AA men in the clinics.

FIGURE 20

Chlamydia testing rates at youth clinics, by site



Accomplishments:

- **Developed patient materials** with input from staff and patients on alcohol treatment medications tailored to B/AA men.
- Convened a **day-long training on racial humility** for all the mental health psychiatrists, nurse practitioners, and clinical pharmacists - all of whom prescribe medications.

Future Plans:

The plan for the coming year is continue improvement activities in clinics to ensure 10% of B/AA men with alcohol use disorder will have an active prescription for treatment medication. This measure is considered a watch metric for the BAAHI Steering Committee and is being monitored as an internal quality measure in Behavioral Health.

CULTURAL HUMILITY

Goal: Create an organizational culture of equity

The workgroup highlighted the need to acknowledge and understand the impact of racism on health, confront implicit bias, create systems to ensure equitable care and service for B/AA residents and all residents.

Accomplishments: Over 500 staff, including over 300 managers, completed a 4 day racial equity training

The Cultural Humility workgroup focused its work initially on leadership training to facilitate policy change. The workgroup encouraged the creation of a racial humility in-service training for executives, directors and managers facilitated by Dr. Kenneth Hardy, a nationally renowned speaker and educator on race and racism. The training, begun in 2014, is offered several times per year and occurs over 4 full days. Dr. Hardy's approach works to raise awareness of racism as an organizing force in society, as well an unacknowledged actor in interpersonal relationships. As of early 2018, over 500 SFDPH staff had been through the training, most of them in management or executive positions. In 2017 a full time staff person was added to organize the training and develop other training opportunities for line staff. That development process is ongoing. Additional activities have been developed by staff, including site-specific workgroups and a discussion series.

Future Plans:

- Continued training with Dr. Hardy for management staff through 2018
- Ongoing development of activities to further discussion about cultural humility within work units.
- Training for line staff in cultural humility and implicit bias planned for 2018-19
- Expansion of BAAHI Equity Learning Series discussion groups to support staff learning about the impact of racism on health and equity-focused health programming and policy

WORKFORCE DEVELOPMENT

Goal: improved recruitment, hiring, advancement and inclusion of B/AA staff

Over the initial years of BAAHI the group highlighted issues including the lack of accurate data, the lack of centralized oversight of hiring, lack of explicit anti-bias focus in hiring, and structural barriers in the system. This led to the extraction and analysis of SFPDH workforce demographic data, showing staff demographics that do no match the SFDPH service population. The group also highlighted issues in mobility for B/AA staff members.

Accomplishments: New hiring standards created, new unit of HR created to improve oversight and program development around equity

- Video on anti-bias interviewing techniques mandatory for all hiring panel members
- HR oversight of hiring panel diversity
- Improved collection of race/ethnicity data in staff profiles, allowing reporting of staff diversity
- Hiring of recruitment staff with a focus on improved diversity of applicant pools
- Creation of the Office of Diversity, Inclusion and Workforce Development (ODIW) as a new Human Resources unit.

Future Plans:

Human resources staff are currently working on an Equity Action Plan to direct equity efforts around hiring and advancement. The above activities are being continued and expanded.

Over 500 staff completed a 4 day racial equity training

The BAAHI Learning Community

As part of the development of a sustainable infrastructure, the BAAHI backbone staff expanded from a single administrative staff person to an executive lead with several support staff. That has allowed an expansion of activities outside of the workgroups, focused primarily on offering opportunities for staff to learn about B/AA health disparities, best practices in creating equity, and form relationships with coworkers tackling similar issues. The goals of the learning community are two-fold. First, the increased awareness of B/AA health disparities generates new work around B/AA health, which must occur in all areas of the department to impact the wide array of disparities. Secondly, and crucially, the work aims to normalize the discussion of race, inequity and racism among staff.

Initially, the only specific non-clinical BAAHI activity was the *Think Tank*, a meeting that brought together invited staff to discuss the workgroup activities. That meeting has since been opened to all staff and reformulated as a learning community where equity projects across the department are shared, and expert speakers deliver educational material. Examples of Think Tank speakers and topics include:

- **The Intersection of Black Lives Matter and Public Health -**
  Jessica Brown, Center for Learning and Innovation, Population Health Division
- **Alcohol Treatment Medication Use: Addressing Racial Disparity in Deaths From Alcohol -**
  Dr. Judith Martin, Medical Director, Substance Use Services
- **Black to The Future -**
  Sheryl Davis, Director of the Human Rights Commission
- **Reaping the Harvest of Success in HIV for Black Residents -**
  Getting to Zero panel presentation

In addition to the Think Tank, a more distributed learning community, called the Equity Learning Series (ELS), is being introduced across the department. The Series brings articles, videos and speakers to staff to spark discussion around B/AA health and health inequities generally. ELS groups are active at the Population Health Division and at ZSFG. Future groups are planned in other areas of the department. Recent examples of topics addressed in ELS include:

- *Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care*
- *Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities*
- *Racism and Health I: Pathways and Scientific Evidence*
- *Under the Shadow of Tuskegee: African Americans and Health Care*

Beyond BAAHI

The focus on B/AA health extends beyond BAAHI. The disparities in health are so wide ranging that increased attention to B/AA residents is warranted across SFDPH based solely on the need evident in the data. Here is a limited review of efforts to improve B/AA health across the department. The list is not exhaustive, but is representative of the variety of work being done.

BLACK/AFRICAN AMERICAN WELLNESS PEER LEADERSHIP (BAAWPL)

In 2017, the Population Health Division of the SFDPH awarded over $1 million in funding to two local organizations to deliver health promotion services to the Black African/American population. Rafiki Coalition and Bayview YMCA were the two awardees and complete their first year of programming in June 2018. The agencies deliver services in five modalities; Outreach & Engagement, Wellness Promotion, Screening & Assessment, Individual & Group Therapeutic Services, and Service Linkage. Beyond services, the BAAWPL awardees were asked to meet new standards of collaboration and evaluation. Over the last year, the agencies have shared programming in new ways, tried innovative approaches to health and gotten positive feedback from the community. Positive examples include an Afro-Vegan nutrition class at Rafiki, an

intergenerational men's support group at the Bayview YMCA, and joint bike rides and hikes shared between the two groups. Evaluation data over the coming years will help show how these approaches are promoting healthy living among participants, and impacting community health overall.

BLACK/AFRICAN AMERICAN FAMILY BEHAVIORAL HEALTH SERVICES

SFDPH Children, Youth and Families System of Care issued the Black/African American Family Behavioral Health Services (B/AAFBHS) Request for Qualifications (RFQ) in 2018. The program is a collaboration with the Department of Children, Youth & Their Families (DCYF) to identify a list of qualified applicants with proven experience in advocacy, engagement, behavioral health treatment, and community capacity building activities that support the emotional health and well-being of B/AA children, youth, and their families in San Francisco, or a similarly diverse urban environment. The B/AAFBHS strategy represents an intentional and focused investment to expand access to effective, culturally responsive behavioral health treatment and supports for B/AA children, youth and families. The final program design will include increased access to behavioral health providers in the community and greater coordination and capacity among organizations serving B/AA families.

END HEP C SF

Local data show that hepatitis C (Hep C) disproportionately impacts San Francisco's Black/African American population, as it does throughout the nation. A coalition, including the health department, came together as the END Hep C Task Force to expand access to newly available curative treatment for Hep C, and promote services to decrease the number of new Hep C infections. In order to reduce the disparity of Hep C among Black/African Americans, the End Hepatitis C Task Force is providing education and testing to the B/AA community by partnering with service providers and residents in B/AA communities. The Task Force has also taken deliberate action to include B/AA community members in the decision making and planning process on multiple levels.

GETTING TO ZERO (HIV/AIDS)

From the early days of the HIV/AIDS epidemic there has been a disparity in incidence among racial groups. Due to the widespread use of HIV prevention tools, there has been a decline in HIV infection rate; however, disparities remain. SFDPH, various community based organizations, and community leaders in San Francisco have come together to form the Getting to Zero initiative (GTZ). The purpose of this group is to get to zero HIV infections, zero HIV-related deaths, and zero stigma. The tools used by the initiative include HIV education, counseling, social media campaigns, testing, linkage to care for treatment, post-exposure prophylaxis (PEP), pre-exposure prophylaxis (PreP), and viral suppression. Specific programming has been created to improve access to these tools in the B/AA community, including directed education around PrEP, improved access to testing and focused outreach.

SAN FRANCISCO TOBACCO FREE

The SF Tobacco Free Coalition is a project supported by SFDPH. The group explicitly focuses on community leadership in populations disproportionately affected by smoking. Grants to community agencies offer training in community-based participatory research and advocacy. The coalition championed the current campaign to eliminate menthol flavored tobacco products in the city, responding to the documented history that these products were targeted to B/AA communities and lead to high smoking rates. SFDPH also funds cessation services specifically directed at B/AA smokers. In 2018, new funding will enhance tobacco related services tailored to reduce smoking in the B/AA community.

HEALTHY HEARTS

Healthy Hearts is a CDC funded program designed to reduce heart disease disparities in the B/AA and Latino communities. SFDPH is using these funds for activities that support the BAAHI hypertension project, as well as other community and clinic based services. In particular, navigators were placed at primary care clinical sites with high proportions of B/AA or Latino patients to assist these patients in

taking advantage of available services. The navigators also support expanded services like walking groups at ZSFG and Southeast Health Center, as well as the food pharmacy program. Navigators also support a program of activity and park prescriptions; these are printed prescriptions from medical providers in the clinic that direct patients to SFDPH funded community health promotion activities (eg. the YMCA exercise programs) or to public park-based activities offered by the Parks and Recreation Department.

CAVITY FREE SF

The San Francisco Health Improvement Project, with support from the Metta and Hellman foundations, formed a working group around children's oral health in 2011. Among the groups findings was that children entering kindergarten in San Francisco, high rates of dental decay are seen in Chinese, B/AA and Latino children. That group led to a collaboration between SFDPH, UCSF and community members called Cavity Free SF that is committed to reducing the oral health disparity in San Francisco. In the last several years the project has focused on expanding the use of fluoride varnish by public and private medical providers, as well as public education in the Chinatown and Bayview neighborhoods. The initiative has shown a great impact on preventative health practices in Medi-Cal providers as well as some early improvements in cavity rates among entering kindergarteners.

THE ZUCKERBERG SAN FRANCISCO GENERAL EQUITY COUNCIL

In 2017, Zuckerberg San Francisco General Hospital (ZSFG) established an Equity Council with leaders and front-line staff to empower staff to eliminate disparities and promote inclusion. The council does not have an exclusive focus on B/AA health. However, its focus on disparities necessarily places the poor health of B/AA patients at the forefront, aligning it fully with the goals of BAAHI. The council's priorities are:

- Developing our people: Communicate with all levels of the organizations about equity-related initiatives, lessons learned and best practices;
- Assessing disparities: Integrate equity coaching into various ZSFG initiatives;
- Monitoring and supporting ZSFG participation in the SFPDH-wide Sexual Orientation & Gender Identity training initiative;
- Utilizing race, ethnicity and language data to better understand patient needs, guide decision-making and promote continuous improvement.

LAGUNA HONDA HOSPITAL (LHH)

Laguna Honda staff have focused on training and recruitment in 2017. Leadership implemented training in cultural humility and implicit bias at all levels of staff with assistance from the City and County Department of Human Resources. Staff have formed a workgroup focused on using Lean continuous improvement tools to integrate equity practices into the workplace, as well as a reading series and targeted events. LHH is working to pilot workplace bias training in 2018.

HOPE SF WELLNESS PROGRAM

Hope SF is an ambitious public housing redesign initiative to create mixed income housing without displacement. The initiative combines efforts from multiple city agencies, including SFDPH, to improve conditions for housing residents. The program borrows from the most successful national models to focus on revitalizing the whole community, not just on constructing new buildings in the four target sites: Hunters View, Potrero Terrace, Sunnydale, and Alice Griffith. This work is relevant to B/AA health because the Hope SF residents are 31% Black/African American. Each Hope SF site is planned to include a Wellness Program, operated by SFDPH and staffed by behavioral clinicians, peer educators and nursing staff. The Wellness Centers also offer an array of community building and health promotion services like parenting and nutrition classes. This is responsive to data showing that public housing residents are more likely to suffer from conditions like obesity, hypertension, asthma, diabetes and cardiovascular disease.[17]

CONCLUSION

The disparities in B/AA health have been created by decades of public policy. Consequently, the problems will not be corrected with brief interventions or projects. The Department of Public Health is committed to long term engagement with the community and the creation of new approaches. We do not expect to make a difference either through the use of methods that have already proven ineffective, or through short term practices that do not impact structural upstream causes. We also recognize that innovation, community engagement and structural change all will require partnership with the Black/African American community and a variety of agency partners. We invite everyone with concern about these critical issues to find ways to have an impact.

There are many ways that community members and city partners can help improve the health of the Black/African American community. The first step is normalizing the topic of race and racism so that problems and solutions can be discussed openly. A shared understanding of racism and its role in policy and practice allows a real dialogue about action to begin.

WHAT YOU CAN DO TO ADVANCE HEALTH EQUITY:

EVERYONE:

- Work to understand the ways in which racism has impacted and continues to impact how B/AA people live in San Francisco
- Continue to be aware of health disparities
- Work to eliminate personal bias and help others to identify their own biases
- Interrupt biased behavior toward B/AA people when you witness it
- Support - through advocacy, voting and education of peers – correction of systemic inequities that impact the health of B/AA people

GOVERNMENT AGENCIES:

- Review policies to ensure equitable access for all (correct upstream causes of health disparities)
- Review benefits to ensure additional support where B/AA communities have higher need
- Take into account health concerns when crafting programs for the B/AA community

COMMUNITY-BASED ORGANIZATIONS:

- Review programming to ensure that the health burdens of B/AA families are considered
- Create programs that directly address healthy living and support healthy lifestyles
- Advocate for upstream solutions and document the health impacts of such interventions to build the case for further changes
- Use the data provided here to raise funding to expand programming to serve B/AA specific health needs (including those related to living conditions)

BLACK/AFRICAN AMERICAN COMMUNITY MEMBERS:

- Continue to make efforts of support your own health and the health of your family
- Seek out services that help improve your individual health and deal with the stress associated with experiences of racism
- Advocate for health programming from community and government service providers
- Advocate for changes to upstream conditions that contribute to poor community health (eg. the lack of healthy food access points or healthy activities)

Working together we can ensure that all members of the San Francisco community have an equal opportunity to live long and healthy lives.

Citations

1. Cunningham TJ, Croft JB, Liu Y, Lu H, Eke PI, Giles WH. Vital Signs: Racial Disparities in Age-Specific Mortality Among Blacks or African Americans — United States, 1999–2015. MMWR Morbidity Mortality Weekly Rep 2017; 66:444–456.
2. California Department of Public Health, VRBIS Death Statistical Master File Plus 2005-2017. Not published.
3. World Health Organization website. http://www.who.int/social_determinants/sdh_definition/en/
4. San Francisco Community Health Needs Assessment 2016. https://www.sfdph.org/dph/hc/HCAgen/HCAgen2016/May%2017/2016CHNA-2.pdf
5. Robert Wood Johnson Foundation website. https://www.rwjf.org/en/culture-of-health/2016/03/what_s_the_connectio.html
6. TRENDS IN DELINQUENCIES AND FORECLOSURES IN CALIFORNIA. Community Development Department, Federal Reserve Bank of San Francisco. April 2009. https://www.frbsf.org/community-development/files/ca_northern_0409.pdf
7. Martha Ross and Natalie Holmes. Brookings Institute. The Avenue: Employment by race and place: snapshots of America. February 27, 2017
8. SAN FRANCISCO HOMELESS COUNT & SURVEY, 2017comprehensive report. http://hsh.sfgov.org/research-reports/san-francisco-homeless-point-in-time-count-reports/
9. Traffic-Related Air Pollution: A Critical Review of the Literature on Emissions, Exposure, and Health Effects. Health Effects Institute. Special Report 17, January 2010
10. San Francisco Community Health Needs Assessment 2016, Appendices. https://www.sfdph.org/dph/hc/HCAgen/HCAgen2016/.../2016CHNAAppendices.pdf
11. Wyatt SB1, Williams DR, Calvin R, Henderson FC, Walker ER, Winters K. Racism and cardiovascular disease in African Americans. Am J Med Sci. 2003 Jun;325(6):315-31.
12. LaPrincess C. Brewer, MD, MPH, and Lisa A. Cooper, MD, MPH. Race, Discrimination, and Cardiovascular Disease. AMA Journal of Ethics; Virtual Mentor. June 2014, Volume 16, Number 6: 455-460.
13. California Department of Public Health, Death Statistical Master Files for 2007-2016.
14. California Department of Public Health, Birth Statistical Master Files for 2007-2016.
15. Buchbinder, Susan. Talk at the Conference on Retroviruses and Opportunistic Infections, March 5-7, 2018. Boston, MA, Abstract 87.
16. Collective Impact: Large-scale social change requires broad cross-sector coordination, yet the social sector remains focused on the isolated intervention of individual organizations. John Kania & Mark Kramer. Stanford Social Innovation Review, Winter 2011
17. Health Impact Project. Connecting Public Housing and Health: A Health Impact Assessment of HUD's Designated Housing Rule. Final report. June 2015. http://dx.doi.org/10.15585/mmwr.mm6617e1

2018
Black/African-American Health Report

BLACK/AFRICAN-AMERICAN HEALTH INITIATIVE