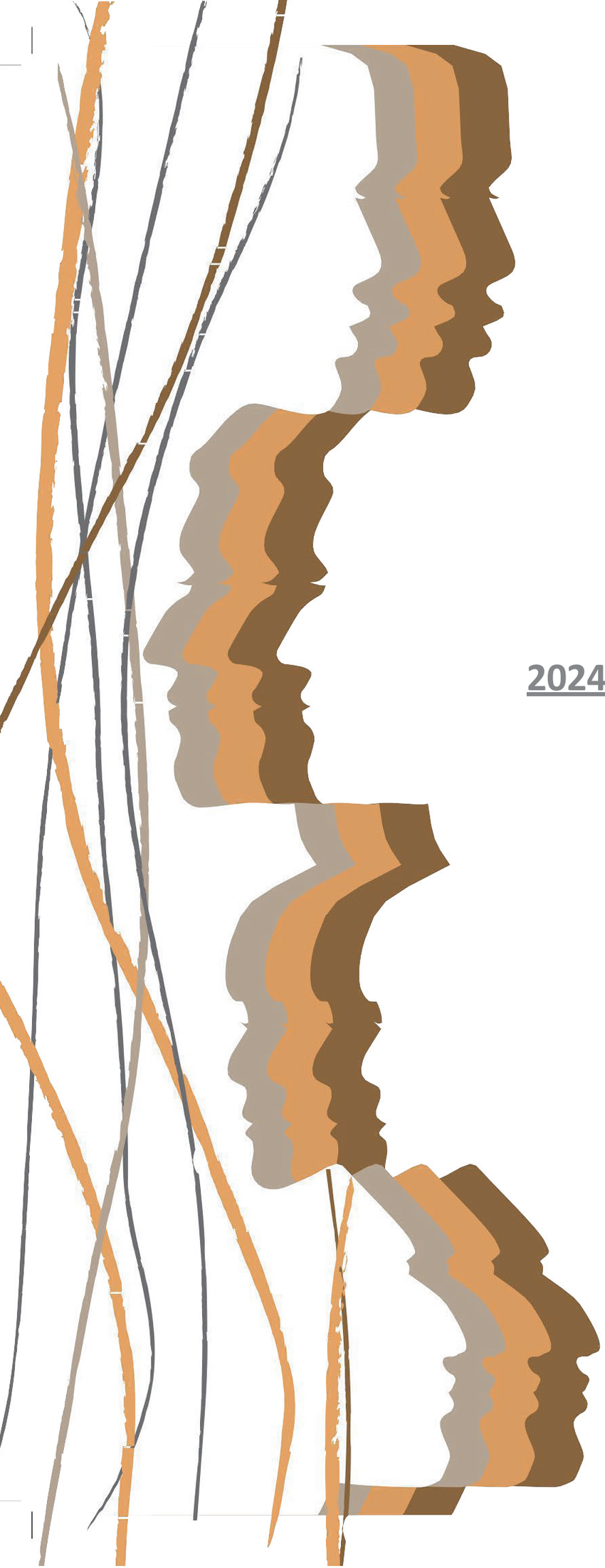


Commission on Minority Health

2024 Local Conversations Round 3: From Input to Action

hosted by

Cleveland Department of Public Health

(Local Office of Minority Health)

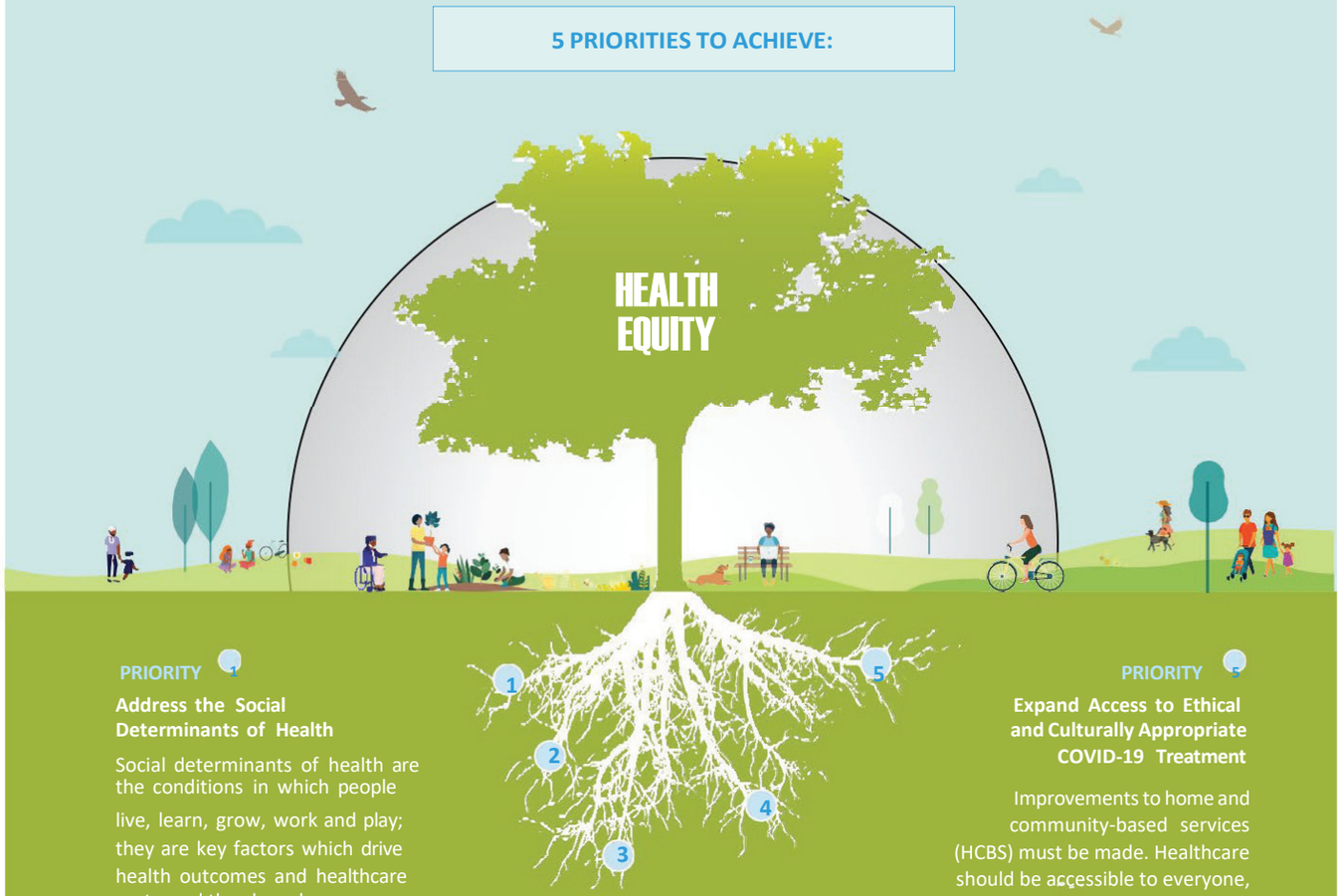
(Cuyahoga County)

Report to the Community

ADDRESSING HEALTH INEQUITIES IN THE ERA OF COVID-19

Disparities in COVID-19 health outcomes stem from health inequities rooted in systemic and unjust social and economic policies. The pandemic has worsened existing health inequities, disproportionately affecting communities of color, immigrant communities, people with disabilities, and other marginalized groups. Congress must act now. This graphic illustrates concrete steps that the federal government and states must take to mitigate the impact of the immediate crisis, and policy solutions to adopt once the national emergency declaration has been lifted.

5 PRIORITIES TO ACHIEVE:



PRIORITY 1

Address the Social Determinants of Health

Social determinants of health are the conditions in which people live, learn, grow, work and play; they are key factors which drive health outcomes and healthcare costs, and they have been completely upended by COVID-19.

PRIORITY 2

Build Strong Financial Incentives for Improved Health Equity in Our Health Care System

We can help close the disparity gap by integrating performance measures into payment models that aim to reduce health disparities.

PRIORITY 3

Organize and Build a Robust Health Infrastructure in Marginalized Communities

The equitable allocation of new resources is critical for many low-resourced areas to bolster the capacity needed to implement staff-intensive steps like widespread testing and contact tracing.

PRIORITY 4

Ensure Equitable Access to Affordable Health Insurance

Health coverage must be available and affordable to the entire population, no exceptions.

PRIORITY 5

Expand Access to Ethical and Culturally Appropriate COVID-19 Treatment

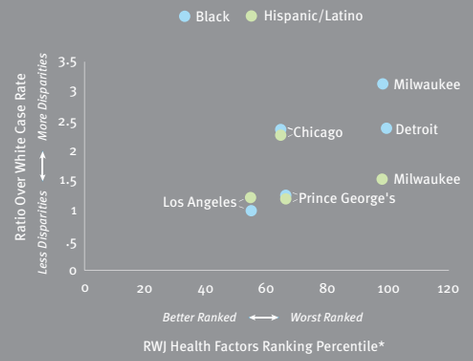
Improvements to home and community-based services (HCBS) must be made. Healthcare should be accessible to everyone, regardless of what culture they hold or language they speak.

HEALTH DISPARITIES

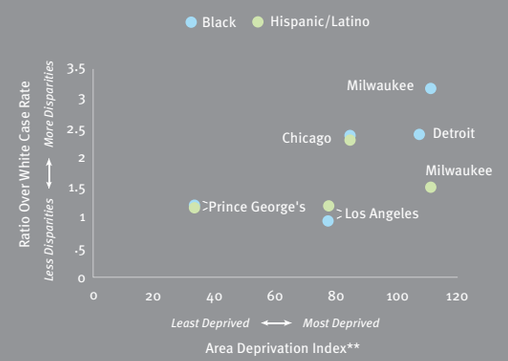
NEARLY 2X GREATER Nationally, African-American deaths from COVID-19 are nearly two times greater than would be expected based on their share of the population. In four states, the rate is three or more times greater.[1]

Hispanics/Latinos make up a greater share of confirmed cases than their share of the population. In eight states, it's more than four times greater.[1] **IN 42 STATES + D.C.**

COVID Case Disparity Correlates With Health Factors



COVID Case Disparity Correlates With Area Deprivation Index



*The Robert Wood Johnson (RWJ) Foundation County Rankings includes two composite scores, one representing how healthy counties are within the state (health outcomes), and the other measuring a variety of health factors (behaviors, clinical care, and the social, economic, and physical environment) that influence health outcomes. For example, see their rankings for Texas.

**The Area Deprivation Index (ADI) is a measure created by the Health Resources and Services Administration (HRSA), accounts for rankings of socioeconomic status by region and is used by health systems and providers to target program delivery; Quintile 1 (privileged) to Quintile 5 (deprived).

[1] Daniel Wood and Maria Goody, "What Do Coronavirus Racial Disparities Look Like State by State?" National Public Radio, May 30, 2020, available online at https://www.npr.org/sections/health-shots/2020/05/30/865413079/what-do-coronavirus-racial-disparities-look-like-state-by-state.

History of Local Conversations: Where it All Began

National Partnership for Action to End Health Disparities

Spearheaded by the Office of Minority Health, the National Partnership for Action to End Health Disparities (NPA) was established to mobilize a national, comprehensive, community-driven, and sustained approach to combating health disparities and to move the nation forward in achieving health equity. Through a series of Community Voices and Regional Conversations meetings, NPA sought input from community leaders and representatives from professional, business, government, and academic sectors to establish the priorities and goals for national action. The result is the National Stakeholder Strategy for Achieving Health Equity, a road map that provides a common set of goals and objectives for eliminating health disparities through cooperative and strategic actions of stakeholders around the country.

Concurrent with the NPA process, federal agencies coordinated governmental health disparity reduction planning through a Federal Inter agency Health Equity Team, including representatives of the Department of Health and Human Services (HHS) and eleven other cabinet-level departments. The resulting product is the HHS Action Plan to Reduce Racial and Ethnic Health Disparities, launched simultaneously with the NPA National Stakeholder Strategy in 2011. The HHS plan outlines goals, strategies, and actions HHS will take to reduce health disparities among racial and ethnic minorities. Both documents can be found on the Office of Minority Health web page at mih.ohio.gov/local-partnerships/local-conversations.

Ohio's Response to the NPA

In support of the NPA, the Ohio Commission on Minority Health (OCMH), an autonomous state agency created in 1987 to address health disparities and improve the health of minority populations in Ohio, sponsored a statewide initiative to help guide health equity efforts at the local and state levels. In Phase I of this initiative, OCMH sponsored a series of nineteen Local Conversations on Minority Health throughout the state. The purpose of these gatherings was to carry out community-wide discussions on local health disparities in which health needs could be identified and prioritized from the community's perspective, and strategies could be generated toward local action plans to address minority health needs. Sixteen of the Local Conversations were geographically-based and were held in the state's large and small urban regions. In addition, three statewide ethnic health coalitions convened ethnic-specific Local Conversations for Latino, Asian American, and Native American groups which brought in representatives from these populations across the state. In Phase II, the Local Conversations communities continued broad-based dialogues on health disparities and refined local action plans. In Phase III, the Commission initiated a partnership with the Ohio Department of Health to support their efforts to fulfill the expectations for the CDC National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities.

Cleveland Office of Minority Health (COMH)

Cleveland City Council established the Cleveland Office of Minority Health (COMH) in 2007 as a division of the Cleveland Department of Public Health-Division of Health. The COMH provides education to individuals and organizations on local health disparities that impact communities of color and underserved populations and the community at large. The local office provides leadership in reducing health disparities through programs, plans and strategies focusing on four core competencies. In our work we:

- Monitor and report the health status of minority populations
- Inform, educate, and empower people
- Mobilize community partnerships and action
- Develop policies and plans to support health effort

The vision of the COMH is to improve the health status of Cleveland's racial/ethnic population groups. The COMH seeks to coordination of community health efforts and provide information on the health of Cleveland's African American/Black, Asian American /Pacific Islander, Hispanic/Latino, and Native American communities. The office works with public and private partners to improve the effectiveness and efficiency of health initiatives through collaboration to address local emergent health disparities and support underserved populations.

Cleveland's Local Conversations Timeline
Round 1

First Local Conversation on Minority Health: Tuesday, October 7, 2008

More than 300 participants attended the first Local Conversation on Minority Health including strong representation from the diverse racial/ethnic groups in the city (African Americans, 80%; Asian American, 3%; and Hispanic/Latino, 10%). Attendees at this event worked to identify needs in the community affecting minorities. Organizers formed breakout sessions representing African American/Black, Hispanic/Latino, and Asian American/ Pacific Islander. Because their needs and perspectives are unique, we held a separate group for youth. Each group included a facilitator and a scribe who helped the groups to identify and reach consensus on the top needs and strategies to address the needs.

Priority Setting Session
Second Local Conversation Minority Health: Monday, December 14, 2010.

The purpose of the Phase II Priority Setting Session was to develop an action plan to select priority health needs in Cleveland. Fifteen individuals participated in the discussion. The group consisted of persons representing racial and ethnic community members, community agencies, hospitals, government, academia and youth focused groups. The goal of the second local conversation was to set priorities based on the original format of resource, service, capacity, and infrastructure needs.

Round 2: Local Conversations 2016

The local office aligned the content of the SFY 2016 Local Conversations with the NPA and included
feedback on service, resource, infrastructure, and capacity- building needs identified during the

Local Conversations in 2010. Round 2 Conversations in 2016 provided feedback on the progress made in the community over the past 5- year period. The Cleveland Office on Minority Health presented two Community Conversation events.

The first event was held was on June 29, 2016, at Trinity Commons in Cleveland, Ohio and consisted on focused discussions on African American and Asian American health issues. Participants included health
care professionals, community advocates and other social service providers.

The second event was June 30, 2016, at the Hispanic Alliance in Cleveland and focused on the health concerns of Hispanic/Latino residents, health and other social service providers. To accommodate the public, morning sessions (10:00am to 12:00pm and afternoon sessions (2:00pm to 4:00pm) were scheduled for both events. Community partners donated refreshments and lunch for each session. Over 100 participants attended the course of a 2-day period. The structure of the day consisted of a modified version of the State of Ohio's Health Assessment Forum. The schedule of the day for each event included a brief overview on the history of the Community Conversations at the local level and the impact of chronic health conditions on minority populations.

Facilitators led small group sessions and provided each group with the findings from the 2011 Community Conversation sessions. Facilitators worked with each group to discuss and identify progress made on resource, service, capacity building and infrastructure needs and time to identify (1) Community Strengths; (2) Community Threats and Opportunities; (3) City/County Health Priorities; and (4) Service Gaps and Next Steps.

In addition to each community's specific resource, service, capacity building and infrastructure needs, participants responded to the following survey questions about Community Strengths, Threats and Opportunities, Service Gaps and Next Steps. This survey strategy was used in Round 3 of the virtual and Latino sessions.

ROUND 3: LOCAL CONVERSATIONS 2023

The local office hosted a Racism as a Public Health Crisis Town Hall April 28, 2023 at the Jerry Sue Thornton Center in Cleveland. The town hall meeting included a tabletop discussion activity that convened participants to discuss the relationship between health disparities and racial equity.

Participants in the discussion identified racism as a root cause of health inequities and subsequently, health disparities. When asked how racism affects them in their neighborhoods and workplaces, participants reported that racism is woven in the fabric of our institutions,

organizations, government and all sectors. By their own observations and experiences, the group indicated that health disparities are the result of racism which in turn:

- Govern the allocation of resources unfairly
- Limits access and quality primary and mental health services for communities of color
- Negatively impacts the quality of education and educational standards for African Americans
- Has resulted in police profiling and criminal justice overload for persons of color and Black men specifically;
- Pay and leadership inequity for African Americans;
- Significantly reduces housing opportunities and housing affordability for Black families
- Allows redlining to further erode the health and safety of Black and Brown Cleveland neighborhoods;
- Supports funding formulas for schools (property taxes) that leaves school districts without appropriate resources;
- Limits opportunities for advancement in the workplace
- Allows micro aggressions in the workplace without redress
- Promotes legislative actions that suppress voting rights and further attempts to minoritize communities of color and LGBT groups by limiting reproductive health options,
- Allows food injustice to occur for the most vulnerable and in the poorest neighborhoods
- Causes stress and fear in the persons who exist in racist conditions

RECOMMENDATIONS:

Groups developed a list of recommendations that participants felt we must address to improve health and racial equity in the City of Cleveland:

Recommendation #1

Collaborate with county partners to strengthen equity efforts locally and regionally

Recommendation #2

Encourage equity as a value working across sectors to promote quality equity education and training is required and provided to employees at all levels of the organization.

Recommendation #3

Work collaboratively to promote and spur civic engagement among Cleveland residents.

Recommendation #4

Promote community policing initiatives, including increasing community engagement officers to improve safety efforts across the city.

Recommendation #5

Increase community engagement and transparency with planned events, community conversations and town hall meetings such as this on a regular basis.

Recommendation #6

Invest in racial equity support and reconciliation programs to assist persons in the workplace needing

Recommendation #7

Continue to support the expansion of community parks, green spaces, community gardens to promote neighborhood beautification and support sustainable food efforts.

The tabletop discussion was well received by participants. Our efforts to date were summarized by one participant in the following statement:

"The panelists and the audience were unapologetic in even say racism and talking about its effects without softening the blow. Event when looking at the audience, no one looked checked out or exhausted by the conversation, which lets me know we have made progress in the last ten years".

Conversation 2: Dia del Nino - April 29, 2023

The local office held a second conversation in partnership with MetroHealth Hope Institute and the as part of the Children's Day activities located at the Pivot Center of Art Dance and Expression. Participants were engaged in 1:1 conversation about their health concerns and completed a health survey. Staff were able to engage 45 participants. The demographic breakdown of the group was eighty-two percent female and 18% male. Puerto Ricans made up 38% of the participant group. 29% were Mexican; 13% Dominican; 7% Guatemalan; 4% Salvadoran; 4% Ecuadorian; 2% South American; 2% American and 2% Spanish.

Latino Health Concerns:

Participants identified the following health concerns as indicated in the table below in response to the following question:

In your opinion, what are the primary (top five) health problems in the Latino community?

Competitiveness	Obesity	Diabetes	Stroke	Heart Disease
Obesity	HBP	Cancer	Heart Disease	Diabetes
Obesity	Diabetes	Blood pressure	Heart Disease	Stroke
HBP	Diabetes	Heart disease	Cancer	Poor Nutrition
Depression	Diabetes	Diabetes	Obesity	Alcohol Use
Diabetes	Stress	Heart Attack	Cancer	Obesity
Diabetes	Cancer	Drugs	Obesity	Kidney Disease
Depression	Kidney Disease	Heart Disease	Mental Health	Stress
Diabetes	HBP	High Cholesterol	Heart Attack	Migraine
Poor Diet	Lack of Exercise	Lack of knowledge about healthy eating	Culture	Pulmonary Issues
Little or no access to medication	Unhealthy	Lack of financial resources	Poor nutrition	Cancer
Cholesterol	Diabetes	HBP	Heart Disease	
Diabetes	HBP	Depression	Depression	
Hypertension	Diabetes	Obesity	Ovarian cancer	
Cancer	Allergies	Coughing	Stomach problems	
Blood pressure	Heart disease	Colitis	Obesity	
Diabetes	HBP	Stroke	Heart Disease	
Obesity	Bullying	Lead poisoning	Heart Disease	
Diabetes	Obesity	Stroke	Diet	
Diabetes	Stress	Anxiety	Heart Disease	
HBP	Diabetes	Cholesterol		
Diabetes	Blood Pressure	Depression		
Diabetes	HBP	Asthma		
Thyroid				
Diet	Mental Health	Diabetes		
Diabetes	Depression	Heart Disease		
Diabetes	Asthma	HBP		
Obesity				

Chronic diseases such as diabetes, heart disease, cancer and hypertension were most frequently identified as health; however there were frequent mentions of obesity, poor nutrition and lack of exercise. Stress, depression, anxiety was also identified as leading health concerns. When asked how widespread these problems were in the Latino community, How widespread (how common) is each problem on a scale of 1 to 10? 1 being not very widespread and 10 being very widespread), 64% of participants reported that these problems were very widespread and 36% indicated that they were moderately widespread. With regards to impact on the Latino community, 65% of respondents indicated that these problems effect the Hispanic/Latino population more than other racial and ethnic groups, while 24% believed that the identified health problems did not impact Latinos more than other groups.

Health Literacy:

Participants were questioned about the level of understanding of health information that they receive from primary care physicians and other medical or clinical personnel. They are asked to respond to the following statement using a 5-point Likert scale.

1. I understand all of the health information given to me.
2. I understand the written health information given to me.
3. I understand the information health providers tell me
4. I do not understand any of the health information given to me

In response to Q1, 86% of respondents strongly agrees/agreed that they understand all of the health information given. Seven percent (7%) of respondents were neutral reporting that they somewhat understand the health information given to them, while 7% strongly disagreed and reported that they do not understand the health information given to them.

In response to Q2, 79% of participants reported that they understood written information given to them in a clinical setting, while 14% reported not understanding written information provided to them. Seven percent (7%) reported somewhat understanding the written information provided to them in the clinical setting.

In response to Q3, 85% reported understanding the information that providers tell them and 15% do not understand the information providers tell them.

In response to Q4, the percentage of respondents disagree that they do not understand any of the health information given to them, the level of understanding drops from 86% in Q1 to 61%. Thirty-six percent of respondents report that they do not understand any of the health information given to them whole 3% report somewhat understands any of the information given to them. Health literacy remains an issue that requires additional attention from health care and community providers.

Health Insurance Status:

Sixty-three percent of respondents reported having health insurance; 30% reported having no insurance and the status of 7% of the respondents was unknown.

Primary Physician:

75% report having a primary care physician
21% reported not having a primary care physician
4% unknown

Place of Care:

62% of respondents reported receiving their medical care from the MetroHealth System. Twenty one percent report receiving care from Cleveland Clinic and 14% of respondents reported receive care from Cleveland Clinic and Metro. Three percent of respondents reported receiving care from the federally qualified health center, Neighborhood Family Practice.

Emergency Room Visits:

Respondents reported the number of times they visited the emergency room over the past year.

	FREQUENCY	PERCENTAGE OF RESPONDENTS
A	O times	11%
B	1 time	42%
C	2 times	23%
D	3 times	12%
E	4 or more times	12%

Hospitalizations:

Over the past year, 19% of respondents reported being hospitalized. Eighty-one percent of respondents were not admitted into the hospital during the past year.

Access to Care:

Transportation

With regards to transportation, 75% of respondents reported that they are not experiencing transportation issues that keep them and their families from going to the doctor. Travel times from the primary residence to receive health care services in terms of time spent traveling ranged from one minute to 20 minutes. In terms of distance, respondents reported less than one mile to three miles.

Service Availability
What services are needed in your community but are not available?

In response to this question, respondents reported that they have had trouble accessing the following services: COVID resources, nutrition classes, community kitchen, Latino specific services, service located on the South side of Cleveland particularly in Parma and in Medina County. Pharmacy and dental services particularly for children, were also identified as areas of need as well as access to car seats.
Respondents also reported the need for safe spaces to exercise.

Service Utilization:
What kind of healthcare services have you received in the past year?

Over the past year, respondents reported accessing the following health care services: Preventative care, mammography, diabetes management, cardiology, ophthalmology,

MRI, lab testing, allergy testing, general medicine knee surgery, routine office visits and asthma treatment.

Service Needs:

Was there a service that you needed but did not receive in the past year?

Respondents reported the need to more information on how to obtain insurance and assistance programs for medication. One respondent reported that he needed rheumatology.

Overwhelmingly, 95% of respondents reported that if new services were made available in the community they would utilize them.

Service Priorities:

In order of importance, respondents prioritized service needs in the following order:

1. Weight Management
2. Hypertension
3. Cancer
4. Heart Disease
5. Diabetes

Following these chronic health conditions, respondents identified mental health services, particularly addressing depression as a high service need.

Environmental/Neighborhood Concerns:
What would make your neighborhood better? (Pick all that apply)

a. Community park
b. More safety
c. More housing
d. A grocery store
e. Better transportation
f. Other: _____

In response to this question 42% of respondents identified safety as an issue that would improve their neighborhood, followed by a community park (20%), better transportation and roads (18%), a grocery store (10%) and more housing (9%). Neighborhood clean-up and beautification were other areas identified for improvement.

Engagement

What can agencies and health organizations do to get you involved in the programs and services offered/provided by their organizations?

1. Workshops and seminars
2. Skill building sessions
3. Cooking classes
4. Exercise classes

5. Offer more engagement
6. Hire more staff to provide services

Trusted Community Agents:

Respondents identified the following agencies as trusted partner in the community.

1. Cleveland Clinic
2. Cleveland Police Department
3. Tri- C Access Center
4. Esperanza
5. Hispanic Committee
6. Inglesia Church
7. Julia De Burgos
8. May Dugan
9. MetroHealth
10. Metro West Community Development
11. Neighborhood Family Practice
12. The Centers

The local office looks forward to continued collaboration with the Latinx community.

Virtual Conversations November 17 – 18, 2023

The local office hosted two virtual conversations. Community members, service providers with specialties from mental health and addiction, primary health, health outreach and public health participated in the conversations. Staff provided an overview of the work of the local office, a history of the local conversations and an update on local health disparities. Staff facilitated a discussion with the group regarding health concerns and needs beginning with the impact of COVID on the community.

COVID Discussion:

Are you vaccinated? If no, why not:

Participants shared their vaccination status with the group. 81% of participants reported they were vaccinated and 19% were not. Individuals who were not vaccinated reported contracted COVID, some more than once and fell that they had immunity against subsequent infections. Another participant shared that she is unable to receive the vaccine because her medical conditions prevent it. She knows she will not get the new booster.

How did COVID Impact You? Describe your experience and observations. Did you get COVID? If so, were you admitted into the hospital? Is COVID still a threat?

Here are the sentiments and comments shared from group participants.

"I am vaccinated and mask wearing. I will get the new booster when it becomes available. Yes I believe COVID is still a threat. I saw people working essential jobs outside of healthcare such as auto factories and fast-food restaurants who were affected who had very little access to PPE and their companies did not require mandatory vaccination and did not require their employees to wear masks."

"COVID took a toll on monetarily for some; inflation has been huge."

"COVID has had a severe impact on people's mental wellness."

"Education is the key. Many people have not taken COVID seriously. I think we needed to see more social media postings on Instagram and Tik Tok; places where young people pay attention."

"COVID had a huge impact on my family. We had a nuclear family contract. If my family members were not vaccinated, they were not allowed to come into my home. I recall that there were a lot of negative messages. A great deal of effort needed to be taken to counteract misleading messages.

"I saw a clear bias in communities of color, especially within hospital systems. There was bias in training and testing as well."

"I observed social isolation across all ages and a lack of connection particularly among seniors."

"There was a great deal of communications on the importance of testing but testing was not readily available in communities without testing centers and all CVS stores were not offering testing. As a result, some were challenged because they did not have transportation to get tested."

"Online ordering for at home tests from the federal government was challenging, especially for the elderly."

"I observed many conspiracy theories among younger people who did not seem to consider the impact of COVID on family members."

"For some, the impact of COVID was higher paying jobs; some people never stopped working.

"COVID really highlighted the mistrust of the hospital system.

"COVID had a huge impact on hospital personnel early in the pandemic"

"COVID increased the level of collaboration between hospitals and public health that should carry over into other areas, such as chronic disease."

I saw COVID largely impacting Blacks and Latinos. There was a lack of education around COVID and difficulty to advocate when you are not being heard."

“Young people were the last to get the vaccine because no one thought they needed vaccination. One person commented that although they were vaccinated, they did not get their children vaccinated.”

“It may have been good to incentivize families to get vaccinated.”

“One participant observed that young people did not believe they would get sick so they did bother getting vaccinated.”

“The vaccine was not available to youth for a long time, so some did not see the need.”

“Some organizations worked very diligently to insure equitable access. Community leaders quickly identified populations that were not going to have access; organizations were meeting weekly adding individuals and organizations to the table including health departments. Organizations demonstrated their capacity to work together”.

“Transportation was a huge barrier to vaccination.”

“I have a sibling with a suppressed immune system and COPD who contracted COVID three times... Her first case resulted in pneumonia at the very beginning of the pandemic when folks really did not really understand COVID. The hospital staff was terrified. Her sister spend 6 weeks in isolation. Trying to coordinate her sister’s care and advocating for her was difficult. Physicians were reticent to share information. She believes her sister would have died. She had two other bouts of COVID despite being vaccinated and boosted. She is a long hauler and is on oxygen 24/7, which has created a housing issue, since she has difficulty getting around. She had to move into a smaller apartment. We have learned that affordable housing is a nightmare.”

“I am also concerned about my brother who has cerebral palsy and severe asthma. “

“Hospital personal have little regard for people’s pain. I experienced nosebleeds from COVID testing.”

“There was a great fear of testing. When home tests became available, the community could have benefited from education on how to test correctly.”

“People really did not know which vaccine was better. Healthcare professionals offered little clarity on the differences between the vaccines. We had to wait to hear that J&J was hurting people.”

“COVID definitely increased the utilization of community health workers and that has been excellent for the community.”

CONCLUSIONS & RECOMMENDATIONS:

Overall the group felt that hospital systems and public health responded very quickly as the pandemic was unfolding. Though understandable based on the impact of COVID on the senior population, many felt that engagement of families, children and youth was lacking. Vaccination uptake for children and youth never achieved traction in the community. A multi directional outreach approach is recommended for youth and the elderly given the capacity of children and youth to spread the virus. Group members also recommended enhanced support to persons with developmental disabilities, person who are blind, deaf and hearing impaired and person living in public housing communities. Overall, there was confidence that the healthcare system

would be prepared to address future pandemics and the lessons learned from community members will serve as a bridge to engage trusted community members in the future.

CHNA Update: Healthcare needs and priorities

Staff provided an overview of the Cuyahoga County Needs Assessment, which was finalized and released at the end of calendar year 2022. The assessment, which included primary and secondary health data, key stakeholder interviews and community engagement groups identified the following priorities for the county.

Overall participants felt that the County's priorities were in alignment to the needs and conditions that they have observed. Additionally, participants had the following recommendations on health issues that are priorities in our community.

Recommendations:

1. We need to connect children to health care and immunizations for all races and all ethnicities
2. Drug use- we need to reduce stigma and engage in real harm reduction IVDU access to harm reduction kits and clean needles
3. HIV services should target persons who are homeless or in prostitution. More wraparound services can be provided including bus passes for person taking PREP. We would also do a better job in serving women with more kids, removing the stigma by normalizing the conversation; HIV is part of the STI conversation.
4. Focus on socio economic priorities is on point. We need to provide more affordable dental care in general and particularly in school-age children.

5. Affordable housing remains an ongoing issue in our community that needs to be addressed

Thoughts on Infant Mortality:

1. With respect to infant mortality, the three health systems are working better together, but we need to hear more about how the systems target and treat high risk pregnancies.

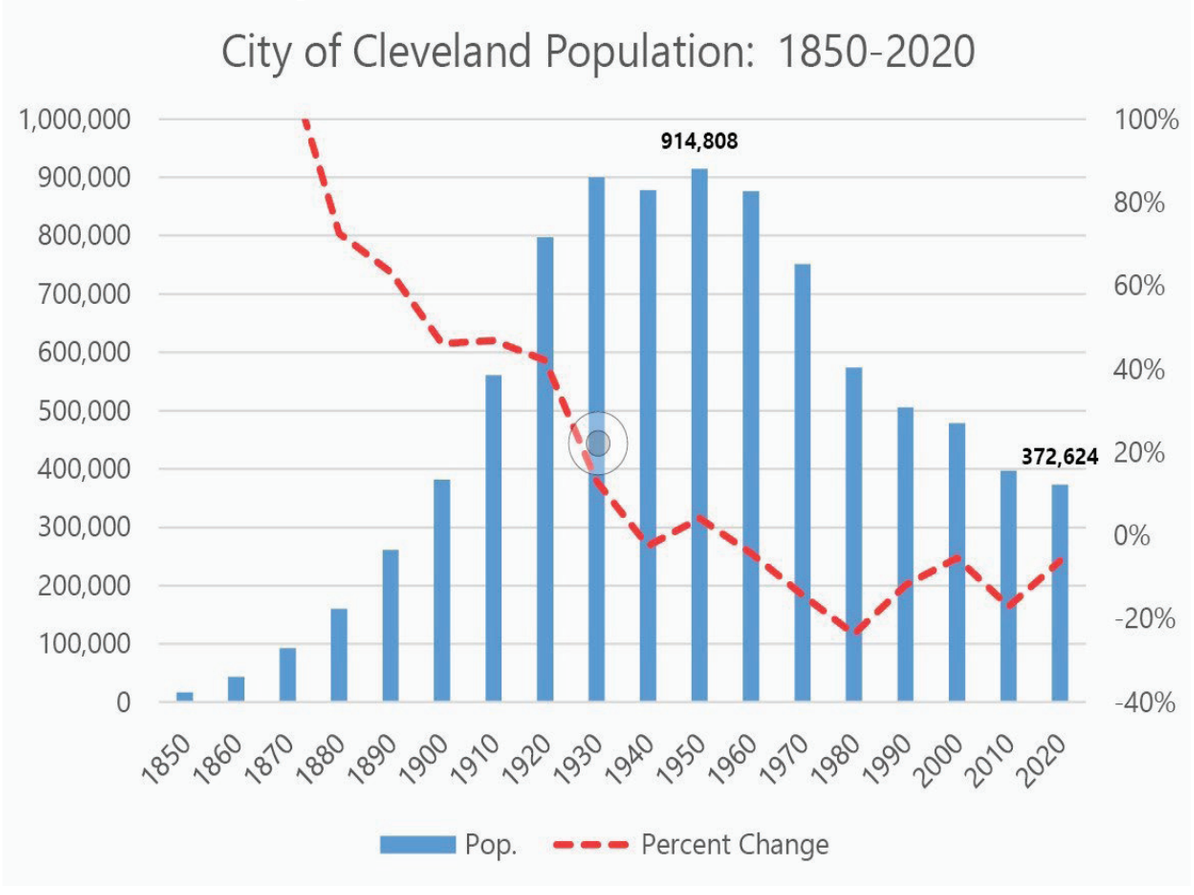
2. We have new programs, but the IM rates are not getting better. New programs led by Black women is a step in the right direction in terms of representation. We need to continue to build capacity of Black led organizations.

3. Hospital systems have to assess their intentions when it comes to IM and Black women's care in general. If there are good intentions, the results do not match the intent. I am not sure that hospitals are invested in the same ways as those working in community and public health to eliminate disparities.

4. When the health department produced the film Toxic, it underscored the need for greater accountability on the service delivery end from hospitals. The question is, "where is the accountability when bad things happen and who communicates when good news happens? What happens when women get support? We must do better storytelling about our concerns and our solutions.

5. Public health remains at the center education. We must teach people how to care for themselves- whole body/whole life wellness; we must teach the medical community how to give good care and we must use more African American caregivers.

Community Context: Where We Were Then and Now



Diverse racial/ethnic groups constitute most of the Cleveland's population. Cleveland is the
largest city in Cuyahoga County and the second largest city in the State of Ohio. According the 2020 Census, there were approximately 372,624 residents in Cleveland. We continue to see a decrease in residents in Cleveland, which is consistent to reductions occurring in Cuyahoga County.

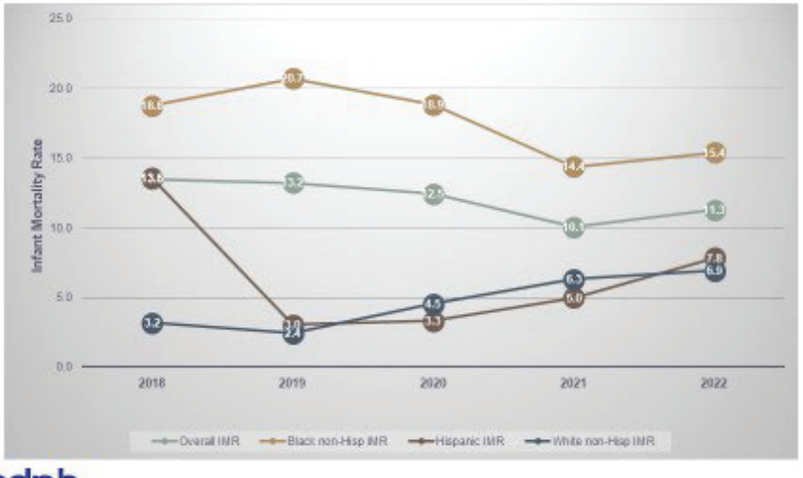
	BY NUMBER			BY PERCENT OF CITY		
Hispanic or Latino / Race	**2010**	**2020**	**Change**	**2010**	**2020**	**Change**
Hispanic or Latino	39,534	48,699	+9,165	10.0%	13.1%	+3.1%
Not Hispanic or Latino	357,281	323,925	-33,356	90.0%	86.9%	-3.1%
Black or African American Alone, Not Hispanic or Latino	208,208	176,813	-31,395	52.5%	47.5%	-5.0%
White alone, not Hispanic	132,710	119,547	-13,163	33.4%	32.1%	-1.4%
American Indian and Alaska Native alone, Not Hispanic	997	844	-153	0.3%	0.2%	-0.0%
Asian alone, not Hispanic	7,213	10,390	+3,177	1.8%	2.8%	+1.0%
Native Hawaiian and Other Pacific Islander alone, not Hispanic	70	100	+30	0.0%	0.0%	+0.0%
Some Other Race alone, not Hispanic	599	1,970	+1,371	0.2%	0.5%	+0.4%
Two or more races, not Hispanic	7,484	14,261	+6,777	1.9%	3.8%	+1.9%
	396,815	372,624	**-24,191**			

Communities of color represent the largest percentages in the City of Cleveland. The demographic breakdown of Cleveland is: 119 547 (33.3%) White/Caucasian; 176,813 (47.5%) Black/African American; 10,490 (3%) Asian American/Pacific Islander; 48,699 (13%) Hispanic/Latino and 1,164 (0.3%) American Indian/Alaska Native; 844 (.02%). Persons of two or more races make up 3.8 of the population

Overall Health:

- In 2014, African Americans were 1.63 times more likely to report being in fair or poor health than Caucasians (10% compared to 14% today.
- In 2021 Black, Hispanic, and AIAN adults were more likely to report fair or poor health status than their White counterparts, while Asian and NHOPI adults were less likely to indicate fair or poor health.
- One quarter of AIAN adults (25%) and roughly two in ten Black (20%) and Hispanic (21%) adults reported fair or poor health status compared to 14% of White adults as of 2021 (Figure 15). In contrast, 9% of Asian adults and 12% of NHOPI adults reported fair or poor health status (National Center for Health Statistics and Kaiser Family Foundation, 2021).

Where We Were Then & Now
Infant Mortality



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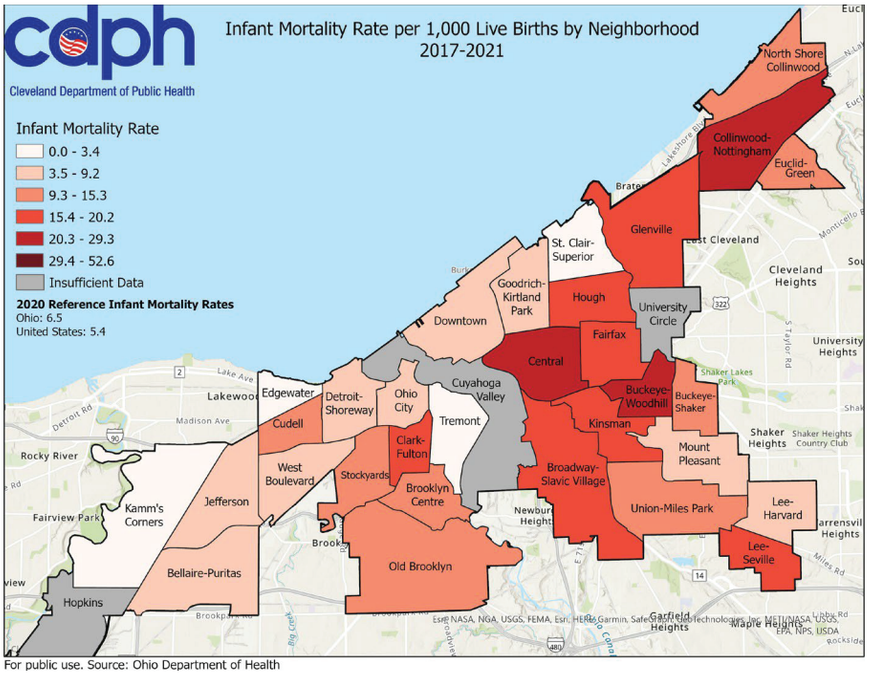
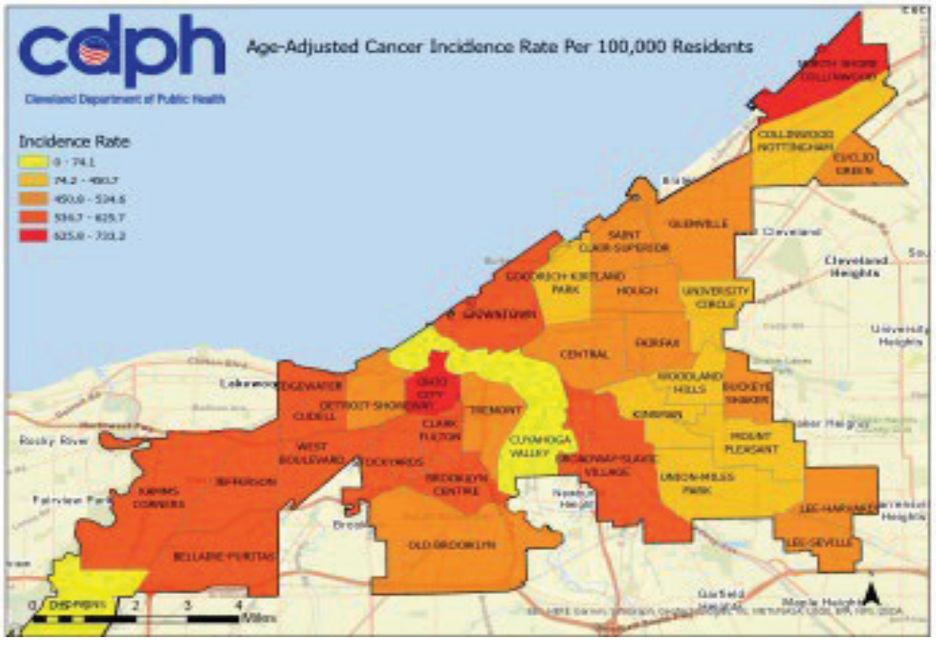


For public use. Source: Ohio Department of Health



Between the years of 2017 and 2021, Cleveland saw an average of 2,097 new cancer diagnoses and 829 cancer deaths per year. Although still high, there was a 14% decrease in the age-adjusted incidence rate of cancer between 2017 and 2021. Age-adjusted cancer mortality saw a more saw a more modest decrease of 8.5% in the same period.

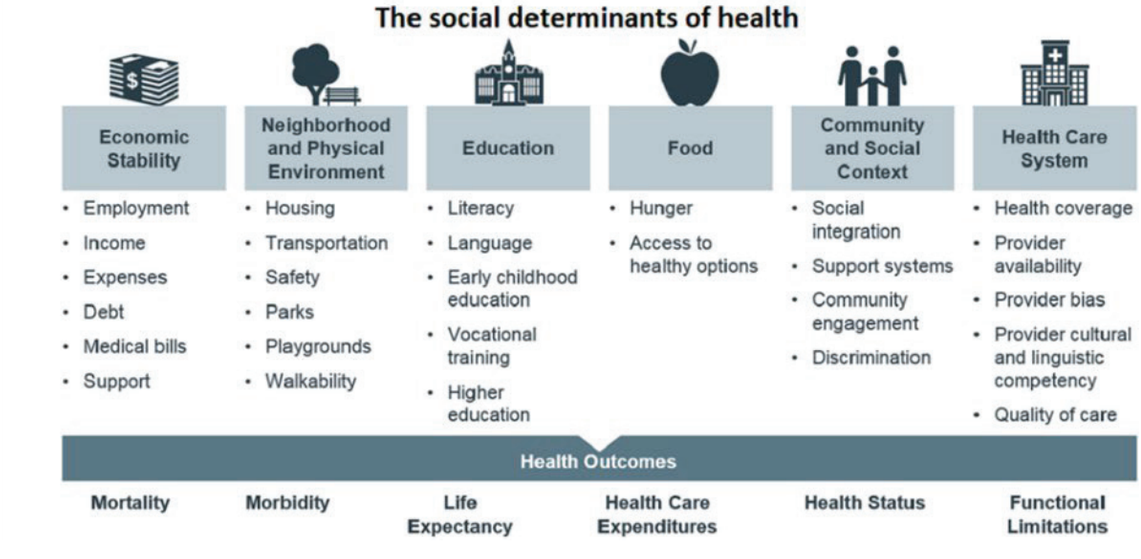
Between 2017 and 2021, cancer incidence was highest in the 65-74 age group. The highest morality rates were observed in the age groups 65-74 years and 75-84 years. In Cleveland, cancer disproportionately affects Black males.

Overall, more males than females were diagnosed with cancer during these years, except among the Asian and Hispanic populations, where more females were diagnosed. The mortality rate for males remained higher than females in all racial/ ethnic groups.

Conclusion:

Community members are increasingly active in improving the health of the community. Over the past 5 years, we have observed an exponential increase in the community assessments, community conversations, focus groups, and town hall meetings. The health space does not belong to hospitals and public health alone. Rightfully , the health space into diverse spheres- community planning and economic and workforce development, community relations, environment and sustainability and in faith communities. With the support of philanthropy, needs are being assessed at the neighborhood level with residents developing strategies for change. In the past year, three local communities have completed and disseminated needs assessments alongside the county wide CHNA. Those assessments are housed on the Health Northeast Ohio platform at www.healthyneo.org. While there are local nuances, there is agreement that we must continue to work collaboratively on improving the conditions of the Cleveland community as we work to eliminate racial inequity and health disparities.

In addition underserved populations have begun assessing health needs of their communities. The LGBT and Asian Pacific Islander communities are in the process of completing assessments in Cleveland. The Cleveland Department of Public Health and the Office of Minority Health serve on these planning and assessment committees and will be working in various capacities with each of these groups on their implementation strategies.



What's Ahead?

The local office plans to engage community members to discuss this report to inform its future work. Through our involvement with local coalitions, heath care and community partners, we expect to work of SDOH issues more extensively as the Department's Health Equity and Social Justice Division Interdepartmental Equity Team continues to shape and inform our work going forward.

We look to future. It is full of potential and hope. The Cleveland Office of Minority Health thanks the Ohio Commission on Minority Health for its continued partnership and looks forward to *continuing the conversation* in the years to come.

The National Partnership for Action to End Health Disparities

Spearheaded by the Office of Minority Health, the National Partnership for Action to End Health Disparities (NPA) was established to mobilize a national, comprehensive, community-driven, and sustained approach to combating health disparities and to move the nation forward in achieving health equity. Through a series of Community Voices and Regional Conversations meetings, NPA sought input from community leaders and representatives from professional, business, government, and academic sectors to establish the priorities and goals for national action. The result is the National Stakeholder Strategy for Achieving Health Equity, a roadmap that provides a common set of goals and objectives for eliminating health disparities through cooperative and strategic actions of stakeholders around the country. Concurrent with the NPA process, federal agencies coordinated governmental health disparity reduction planning through a Federal Interagency Health Equity Team, including representatives of the Department of Health and Human Services (HHS) and eleven other cabinet-level departments. The resulting product is the HHS Action Plan to Reduce Racial and Ethnic Health Disparities, launched simultaneously with the NPA National Stakeholder Strategy in 2011. The HHS plan outlines goals, strategies, and actions. HHS will take to reduce health disparities among racial and ethnic minorities. Both Documents can be found on the Office of Minority Health web page at https://mih.ohio.gov/local-partnerships/local-conversations.

Ohio's Response to the NPA

In support of the NPA, the Ohio Commission on Minority Health (OCMH), an autonomous state agency created in 1987 to address health disparities and improve the health of minority populations in Ohio, sponsored a statewide initiative to help guide health equity efforts at the local and state levels.

In Phase I of this initiative, OCMH sponsored a series of nineteen Local Conversations on Minority Health throughout the state. The purpose of these gatherings was to carry out community-wide discussions on local health disparities in which health needs could be identified and prioritized from the community's perspective, and strategies could be generated toward local action plans to address minority health needs. Sixteen of the Local Conversations were geographically based and were held in the state's large and small urban regions. In addition, three statewide ethnic health coalitions convened ethnic-specific Local Conversations for Latino, Asian American, and Native American groups, which brought in representatives from these populations across the state.

In Phase II, the Local Conversations communities continued broad-based dialogues on health disparities and refined their local action plans. The Cleveland Health Disparity Reduction Plan in this document is a result of this process. The lead agency for the Local Conversations in Cleveland was the Cleveland Office of Minority Health.

In Phase III, the 2024 Local Conversation Initiative, the Ohio Commission on Minority Health received partial funding support for the "Local Conversation Initiative" from the Ohio Department of Health through a sister state agency partnership. This federal funding support was provided by the *Ohio Department of Health* through *the Center for Disease Control and Prevention Grant – Initiative to address COVID-19 Health Disparities Among populations at High-Risk and Underserved, including racial and ethnic minority populations and rural communities*. This funding provided an opportunity to obtain input from participants on the impact of COVID-19 with their communities. During this round of the local conversations the Ohio Commission on Minority Health supported 16 local conversations across the state. These efforts were geographically based and were held in the state's large and small urban regions. In addition, three statewide ethnic health coalitions convened ethnic specific Local Conversations for Latino, Asian American, and African American groups, which brought in representatives from these populations across the state.

Cleveland Office of Minority Health (COMH)

The Cleveland Office of Minority Health (COMH) was established in 2007 as a division of the Cleveland Department of Public Health-Division of Health. The COMH educates individuals and organizations on health issues impacting minority populations and the community at large and provided leadership in reducing health disparities through innovative strategies focused on four core competencies to:

- Monitor and report on the health status of minority populations
- Inform, educate, and empower people
- Mobilize community partnerships and action
- Develop policies and plans to support health efforts

The vision of the COMH is to improve the health status of Cleveland's racial/ethnic population groups.

The COMH seeks to serve as a clearing- house for the coordination of community health efforts and information targeting Cleveland's African American/Black, Asian American /Pacific Islander, Hispanic/Latino, and Native American populations. The office works with public and private partners to improve the effectiveness and efficiency of health initiatives through collaborative efforts.

Cleveland Demographics

Diverse racial/ethnic groups constitute the majority of Cleveland's population. Cleveland is the largest city in Cuyahoga County and the second largest city in the State of Ohio. According to the 2015 Census, there were approximately 388,072 residents in Cleveland. The demographic breakdown of Cleveland is:

144,750	(37.3%)	White/Caucasian
206,842	(53.3%)	Black/African American
76,838	(1.98%)	Asian American/Pacific Islander
38,807	(10%)	Hispanic/Latino
1,164	(0.3%)	American Indian/Alaska Native
10,866	(2.8%)	Two or more races

Cuyahoga County Demographics

Persons of color represent almost one-third of the total population of Cuyahoga County. Cuyahoga County is the most populous county in Ohio and Cleveland is the county seat.

According to the U.S. Census Bureau, there were an estimated 1,259,828 residents in Cuyahoga County in 2014. The racial/ethnic composition of Cuyahoga County is:

811,329	(64.4%)	White/Caucasian
381,728	(30.3%)	Black/African American
37,795	(3.0%)	Asian American/Pacific Islander
68,031	(5.4%)	Hispanic/Latino
2,520	(0.2%)	American Indian/Alaska Native
37,795	(3.0%)	Two or more races

Cuyahoga County Death Rate for Top Health Conditions 1999-2014

County Ranking	Disease/Condition	County Death Rate Per 100,000	State Death Rate per 100,000
17th	Heart Disease	**251.56**	186.38
32th	Cancer	**200.77**	177.84
84th	Lung Disease	38.04	42.21
83rd	Accidents	**42.55**	50.8
80th	Stroke	19.74	40.03
79th	Alzheimer's	23.57	27.65
77th	Diabetes	23.57	25.68
75th	Influenza	13.45	16.88
26th	Nephritis/Kidney Disease	**15.98**	14.06
13th	Septicemia/Blood Disease	**14.21**	12.15
59th	Suicide	10.42	12.55
14th	Liver Disease	**10.64**	10.38
51st	Hypertension	7.91	9.3
68th	Parkinson's	5.46	7.79
4th	Homicide	**8.8**	5.22

***Higher than State Average**
Data Taken From: World Health Rankings – World Health Organization, CDC

According to World Health Rankings Data compiled by the Center for Disease Control (CDC) and the World Health Organization (WHO), between 1999 and 2014, the mortality rate per 100,000 in Cuyahoga County exceeded Ohio mortality rates for the following chronic health conditions: Cancer, heart disease, non-intentional accidents, kidney disease, blood infections, liver disease and homicide. These findings are consistent with the Robert Wood Johnson Foundation's 2014 and 2015 Health Rankings data which ranks Cuyahoga County 65th (2014) and 43rd (2015) out of 88 counties in health outcomes measuring length of life and quality of life. Cuyahoga County ranked 46th (2014) and 64th (2015) in the health factors, which include socioeconomic factors, health behaviors, access to care and quality of care.

Understanding that persons of color, particularly African Americans and Latinos are disproportionately affected by cancers, heart disease, diabetes, homicide and infant mortality, the focus of the local office remains centered on establishing and maintaining partnerships to raise awareness, improve education, early detection and treatment of these life-threatening conditions. Through its partnerships with local health providers, social service and faith-based organizations, the local office continues to advocate for increased funding and services where they are needed the most. This includes working to establish better mechanisms for data collection and reporting, developing neighborhood- based initiatives based upon local data findings and building capacity for employing community health workers in strategic areas and implementing disease self-management models in neighborhood settings.

Cleveland, Ohio Socioeconomic Indicators

Cleveland's racial/ethnic populations fare worse than their Caucasian peers on a number of socioeconomic indicators that have an impact on health. The overall poverty rate in Cleveland was 35.9% in 2014; there were particularly high rates of poverty for children (53.5%), due in part to the high number of female-headed households in the City. The greatest concentration of poverty is found on the city's east and near west sides, where many of the City's Hispanic and African-American residents live. African Americans and Hispanics are three times more likely to live in poverty than Whites (Health Improvement Partnership-Cuyahoga, 2014).

According to a Cuyahoga County Health Needs Assessment conducted by the Center for Health Affairs,

40.9% of Hispanic and 43.1% of African-Americans residents live in poverty in Cleveland. In addition, a total of 18% of African-Americans aged 18-64 in the county were uninsured. Lack of insurance or being under-insured has been found to be a risk factor for decreased access to high quality care, delays in seeking care, and a low priority placed on preventive care (http://www.healthpowerforminorities. com).

Health Disparities in Cleveland

The Cleveland Office of Minority Health has continued to experience barriers locating local data on health disparities. The lack of timely data collection and reporting of minority health data has been identified as an area of concern across health service delivery sectors. However, new initiatives such as Health Data Matters (HDM) are working with local health departments and other local organizations to provide access to "comprehensive data and tools to understand and describe health in Cleveland and Cuyahoga County" (HDM). The COMH continues to work with community partners on strategies that will allow for greater access and use of local data. Currently available data indicate that people of color residing in Cleveland continue to face significant health disparities.

Overall Health

In 2014, African Americans were 1.63 times more likely to report being in fair or poor health than Caucasians (10% compared to 14%- National Center for Health Statistics).

HIV/AIDS Prevalence in Cleveland

As of December 31, 2014, there were 4,967 people diagnosed with HIV living in Cuyahoga County. Of these, 3,343 (67%) people were Cleveland residents and 49%, or 1,652 of them had AIDS. Nearly 62% of AIDS patients were African American, 25% were Caucasian non- Hispanic, 12% were Hispanic, and less than 1% was of other race. Three in four (75%) were male. People with HIV-only were younger, with about 29% being 34 years of age and younger. Ninety percent of individuals with AIDS were aged 35 and older.

Infant Mortality

Cleveland's 2015 Infant Mortality Rate was 15.6 deaths/1,000 live births. This is much higher than the reported IMR in Ohio of 6.8 deaths/1,000 live births. (Ohio Department of Health) However, the disparity ratio in Cleveland was 1.42 (12.6 deaths/1,000 live births for Caucasian babies compared to 17.9 deaths/1,000 live births for African American babies) meaning that African American infants were 42% more likely to die before reaching their first birthday than Caucasian infants. This pattern was also similar for low birth weight and very low birth weight births.

Obesity

A Cuyahoga County Health Needs Assessment conducted by the Center for Health Affairs found that females were more likely to be obese than males and that African American and Hispanic children were more likely to be obese than Caucasian children. The rate of obesity among adults in

Cuyahoga County was 24.7% in 2012—lower than the national (28%) and state averages (30%). However, the obesity rate among African Americans was 37% or 18% higher than the rate among Caucasians (19%).

Cancer

According to the Ohio Annual Cancer Report, the total cancer mortality rate per 100,000 people in Ohio was 201 for African Americans and 180 for Whites in 2015. Specifically, African Americans had much higher mortality rates per 100,00 people compared to white residents for prostate cancer (38 to 18 deaths), lung & bronchus cancer (60 to 54 deaths), colon & rectal cancer (19 to 16 deaths), and breast cancer (18 to 12 deaths).

Cancer is the 2nd leading cause of death in Cuyahoga County. In 2014, there were approximately 7,741 new cases of invasive cancer of all types among Cuyahoga County residents with an age-adjusted rate of 492 per 100,000 people (Cuyahoga County Board of Health 2016). Clevelanders experience a higher rate of cancer burden in comparison to Cuyahoga County, Ohio and the nation.

Diabetes

In 2014, the rate of mortality from diabetes in the City of Cleveland was 34.7 per 100,000. 14 neighborhoods had higher rates than the City average. Thirteen African Americans neighborhoods had higher rates of diabetes mortality than the City average. The mortality rate from diabetes in Ohio for African Americans was 36.6 per 100,000 compared to 38.8 per 100,000 for Caucasians.

In 2015, the Ohio Department of Minority Health reported that African Americans are 79% more likely to die from diabetes than their White counterparts.

Tobacco

In Cleveland, 35.8% of African-Americans/Blacks were smokers.

Sources of demographic and health data: www.factfindercensus.gov

Ohio Department of Health, http://www.odh.ohio.gov

Cleveland Department of Public Health, www.healthinfo.org

The Prevention Research Center for Healthy Neighborhoods (PRCHN)

Cleveland's Local Conversations Timeline

Round One

First Local Conversation on Minority Health: Tuesday, October 7, 2008

The first Local Conversation on Minority Health was attended by more than 300 participants,

including strong representation from the diverse racial/ethnic groups in the city (African Americans, 80%; Asian American, 3%; and Hispanic/Latino, 10%). Attendees at this event worked to identify needs in the community affecting minorities. For the discussions, breakout sessions were divided into racial and ethnic groups representing African American/Black, Hispanic/Latino, and Asian American/ Pacific Islander. Because their needs and perspectives are unique, a separate group was held for youth. Each group included a facilitator and a scribe who helped the groups to identify and reach consensus on the top needs and strategies to address the needs.

Priority Setting Session

Second Local Conversation Minority Health: Monday, December 14, 2010

The purpose of the Phase II Priority Setting Session was to develop an action plan to select priority health needs in Cleveland. A total of 15 people took part in the discussion. The group consisted of individuals who represented racial and ethnic community members, community agencies, hospitals, government, academia and youth focused groups. The goal of the second local conversation was to set priorities based on the original format of resource, service, capacity, and infrastructure needs.

Round Two: Local Conversations June 29-30, 2016

The content area for the FY 2016 Local Conversations was aligned with the NPA and includes feedback on service, resource, infrastructure, and capacity building needs identified during the Local Conversations in 2010. The Round 2 Conversations in 2016 provided feedback on the progress made in the community over the past 5-year period. The Cleveland Office on Minority Health presented two Community Conversation events. The first event was held was on June 29, 2016, at Trinity Commons, 2307 Prospect Avenue in Cleveland, Ohio and consisted on focused discussions on African American and Asian American health issues. Participants included health care professionals, community advocates and other social service providers.

The second event was held on June 30, 2016, at the Hispanic Alliance, 3110 West 25th Street in Cleveland and focused on the health concerns of Hispanic/Latino residents, health and other social service providers. To accommodate the public, morning sessions (10:00am to 12:00pm and afternoon sessions (2:00pm to 4:00pm) were scheduled for both events. Refreshments and lunch were provided at each session. Over 100 participants attended the course of a 2-day period.

The structure of the day consisted of a modified version of the State of Ohio's Health Assessment Forum. The schedule of the day for each event included a brief overview on the history of the Community Conversations at the local level and the impact of chronic health conditions on minority populations.

Small group sessions then were led by facilitators who provided each group with the findings from the 2011 Community Conversation sessions. Facilitators worked with each group to discuss and identify progress made on resource, service, capacity building and infrastructure needs and time to identify (1) Community Strengths; (2) Community Threats and Opportunities; (3) City/County Health Priorities; and (4) Service Gaps and Next Steps.

In addition to each community's specific resource, service, capacity building and infrastructure needs, participants responded to the following survey questions about Community Strengths,

Threats and Opportunities, Service Gaps and Next Steps.

COMMUNITY STRENGTHSAND OPPORTUNITIES

1. What are the 2-3 most important characteristics of a healthy city and county?

2. What makes you most proud of your city and county?

3. What are some specific examples of people or groups working together to improve the quality of life in your county and region?

4. What do you believe are the 2-3 most important issues that must be addressed to improve the health and quality of life in your county and region?

5. What do you believe is keeping your county and region from doing what needs to be done to improve health and quality of life?

FORCES OF CHANGE:

- What recent changes or trends are occurring or are on the horizon that may impact the health of your community?
- Of these changes or trends, which are occurring locally? Regionally? Nationally? Globally?
- What characteristics of your region or state may pose an opportunity or threat to your community's health?
- What may occur or has occurred that may pose a barrier to achieving the shared vision?

African American Workgroup

In the 2010 Community Conversation and Priority Setting Session, the group focusing on African American health needs stressed:

1. The need to employ a multi-system approach to address the needs of the African American community as well as the other minority communities. They recommended that a comprehensive marketing campaign reflecting the diversity of the community be developed to frame the approach. This approach would include understanding the cultural aspects of the communities to be served as the basis for the coordination of a community wide culturally based health/social services needs assessment.
2. The need for consumers needed to take ownership for their health destinies. Although individuals have been exposed to barriers such as institutionalized racism and discrimination, any health paradigm promoted should include a component of individual responsibility. In order to further this concept, consumer **health literacy needs** to be raised. Health literacy would include translating medical jargon into understandable terms and describing healthcare plans in layman terms. Succinct information about "what you are signing up for including co-pays" was considered helpful.
3. The need to **determine the scope of the health equity problems** for the local community. Participants expressed concern over not knowing exactly what "we are dealing with" in regard to health disparities. The community needs to be accountable for addressing issues that hinder individual growth such as racism, language barriers and lifestyle choices. The **community focus should be on empowering the individual** who will then be strong

enough to help the community. A proactive health stance is needed versus reactionary measures. The group perception is that the current system is not "healthcare but sick care." The group encouraged collaboration among the various ethnic communities so that the community could be better served. This strategy may result in more resources, improved services, enhanced capacity and expanded infrastructure.

Major Resource Needs Identified

1. Primary care physicians
2. Culturally competent practitioners
3. Literacy health specialist/educators
4. Everyday role models of people living healthy lifestyles
5. Community care navigators and knowledge workers links

Major Strategies to Address Resource Needs Included

1. Developing a pipeline of youth into science and technology field
2. Exposing young people to health professions
3. Providing incentives/loan repayment for health professions study
4. Designing electronic medical health records
5. Training on how to collaborate

Major Service Needs Identified

1. Conflict management
2. Non-traditional supportive mental services that can remove stigma
3. Health promotion and preventive health services in schools and workforce settings
4. Low cost/no cost pharmaceutical services
5. More services for single adults who do not have children

Major Strategies To Address Service Needs Included:

1. Conducting a culturally-based community health needs assessment
2. Removing barriers to self-motivation
3. Eliminating institutional racism
4. Empowering consumers

Major Capacity Building Needs Identified

1. Evaluation of current programs to determine if they are effective
2. Improved group collaboration (general and inter-ethnic)
3. Qualified educated, culturally sensitive workforce
4. Better educated and empowered consumers
5. Reduction of unnecessary competition and duplication of services

Major Strategies To Build Capacity Included:

1. Creating a comprehensive database for healthcare services
2. Engaging local vendors for distribution of the healthcare database
3. Placing a PDF of the database on the Ohio Department of Health website
4. Ask the funders to provide information about funded agencies and programs
5. Updating 211 listings to include healthcare services.
6. Establishing a continual quality improvement rating program based on standards.
7. Promoting collaborative efforts among community transportation providers.

Major Strategies To Address Infrastructure Needs Included:

1. Containing the outgrowth of hospitals
2. Coordinating efforts by the healthcare systems
3. Eradicating "classism"
4. Maintaining flexibility with clinical guidelines
5. Paying attention to the individual needs of the patient/consumer

Participants were asked to rate on a scale of 1 to 10 (1 meaning very little and 10 meaning very much) the level of progress that has been made to address identified resource, service, capacity and infrastructure needs. If participants believed that progress had been made toward implementing strategies to address the needs identified, facilitators asked them to report on local efforts that have helped meet those needs.

Community Progress Addressing Needs of the African American Community

Multi-systems Marketing, Health Literacy and Consumer Empowerment: 4/10

On a scale of 1 to 10, participants rated the overall level of progress within the last 5 years to implement multi-systems approaches through marketing, culturally relevant community assessments and health literacy activities at **4 out of 10.** Although great inroads have been made, there is still a lot of work to be done in this area.

There was consensus that the passage and implementation of the Affordable Care Act (ACA) and Medicaid expansion has helped reduce the number of uninsured individuals in Cleveland and Cuyahoga County as well as reduce the use of emergency rooms as the primary source of care and provide appropriate preventative screenings. Pharmaceutical programs at Walgreens and Rite Aid have improved access to low-cost medication and immunizations. The use of Community Health Workers (CHW) has helped to provide critical follow up in addressing chronic health issues in African American communities, but greater expansion will be necessary to effectively impact outcomes. Participants noted that the use of CHW in Cleveland and Cuyahoga County is comparatively less than other areas in Ohio, such as Columbus and Cincinnati. Additionally, there is a need to employ more Health Educators in the field. Participants reported that too often, the health education role is delegated to Program Managers and Social Workers as an activity rather than developed targeted health education programs. Health outcomes can be greatly improved with appropriate follow-up and ongoing health education provided by Health Educators and chronic disease self-management programs.

Participants felt that programs like Susan G. Komen, MomsFirst and the Health Literacy Institute at St. Vincent's Charity Hospital have worked to improve health literacy among targeted populations in the

community. The Healthy Cleveland Guide to Health Insurance was identified as a resource to help navigate insurance benefits. Nevertheless, there needs to be more training for professionals in health literacy and how to insure that developed materials meet the needs of underserved and ethnic populations. Organizations should have a process for making sure educational materials are age appropriate. More effort should be made to provide infographics and story-telling to enhance health literacy efforts. As the aging population grows, special efforts must be made to address health literacy among seniors.

The development and expansion of mobile food pantries and efforts to provide fresh fruits and vegetables at corner store markets have increased consumer potential towards accessing and prepare healthy foods for their families.

Although community partnerships such has the Health Improvement Partnership (HIP-Cuyahoga), Better Health Partnership and the Healthy Cleveland Initiative have done a great deal to improve opportunities for policy development and create opportunities to promote health living, so much more collaboration and community engagement will be necessary to move the needle on health disparities and other pressing local needs such as infant mortality and community violence.

Resource Service Needs: 3/10

On a scale of 1 to 10, participants rated the overall level of progress within the last 5 years to develop a pipeline of youth into science and technology field, exposing young people to health professions, providing incentives and loan repayment for health professions study, design electronic medical health records and train others on collaboration at **3 out of 10.**

Great efforts have evolved over the past 5 years to develop a pipeline into the health professions. Youth Scholar programs at University Hospitals, Cleveland Clinic and MetroHealth and partnership between Cleveland State University (CSU) and Northeast Ohio Medical University (NEOMED) have made great strides in engaging young people to consider local health professions and providing financial and academic incentives to enroll in local medical schools and health programs. The development and expansion of health and science programs within Cleveland Metropolitan School District (CMSD), such as Martin Luther King, Health Careers Louis Stokes, John Hay and charter schools will provide greater opportunities in the future to grow the pool of health professionals who are committed to giving back to Cleveland and the Cuyahoga County region. The Cleveland Regional Inter-Professional Area Health Education Center (CRI-AHEC) housed in the CSU School of Nursing is a promising effort to expand youth engagement into local health professions. The Health Professions Affinity Community (HPAC) program is one of the largest health professions pipeline programs for youth in the country. The program empowers youth to identify health concerns and create community health programs to address them. More time is needed to assess the impact of these programs in Cleveland and Cuyahoga County Participants recommend that programs provide more opportunities for students to engage with community members in real time projects to improve health.

There was consensus that all the hospital systems and most social service agencies providing health related services have implemented electronic health records in their organizations and is no longer an issue. On the other hand, there is still considerable need to provide training opportunities on collaboration and community engagement and to improve the inclusion of community residents and community advocates in assessing need, planning and implementing services.

Service Needs: 6/10

On a scale of 1 to 10, participants rated the level of progress within the last 5 years to conduct a culturally-based community health needs assessment, removing barriers to self-motivation, eliminate institutional racism empower consumers at **6 out of 10.**

Although hospitals and health departments are required by law to conduct community needs assessments, participants agree that data collection and reporting must be communicated to the larger community providing specific data on race and ethnicity. This data is collected but is not always reported in meaningful ways to the community. Participants also agree that needs assessments are generic and do not incorporate aspects of culture in them. Addressing social determinants of health will require a wider group of sectors to focus on health planning. Participants believe that little has been accomplished to eliminate institutional racism; they question whether this can ever be done.

Capacity Needs: 2/10

On a scale of 1 to 10, participants rated the level of progress within the last 5 years to develop and promote an electronic database as a resource for collecting and sharing health information and obtain better information on programs and organizations receiving funding in the community at **2 out of 10**.

Participants reported very little progress in effectively identifying and communicating community resources for health. Although United Way Services includes health resources in the 211 system, there is no single community resource that identifies private and public local health planning efforts, policy development issues, agencies working to reduce chronic health issues, agencies focusing their service efforts on specific target populations, etc. Participants noted that funding sources provide an ongoing listing of the programs that they fund; however, there is very little feedback to the community on the effectiveness of those programs. Participants believe that the Public Health Accreditation Board (PHAB) standards will help the Cleveland Department of Public Health and the Cuyahoga County Board of Health establish and maintain quality improvement standards for their programs and services. Hospitals are required to collect patient satisfaction information. More effort needs to be made to publish this information to the community at large and obtain information on how hospital systems address patient satisfaction and service delivery issues. Additionally, the Medicaid managed care (Care Source, United, Molina and Paramount) companies should share more information to the community around diagnosis, patient experience and quality improvement efforts, including community partnerships to improve services for their enrollees.

With regards to transportation and parking as barriers to access, participants felt that the existing system of providing transportation for patients needs to be revamped. Existing transportation programs offered through the managed care companies and Paratransit are limited; riders are forced to spend many hours beyond their scheduled appointments waiting for pick-up and drop-off. In most cases, parking access is expensive. A few participants believe this is the result of a few companies driving up parking rates in their contracts with hospitals.

Infrastructure Needs: 1/10

On a scale of 1 to 10, participants rated the level of progress within the last 5 years to contain the outgrowth of hospitals, coordinate efforts by the healthcare systems, eradicate classism, maintain

flexibility with clinical guidelines and focus on the individual needs of the patient and consumers **at 1 out of 10.**

Progress on addressing infrastructure needs was the lowest rated area by participants attending the session on African American health needs. Participants reported that the evaluation of existing programs is not working the way that it should. Further, efforts to develop a qualified, culturally competent workforce have been slow with very few metrics reporting on progress with different professional sectors. Organizations, particularly hospitals operate in silos both internally and externally in the community. Turf issues continue to impede progress as it relates to health planning among hospital systems. Continuing efforts must be made to build trust and to partner programmatically on key health initiative. The community has been sluggish in developing a comprehensive health promotion effort that includes all sectors to address the social determinants of health. There has been very little collaboration with the workforce development sector, housing, law enforcement, child welfare and criminal justice. Meaningful conversations about how poverty, safety and environmental issues contribute to health disparities have barely scratched the surface. Improvement of health for persons of color in the region will be contingent upon how well these sectors come together to plan, assess effectiveness and reduce duplication of health services in our communities. Better coordination overall, particularly among hospital systems, is necessary as well as community focused efforts.

With regards to physician/patient communication, participants were opposed to hospitals and clinics having flexible clinical guidelines. They believed that clinical standards should be uniform in healthcare delivery settings. Overall, participants felt that a major systems and policy change would be necessary to allow physicians spend more time with patients during appointments. In fact, they believe more training is necessary for physicians overall in the delivery of culturally competence care as well as utilizing Nurse Practitioners, Health Educators and community-based programs to address minority health needs. Participants also identified a need for an established referral process for follow-up through CHW networks and community chronic disease self-management programs like Evi-Base, Fairhill Community Partners and Friendly Inn.

COMMUNITY STRENGTHS AND OPPORTUNITIES

1. What are the 2-3 most important characteristics of a healthy city and county?
    - Access to food and transportation
    - Employment opportunities
    - Neighborhood ownership, unity relationships
    - Security/safety
    - Education
    - Personal Health

2. What makes you most proud of your city and county?
    - Community is rich in services
    - Community viewed as a leader in the field of HIV
    - Arts/Culture
    - Great restaurants
    - Leading educational institutions

3. What are some specific examples of people or groups working together to improve the health and quality of life in your county and region?

Cleveland Central Promise	Job Corps	Creating Greater Destinies
Neighborhood Connections	Tri-C	Bridges of Hope
Minority Health Alliance	A Vision for Change	Cleveland Foodbank
HIP-C	Sisters of Charity	REACH Programs
Fairhill Community Partners	Healthy Cleveland	Urban Gardeners
FQHCs	Hispanic Health Committee	Community Development Corporations
Care Source	Office of Minority Health	Hospitals

4. What do you believe are the 2-3 most important issues that must be addressed to improve the health and quality of life in your county and region?

- Collaboration barriers need to be overcome to improve health and address, literacy, segregation, education, racism, infrastructure and lead issues.
- Segregation and institutional racism
- Lead
- Food access
- Income and education disparities
- Access to health care
- Obesity and Diabetes management
- Buildings and infrastructure of roads
- Minority business development
- Economic development

5. What do you believe is keeping your county and region from doing what needs to be done to improve health and quality of life?

- Coordination, gathering and aggregation of data
- Lack of transparency
- Willingness to share data and act on it
- Eliminating political agendas, egoism, turf issues and duplication of effort
- Adequate funding to address health issues
- Lack of information/education
- Trust/Abuse of power/Stereotypes
- Lack of vested leadership and key stakeholders who are proponents of health
- Bureaucratic red tape
- Disenfranchised populations and groups
- Too many top-heavy approaches

FORCES OF CHANGE:

1. What recent changes or trends are occurring or are on the horizon that may impact the health of your community?

Election	Institutional Collaboration	Forced ACA coverage
Medicaid Expansion	City/County Collaboration	Health Span closure
Gentrification	Political In-fighting	Minimum Wage Proposal in Cleveland
Outsourced jobs	Gun Violence	Proposed eligibility expansion for breast and
Emerging diseases such as Zika	Lack of Trust of Police	

Growth- new cancer centers	Leadership Development	cervical cancer programs SB3 Ohio 313
Technology	Police Brutality	Growing conversation on addressing social determinants of health
Environment	Segregation	
Project Corridor	Lack of investment	
Demolition of abandoned houses	Environmental Dumping in low-income areas	
Human Rights Violations	RNC- health platform	

2. Of these changes or trends, which are occurring locally? Regionally? Nationally? Globally?

3. What characteristics of your region/pose an opportunity or threat to community's health?

4. What may occur or has occurred that may pose a barrier to achieving the shared vision?

African American Health Concerns

Top Causes of Death for African Americans in 2014

- Heart Disease
- Cancer
- Stroke
- Accidents
- Diabetes
- Chronic Lower Respiratory Disease
- Kidney Disease
- Homicide
- Septicemia
- Alzheimer's

The Health Policy Institute of Ohio reported that African-American/Black Ohioans were much more likely than other racial and ethnic groups to experience poor health outcomes for many of the metrics reviewed, including shorter average life expectancy and a higher infant mortality rate — key indicators of the overall well-being of a population (2016).

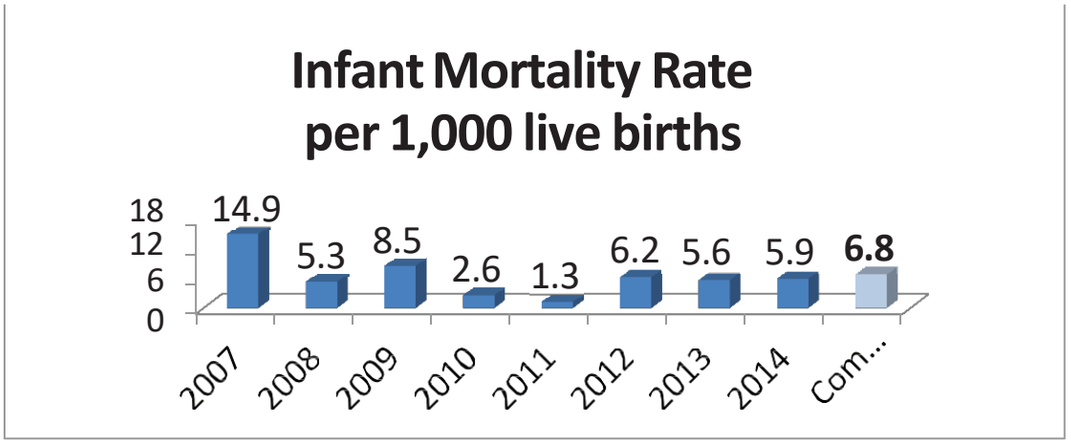
Infant Mortality in Ohio:

Table 1: Ohio Infant Mortality Rate, 2014 (Number of Deaths per 1,000 Live Births)

Group	2013	2014	National Rate (2013)*
All Races	7.4	6.8	6.0
Race			
White	6.0	5.3	5.1
Black	13.8	14.3	11.2
American Indian	**	**	7.6
Asian/Pacific Islander	**	**	4.1
Ethnicity			
Hispanic	8.8	6.2	5.3
Non-Hispanic***	7.3	6.9	6.1

** Most recent national data available, except for 2014 infant mortality rate for all races.*
*** Rates based on fewer than 20 infant deaths are unstable and not reported.*
**** Non-Hispanic births and deaths include those of unknown ethnicity.*

Table 2: Infant Mortality Rates MomsFirst Program 2007-2014



2015 MomsFirst Participants by Neighborhood Served

Neighborhood	*Count*	*Percent of Participants Served*
Unknown	135	7.4%
Brooklyn Centre	32	1.7%
Buckeye - Shaker	67	3.7%
Central	168	9.2%
Clark – Fulton	48	2.6%
Corlett	17	0.9%
Cudell	45	2.5%
Detroit Shoreway	39	2.1%
Downtown	58	3.2%
Edgewater	13	0.7%
Euclid Green	16	0.9%
Fairfax	34	1.9%
Forest Hills	22	1.2%
Glenville	154	8.4%
Goodrich / Kirtland Park	11	0.6%
Hough	141	7.7%
Industrial Valley	1	0.1%
Jefferson	21	1.1%
Kamms Corners	4	0.2%
Kinsman	62	3.4%
Lee – Miles	80	4.4%
Mt. Pleasant	72	3.9%
North Broadway	26	1.4%
North Collinwood	51	2.8%
Ohio City - Near West Side	48	2.6%
Old Brooklyn	26	1.4%
Puritas – Longmead	31	1.7%
Riverside	9	0.5%
South Broadway	59	3.2%
South Collinwood	27	1.5%

St. Clair / Superior	80	4.4%
Stockyards	26	1.4%
Tremont	29	1.6%
Union - Miles Park	53	2.9%
University	2	0.1%
West Blvd.	38	2.1%
Woodland Hills	85	4.6%
Grand Total	**1830**	100.0%

Local data compiled by the Health Improvement Partnership- Cuyahoga County reported that:

- African Americans and Hispanics are three times more likely to live in poverty as Whites
- The unemployment rate for African Americans in Cuyahoga County in 2013 was 21.5% compared to 17.8% among Latinos and 9.6% among Whites
- Youth of color are twice as likely to be obese than their white counterparts
- African Americans have a higher prevalence of HBP and are 4 times more likely to experience complications from HBP than Whites
- The City of Cleveland and inner ring suburbs have the lowest life expectancies.
- In less than a 10-mile radius, some communities experience a 20-year difference in life expectancy

The American Heart Association reported in 2015 that 37% African American men and 57% African American women are obese.

In 2014, the Centers for Disease Control and Prevention reported that 41% African American men and 45% African American were prescribed medication for high blood pressure in the last year.

Among African Americans, the incident rate of asthma is 28% higher than among Whites.

In the African American females, the incidence rate of systemic lupus erythematosus (SLE) is around two to three times greater than White females.

The incident rate of cancer among African Americans is 10% higher than among whites. African Americans and Latinos are also approximately twice as likely to develop diabetes as Whites.

The top 5 Cancer Mortality Rates in the City of Cleveland for African Americans 2009-2013 were as follows:

- Trachea, Bronchus and Lung Cancer – 88.3 per 100,000
- Colorectal Cancer – 27.0 per 100,000
- Pancreas Cancer – 20.0 per 100,000
- Prostate Cancer – 19.6 per 100,000
- Breast Cancer – 18.7 per 100,000

Sources:
Cleveland Department of Public Health Office of Communicable Disease and Epidemiology
Cleveland Department of Public Health MomsFirst Program
News Medical: Life and Sciences in Medicine. Ananya Mandal, MD. *Minority Health Disparities accessed* (2016).
http://www.cdc.gov/healthyyouth/disparities/
http://crchd.cancer.gov/disparities/defined.html
Ohio Department of Health

Top Participant Rated Health Priorities for African Americans

During the session, participants completed a worksheet prioritizing the magnitude of the health problem, severity of the problem and the magnitude as it relates to health disparities. Those priorities, according to disparity and impact, are identified.

	Health Issue	Magnitude of Problem of Health Disparities and Impact on Vulnerable Populations
1	Maternal and Infant Health	9.9
2	Violence	9.7
3	Employment Poverty Income	9.6
4	Nutrition	9.4
5	Tobacco	9.3
6	Education/Family and Social Support	9.2
7	Food Environment	9.1
8	Obesity	9.0
9	Air/Water and Toxic Substances	8.9
10	Mental Health/Access to Dental Care/Active Living Physical Activity/Housing/Sexual Reproductive Health	8.8
11	Access to Behavioral Health Care	8.7
12	Coverage and Affordability of Healthcare	8.6
13	Oral Health	8.5
14	Alcohol and Other Drug Abuse	8.4
15	Access to Healthcare	8.3

Gaps and Recommendations:

- Establish practical community-based programs at convenient times and in convenient locations based on resident input and involvement
- Expand healthy corner store options in the community
- Provide funding to the areas that need the most assistance to improve health equity in the city and county region
- Establish community specific health planning efforts bringing engaging participation from all service sectors, residents, funders, planners and other policymakers
- Assess training needs for healthcare professionals; hospitals will report their efforts to maintain a diverse workforce and how that workforce is educated
- Utilized community health worker programs to assist hospitals in the community for follow up and ongoing care coordination
- Expand health education and community health worker programs in the region
- Expand existing efforts to engage youth into healthcare professions, establishing resource directory of these programs and reporting on their efforts in a way that the community will understand
- Improve efforts to access healthcare disparity data among African Americans locally
- Continue to pursue federal funding to address community health disparities
- Expand nutrition education and healthy eating programs across the City

- Identify organizations working on childhood obesity to assess if needs are being met
- Establish referral mechanisms between hospitals and community-based agencies that work on disease specific health issues for ongoing patient education and support
- Include cultural competence as part of the funding protocol for health specific agencies
- Healthcare organizations should establish a plan/set of recommendations to demonstrate the relationship between health outcomes and social determinants of health and how each sector might contribute to improving health equity in our region
- Improve organizational collaboration

Asian American Workgroup

Community Progress Addressing Needs of the Asian American Community

Reducing Stereotypes – Improving Community Resources
Progress Made: 3/10

Participants report that there have been stereotypes about the Asian community that continue to thwart their ability to seek and obtain resources. Although there is still great concern about misperceptions and stereotyping about income, education and literacy about Asian American communities, some progress has been made establishing resources in the community including:

- The establishment of the International Community Health Center, ASIA-ICHC, which opened in 2013, has served over 1000 patients. Asia Inc. will open a second office this year to accommodate the growth of the immigrant community in Akron.
- Expanded interpretation and translation services provided to the Greater Cleveland community through Asia Inc. The Interpretation and Translation Department has a language capacity of over 55 ethnic dialects.
- Increased diversity in the Cleveland Asian Festival has improved awareness of the Asian community in Greater Cleveland.
- Availability of the U.S. Department of Agriculture's *My Plate* in several Asian languages including Chinese (simplified and traditional), Filipino-Tagalog, Hindi, Indonesian, Italian, Japanese, Korean, Malay, Pashto, Thai, Urdu, and Vietnamese.
- The U.S. Census questionnaire now includes more Asian ethnic groups.

Develop a pipeline to increase the number Asian American health care professionals to work in their communities.

Progress made – 0/10

Participants report Asian communities have varying levels of educational attainment. High school and college completion is not the norm among Asian communities. For example, the SE Asian community has low high school and college retention. While there has been some outreach, it has

been varied. Different outreach strategies are necessary for different Asian communities. Aggregation of school data disallows the opportunity to develop culturally specific outreach strategies.

Service providers should improve their awareness of Asian American communities and make the Asian American communities more aware of available, existing resources.
Progress made – 8/10

Improvements to raise the awareness of Asian American communities among the general population over the past 5 years include:

- The Cleveland State University Music Festival
- Dragon Dance Team
- One World Day
- Night Market
- Animal Statue placement to celebrate Chinese New Year
- Continued development of Asia Town
- Asian Heritage Month
- Work with International Students

Participants note that there is a lack of acceptance of bi-racial Asians and some level of targeted outreach needs to be extended to this group.

Use of best practices – Building health focused service capacity of Asian American organizations
Progress made – 6/10

Despite the great success in opening a federally qualified health center (FQHC) and its expansion in Akron this year, much more needs to be done, since the International Health Center is the first of its kind in the Midwest. More needs to be done with refugee health screening. Over the past five years, many Asian Americans have traveled to New York, Chicago and Minnesota for Hepatitis B treatment. Participants reported that there is a need for more widespread use of the FQHC.

Using schools as a source of advancing cultural diversity
Progress made: 4/10

Participants reported that there needs to be more improvement in translating books and learning resources for Asian American youth. Participants realize that this may not even be possible to serve all groups within the Asian American culture. Overall, school curriculum needs to include Asian history and languages. Many second-generation Asians do not speak their own languages. Using Solon High School as an example, participants report that the school has a high Asian population, but Asian/Pacific Islander studies is not part of general education classes at the high school level. The development and expansion of afterschool programming could be utilized to help bridge the cultural gap and to improve civic engagement.

Additional resources for health data are needed for the Asian American population. Current data sources group all Asian American ethnic groups.
Progress made: 4/10

Through the Ohio Asian Advisory Council, the Ohio Asian Health Coalition and the CDC Raise Summit and the St. Clair/Superior Community Development Corporation, there have been efforts to collect and report data about the health status of Asian Americans. However, participants note data and funding are related. By law, health organizations must collect health data on ethnic groups; yet, they do not necessarily share this information with the groups impacted. Current reporting is done to satisfy funder requirements. Consumers are not made aware of the data. There is a need for infographics to

be shared with the community. There is potential to develop a local data sharing hub to collect and report on key health data for planning and program development.

Develop local leadership development to assist in building community capacity and accessing funding and other resources.
Progress made: No rating

Governors Strickland and Kasich developed efforts to develop and maintain groups discussing the needs of the Asian community at the state and federal levels. The Asian Council was convened and provided quarterly updates; however, there were some barriers translating the data and information collected and reporting it back to counties. There were additional barriers translating data for each ethnic group represented on the Council.

SERVICE NEEDS:

More health services in the Asian community along with patient navigators.
Progress Made: 7/10

With funding from the Ohio Association of Food Banks and support from the Asian American Health Coalition and Jobs and Family Services (JFS), the local community enrolled 900 Asian community members in health insurance plans. There was much less success in getting Medicaid and Medicare materials translated, but some written information was made available as it relates to immigration and eligibility. Participants remain concerned about the reach of these programs into the Asian American community but look forward to the development of video projects to assist in this process.

There is a need for more culturally competent services.
There is a need for acculturation services to assist new immigrants and refugees with adjusting to the community while retaining their own cultural identity
Progress made: No rating

Participants report that there has been some improvement in this area through the Refugee Collaborative comprised of local refugee service organizations and resettlement partnerships who work together to address the needs of the refugee population. Although case workers are provided through the refugee service programs, they are not able to provide all of the services that are needed by the population.

Participants also report that providers are not inclusive of consumers in the planning and delivery of services; they still think they know what is best. Training is needed to help providers get to a place of cultural humility. Participants note that there are no identified incentives to change.

CAPACITY NEEDS:

The need for data reporting to the Asian community and more professional translators and interpreters in multiple languages and increased awareness of effective and best practices and public visibility were identified as capacity needs for the Asian Community.

Progress Made: 6/10

Much of this effort has been done through the establishment and expansion of the International Health Center. Continuing and expanding upon the current effort will be necessary to meet the capacity needs of the Asian American community.

INFRASTRUCTURE NEEDS:

There is a need for professional schools that have a mandatory diversity curriculum. Asian American students need to be sensitized to giving back to their communities by providing health care services either paid or as volunteers. Northeast Ohio needs to retain Asian American graduates.

Progress made: No rating

There has been some improvement with these efforts through the Cleveland State University/NEOMED Partnership, the Area Health Education Centers and programs at local hospitals, such as University Hospitals. A mechanism for reporting needs to be developed to keep the community aware of the progress of such efforts.

COMMUNITY STRENGTHS AND OPPORTUNITIES

What are the 2-3 most important characteristics of a healthy city and county?

- Access to care
- Preservation of culture

What makes you most proud of your city and county?

- Local funders see and understand needs related to diversity
- Local business support
- Asia Town
- Social service world
- Connectedness – big city, but small-town connections
- City brings resources
- Collaboration

What are some specific examples of people or groups working together to improve the health and quality of life in your county and region?

- Health Improvement Partnership
- YMCA
- Refugee Collaborative
- Better Health Partnership
- Strong academic research base in Cleveland
- CDC Reach grants – of the 49 across the country, 3 are in Cleveland

What do you believe are the 2-3 most important issues that must be addressed to improve the health and quality of life in your county and region?

- Jobs
- Housing
- Safety
- Partnerships on data collection and reporting

- Policy

5. What do you believe is keeping your county and region from doing what needs to be done to improve health and quality of life?

- Coordination, gathering and aggregation of data
- Lack of transparency
- Willingness to share data and act on it

FORCES OF CHANGE:

1. What recent changes or trends are occurring or are on the horizon that may impact the health of your community?

2. Of these changes or trends, which are occurring locally? Regionally? Nationally? Globally?

3. What characteristics of your region or state may pose an opportunity or threat to your community's health?

4. What may occur or has occurred that may pose a barrier to achieving the shared vision?

    - Election year
    - Racism
    - Fear and rules about Immigration (undocumented)
    - Community safety – Police/Community relations
    - Hepatitis B breakouts
    - The ISIS Phenomenon and its effects on the Arab American population

COMMUNITY GAPS:

Gap #1- Language and cultural translators

- Increase the number of interpreters and translators available in the community
- Increase the types of languages available for translation and interpretation
- Increase the amount of health literature that is appropriate in the community

Gap #2- Community needs more data on its health status across ethnic groups

- Offer more community forums to share health information
- Invite more diverse groups to participate in information forums
- Disseminate (perhaps to grocery stores) information on health trends

Gap #3- Generational Barriers

- Include parents in all strategies
- Solicit parents' input in all planning and activities in the community
- Encourage the elimination of intracultural stereotypes, such as beliefs about employment and education within some Asian American communities

Gap #4- Lack of nutritionists and dieticians who are aware of Asian American nutrition and cooking practices.

- Develop core of culturally competent professionals to address this issue
- Expand healthy cooking classes within programming in the community

Gap #5- Lack of safe spaces for physical activity

- Create new partnerships that will expand opportunities for healthy activities within programs and in the community

Asian American Health Concerns

According to the Centers for Disease Control and Prevention (CDC), the 10 leading causes of death for Asian Americans or Pacific Islanders in 2010 were:

Cancer
Heart Disease
Stroke
Unintentional injuries
Diabetes
Influenza and Pneumonia
Chronic Lower Respiratory Diseases
Nephritis, Nephrotic Syndrome, & Nephrosis (Kidney Disease)
Alzheimer's
Suicide

It is important to note that Asian American communities are heterogeneous; it is difficult to approximate primary health concerns for a general Asian American population. Health concerns are better identified and addressed by cultural group because many Asian American populations do not utilize mainstream sources. Some of the following concerns were identified by participants and highlighted in the 2016 RAISE Summit presented by Asian Services in Action:

- Hepatitis B remains a concern for Asian immigrant and African populations
- Obesity is identified as the primary cause of mortality in the Asian American community
- Heart disease
- 7% of Asian American/Native Hawaiian/Pacific Islanders currently have Type 2 Diabetes. The percentage is higher among Cambodians (22%) and Asian
- Extremely high rates of cancer; Asian Americans are 3-13 times more likely to die of liver cancer than their White counterparts.
- Over 50% of Burmese and Bhutan refugees who re-settle in urban areas is at high risk for developing Type 2 Diabetes.
- Vietnamese women are 5 times more likely to develop cervical cancer
- PTSD and other trauma issues impacting Asian American refugees including suicide
- Domestic violence is an issue in some Asian American communities
- Seasonal affective disorder impacting some groups within the Asian community

In 2015, the CDC reported that 7% of Asian Americans reported having fair to poor health in 2015. 15 percent of men 18 years and 5% of women (2012-2014) reported current tobacco use (CDC, 2012-2014)

Latino American Workgroup

Community Progress Addressing Needs of the Latino American Community

In the 2010 Community Conversation, the group focusing on African American health needs reported that more community-wide conversations about health and health disparities were needed as a strategy for building awareness and engaging the community. Participants believed that there has been "mal-distribution" of resources in the community and that this has led to a perceived mistrust of the medical system. There was a deep concern about the ability for Latinos to access the available resources and to receive adequate care by knowledgeable bilingual healthcare /social workers. Participants also did not believe that when their community expressed a need or wanted to resolve an issue the larger community actively listened to them. The group identified several resource needs, including more effective outreach strategies, and the identification and implementation of best practices in health programs. They also saw a need for a needs assessment to better understand Latino health needs because current data is not comprehensive nor is appropriately sampled.

Overview of the Day:

The Latino conversation included service providers, community advocates, churches, youth and residents. During the morning session, healthcare and social service providers met to discuss progress made on issues identified in the 2010 session. Additionally, youth were present to participate in the discussion and complete survey information about their concerns. Resource, service, capacity and infrastructure needs identified, and the rates of progress achieved the past five years are outlined below.

Major Resource Needs
Progress Made: 6/10

1. Effective strategies for outreach
2. Improved access to information about best practices
3. Better needs assessment/data on health needs of Latinos

Major strategies for resource needs

1. Fostering more networking opportunities for Hispanics/Latinos
2. Establishing a community-wide Hispanic/Latino Health Committee
3. Using community members to do outreach
4. Conducting needs assessments that will provide better data on Latino health needs

Major Service Needs
Progress Made: 6/10

1. Services for undocumented residents
2. Sexual health education/prevention of HIV/STDs
3. More primary care services
4. More mental health and substance abuse services

Major strategies for service needs

1. Building awareness of available Services by going to gathering places like the grocery stores, barber shops and churches
2. Offering more health fairs
3. Creating a directory of services/resources that is in Spanish and English
4. Training people in the community to be advocates
5. Educating physicians on the Hispanic/Latino culture

Major Capacity Needs
Progress made: 6/10

1. Employ Health advocates to help patients navigate the health system
2. Increase in interpretation services
3. More Latino/bilingual physicians
4. Better collaboration and coordination of efforts
5. Latino workforce development in healthcare

Major strategies for capacity needs

1. Creating youth mentoring programs that will lead to a better qualified workforce
2. Rewarding competence in health professionals
3. Organizing Latin physicians in Cleveland
4. Offering incentives for bilingual/Latin professionals to stay in Cleveland
5. Providing staff training and education in cultural sensitivity/awareness
6. Providing trainings for medical students to work with Latino patients

Major infrastructure needs

Progress Made: 5/10

1. Greater capacity for primary medical care and mental health services
2. Comprehensive services for behavioral and physical health
3. Spanish-speaking medical homes
4. Board development and greater participation of Latinos in leadership roles
5. Funding

Major strategies for infrastructure needs

1. Developing mobile programs that go into the community
2. Identifying funding to expand transportation services
3. Providing diversity trainings to service providers/workers
4. Creating Spanish web-based materials for the computer literate
5. Designing materials with basic literacy levels in mind

Youth Capacity and Infrastructure

Progress Made: 4/10
1. Training for youth on understanding the healthcare system

2. Engaging youth in program and service planning

3. Building relationships between youth and agencies to address policy issues

Overall, service providers reported that there are many organizations within the community who assist in coordinating and providing services to the Latino community, especially with the health care providers. Nevertheless, a higher level of cooperation and coordination is needed in order to provide effective services. Additionally, a much higher level of effort must be made to develop a culturally competent workforce to help reduce the chronic health conditions that are rampant within the community. There is so much more needed from hospitals and health centers in the area of data collection and reporting. Developing a plan to serve and provide assistance for undocumented persons is an area that has been largely unaddressed. This needs to be addressed among service leaders in the community.

The Hispanic Nurses Association and Latino Medical Student Association can coordinate with hospitals and health centers to provide needed training to professional in the community who need ongoing cultural competency training. As far as youth engagement is concerned, hospital systems must keep working to engage youth people into the health sciences by expanding their existing programs. Esperanza is doing a great job working with youth. They must continue involving them in community planning activities. Political leaders (Hispanic Roundtable- Hispanic Business Center) and funders must work to help communities address food desert issues.

Top Health Priorities for Latino Americans

Health and Social Service Providers

	Health Issue	Magnitude of Problem of Health Disparities and Impact on Vulnerable Populations
1	Mental Health/Access to Behavioral Health Care	9.5
2	Employment Poverty & Income	9.4
3	Obesity	9.3
4	Diabetes	9.0
5	Alcohol and Other Drug Abuse	8.9
6	Housing/Cancer	8.7
7	Education/Family Social Support	8.6
8	Health Care Coverage and Affordability	8.5
9	Cardiovascular Disease/Access to Healthcare	8.4
10	Food Environment	8.3
11	Tobacco/Physical Activity/Transportation/Active Living	8.0
12	Maternal and Infant Health	7.9
13	Violence	7.8
14	Sexual and Reproductive Health/Access to Dental Care	7.7
15	Oral Health/Respiratory Disease	7.6

The afternoon session targeted residents and community advocates. The discussion was facilitated in Spanish for persons whose primary language is Spanish. Bi-lingual participants completed a written survey of the questions presented in the group session.

Resident and Community Advocate Survey Questions:

Name (Optional)
Ethnicity: Please selectone

Hispanic/Not Hispanic
Gender at Birth:
Race:
Age:
Zip Code:
Primary Language Spoken in the Home:
Second Language Spoken in the Home:

Resident Questions:

1. In your opinion, what are the primary (top five) health problems in the Latino community?
2. How would you prioritize them from most important (5) to least important (1)
3. How well do you understand the health information given to you by hospitals and service organizations in your community? Circle One
    - I understand all of the health information given to me
    - I understand most of the health information given to me
    - I understand some of the health information given to me
    - I understand a little of the health information given to me
    - I do not understand any of the health information given to me

4. What can agencies and health organizations do to get you involved in the programs and services offered/provided by their organizations?

5. Do you have a primary care physician or family physician that takes care of your health needs?

6. If not, what keeps Latino/your family from accessing basic health care? Or if you and your family are not going to the doctor, what keeps you from going?

7. Are you currently having transportation issues that keep you and your family from going to the doctor?
8. How far from your home do you travel to receive health care services?
9. What kind of healthcare services have you received in the past year?
10. Was there a service that you needed but did not receive in the past year? If yes, why?

11. What services are needed in your community but are not available?

12. Where do you access your services?

    - Hospital/primary care physician
    - Health center or free clinic
    - Urgent care center
    - Emergency room

13. If more services were made available in your neighborhood, would you access them?
    a. Why?
    b. Why not?
14. What organizations in the community do you trust?
15. Do you have health insurance?
16. Has the Affordable Health Care Act helped you or your family access health care services?

Leading Causes of Death for Hispanics in 2013

- Cancer
- Heart Disease
- Accidents (unintentional injuries)
- Stroke
- Diabetes mellitus
- Chronic liver disease and cirrhosis
- Chronic lower respiratory diseases
- Alzheimer's disease
- Influenza and pneumonia
- Kidney Disease: Nephritis, nephrotic syndrome and nephrosis
- Intentional self-harm (suicide) / Assault (homicide)

Respondent/Group Participant Findings:

Race/Ethnicity: 98% of survey respondents identified as Hispanic/Latino. Ethnicities represented included Puerto Rican, Dominican and Peruvian.

Gender: 70% of survey respondents were female; 23% male and 7% unknown.

Age: 36% of respondents were 12-18 years of age; 18% were 19-24 years of age; 21% were 35-53 years of age; and 21% were 54-75 years of age and 4% unknown.

Health Literacy: 18% of survey respondents reported understanding **all** of the health information; 18% reported understanding **most** of the health information given to them by hospitals, clinics and social service providers; 11% reported understanding **some** of the health information distributed and 11% reported understanding **a little of** the health information presented to them by hospitals, clinics and other service providers. 42% did not respond to the question.

In the group session 24% of participants reported understanding **all** health information presented to them; 43% reported understanding **most** information and 33% reported understanding **some** of the health information presented to them.

Engagement: When asked what providers could do to get residents more involved in their programming, the responses ranged from "nothing" to answers such as collecting more community health information; providing workshops, scheduling health fairs and educational events at more convenient times; promote events better; provide more events at churches, in homes and community centers.

Organizational Trust: Survey respondents identified 16 agencies that they trust in the community and group participants identified 14 agencies that they trust. Their responses included the following:

SURVEY RESPONDENT	GROUP PARTICIPANTS
Care Source	Alpha Y Omega Church
Cleveland Clinic	Boys and Girls Clubs
Cleveland Department of Public Health	El Barrio
CDPH Lead Program	Esperanza
Churches	Hispanic Alliance

Department of Aging	Impact Church
El Barrio	Inglesia Nueva Vida Church
Elim Church	Job and Family Services
Hispanic Alliance	La Sagrada Familia Church
Job and Family Services	Murtis Taylor
Lutheran Hospital	NFP
MetroHealth	St. Michael's Church
Neighborhood Family Practice (NFP)	Salvation Army
None (2)	Schools
Schools	
Social Security Administration	

Primary Care Physician: 64% of survey respondents reported having a primary care physician (PCP); 11% reported not having a PCP and 25% did not respond. 84% of group respondents reported having a PCP; 16% did not have a PCP.

Barriers to Access: Respondents and group participants reported the following barriers that impacted their access to healthcare services: (1) Expenses; (2) No reason to go; (3) Transportation; (4) Language barriers; (5) Lack of Accessibility; (6) Lack of Education; (7) Fear; (8) Limited Healthcare; (9) Lack of Compassion; (10) Services Not Impactful.

Services Received in the Past Year:

Participants report receiving the following services in the past year:

- Annual check-up physical or dentist
- Eye doctor
- Treatment for: Lupus, pancreatitis
- Diabetes Education
- Nutrition Education

Services Needed But Not Received:

- Mental Health Services
- Bilingual Mental Health Services
- Women's Services
- Places for Physical Activity
- Better/More health information

Location of Services Received: Most respondents reported receiving services at the hospital or PCP office; health center or free clinic. Several reported receiving care from an ER or Urgent Care.

Health Insurance: 68% of respondents reported having health insurance; 7% did not have health insurance; 25% did not respond to the question.

Transportation: 20% identified transportation as a barrier to accessing healthcare; 80% did not identify transportation as a barrier to accessing healthcare.

Travel Time to Access Health Care:

- 60% of respondents reported traveling 5-10 minutes to access a hospital or doctor
- 10% of respondents reported traveling "very far" to access healthcare
- 10% reported traveling 10-15 minutes to access healthcare
- 10% reported traveling one-half mile to access healthcare

- 10% reported traveling 5 miles or more to access healthcare

Affordable Care Act:

- 50% reported that the ACA was beneficial to them
- 50% reported ACA was problematic for them

Top Health Priorities for Latino Americans

Residents & Community Advocates

Access	Child Abuse	Homelessness
Arthritis	Diet	Migraine
Asthma	Heart Disease	Stress
Air Pollution	HIV	Vertigo
Cancer	Senior Care	Pregnancy
Child Abuse	Transportation	Hypertension
Cholesterol	Thyroid	Alzheimer's
Diabetes	Osteoporosis	Mental Health
Depression	Infection	Infant Mortality
Drug Addiction	Lupus	Medication
Epilepsy	Obesity	Food
Fibromyalgia	Kidney Disease	

Conditions Most Frequently Mentioned:

- Diabetes
- Depression/Mental Health
- Cancer
- Obesity
- HIV

Community Strengths & Opportunities

1. What do you believe are the 2-3 most important characteristics of a healthy city/county? What makes you most proud of your city and county?
    - Access to healthcare
    - Access to healthy food
    - Good physical and mental health
    - Good jobs and Education
    - Safety
2. What are some specific examples of people or groups working together to improve the health and quality of life in your city and county?
    - Nueva Luz
    - Hispanic Alliance
    - Neighborhood Family Practice
    - Cleveland Clinic

3. What do you believe are the 2-3 most important issues that must be addressed to improve the health and quality of life for minority populations in your city and county?

- Addressing access to services for undocumented persons
- Providing bi-lingual services and healthcare professionals
- Better planning and coordination with community-based agencies

4. What do you believe is keeping your county and region from doing what needs to be done to improve health and quality of life?

- Politics
- Lack of appropriate funding for programs and services
- Incomplete data about health information

Forces of Change:

1. What recent changes/trends are occurring or are on the horizon that may impact on the health of your community?

- Upcoming elections
- Tax levies
- Health policies impacting Medicaid

2. Of these changes or trends, which are occurring locally? Regionally? Nationally? Globally?

- These changes are occurring regionally and nationally

3. What characteristics of your region may pose an opportunity/threat to community health?

- Poor health habits
- Economic and social conditions that are harmful

4. Whatmay occur or has occurred that may pose a barrier to achieving the shared vision?

- Uncertain that there is a shared vision about health locally or regionally.

Gaps and Recommendations:

- Convene regular, ongoing conversations about health issues and health policy
- Clarify role of HIP-C and Healthy Cleveland in local planning efforts
- Improve level of engagement of MetroHealth with the community
- Develop and implement more effective screening and community education events
- Utilize Hispanic Alliance to coordinate health efforts for the Latino community in conjunction with other community leaders
- Engage the Northeast Ohio Association of Hispanic Health (NOAHH) to develop/expand training efforts on community advocacy;

- Identify funding to reduce waiting lists for behavioral health treatment.

- Include legal aid as a part of patient advocacy efforts;

- minority populations; ongoing turnover has disrupted traction and engagement in the community;
- Provide more health screening in schools and treatment facilities.
- Develop, maintain and update regularly a bilingual directory of healthcare and social services in the Latino community;
- Work with MetroHealth to provide bilingual resource directory of programs and services;
- Provide more school-based services tracking and reporting efforts to the community;
- Establish a plan to collect/report health data to the community in an understandable way;
- stablish more bilingual programs to address chronic health conditions;
- Provide more healthy community activities;
- Market programs through Facebook, Twitter, Snapchat;
- Establish culturally specific/relevant programs in churches to engage the community;
- Provide hospital/ health clinic orientation sessions in Spanish;
- Improve communication around health education and health policy in the community

Participating Agencies

American Sickle Cell Anemia Association
Ana Velez – Metro Health Medical Center
Asian Services Inc.
CareAlliance
Care Source
Carmella Rose Health Foundation
Center for Community Solutions
Center Point Program – Cleveland Department of Public Health
Children's Hunger Alliance
City of Cleveland Community Relations Board
Cleveland City Council Ward 14
Cleveland Clinic
Cleveland Department of Public Health
Cleveland Dialysis Center (CDC)
Cleveland MOTTEP
Cleveland Office of Minority Health
Cleveland Rape Crisis Center
Cleveland Regional Perinatal Network

Community Advocate
Cuyahoga County Board of Developmental Disabilities
Cuyahoga County Office of Health and Human Services
Diana Dela Rosa – Cleveland Clinic
Early Childhood Options
Environmental Health Watch
Foundation Center
Healthy Cleveland Initiative
Hispanic Alliance
Horizon Education Centers
LifeBanc
Ludy Sanchez – Resident
Marixa Romero – Metro Health Medical Center
MetroHealth Medical Center
MomsFirst City of Cleveland
Monica Olivera – Alzheimer's Association
Monica Starks Foundation
Molina Healthcare
Murtis Taylor
Nueva Luz Urban Resource Center
Ohio Asian American Health Coalition
Ohio Commission on Minority Health
Ohio Latino Affairs Commission
Paramount Advantage
Prevention Research Center CWRU
PTL Development Corporation
Seven Streams Consulting
St. Vincent Charity Hospital
Stockyard Development
Susan G. Komen Northeast Ohio
The Centers
University Hospitals of Greater Cleveland
US Bank
Vision of Change
VNA Ohio Hospice
YDH Consulting
UHCAN Ohio

Cleveland Office of Minority Health

Community Conversations 2016 Participant Listing

June 29, 2016 – Trinity Commons

Avril Albaugh – Cleveland Regional Perinatal Network
Nick Albaugh – Cleveland Office of Minority Health Intern
Gena Austen-Bau – Care Alliance
Gloria Sutton Blevins – Early Childhood Options
Sonya Callahan, Cleveland MOTTEP
Emily Campbell – Center for Community Solutions
Delores Collins – Vision of Change
Ashley Choi – Asian Services Inc.
Sara Continenza – PTL Development Corporation
Victoria Davis – MomsFirst City of Cleveland
Simmie Davis – COMH Advisory Board Seven Streams Consulting
Yvonne Drake – Care Source
Maleka Embry – REACH Community Fellow Prevention Research Center CWRU
Delores Gray – Care Alliance
Gregory Hall – Ohio Commission on Minority Health
Yolanda Hamilton – LifeBanc YDH Consulting
Erika Hood – REACH Active Living Strategy Coordinator Prevention Research Center
Sadie Jackson - Kathy Rothenberg-James – Cleveland Department of Public Health
Scheretta Jeffries – Molina Healthcare
Linda Kimble – Cleveland MOTTEP
Cathy Kopinsky – St. Vincent Charity Hospital
Tara Lett – Murtis Taylor
Mildred Lowe – Community Advocate
Mark McClain – COMH Advisory Board Community Advocate
Briana McIntosh – Prevention Research Center
Frances Mills – Cleveland Office of Minority Health
Queen Moss – St. Vincent Charity Hospital
Yvonne Oliver – UHCAN Ohio
Petrina Patterson – University Hospitals of Greater Cleveland
Lisa Persico – Susan G. Komen Northeast Ohio
Andrea Martemus Peters – MetroHealth Medical Center
MacKenzie Phillips – Cleveland Regional Perinatal Network
Sabrina Roberts – Cuyahoga County Office of Healthand Human Services
Manju Sakarappa – Ohio Asian American Health Coalition
Candace Smith – Paramount Advantage
Monica Starks – Monica Starks Foundation
Teleange Thomas – Foundation Center
Lauren Trohman – Cleveland Department of Public Health
Cathy Vue – Asian Services Inc.
Megan Walsh – MomsFirst – City of Cleveland
Sandra Wood – Cleveland Department of Public Health

June 30, 2016, Community Conversation – Hispanic Alliance

Hilda Abreu - Stockyard Development
Nicolas Albaugh – Office of Minority Health Intern
Maria Atala – CDC
Esperanza Barrillas – Resident
Waleska Berrios – Resident
Racheal Batista – Cuyahoga County Board of Developmental Disabilities
Keyriam Casiano – Youth
Darreh – Youth
Betzaida Cruz – Resident
Brian Cummins – Councilman City of Cleveland Ward 14
Michelle DelToro - Cleveland Clinic
Margarita Diaz – MetroHealth Medical Center
Iua Fernandez – Resident
Marilyn Gesing – Cleveland Clinic
Angela Green – US Bank
David Gretick – Center Point Program – Cleveland Department of Public Health
Kim Foreman - Environmental Health Watch
Janice Gonzalez – Cleveland Clinic
Merle Gordon – Cleveland Department of Public Health
Diana Gueits – Cleveland Clinic
Dora Harper – VNA Ohio Hospice
Marisa Herran – MetroHealth Medical Center
Astrid Hernandez
Millie Hernandez – Resident
Keyla – Resident
Kathy Rothenberg-James – Cleveland Department of Public Health
Joseph– Youth
Katherine– Youth
Awilda Lugo – Resident
Lair Marin Marcum – Ohio Latino Affairs Commission
Kelly Malcolm – Children's Hunger Alliance
Frances Mills – Cleveland Office of Minority Health
Neyshali– Youth
Sonia Matis – Hispanic Alliance
Francisco Medina – Resident
Ida Mendez – Nueva Luz Urban Resource Center
Mildred Maldonado
Juan Molina Crespo – Hispanic Alliance
Eduardo Munoz – Metro Health
Carmen Negron – Resident
Lourdes Negron – Metro Health
Lisa Nunn – Horizon Education Centers
Monica Olivera – Alzheimer's Association
Luz Oyola – MetroHealth Cancer Center
Ginny Pate – Carmella Rose Health Foundation
Ruth Sudilovsky-Pecha – Cleveland Rape Crisis Center

Gil Pena – American Sickle Cell Anemia Association
Kebin – Youth
Erika– Youth
Maria Ritchie – Care Source
Kim Rodas – Nueva Luz Urban Resource Center
Gricelis– Youth
Charlivette Ocasio Rivera – Resident
Constancia Rivera – Resident
Marcelina Rivera – Resident
Lisa Roman – City of Cleveland Community Relations Board
Marixa Romero – Metro Health Medical Center
Diana Dela Rosa – Cleveland Clinic
Ludy Sanchez – Resident
Jasmine Santana – Hispanic Alliance
Rachael Sommer – Healthy Cleveland Initiative
Patricia Sparza – Metro Health Medical Center
Mayrim– Youth
Patricia Tousel – MetroHealth Center
Dharma Valentin – The Centers
Ana Velez – Metro Health Medical Center
Jeanette Velez – Lutheran Hospital
Jennifer Vazquez – Resident
Ana Vazquez – Resident
Maria Vazquez – Resident
Emily Warren – MetroHealth Medical Center
Sandra Wood – City of Cleveland
Community Residents 22

Cleveland Office of Minority Health Advisory Board

Francis Afram Gyening, Care Alliance
Katrice Cain, Center for Reducing Health Disparities
Emily Campbell, Center for Community Solutions
Eugenia Cash, Cleveland Metropolitan School District
Ashley Choi, Asia Inc.
Britt Conroy MD, Case Western Reserve University
Mittie Davis-Jones, COMH Evaluator Simmie
Davis, Seven Stream Consulting Maleka
Embry, Prevention Research Center Valerie
Evans, Rising Above
Reverend Tonya Fields, New Freedom Ministries
Giselle Greene, MD, Sisters of Charity Health System
Diana Gueits, Cleveland Clinic Foundation
Erika Hood, Prevention Research Center
Pamela Hubbard, Golden Ciphers
Bruce Kafer, Louis Stokes Veterans Administration
Cathy Kopinsky, St. Vincent's Charity Hospital

Margaret Larkins-Pettigrew, MD University Hospitals Cleveland
Mark McClain, Community Advocate
Ben Miladin, United Way Services of Cleveland
Reverend Dr. Tony Minor, Community of Faith Assembly
Charles Modlin, MD Cleveland Clinic Foundation
Lissette Piepenburg, University Hospitals Jean
Polster, Neighborhood Family Practice Reverend
James Quincy III, Lee Road Baptist Church Nelson
Ramirez, Hispanic UMADAOP
Reverend Max Rodas, Nueva Luz Resource Center
Kim Sanders, NEON
Muqit Sabur, Community Advocate
Jasmin Santana, Hispanic Alliance
Candace Smith, Paramount Advantage
Rachel Sommer, Health Cleveland Initiative
Heather Torok, St. Luke's Foundation
Cathy Vue, Asia Inc.
Megan Walsh, MomsFirst Program
Mary Warr, ADAMHS Board Cuyahoga County

Cleveland Office of Minority Health Staff

Frances Mills, Director

The National Partnership for Action to End Health Disparities

Spearheaded by the Office of Minority Health, the National Partnership for Action to End Health Disparities (NPA) was established to mobilize a national, comprehensive, community-driven, and sustained approach to combating health disparities and to move the nation forward in achieving health equity. Through a series of Community Voices and Regional Conversations meetings, NPA sought input from community leaders and representatives from professional, business, government, and academic sectors to establish the priorities and goals for national action. The result is the *National Stakeholder Strategy for Achieving Health Equity*, a roadmap that provides a common set of goals and objectives for eliminating health disparities through cooperative and strategic actions of stakeholders around the country.

Concurrent with the NPA process, federal agencies coordinated governmental health disparity reduction planning through a Federal Interagency Health Equity Team, including representatives of the Department of Health and Human Services (HHS) and eleven other cabinet-level departments. The resulting product is the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*, launched simultaneously with the NPA *National Stakeholder Strategy y* in 2011. The HHS plan outlines goals, strategies, and actions. HHS will take to reduce health disparities among racial and ethnic minorities.

Ohio's Response to the NPA

In support of the NPA, the Ohio Commission on Minority Health (OCMH), an autonomous state agency created in 1987 to address health disparities and improve the health of minority

populations in Ohio, sponsored a statewide initiative to help guide health equity efforts at the local and state levels.

In Phase I of this initiative, OCMH sponsored a series of nineteen Local Conversations on Minority Health throughout the state. The purpose of these gatherings was to carry out

community-wide discussions on local health disparities in which health needs could be identified and prioritized from the community's perspective, and strategies could be generated toward local action plans to address minority health needs. Sixteen of the Local Conversations were geographically-based and were held in the state's large and small urban regions. In addition, three statewide ethnic health coalitions convened ethnic-specific Local Conversations for Latino, Asian American, and Native American groups which brought in representatives from these populations across the state.

In Phase II, the Local Conversations communities continued broad-based dialogues on health disparities and refined their local action plans. The Cleveland Health Disparity Reduction Plan in this document is a result of this process. The lead agency for the Local Conversations in Cleveland was the Cleveland Office of Minority Health.

Cleveland Office of Minority Health
INFORM • EDUCATE • EMPOWER

CDPH
Cleveland Department of Public Health

Cleveland Office of Minority Health

The Cleveland Office of Minority Health (COMH) was established in 2007 as a division of the Cleveland Department of Public Health. COMH is a project of the Ohio Commission of Minority Health which makes efforts to eliminate health disparities through innovative strategies focused on four core competencies to:

- Monitor and report the health status of minority populations
- Inform, educate, and empower people
- Mobilize community partnerships and action
- Develop policies and plans to support health efforts

The vision of the COMH is to achieve equal health status for all of Cleveland's racial/ethnic population groups.

The COMH seeks to serve as a clearing-house for the coordination of community health efforts and information targeting Cleveland's African American/Black, Asian American /Pacific Islander, Hispanic/ Latino, and Native American populations. The office works with public and private partners to improve the effectiveness and efficiency of health initiatives through collaborative efforts.

Cleveland Demographics

Diverse racial/ethnic groups constitute most of the Cleveland's population. Cleveland is the largest city in Cuyahoga County and the second largest city in the State of Ohio. According to the 2000 Census, there were approximately 444,313 residents in Cleveland. The demographic breakdown of Cleveland is:

182,168	(41%)	White/Caucasian
226,599	(51%)	Black/African American
5,776	(1.3%)	Asian American /Pacific Islander
32,434	(7.3%)	Hispanic/Latino
1,332	(0.3%)	American Indian/ Alaska Native
9,774	(2.2%)	Two or more races

Cuyahoga County Demographics

Persons of color represent almost one-third of the total population of Cuyahoga County. Cuyahoga County is the most populous county in Ohio and Cleveland is the county seat.

According to the U.S. Census Bureau, there were 1,275,709 residents in Cuyahoga County in 2009.

The racial/ethnic composition of Cuyahoga County is:

850,089	(66.7%)	White/ Caucasian
373,782	(29.3%)	Black/African American
3,827	(0.3%)	Asian American /Pacific Islander
30,617	(2.4%)	Hispanic/Latino
1,275	(0.1%)	American Indian/ Alaska Native

Cleveland, Ohio Socioeconomic Indicators

Cleveland's racial/ethnic populations fare worse than their Caucasian peers on a number of socioeconomic indicators that have an impact on health. The overall poverty rate in Cleveland was 26.3% in 2000, with particularly high rates for children (38%), due in part to the high number of female-headed households in the city. The greatest concentration

of poverty is found on the city's east and near west sides, where many of the city's Hispanic and African-American residents live. According to a Brookings Institute report on the status of large metropolitan regions in the country, Cleveland had the second highest Hispanic and African-American poverty rates of the 23 target cities included in the study (http://www.brookings.edu/metro/StateOfMetroAmerica.aspx). In addition, a total of 26.4% of African-Americans aged 18-64 in the city were uninsured. Lack of insurance or being underinsured has been found to be a risk factor for decreased access to high quality care, delays in seeking care, and a low priority placed on preventive care

Health Disparities in Cleveland

The Cleveland Office of Minority Health has encountered many barriers locating local data on health disparities. The lack of data on health disparities that impact racial and ethnic communities is a clear indicator of the work that must be done. Health information on Cuyahoga County was easily located but data specific to the minority populations in Cleveland were difficult to find. The lack of data has been problematic to community-based organizations that are working to apply for grants on a local level. The COMH has begun working with community partners on strategies that will allow for greater access and use of local data. Currently available data indicate that people of color residing in Cleveland face significant health disparities.

Overall Health

Overall, African Americans were 1.77 times more likely to report being in fair or poor health than Caucasians (21.2.1% compared to 12.0%).

HIV/AIDS Prevalence in Cleveland

As of June 1, 2010, there were 4,176 people diagnosed with HIV living in Cuyahoga County. Of these, 2,963 (71%) people were Cleveland residents and 54.4%, or 1,615 of them had AIDS. Nearly 60% of AIDS patients were African American, 24% were Caucasian non-Hispanic, 12% were Hispanic, and less than 1% was of other race. Three in four (74%) were male. People with HIV-only were younger, with about 16% being 30 years of age and younger. Eighty-five percent of individuals with AIDS were aged

40 and older.

Infant Mortality

Cleveland's 2007 Infant Mortality Rate was 15.9 deaths/1,000 live births. However, the disparity ratio was 1.5 (12.8 deaths/1,000 live births for Caucasian babies compared to 19.2 deaths/1,000 live births for African American babies) meaning that African American infants were 50% more likely to die before reaching their first birthday than Caucasian infants. This pattern was also similar for low birth weight and very low birth weights.

Obesity

A study of obesity in Cleveland conducted between 1999 and 2007 found that females were more likely to be obese than males and that African American and Hispanic children were more likely to be obese than Caucasian children. The rate of obesity among adults in Cleveland was 33% in 2006—higher than the national (25.1%) and state averages (28.4%). Between 2005 and 2006, the obesity rate among African Americans was 42% or 17.6% higher than the rate among Caucasians (24.4%).

Cancer

The 2004 death rate from breast cancer for African American women in Cuyahoga County was 30.1% above the Ohio and U.S. rates. According to the 2007 Big Cities Health Inventory Report, Cleveland ranked #5 among the largest 54 cities in the United States for both cancer mortality and female breast cancer mortality rates based on 2004 data.

Diabetes

Diabetes was the 8th leading cause of death in Cleveland in 2002, accounting for 3.2% of all deaths. The mortality rate from diabetes in Ohio for African American males was 64.9 per 100,000 compared to 32.8 per 100,000 for Caucasian males. Unemployed people were twice as likely to have been diagnosed with diabetes as those that were employed full-time (14.6% versus 6.6%).

Tobacco Use:

In Cleveland, 29.7% of African-American/ Blacks were smokers.

Sources of demographic and health data:

Diabetes Association of Greater Cleveland, http://www.dagc.org/diastatsohio.asp

Cleveland's Local Conversations on Minority Health

First Local Conversation on Minority Health: Tuesday, October 7, 2008

The first Local Conversation on Minority Health was attended by more than 300 participants, including strong representation from the diverse racial/ethnic groups in the city (African Americans, 80%; Asian American, 3%; and Hispanic/Latino, 10%). Attendees at this event worked to identify needs in the community affecting minorities. For the discussions, breakout sessions were divided into racial and ethnic groups representing African American/Black, Hispanic/Latino, and Asian American/ Pacific Islander. Because their needs and perspectives are unique, a separate group was held for youth. Each group included a facilitator and a scribe who helped the groups to identify and reach consensus on the top needs and strategies to address the needs.

African American

Approach

The African American group stressed the need to employ a multi-system approach to address the needs of the African American community as well as the other minority communities. A comprehensive marketing campaign that reflects the diversity of the community should be used to frame the approach. This approach would include understanding the culture aspects of the communities to be served as the basis for the coordination of a community wide health/social services needs assessment.

Individuals/Consumers

The African American group believed that consumers need to take ownership for their health destinies. Although individuals have been exposed to barriers such as institutionalized racism and discrimination, any health paradigm should include a component of individual responsibility. To further this concept, the health literacy of consumers needs to be raised. Health literacy would include translating medical jargon into understandable terms

and describing healthcare plans in layman terms. Succinct information about "what you are signing up for including co-pays" would also be considered helpful.

Participants also spoke of internalized self-hate that generates external consequences as seen with reckless behaviors resulting
illness. Participants stated that "loving oneself" and "recreating life deliberately" are crucial to healthy lifestyles. Restoration of individuals as well as communities was discussed. To initiate the restorative process, individuals need to experience self-love in order to heal
their own communities.

Community Stakeholders (service providers, health systems and funders)

The scale of the health equity problem needs to be determined for local communities. Participants expressed concern over not knowing exactly what "we are dealing with" regarding health disparities. The community needs to be accountable for addressing issues that hinder individual growth such as racism, language barriers and lifestyle choices. The community focus should be on empowering the individual who will then be strong enough to help the community. A proactive health stance is needed versus reactionary measures. The group perception is that the current system is not "healthcare but sick care."

The group encouraged collaboration among the various ethnic communities so that the community could be better served. This strategy may result in more resources, improved services, enhanced capacity and expanded infrastructure.

Major resource needs

1. Primary care physicians
2. Culturally competent practitioners
3. Literacy health specialist/educators
4. Everyday role models of people living healthy lifestyles
5. Community care navigators and knowledge workers links

Major strategies for resource needs

1. Developing a pipeline of youth into science and technology fields
2. Exposing young people to health professions
3. Providing incentives/loan repayments for health professions study
4. Designing electronic medical health records
5. Training on how to collaborate

Major service needs

1. Conflict management
2. Non-traditional supportive mental services that can remove stigma
3. Health promotion and preventive health services in schools and workforce settings
4. Low cost/no cost pharmaceutical services
5. More services for single adults who do not have children

Major strategies for service needs

1. Conducting a culturally-based community health needs assessment
2. Removing barriers to self-motivation
3. Eliminating institutional racism
4. Empowering consumers

Major capacity building needs

1. Evaluation of current programs to determine if they are effective
2. Improved group collaboration (general and inter-ethnic)

3. Qualified educated, culturally sensitive workforce
4. Better educated and empowered consumers
5. Reduction of unnecessary
6. competition and duplication of services

Major strategies for capacity building

1. Creating a comprehensive database for healthcare services
2. Engaging local vendors for
3. distribution of the healthcare database
4. Placing a PDF printable version of the healthcare database on the Ohio Department of Health website
5. Involving the funding community to access information about who and what types of programs they are funding
6. Updating 211 listings to include healthcare
7. Establishing a continual quality improvement/quality rating program based on standards
8. Promoting collaborative efforts among community transportation providers

Major strategies for infrastructure needs

1. Containing the outgrowth of hospitals
2. Coordinating efforts by the healthcare systems
3. Eradicating "classism"
4. Maintaining flexibility with clinical guidelines
5. Paying attention to the individual needs of the patient/consumer

Asian American /Pacific Islander Resource Needs

The participants were very concerned about stereotypes that inhibit their ability to seek resources, e.g., "the Asian American community is wealthy, all are educated and literate, they are the model minority." The group challenged the community to gain a better knowledge and awareness of the Asian American culture by visiting and talking with their leaders. Participants stressed that the Asian American community is not homogeneous but consists of various cultures/ethnic groups that speak different languages and dialects. There is a general misunderstanding that if materials are translated into Mandarin or Cantonese the language issue is resolved.

The group believed that a pipeline to increase Asian American healthcare professionals need to be developed. Individuals need to be recruited at an early age to explore health careers. This would address the need for additional representation as well as engaging Asian Americans to work within their communities when they receive health-related educational degrees.

The Asian American group highly recommended that service providers broaden their awareness of the Asian American communities and that Asian American communities be made more aware of available existing resources. They wanted to see an increase in the use of best practices but noted that all best practice strategies do not transfer to all minority communities. For example, the strategy of targeting African Americans through barber shops and hair salons does not work for Asian Americans. A better strategy would be to reach out to them via grocery stores or ethnic-specific food markets.

Although there are a few service providers address Asian American health concerns, these organizations will need to build capacity to continue existence. The group agreed that an Asian American center needs to be created. The facility would serve as a community focal point for all

Asian American communities as well as a conduit and link for service providers. The center would have culturally competent staff aware of the Asian American community needs and would be able to address those needs through appropriately translated materials, resources and services.

The group believes that schools should be a major resource for furthering cultural diversity. A heritage/cultural curriculum highlighting the Asian American

experience should be developed. Other cultural groups should be prominently added to the school curriculum. Awareness of other ethnic groups through the school setting may help foster an understanding and/or appreciation for other cultures.

The group would like to see more resources for health data for the Asian American population. Current local data lack breadth. Most data sources include all Asian American ethnic groups together, reflecting a lack of understanding that each group is diverse and has its share of unique health issues. Other resource needs were identified. The group felt strongly about the need for leadership development to assist in building community capacity and in accessing funding and other resources.

Major resource needs

1. A stronger Asian American health professional pipeline
2. Awareness of Asian American communities by service providers
3. A "one stop" Asian American facility/ center
4. Asian American culture curriculum for schools
5. More health data resources for Asian American sub-populations

Major strategies for resource needs

1. Developing a local leadership program
2. Targeting public relations for specific programs for youth and Southeast Asian American populations
3. Working with the statewide Asian American Health Coalition and other partners
4. Being inclusive, planning with all populations in mind, and inviting all organizations to the table
5. Going to Asian American
6. communities and talking to their leaders to learn about the culture

Service Needs

The participants expressed a need for more health services in Asian American communities. There is a need for patient navigators. The concept of health disparities is not understood by everyone. This concept goes beyond personal health and impacts the

community. Participants believed that a grass roots approach is needed within communities to help individuals gain a better understanding. Patient navigators could help individuals navigate the health system and connect to other needed services already available to the community. There is an overarching concern that Asian Americans—particularly those dealing with health insurance like Medicare—do not know the intricacies of the system. Within the community, there is a lack of knowledge as to where to find services. This problem is compounded by the fact that awareness materials and information sessions are usually offered only in English.

Culturally competent services need to be increased. Serving an ethnic group does not make a service culturally competent. There needs to be some basic knowledge

of the culture and customs. Culturally competent staff need to be available and bilingual staff to provide quality translation. Awareness needs to go beyond one culture within an ethnic group. The Asian American community consists of many cultures. There is a misconception that Asian American only means Chinese.

Most current health education materials are made available only in Mandarin or Cantonese. Health education resources need to be made available in the multiple languages and dialects spoken in Asian American communities. There is also a need for acculturation services to assist new immigrants/refugees with adjusting to the community while retaining their own ethnic/cultural identity.

Major service needs

1. Patient navigators
2. Culturally competent services expansion
3. Increased awareness of available resources
4. Education about healthcare issues particularly health insurance

Major strategies to address service needs

1. Motivating existing service providers to serve the Asian American community
2. Educating service providers and foundations about Asian American community service needs
3. Promoting partnerships and working together
4. Advocating and creating policies that help Asian American communities

Capacity needs

The needs of the Asian American community should be identified as a foundation for building agency capacity to address those needs. The results of a recent community wide needs assessment were not disseminated to the Asian American community. Asian American service providers want and need community health assessment information to use in making a case for support with local funders.

More professional translators and interpreters in various languages and dialects are needed within the healthcare system. The myth that being fluent in a particular language automatically creates a qualified translator or interpreter needs to be debunked.

Increased awareness is needed of best practices/effective practices that could be replicated in the Asian American community around healthcare. Currently service providers may not be familiar with healthcare practices that may have been successful with Asian American populations in other geographic areas.

Public visibility was also seen as a critical need for building capacity. The Asian American community has not made its needs known and this creates a challenge when seeking funding or other resources. In addition there is a sense that community stakeholders have not assisted with making the Asian American community more visible.

Major capacity needs

1. A community wide assessment to identify Asian American health needs
2. Access to translation and
3. interpretation of languages and dialects by healthcare staff
4. Best practices that are relevant to Cleveland Asian American community
5. Enhanced public visibility of Asian American health issues

Major capacity strategies

1. Identifying best practices relevant to the Asian American community and implementing them
2. Implementing a community assessment using surveys and focus groups
3. Understanding the pitfalls of sampling methods for small populations
4. Building relationships with funders
5. Networking with and gaining support from other community groups
6. Providing translation and interpretation training to increase the pool of qualified translators and interpreters

Infrastructure Needs

Though interpreters and translators may be fluent in the language, this does not mean that they are familiar with the aspects of culture and health. Organizations that provide social services may have translators, however, the translators are not necessarily familiar with aspects of healthcare. Training needs to be provided for healthcare workers, outreach workers to teach them about health and culture.

Participants agreed that professional schools like medical and nursing schools should have a mandatory diversity curriculum. In addition to this curriculum, Asian American students need to be sensitized to giving back to their communities by providing healthcare services either paid or as volunteers. Northeast Ohio, in particular, needs to develop strategies to retain Asian American graduates.

Because transportation to health services seems to be an issue for some Asian American communities, a mobile clinic providing medical care would be helpful in some communities for getting consumers to healthcare providers.

Major infrastructure needs

1. Increased knowledge about the relationship between cultural, environmental, socioeconomic and psychological factors and health issues for interpreters and translators
2. Diversity training in professional schools and the desire to give back to the community
3. Mobile clinics to reach Asian American communities
4. Increased transportation options

Major strategies for infrastructure needs

1. Providing training to provide training on health and culture for educational and other organizations
2. Introducing a mandatory diversity curriculum to medical schools.
3. Seeking funding for mobile clinic or work with an existing service provider to expand services to the Asian American community
4. Developing more transportation options/alternatives especially to reach the medical facilities

Hispanic/Latino Resource Needs

The Latino group reached consensus is that more community-wide conversations about health and health disparities are needed as a strategy for building awareness and engaging the community.

Participants believed that there is a “maldistribution” of resources in the community and that this has led to a perceived mistrust of the medical system. There is a deep concern about the ability for Latinos to access the available resources and to receive adequate care by knowledgeable bilingual healthcare /social workers. Participants also did not believe that when their community expresses a

need or wants to resolve an issue that the larger community actively listens to them.

The group identified several resource needs, including more effective outreach strategies, and the identification and implementation of best practices in health programs. They also saw a need to improve understanding of Latino health needs through a needs assessment. Their perception was that currently available data is not comprehensive or appropriately sampled.

Major resource needs

1. Effective strategies for outreach
2. Improved access to information about best practices
3. Better needs assessment/data on health needs of Latinos

Major strategies for resource needs

1. Fostering more networking opportunities for Hispanics/Latinos
2. Establishing a community-wide Hispanic/Latino Health Committee
3. Using community members to do outreach
4. Conducting needs assessments that will provide better data on Latino health needs

Service needs

The Latino groupconversation centered on strengthening the service delivery system to the Latino community by improving communication strategies, creating links between the consumer and the services, providing qualified bilingual workers and simply connecting individuals with the services they are seeking.

The participants identified primary care services as a significant need for the Latino community including sexual health education such as prevention of HIV and STDs is needed. More prenatal, mental health and substance abuse services are also needed in the Latino communities. Healthcare and health education services should be developed for undocumented residents. Early childhood intervention services should be made available in a format and language that the families can understand.

Major service needs

1. Services for undocumented residents
2. Sexual health education/prevention of HIV/STDs
3. More primary care services
4. More mental health and substance abuse services

Major strategies for service needs

1. Building awareness of available services by going to gathering places like the grocery stores, barber shops and churches
2. Offering more health fairs
3. Creating a directory of services/ resources that is in Spanish and English
4. Training people in the community to be advocates
5. Educating physicians on the Hispanic/ Latino culture

Capacity needs

Throughout all categories the group continuously expressed the need for culturally sensitive and bilingual workers in healthcare settings. The group believed that consumers are not able to navigate the healthcare system and health advocates/patient navigators are needed to assist with understanding and to access the system so that consumer health needs can be met. Supportive services like interpretation were seen as a way to build overall capacity to fully access healthcare. However, consumer literacy

abilities need to be understood when materials are translated or interpretation is performed. Literacy levels in both Spanish and English need to be taken into account when translating and interpreting materials.

While progress is being made as far as recruitment of Latino individuals into healthcare fields, they have not kept pace with needs; Latino physicians who can fluently speak and understand Spanish and English are especially needed. Collaboration and coordination of efforts/services needs to be strengthened. In general, the healthcare industry needs to employ more Latinos throughout the entire system/network.

In addition to these top five, other capacity building areas were discussed like providing medical students with the opportunity to directly work with the Latino population through the local hospitals. The healthcare facilities that serve Latinopopulations need to be more inviting and to reflect the consumers' culture. It was also stressed that physicians in general are not spending enough time with their Latino patients. This could be attributed to the unfamiliarity with the Latino culture or simply a behavior that permeates the medical environment.

Major capacity needs

1. Health advocates to help patients navigate the health system
2. Increase in interpretation services
3. More Latino/bilingual physicians
4. Better collaboration and coordination of efforts
5. Latino workforce development in healthcare

Major strategies for capacity needs

1. Creating youth mentoring programs that will lead to a better qualified workforce
2. Rewarding competence in health professionals
3. Organizing Latin physicians in Cleveland
4. Offering incentives for bilingual/ Latin professionals to stay in Cleveland
5. Providing staff training and education in cultural sensitivity/awareness
6. Providing trainings for medical students to work with Latino patients

Infrastructure needs

The infrastructure could be easily enhanced by considering extended services hours, creating appropriate material distribution points and building facilities closer to public transportation.

Several items were identified as key to building infrastructure within the Latino community. The capacity to deliver culturally competent medical services would enrich the overall infrastructure. Developing comprehensive behavioral and physical health services were seen as crucial components of adequate infrastructure. The community is fostering the concept of electronic medical records as well as encouraging consumers to have medical homes. However, the medical homes and electronic venues do not appear to be bilingual. Medical homes accommodating various languages will need to be designed and made available to consumers. Participants identified the need to have more Latino representation on local boards of directors particularly health systems. In addition, leadership development needs to be provided for

emerging community leaders. Ultimately, "dinero" is needed to identify, design and implement infrastructure strategies.

Major infrastructure needs

1. Greater capacity for primary medical care and mental health services
2. Comprehensive services for behavioral and physical health
3. Spanish-speaking medical homes
4. Board development and greater participation of Latinos in leadership roles
5. Funding/dinero

Major strategies for infrastructure needs

1. Developing mobile programs that go into the community
2. Identifying funding to expand transportation services
3. Providing diversity trainings to service providers/workers
4. Creating Spanish web-based materials for the computer literate
5. Designing materials with basic literacy levels in mind

Special Category/Youth

Youth and non-youth service providers identified the need for resources, services, capacity building, and infrastructure from their unique perspective.

Resources and Services

1. Health screenings in schools
2. Health education in schools
3. Better access to healthcare resources
4. Educating the community on free or low-cost health resources
5. Holistic approach to healthcare for youth related to mental health and substance abuse

Capacity and Infrastructure

1. Training for youth on understanding the healthcare system
2. Engaging youth in program and service planning
3. Building relationships between youth and agencies to address policy issues

During the first Local Conversation, the Cleveland Office of Minority Health collaborated with a number of hospitals, foundations, radio, television, print media and community agencies.

Collaborating Agencies

University Hospitals Case Medical Center

Cleveland Clinic

MetroHealth Medical Center Partnership to Fight Chronic Disease Sisters of Charity Foundation of Cleveland

Community Partners

Cleveland Branch NAACP

100 Black Men of Cleveland

Urban League of Greater Cleveland Policy Bridge

Neighborhood Family Practice

Northeast Ohio Neighborhood Health Services (NEON)

Care Alliance Health Centers

American Cancer Society

Diabetes Association of Greater Cleveland

Partnership to Fight Chronic Disease

Kidney Foundation of Ohio, Inc.

Center for Reducing Health Disparities

Nueva Luz

Asian American Services in Action

Proyecto Luz

Cuyahoga County Community Mental Health Board

Hispanic Alliance

Better Health of Greater Cleveland

Ohio State University Extension

Children's Defense Fund of Ohio

Minority Health Alliance

Children's Hunger Alliance

Center for Health Promotion Research Case Western Reserve University

Rx Home Healthcare

Center for Community Solutions

Harvard Community Services Center

Boyd & Son Funeral Home

Economic Union Consortium of Greater Cleveland

Neighborhood Connections

Neighborhood Leadership Institute

Cuyahoga County Board of Health

United Church of Christ

United Pastors in Mission

Ohio Asian American Health Coalition

Firm Foundations II

Council of Economic Opportunities of Greater Cleveland

Retired Seniors Volunteer Program

WOIO 19/43

Hospice and Palliative Care Partners of Ohio

Cleveland State University College of Urban Affairs

Zumba Fitness

Radio One

Call & Post

City News

El Sol

Erie Chinese Journal

Cleveland Medical Association

The Gathering Place

Cleveland Council of Black Nurses

Second Local Conversation on Minority Health: Monday, December 14, 2010

Second local conversation on minority health: Cleveland Office of Minority Health Priority Setting Session

The purpose of the Phase II Priority Setting Session was to develop a beginning action plan to select priority health needs in Cleveland. A total of 15 persons took part in the discussion. The group consisted of individuals who represented racial and ethnic community members, community agencies, hospitals, government, academia and youth focused groups. The goal of the second local conversation was to set priorities based on the original format of resource, service, capacity, and infrastructure needs and the results are summarized below.

I. RESOURCE NEEDS

A. A comprehensive assessment of health needs (which includes access to physical and mental health services) for Cuyahoga County to include the following demographics: zip code, age, gender, race/ethnicity, insurance status, Medicare status, disability status per Social Security, and primary language spoken.

B. Literacy health specialists/ educators – more individuals trained as health educators with specialization in both general literacy (outreach to low-literacy populations) and health literacy for all.

C. Community care navigators and knowledge worker links – a network of trained community-based persons who can navigate individuals with health needs to available resources.

II. SERVICE NEEDS

A. Primary care services for medical, dental, and vision care.

B. Education – offering education on healthcare issues including health insurance, prevention, mental health, and advocacy (from grassroots to treetops).

C. Low cost/no cost pharmaceutical services – educating the community about resources for and lobbying for increased access to low cost/no cost pharmaceutical services.

III. CAPACITY NEEDS

A. Evaluation of the effectiveness of current programs targeting the top five diseases disproportionately affecting minorities in Cuyahoga County and determining and disseminating best practices in these five disease areas.

B. Collaboration and coordination – increase cross-cultural collaborations and coordination of efforts to reduce health disparities in Cuyahoga County.

C. Enhanced public visibility of ethnic health issues.

IV. INFRASTRUCTURE NEEDS

A. Funding – utilizing COMH to learn/understand fundamental funding resources available to organizations to provide education and community programs.

B. Coordinated efforts by the healthcare systems – coordinated efforts of all agencies in the sectors where we live, work, and play to eliminate health disparities.

C. Transportation – identifying transportation options and resources related to each community's specific needs.

At the conclusion of the second Local Conversation on Minority Health, the group determined that we need to make sure that the strategies could be addressed and accomplished by the Cleveland Office of Minority Health given the broad scope of the discussion.

COMH Advisory Committee

The Local Conversations on Minority Health would not have been possible without the commitment and hard work from the Office of Minority Health Advisory Board Members. This dedicated group of people assists the Office of Minority Health by offering guidance and through the sharing of their experiences.

Tanyanika Phillips Towe, MD MPH, University Hospitals Case Medical Center

Sujata Burgess, MPA, CHES, Asian American Services in Action

Cheri Collier RN, LD, RD, MS, MBA, MetroHealth Center for Community Health

Pamela Cooper, St John's AME Church

Hermione Malone, University Hospitals Ireland Cancer Center

Linda Dove McIntyre BSN, Northcoast Nurses Coalition

Gary Benjamin, UHCAN Ohio

Carla Harwell, MD, University Hospitals Otis Moss Medical Center

Felicia Adams MPH, MetroHealth Center for Reducing Health Disparities

Jacquelyn Adams, Huron Hospital Glinda

Dames-Fincher, Kindred Spirits Megan E.

Dzurec, MPH, CHES, Center for Community Solutions

Sabrina Roberts, Cuyahoga County

Stanley Miller, Cleveland Branch NAACP

Jonathan Holifield, Urban League of Greater Cleveland

Kristina Austin, The Gathering Place

Max Rodas, Proyecto Luz

Andres Gonzalez, Cleveland Clinic

Michael Byun, Asian American Services in Action Inc.

Mark Batson, PolicyBridge

Charles Modlin, MD., Cleveland Clinic Minority Men's Health Center

Gregory Hall, MD., St Vincent Charity Hospital

Janet Minor, Ohio State University Extension

Debra Mardenborough White, Visiting Nurse Association

Yvonka M Hall, Cleveland Health Department, Office of Minority Health

Jacqueline Meeks, Council for Economic Opportunities of Greater Cleveland

Jean Therrien, Neighborhood Family Practice

Frances Afram Gyening, Care Alliance

Matthew Carroll, Cleveland Department of Public Health

Karen Butler, Cleveland Department of Public Health

Bruce Kafer, Veteran's Administration

Rena Minor, Cleveland Rape Crisis Center

The accomplishments of the Cleveland Office of Minority Health would not have been possible without the continued work and support of the program evaluator, Dr. Mittie Davis Jones.

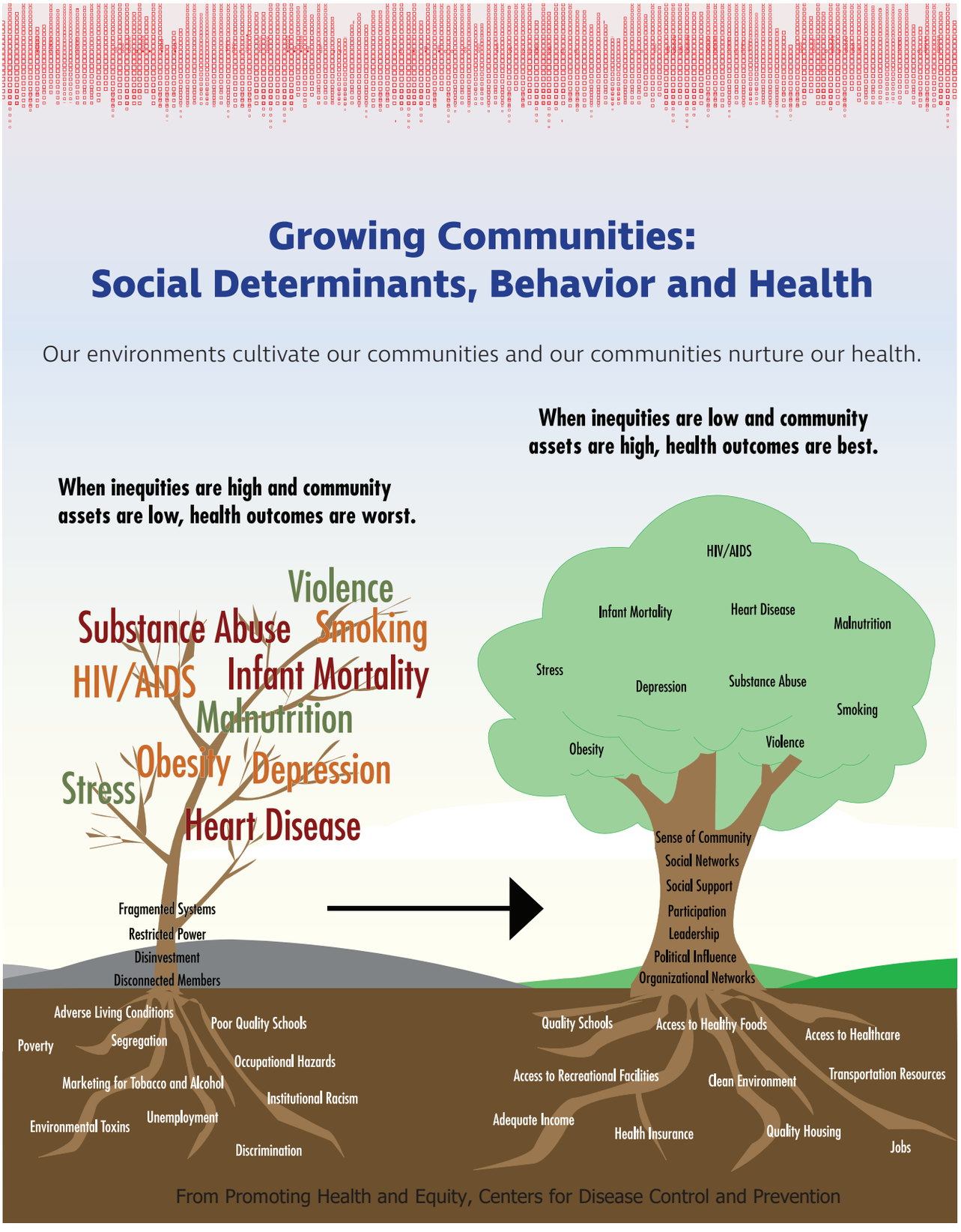
The Cleveland Office of Minority Health staff:

Yvonka M. Hall, Cleveland Office of Minority Health Director

Commission on Minority Health

Growing Communities: Social Determinants, Behavior and Health

Our environments cultivate our communities and our communities nurture our health.

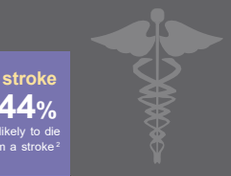


From Promoting Health and Equity, Centers for Disease Control and Prevention

African American Health Inequities Compared to Non-Hispanic Whites

Racial and ethnic health inequities are undermining our communities and our health system. African Americans are more likely to suffer from certain health conditions, and they are more likely to get sicker, have serious complications, and even die from them. These are some of the more common health inequities that affect African Americans in the United States compared to non-Hispanic whites.

AFRICAN AMERICAN HEALTH INEQUITIES: ADULTS



stroke
44%
more likely to die from a stroke [2]

asthma
20%
more likely to have asthma [1]
x3
as likely to die from asthma [1]

breast cancer
40%
more likely to die from breast cancer [2]

heart disease
25%
more likely to die from heart disease [2]

cervical cancer
52%
more likely to die from cervical cancer [2]

obesity
23%
more likely to be obese [5]

prostate cancer
x2
as likely to die from prostate cancer [2]

maternal mortality
x3
as likely to die from a pregnancy-related complication [4]

HIV
x8
as likely to be diagnosed with HIV [3]
x9
as likely to die from HIV [2]

diabetes
72%
more likely to be diabetic [6]

AFRICAN AMERICAN HEALTH Inequities: CHILDREN

Compared to non-Hispanic white children, African American children are more likely to suffer from the following:

infant mortality
x2.5
as likely to die as infants [2]

SIDS
x2
as likely to die of Sudden Infant Death Syndrome (SIDS) [2]

asthma
x2
as likely to have asthma [1]

obesity
56%
more likely to be obese [5]

depression
61%
more likely to attempt suicide as a high-schooler [7]

How do we reduce racial and ethnic health inequities? We must work together to improve our health care system to make it high-quality, comprehensive, affordable, and accessible for everyone.

FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

HEALTH EQUITY ACTION
FOR SYSTEM TRANSFORMATION
AT FAMILIESUSA

January 2019

Asian American, Native Hawaiian, & Pacific Islander Health Inequities Compared to Non-Hispanic Whites

Racial and ethnic health inequities are undermining our communities and our entire health care system. Asian Americans (AAs) and Native Hawaiians and Pacific Islanders (NHPIs) experience significant health inequities that are often inadequately reported or not reported at all. AAs and NHPIs are the fastest growing racial groups in the nation, and one of the most diverse, tracing their heritage to more than 50 different countries. Yet data on the AA and NHPI population is lumped together, masking the distinct health needs within AA and NHPI populations. In this infographic, we compare the health outcomes of non-Hispanic whites with that of AA and NHPIs, with disaggregated data where available.

ASIAN AMERICAN, NATIVE HAWAIIAN, & PACIFIC ISLANDER HEALTH INEQUITIES: ADULTS

Stomach Cancer

Women

76% more likely to develop stomach cancer (Asian and Pacific Islanders)[2]

x2.6 as likely to die from stomach cancer (Asian and Pacific Islanders)[3]

Men

53% more likely to develop stomach cancer (Asian and Pacific Islanders)[2]

x2 as likely to die from stomach cancer (Asian and Pacific Islanders)[3]

Obesity

76% more likely to be obese (Native Hawaiian and other Pacific Islanders)[6]

Pre-natal care

47% more likely to receive late or no prenatal care (Chinese Americans)[1]

x2 as likely to receive late or no prenatal care (Hawaiian and part Hawaiian)[1]

Hepatitis

68% more likely to contract hepatitis A (Asian and Pacific Islanders)[5]

x18 as likely to contract chronic hepatitis B (Asian and Pacific Islanders)[5]

Tuberculosis*

x5 as likely to contract tuberculosis (Asian Americans)[4]

x16 as likely to contract tuberculosis (Native Hawaiian and Pacific Islanders)[4]

*Among U.S.-born persons

Diabetes

76% more likely to be diabetic (Native Hawaiian and Pacific Islanders)[2]

51% more likely to be diabetic (Asian-Indian Americans)[7]

50% more likely to develop end-stage renal disease (Asian Americans)[8]

Liver Cancer

Women

72% more likely to develop liver and IBD cancer (Asian and Pacific Islanders)[2]

47% more likely to die from liver and IBD cancer (Asian and Pacific Islanders)[3]

*IBD = Intrahepatic Bile Duct Cancer

Men

66% more likely to develop liver and IBD cancer (Asian and Pacific Islanders)[2]

58% more likely to die from liver and IBD cancer (Asian and Pacific Islanders)[3]

*IBD = Intrahepatic Bile Duct Cancer

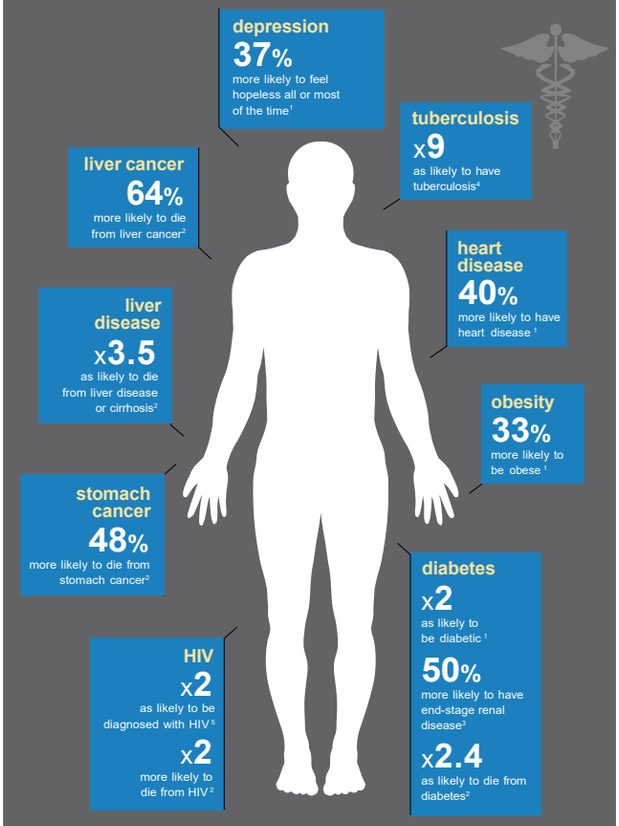
Our common prosperity demands a health system where everyone can attain the best possible health and health care. The roots of health and health care inequities are many, and they run deep in American society--from environmental factors, to living conditions, to lack of access to care, to discrimination, to name just a few. Nevertheless, we can, and must work together to eliminate them to ensure a better future for all.

FAMILIESUSA THE VOICE FOR HEALTH CARE CONSUMERS | HEALTH EQUITY ACTION FOR SYSTEM TRANSFORMATION | A FAMILIESUSA PROJECT | APIAHF ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

American Indian & Alaska Native Health Inequities Compared to Non-Hispanic Whites

Racial and ethnic health inequities are undermining our communities and our health system. American Indians and Alaska Natives are more likely to suffer from certain health conditions, and they are more likely to get sicker, have serious complications, and even die from them. These are some of the more common health inequities that affect American Indians and Alaska Natives in the United States compared to non-Hispanic whites.

AMERICAN INDIAN & ALASKA NATIVE HEALTH INEQUITIES: ADULTS



depression
37%
more likely to feel hopeless all or most of the time[1]

tuberculosis
x9
as likely to have tuberculosis[4]

liver cancer
64%
more likely to die from liver cancer[2]

heart disease
40%
more likely to have heart disease [1]

liver disease
x3.5
as likely to die from liver disease or cirrhosis[2]

obesity
33%
more likely to be obese [1]

stomach cancer
48%
more likely to die from stomach cancer[2]

diabetes
x2
as likely to be diabetic [1]
50%
more likely to have end-stage renal disease[3]
x2.4
as likely to die from diabetes[2]

HIV
x2
as likely to be diagnosed with HIV [5]
x2
more likely to die from HIV [2]

AMERICAN INDIAN & ALASKA NATIVE HEALTH INEQUITIES: CHILDREN

Compared to non-Hispanic white children, American Indian and Alaska Native children are more likely to suffer from the following:

infant mortality
55%
more likely to die as an infant[6]

SUID
x2
as likely to die of sudden unexpected infant death (SUID)[3]

depression
x2
as likely to attempt suicide as a high-schooler[6]
15%
more likely to experience sadness or hopelessness as a high-schooler[7]

How do we reduce racial and ethnic health inequities? We must work together to improve our health care system to make it high-quality, comprehensive, affordable, and accessible for everyone.

FAMILIESUSA

HEALTH EQUITY ACTION CENTER FOR SYSTEM TRANSFORMATION | AN INITIATIVE OF FAMILIESUSA

NATIONAL COUNCIL OF URBAN INDIAN HEALTH

Latino Health Inequities Compared to Non-Hispanic Whites

Racial and ethnic health inequities are undermining our communities and our health system. Latinos are more likely to suffer from certain health conditions, and they are more likely to get sicker, have serious complications, and even die from them. These are some of the more common health inequities that affect Latinos in the United States compared to non-Hispanic whites.

LATINO HEALTH INEQUITIES: ADULTS

asthma
75% more likely to have asthma [4] (Puerto Ricans)

tuberculosis
x3.8 as likely to be newly diagnosed with tuberculosis [5]

cervical cancer
25% more likely to be newly diagnosed with cervical cancer [3]

18% more likely to die from cervical cancer [3]

liver disease
35% more likely to have liver disease [6]

obesity
24% more likely to be obese [7]

HIV
x3 as likely to be diagnosed with HIV [1]

x2 as likely to die from HIV [2]

diabetes
63% more likely to be diabetic [8]

x2.5 as likely to have undiagnosed diabetes [8]

34% more likely to develop end-stage renal disease [9]

33% more likely to die from diabetes [2]

LATINO HEALTH INEQUITIES: CHILDREN

Compared to non-Hispanic white children, Latino children are more likely to suffer from the following:

infant mortality
47% more likely to die as an infant [10] (Puerto Ricans)

asthma
82% more likely to have asthma [4] (Puerto Ricans)

obesity
83% more likely to be obese [7]

depression
34% more likely to attempt suicide as a high-schooler [11]

How do we reduce racial and ethnic health inequities? We must work together to improve our health care system to make it high-quality, comprehensive, affordable, and accessible for everyone.

September 2018 FamiliesUSA.org | FAMILIESUSA

Commission on Minority Health

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Commission on
Minority Health

To access
Local Conversation Report

www.mih.ohio.gov