Cleveland Office of Minority Health

Round 2: Local Conversations on Minority Health

Report to the Community 2016

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National Partnership for Action to End Health Disparities

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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 http:// minorityhealth.hhs.gov/NPA.org.

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 (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 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

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

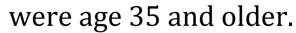
The Cleveland Office of Minority Health has continues to experience barriers locating local data on health disparities. The lack of timely data collection and reporting of minority health data has been identified as an area of concern across health service delivery sectors. However, new initiatives such 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 persons diagnosed with HIV living in Cuyahoga County. Of these, 3,343 (67%) persons 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. Persons with HIV-only were younger, with about 29% being 34 years of age and younger. Ninety percent of individuals with AIDS



were age 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 the 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

Cuyahoga Community Health Needs Assessment, available at:
http://www.hcno.org/pdf/counties/Cuyahoga%20County%20Health%20Assessment%20FINAL.pdf

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

Cleveland Department of Public Health, www.healthinf o.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

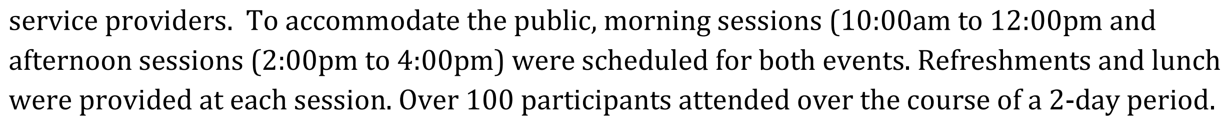
Second Local Conversation Minority Health: Monday, December 14, 2010

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 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.

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 over 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 STRENGTHS AND OPPORTUNITIES

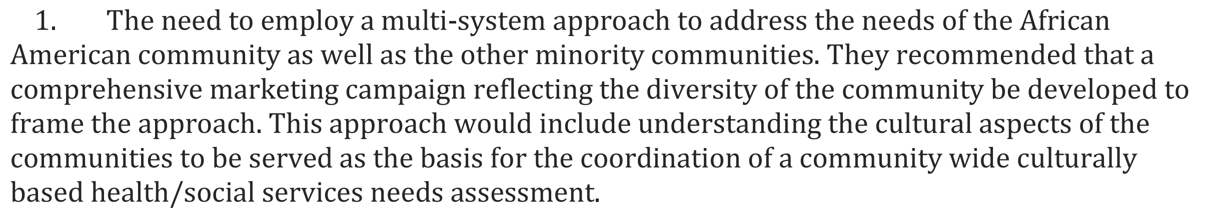
1. What are the 2-3 most important characteristics of a healthy city and county?
2. What makes you most proud of your city and county?
3. What are some specific examples of people or groups working together to improve the quality of life in your county and region?
4. What do you believe are the 2-3 most 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 regards to health disparities. The community needs to be accountable for addressing issues that hinder individual growth such as racism, language barriers and life style 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 as a whole 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 deal 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 professional on health literacy and how to insure that developed materials are meeting 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 as a means to enhance health literacy efforts. As the aging population grows, special effort must be made to address health literacy among senior.

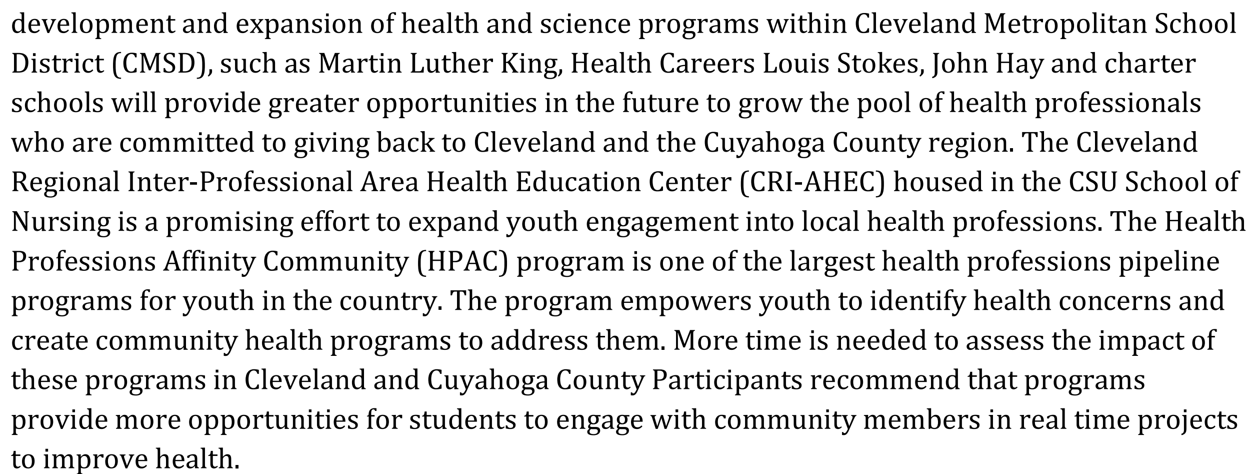
The development and expansion of mobile food pantries and efforts to provide fresh fruits and vegetables at corner store markets has increased consumer potential towards to access and prepare healthy foods for their families.

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

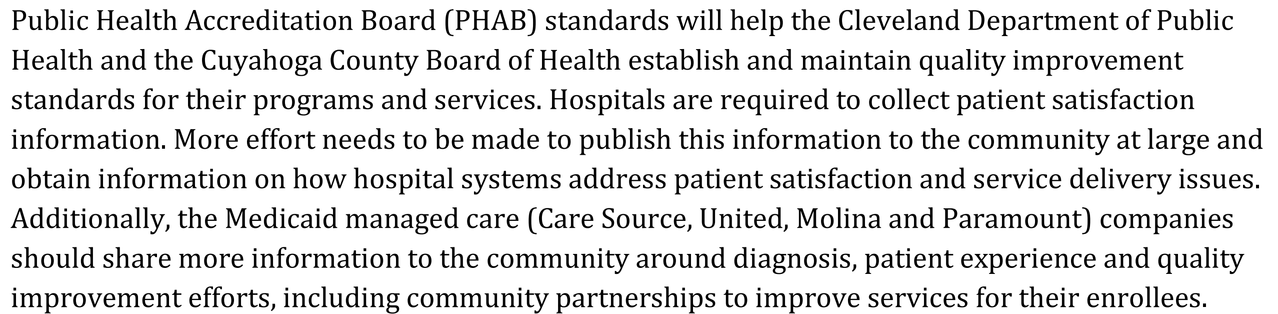
On a scale of 1 to 10, participants rated the level of progress within the last 5 years to conduct a culturally-based community health needs assessment, removing barriers to self-motivation, eliminate institutional racism empower consumers at **6 out of 10.**

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 or not 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 patient 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 cervical cancer programs SB3 Ohio 313
Emerging diseases such as Zika	Lack of Trust of Police	
Growth- new cancer centers	Leadership Development	
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).

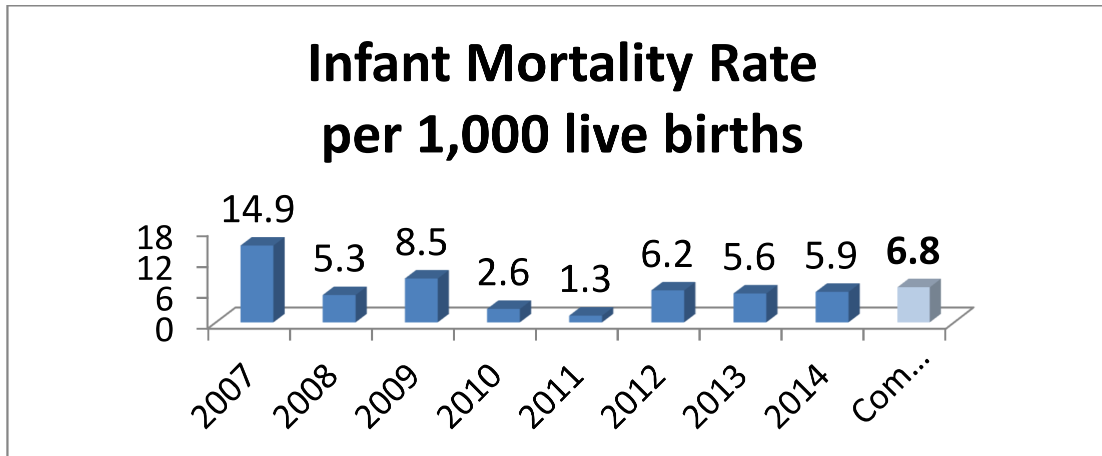
Infant Mortality in Ohio:

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.niaid.nih.gov/topics/minorityhealth/pages/disparities.aspx
http://www.cdc.gov/healthyyouth/disparities/
www.ama-assn.org/.../eliminating-health-disparities.page
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

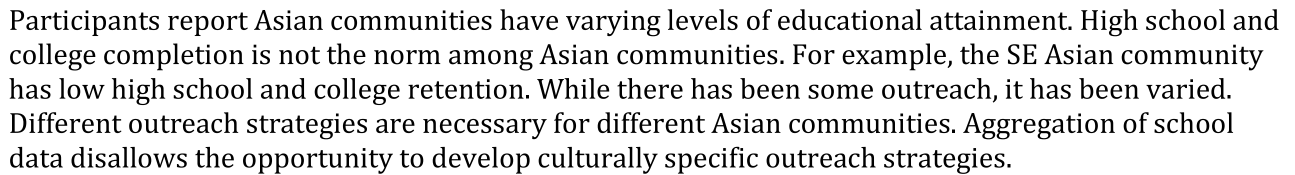
Reducing Stereotypes – Improving Community Resources
Progress Made: 3/10

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

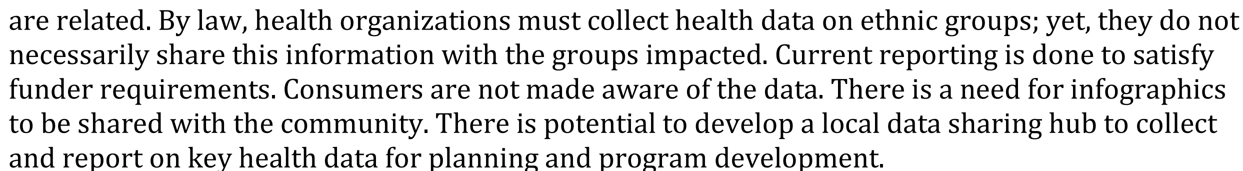
Despite the great success in opening a federally qualified health center (FQHC) and its expansion in Akron this year, much more needs to be done, since the International Health Center is the first of its kind in the Midwest. More needs to be done with refugee health screening. Over the past five years, 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 is 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 needs to help providers get to a place of cultural humility. Participants note that there are not 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 language appropriate in the community

Gap #2- Community needs more data on the 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 professional 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 are 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 that 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 provides 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 select one
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 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?

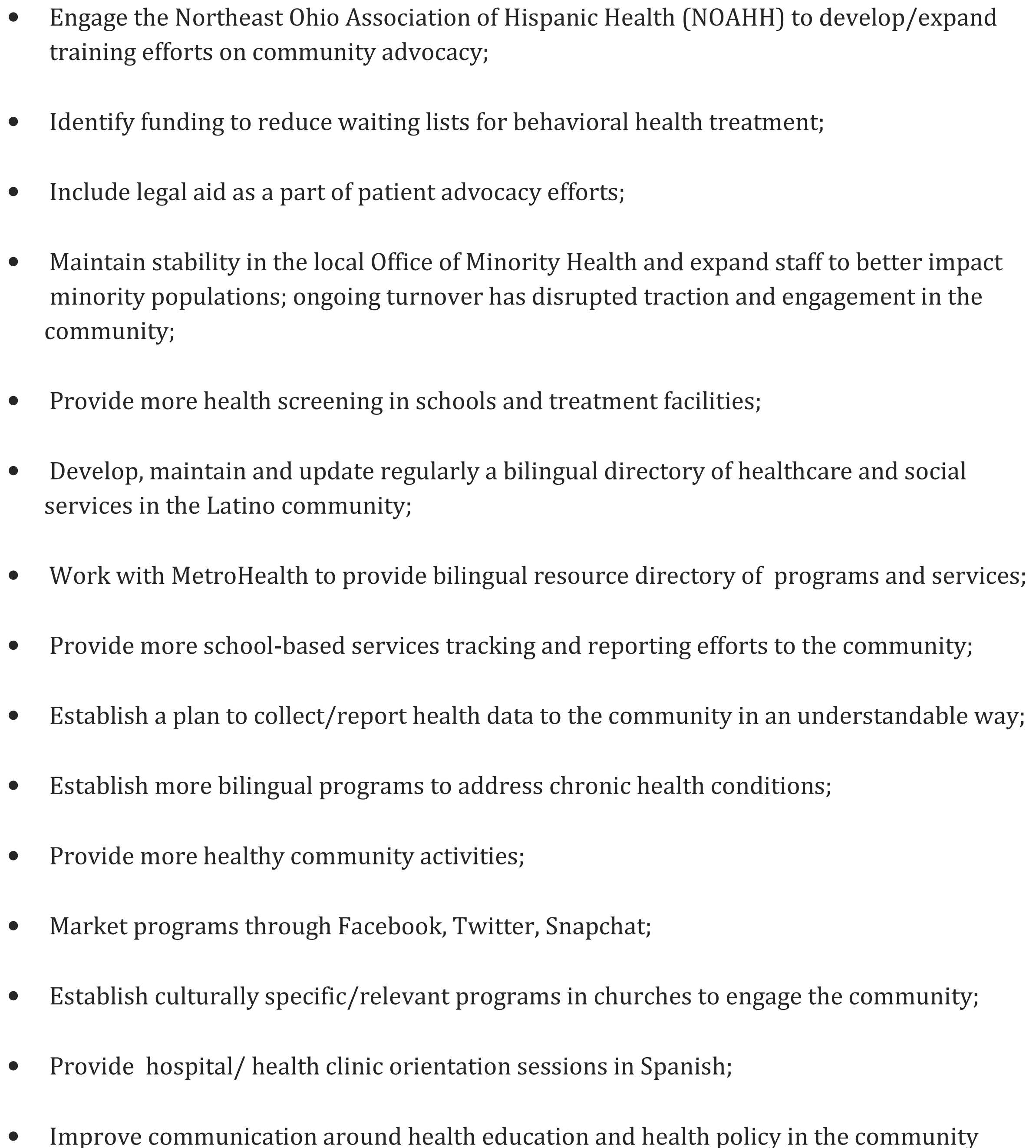
- Poor health habits
- Economic and social conditions that are harmful

4. What may 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;
- Maintain stability in the local Office of Minority Health and expand staff to better impact 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;
- Establish 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.
Care Alliance
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 Health and 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

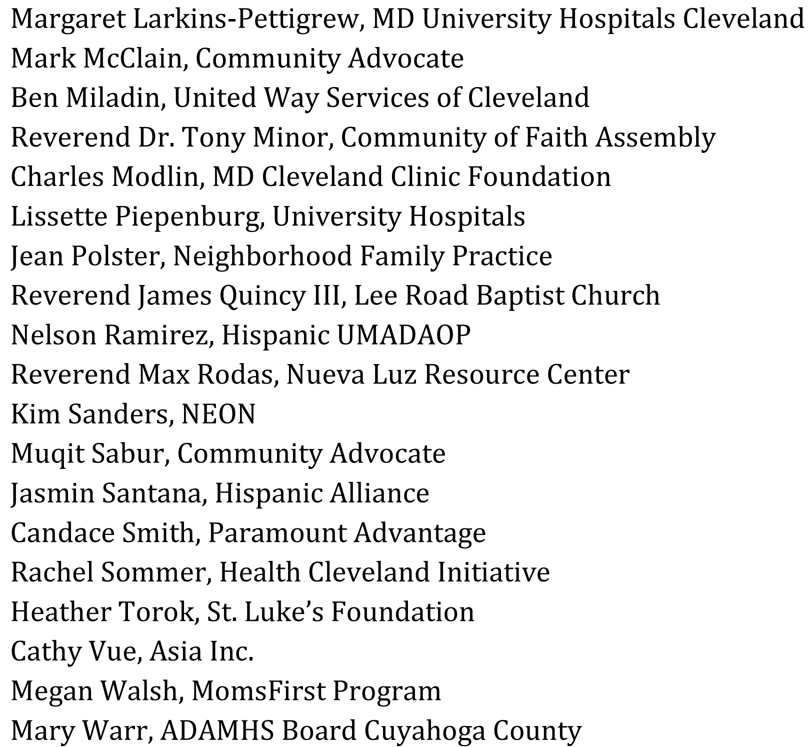
June 30, 2016 Community Conversation – Hispanic Alliance

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