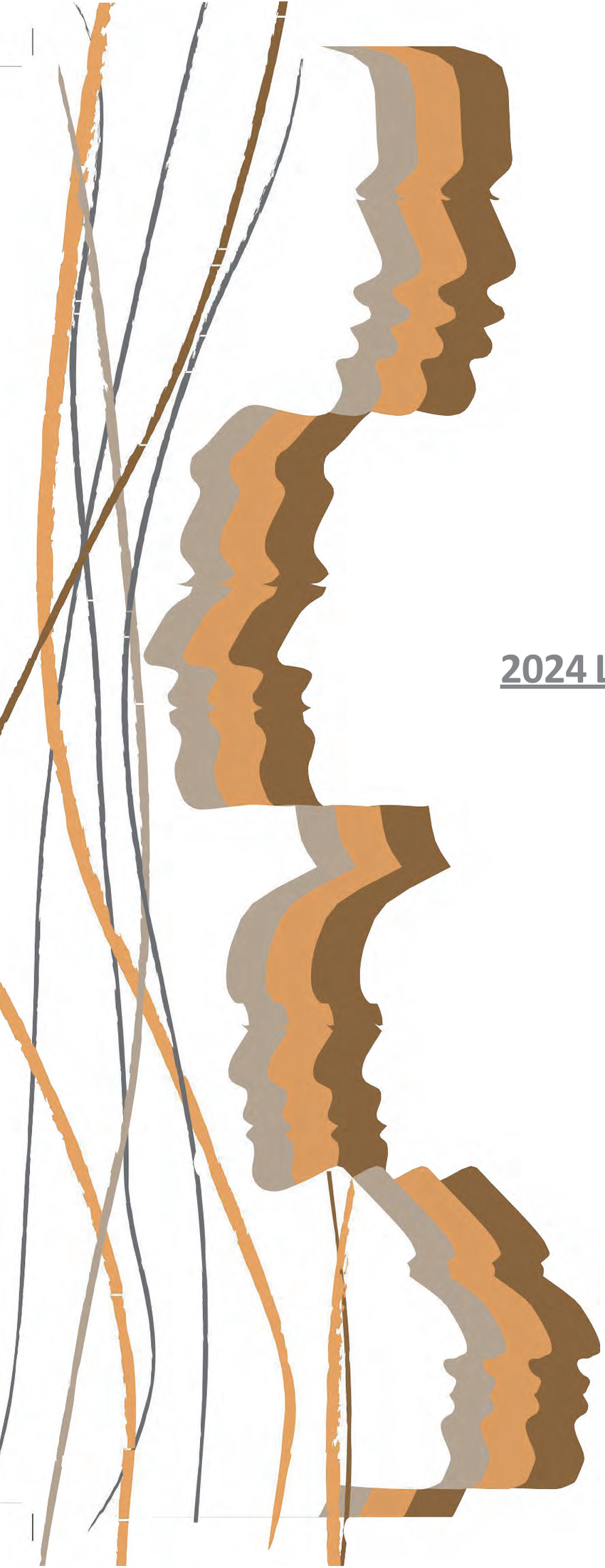


Commission on Minority Health

2024 Local Conversations Round 3: From Input to Action

hosted by

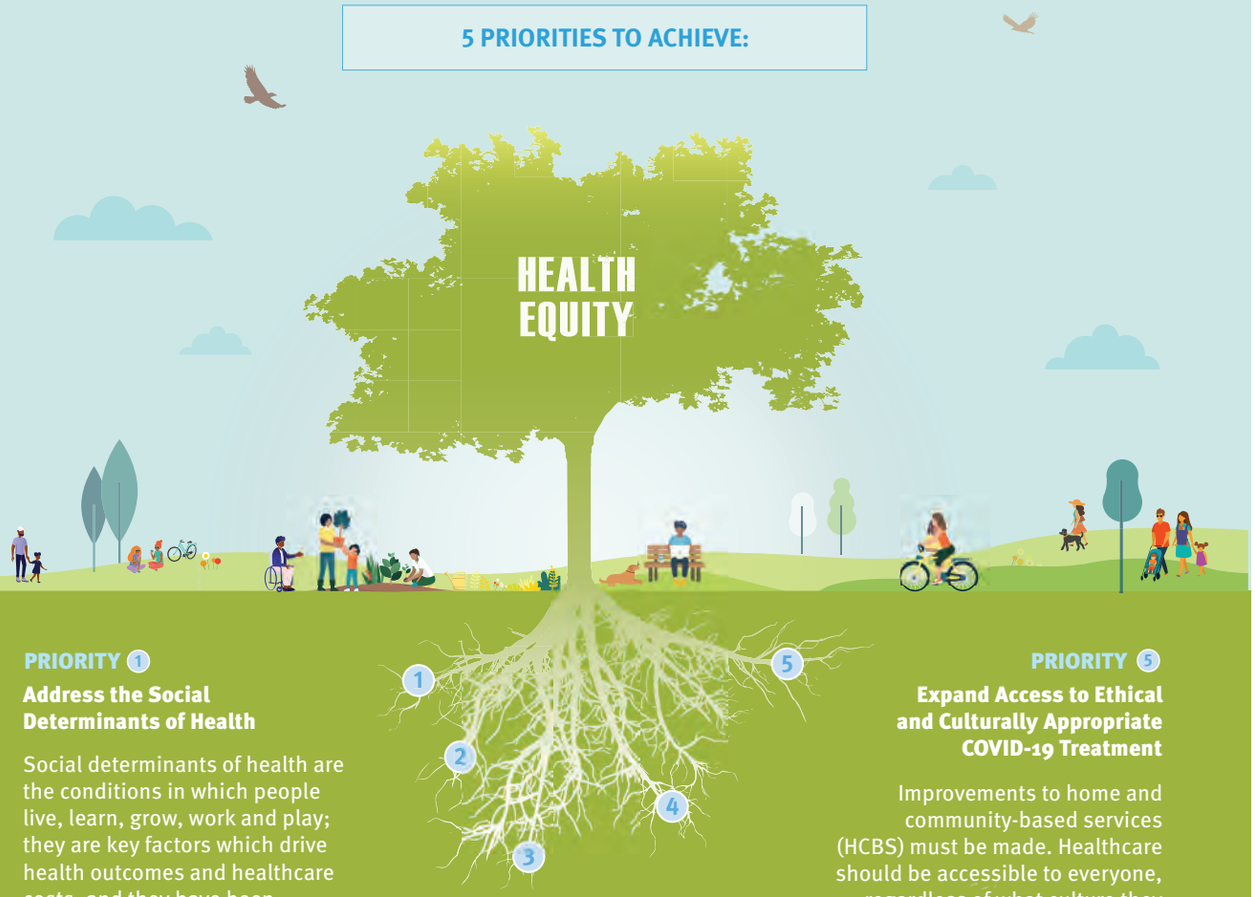
Cincinnati Health Department (Hamilton County)

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

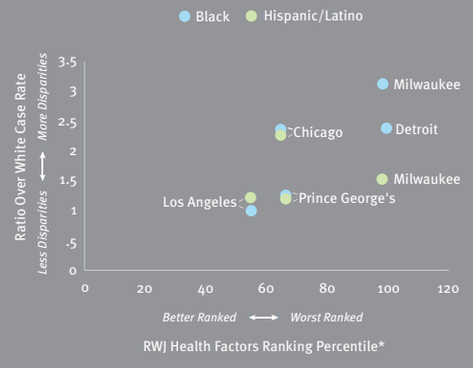
Improvements to home and community-based services (HCBS) must be made. Healthcare should be accessible to everyone, regardless of what culture they hold or language they speak.

HEALTH DISPARITIES

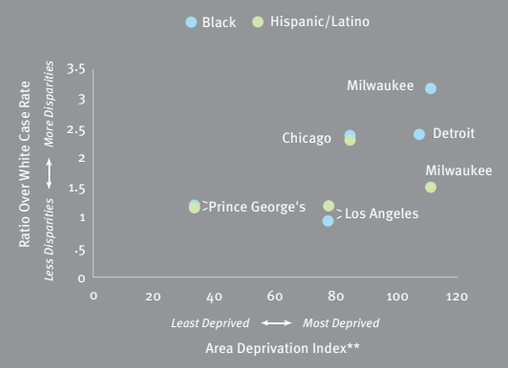
NEARLY 2X GREATER Nationally, African-American deaths from COVID-19 are nearly two times greater than would be expected based on their share of the population. In four states, the rate is three or more times greater.[1]

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.

Local Conversation 2023 – Phase 3 Community Report - Cincinnati

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 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.

About the Cincinnati Health Department

Founded in 1826, the Cincinnati Health Department (CHD) is committed to protecting and improving the health of the people of Cincinnati. As a nationally recognized leader in public health, CHD advocates responsive health and human services that promote healthy living environments and social wellbeing. It strives to reduce inequities such as poverty and unemployment, which often negatively impact people's health.

CHD is a Federally Qualified Health Center (FQHC) and serves more than 40,000 patients annually. It operates six primary care health centers, one free-standing dental center, and thirteen school-based health centers. The school-based health centers are full-service CHD clinics located within Cincinnati Public Schools. These clinics currently serve more than 10,000 students and serve the medical needs of children and families within the community. For more information, visit cincinnati-oh.gov/health.

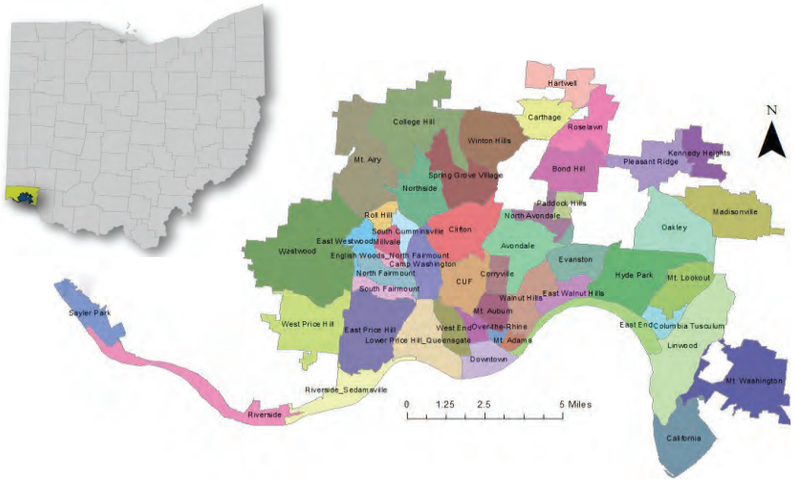
On May 14, 2021, the Public Health Accreditation Board (PHAB) conferred accreditation to the Cincinnati Health Department (CHD). PHAB is a nonprofit organization advancing the continuous quality improvement of tribal, state, local, and territorial public health departments. PHAB's vision is a high-performing governmental public health system that will make the United States a healthier nation.

Geographic Scope – Cincinnati, Ohio

The City of Cincinnati lies in the most southwestern county of the State of Ohio, Hamilton County. Both I-70 and I-71 are major north–south interstate highways running through Cincinnati and Hamilton County. The City of Cincinnati is mostly urban, with over 76.2% of its land area being developed.[1] The city has a vibrant and diverse population, with strong healthcare, educational, and business institutions. It is the largest city in the region and is comprised of 52 distinct neighborhoods (Map I). As of 2020, Cincinnati had 309,317 residents with 51.6% identifying as female and 48.4% identifying as male; this ratio is similar to Hamilton County and to Ohio. Cincinnati's age distribution trends toward young adults, with the highest percent of males and females between the ages of 25-29 years old. Of all Cincinnati residents, 50.6% are White and 40.3% are Black or African American[2], a racial distribution that is considerably more diverse than Hamilton County and the state of Ohio at 67.3% White, 26.6% Black and 81.2% White, 13.2% Black respectively. Age, education, and income distributions also differ between the city and the rest of the country. 37.4% of Cincinnati children live in poverty, compared to 18.6% of Ohio children and 17.0% of children nationally.[3] These and other social and economic factors affect the health status of the residents. For this reason, a Cincinnati specific profile is included to identify unique Cincinnati needs and challenges.

[1] U.S. Geographic Survey
[2] American Community Survey, 2020: ACS 5-Year Estimates Data Profiles
[3] American Community Survey, 2020: ACS 5-Year Estimates Data Profiles S1701 – Poverty Status in the Past 12 Months

Map I: City of Cincinnati Neighborhoods



Source: American Community Survey, 2016-2020 Ohio Development Services Agency

Health disparities in Cincinnati

City-wide, Cincinnati's socially disadvantaged populations are burdened with preventable differences in disease, injury, and violence resulting in suboptimal health. Social determinants of health are complex, multigenerational disadvantages resulting in a diminished understanding of healthy lifestyle, lower utilization of preventative care, limited access to culturally sensitive medical professionals, and distrust of government or medical establishments. Health disparities across race, ethnicity, age, gender, disability, sexuality, socioeconomic status, and neighborhood results in undesired health behaviors, delayed treatments, higher health care costs, and shorter life expectancy. Black Males have the lowest life expectancy in Cincinnati at 66.5 years when compared to White Males (72.6), Black Females (74.7), and White Females (78.2). Black males have the highest rates of mortality related to diseases of the heart and cancer, the two leading causes of death in Cincinnati (Graph I). Infants born to a Black mother in Cincinnati are almost three times more likely to die before their first birthday when compared to their White counterparts (Graph III).

Morbidity and Mortality Burden in Cincinnati

Cincinnati's cause-specific mortality rates for the 10 leading causes of death were comparable to the USA rates in most instances, but higher in accidents (unintentional injuries) and Diabetes Mellitus.

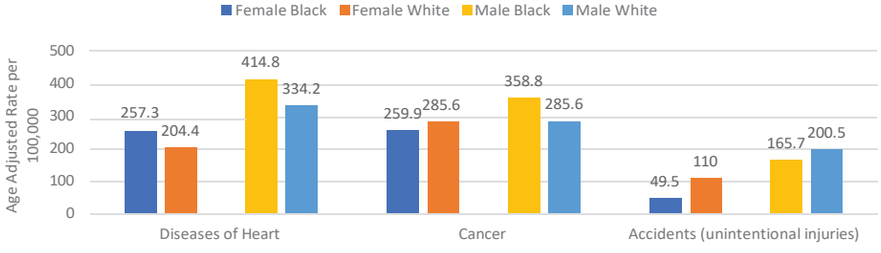
Table I: Crude Mortality Rates (per 100,000 population for the top 10 causes of death in Cincinnati, compared to Ohio, and the United States

Cause of Death	Cincinnati 2017-2021	Ohio 2017-2021	USA 2018-2021
Diseases of heart	206.9	219.5	205.6
Malignant neoplasms	176.6	194.1	182.8
Accidents (unintentional injuries)	89.3	75.7	58.2
Cerebrovascular diseases	55.4	60.9	47.2
Chronic lower respiratory diseases	40.1	43.8	46.4
Alzheimer's disease	35.9	46.5	37.8
COVID-19	42.6	42.4	58.3
Diabetes mellitus	32.4	29.4	15.9
Nephritis, nephrotic syndrome, and nephrosis	23.3	23.6	15.9

*Mortality rates from 2017 to 2021

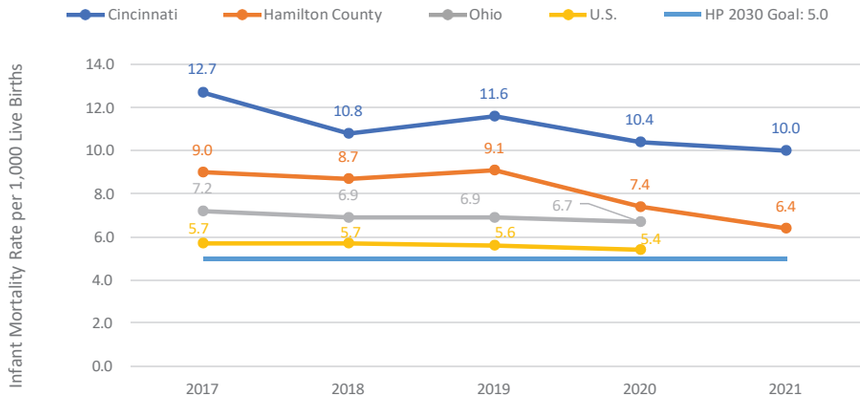
Source: Ohio Department of Health (ODH), Office of Vital Records
CDC Wonder

Graph I: Cincinnati - Leading Causes of Death in Adults 18+ Years by Cause of Death (2016-2020)



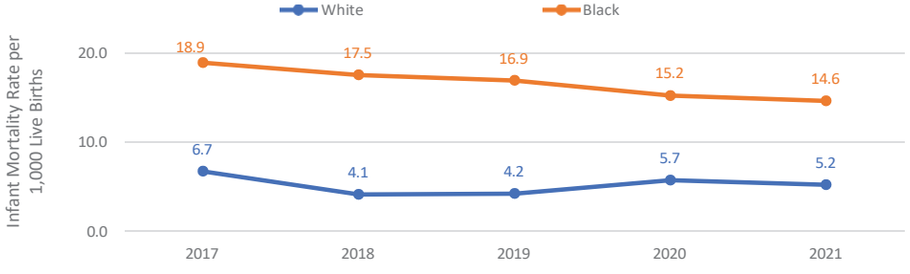
Source: Ohio Department of Health, Office of Vital Statistics

Graph II: Infant Mortality Rate (2017-2021)



Source: Ohio Department of Health, Office of Vital Statistics

Graph III: Cincinnati Infant Mortality by Race (2017-2021)



Source: Ohio Department of Health, Office of Vital Statistics

Cincinnati - COVID-19

COVID-19 has had a profound impact on lives globally. It disrupted daily routines, led to mass lockdowns and social distancing measures, and caused widespread illnesses and losses. It accelerated trends in remote work and online education while highlighting disparities in healthcare. Public health's vaccination response has been significant in mitigating Covid-19 effects, but the pandemic's long-term consequences continue to evolve with growing concerns medically, financially, and socially – including a substantial uptick in reported mental health concerns.

In March 2020, the first case of COVID-19 infection was reported to the Cincinnati Health Department. Three years later in March 2023, the City of Cincinnati had a total of 83,608 cases reported. There have been 3,220 total hospitalizations and 759 total

deaths attributed to Covid-19 in Cincinnati since the onset in 2020. The neighborhoods that experienced the highest case rates are Roselawn with 18,012 cases per 100,000 individuals. Following is Corryville with a case rate of 17,784.5 per 100,000 and Over-the-Rhine with a case rate of 15,773.3 per 100,000 individuals (Map II). Case rates for COVID-19 infection are subject to potential limitations due to socioeconomic disparities relative to geographic location. Impacts on case rates may include lack of testing in under-resourced areas and reduced case reporting for positive at-home testing because COVID-19 testing options varied throughout the pandemic. Originally, Cincinnati residents may have received testing in the hospital, clinic, or pharmacy settings but widespread use of home testing kits became available soon after.

Based on Cincinnati's reported cases, females made up 56% of total cases and males made up 43%. White individuals made up most cases, at 45% followed closely by Black individuals at 43%. Additionally, the 20-29 age range experienced more cases of COVID-19 infection than any other age range. The COVID-19 pandemic had a significant effect on the mental health of adults and children. Rates of anxiety, depression, and substance use disorders have increased since the beginning of the pandemic. In a 2021 study, nearly half of Americans surveyed reported recent symptoms of an anxiety or depressive disorder, and 10% of respondents felt their mental health needs were not being met[1].

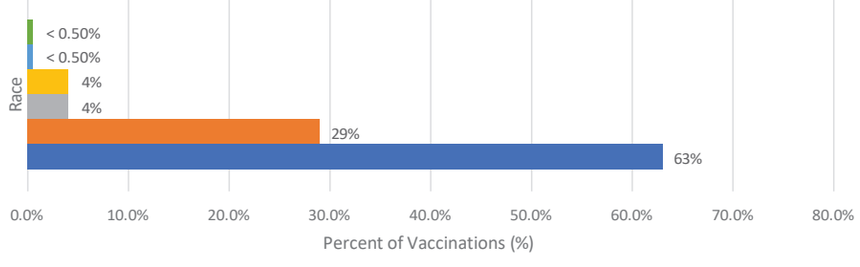
[1] National Institute of Health – Mental Health During the Covid-19 Pandemic.

Covid 19 Vaccinations

In December 2020, COVID-19 vaccine rollout began in the United States. Since the initial introduction of the vaccine, the series has been updated to include a primary and secondary dose along with follow up booster doses. Individuals who were immunocompromised were eligible for additional doses related to the public.

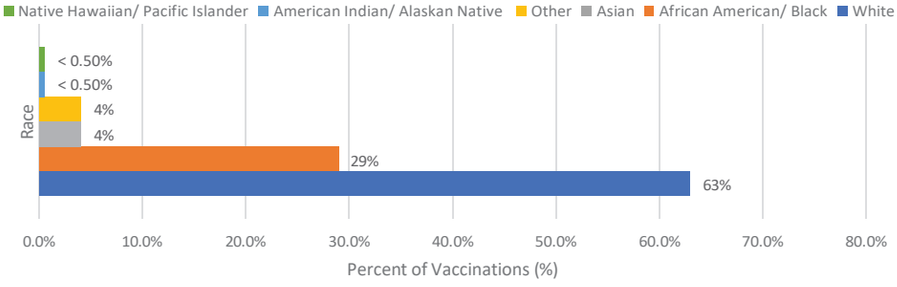
The Cincinnati Health Department administered a total of 102,065 total vaccinations. Of these total doses, 49,615 are first doses, 42,008 second doses and 10,442 booster doses. Generally, eastern areas of the city have higher vaccination uptake. The Clifton and Downtown area have higher rates relative to the surrounding areas. Downtown, Oakley, and Over the Rhine had the highest uptake, with each exceeding 90% of the population with at least one vaccine. The neighborhoods with the lowest vaccine uptake are Roll Hill (20.9%), Winton Hills (26.9%), and CUF (31.1%).

Graph IV: Cincinnati Health Department COVID-19 Vaccinations Given by Race (2020-2023)



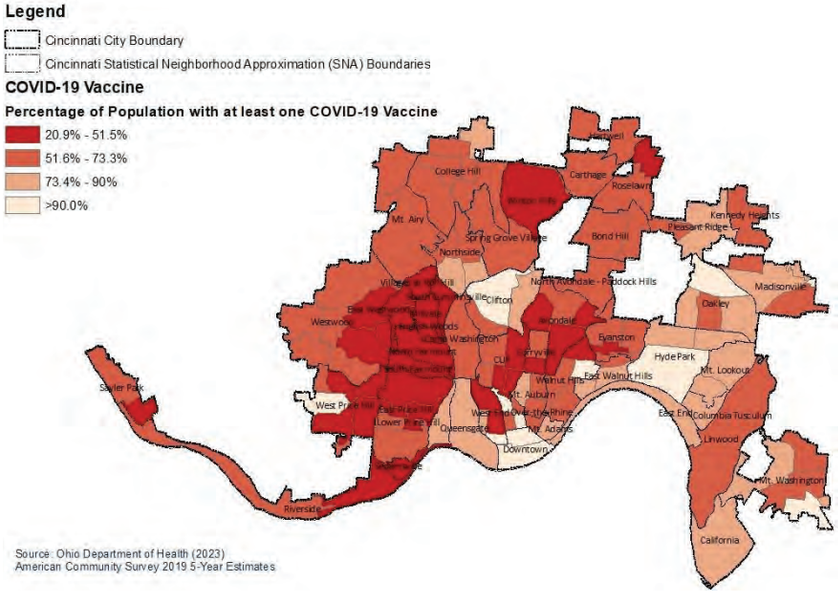
Source: Ohio Department of Health, 2020-2023

Graph V: Cincinnati Health Department COVID-19 Vaccinations Given by Dose (2020-2023)

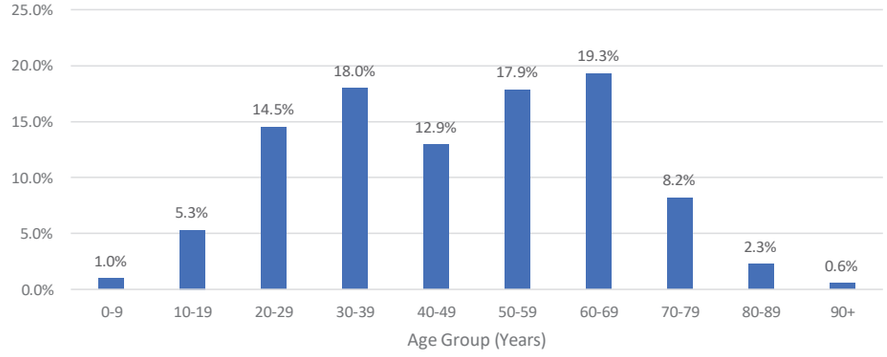


Source: Ohio Department of Health, 2020-2023

Map II: Cincinnati COVID-19 Vaccination Rate by Census Tract (%) (2020-2023)



Graph VI: Cincinnati Health Department COVID-19 Vaccinations by Age Group (2020-2023)



Source: Ohio Department of Health, 2020-2023

Cincinnati's Local Conversations Over the Years

- The first Cincinnati Local Conversations on Minority Health was held Saturday, August 23, 2008, at the Community Action Agency located at Jordan's Crossing, Cincinnati, Ohio, 45237.

- The Second Local Conversation on Minority Health was held Thursday, October 28, 2009, at the Cincinnati Health Department, 3101 Burnet Avenue, Cincinnati, Ohio, 45229.

- The Third Local Conversation on Minority Health was held January 26, 2010, at the Cincinnati Health Department, 3101 Burnet Avenue, Cincinnati, Ohio, 45229.

- The Fourth Local Conversation on Minority Health was held May 21, 2016, at the Community Action Agency located at Jordan's Crossing, Cincinnati, Ohio, 45237. City of Cincinnati Health Department – Local Conversations Community Report Update 2016 cincinnati-oh.gov/health.

Local Conversations 2022 Phase 3

The release of Phase 3: 2022 Local Conversations – Health Equity: From Input to Action provided communities an opportunity to review and update the previous local conversation's efforts. The goal was to seek input from Cincinnati residents regarding their concerns and to identify strategic priorities regarding health disparities and equity efforts where they live, work, and play. Phase 3 expanded investigative efforts to include focus on the impact of COVID-19 on racial and ethnic populations. This effort continued to ensure opportunities for community level input in the development of solutions to achieve equity with a specific lens on COVID-19 and will assist in the update to the 2016 local conversations efforts in Cincinnati, Ohio.

- The first Phase 3 Cincinnati Health Department Local Conversation was held in-person Saturday, May 13, 2023, at the Community Action Agency located at Jordan's Crossing, Cincinnati, Ohio, 45237. Participants were split into five groups. Each of the five groups had a facilitator and a scribe who guided community participants in discussion, to ensure the group were on task to identify critical health issues and services offered by CHD. The facilitator often summarizes key points and decisions made during the meeting. The scribe ensured important information was not lost and provided a record of what transpired during group(s). In addition, each community member participated in the 2023 CHD Community Health Assessment Survey. The REDCap survey assisted in identifying health needs to better serve our community by increasing awareness of health disparities health inequities and COVID-19 on racial and ethnic populations.

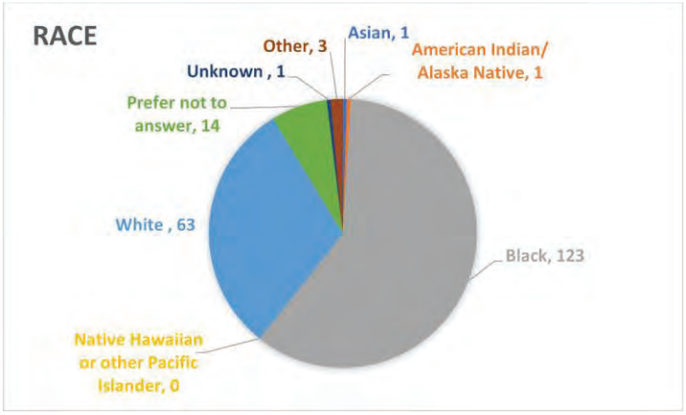
- The second Phase 3 Cincinnati Health Department Local Conversation was held virtually July 26, 2023, Virtual Zoom Meeting. Applying the same concept as in-person, each of the five groups had a facilitator and a scribe who guided community participants in discussion and were given the 2023 CHD Community Health Assessment Survey.

- Concurrent Series of Phase 3 Cincinnati Health Department Local Conversations were conducted through field surveys August 1, 2023, through August 25, 2023, in conjunction with City of Cincinnati planned health, social and entertainment venues. CHD staff assisted community members with completion of the 2023 CHD Community Health Assessment Survey.

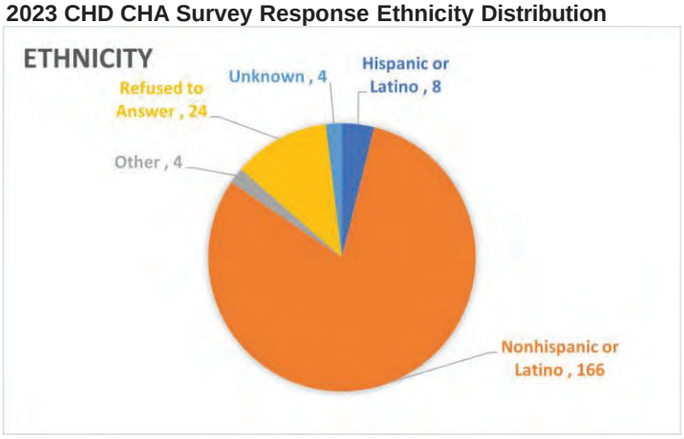
2023 CHD Community Health Assessment Survey Responses

Of the 206 responses to the 2023 CHD Community Health Assessment Survey, 59% were female, 16% were male, 4% were nonbinary, and 21% preferred not to answer.

Graph VII: 2023 CHD CHA Survey Response Race Distribution



Graph VII: 2023 CHD CHA Survey Response Ethnicity Distribution



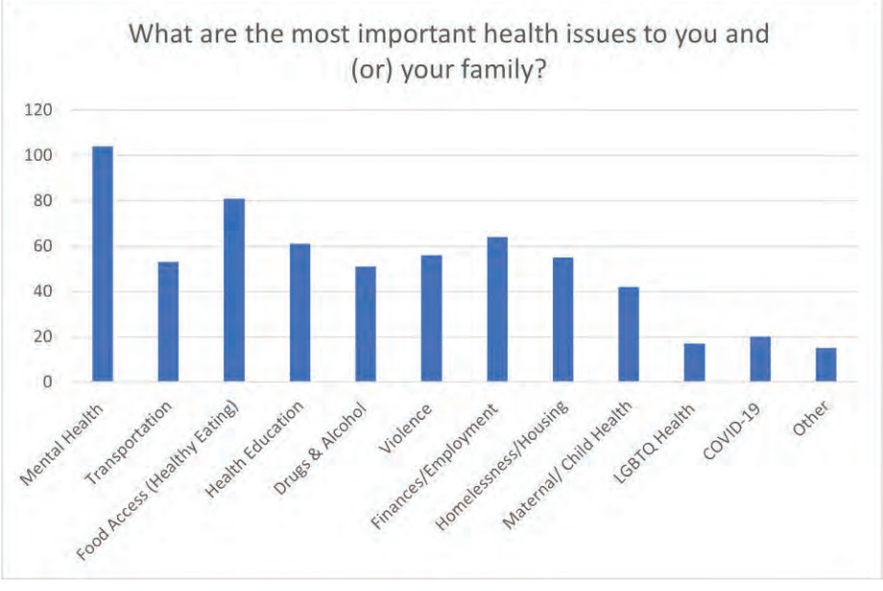
In addition to demographics, survey participants were asked the following questions in multiple choice format:

1. What are the most important health issues to you and/or your family? (Select all that apply)
2. What type of services are most important to you and/or your family? (Select all that apply)
3. What services offered by the Cincinnati Health Department (CHD) are most important to you and/or your family?
4. What topic within health education is the most interesting/useful to you?
5. What aspect of your life was most impacted by the Covid-19 pandemic?
6. How often do you visit a primary care provider?

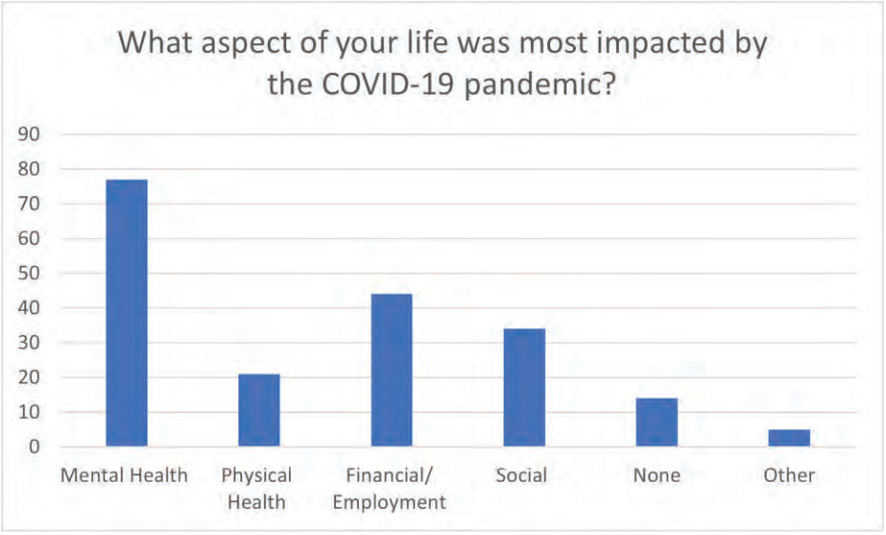
Phase 3 Identified Needs

During Phase 3 of the Local Conversations on Minority Health, community members identified mental health as the most significant health issue and area of greatest impact related to Covid-19. Food access/healthy eating was another identified need by the community, ranking second for most important health issue and third for most important service offered by the Cincinnati Health Department. A third identified need is addressing poverty, with a focus on building financial security and employment, improving access to transportation, and assisting with medical insurance coverage.

Graph VIII: 2023 CHD Community Health Assessment Question 1



Graph IX: 2023 CHD Community Health Assessment Question 1



The unequal distribution of female to male participants during Phase 3 of Local Conversations on Minority Health could be indicative of a greater issue that men in Cincinnati are less likely to seek out health information when compared to women and should be considered when developing programming addressing health needs. As the Local Conversation's team conducted surveys in the field, there was also an identified need to develop data collection tools and health promotion materials in multiple languages, particularly Spanish, to ensure inclusivity.

Addressing disparities in infant mortality is also a critical need identified during Phase 3. Although infant mortality rates have been improving, Cincinnati rates remain higher than Ohio and U.S. rates. Black infants in Cincinnati are almost three times more likely to die before reaching one year of age than White infants.

Most identified needs align with the same needs identified in the Local Conversations on Minority Health 2016 report and this could be linked to a stall in programming due to the Covid-19 pandemic. Additionally, throughout Phase 3, community members expressed a lack of in-depth understanding of what services are offered by the Cincinnati Health

Department indicating a need for improved culturally relevant marketing strategies.

Follow-up Action Plan
The following are recommendations from the community input hosted by Cincinnati Health Department and our partners. We commit to continue to strive to improve the health of our residents.

1. Continue to develop and expand mental health services by recruiting mental health professionals to the workforce and expanding alternative response to crisis programs.
2. Increase access to healthy food in underserved communities, or food deserts, by connecting residents to food resources and related programming.
3. Decrease the burden of poverty by connecting residents with employment, educating on financial security, improving access to transportation, and assisting with medical care coverage.
4. Increase culturally sensitive health promotion services by producing education materials in multiple languages and by having equal representation within programs.
5. Increase dissemination of information by developing easier to use online platforms and by increasing physical presence within the community.
6. Keep the public in the loop by broadly sharing findings after gathering data.

Specifically, CHD commits to:

1. The CHD will continue to develop and expand mental health services by recruiting mental health professionals to the City of Cincinnati Primary Care (CCPC) clinic locations, promoting the Alternative Response to Crisis (ARC) program, and collaborating with key community partners.

2. CHD will continue to address food access/healthy eating, active living, infant vitality, tobacco free living, and men's health through the Healthy Communities Program. The Healthy Communities Program addresses policy, system, and environmental changes that support local population health. The program includes the Live-Work-Play-Cincinnati Coalition with **200+** current members working together to improve health outcomes with a focus on healthy eating and active living (HEAL), behavioral health, and healthy families. Through a health lens, members are dedicated to addressing other social determinants of health such as education, housing, transportation, and safety.

3. The CHD continues to play a crucial role in understanding and working to reduce infant mortality through participation in the Cincinnati-Hamilton County Fetal and Infant Mortality Review (FIMR). The FIMR investigates specific cases of infant or fetal loss through comprehensive medical and social service records reviews as well as, where possible, maternal interviews. Through this holistic approach, recommendations for system changes to reduce infant loss are developed and shared with an action team. Additionally, CHD will continue to partner with Cradle Cincinnati to connect Community Health Workers (CHWs) with pregnant women throughout Cincinnati. CHWs provide additional education and help navigate care with the aim to reduce infant mortality.

4. The CHD will increase culturally sensitive marketing of services to community members by producing promotion and education materials in multiple languages, by increasing online and community presence, and by building relationships through community engagement, collaboration, and governmental relations.

5. As a part of the Public Health Accreditation process, the data gathered from Phase 3 of Local Conversations on Minority Health will be used to guide overall strategic planning. Additionally, the 2023 CHD Community Health Assessment Survey will be adapted for routine utilization, ensuring future goals, objectives, and strategies are developed to serve minority groups and lead to health equity in Cincinnati.

Acknowledgements

In addition to support from the Ohio Commission on Minority Health the following organizations were an integral part of the Phase 3 Local Conversation on Minority Health in Cincinnati, Ohio:

The Cincinnati local conversation on Minority Health partners:

- Community Action Agency – Rachel Prophett
- City of Cincinnati - City Manager's Office – Virgina Tallent
- Cincinnati Metropolitan Housing Authority – Lulu McBride
- All In Cincinnati – Ashley Glass

The Cincinnati Local Conversation on Minority Health team included:

Grant Mussman, MD. MHSA Marye Amin, PhD., MS Ashanti Sater, MPA, CAPM Jose Marques, MA Hannah Back, M.A William Dean, MPH Courtney Calvin, BA, CTTS Malina Harris, BS, CTTS Jasmine Robinson, BA, CCHW, CTTS, CLC

William Pointer, REHS Kimberly Wright, BS Sonya Williams, BS Meriel Vigran, MPH Andre Lovell, MHI Kelly LaFrankie Tiffany White, RD, LD, CLC Wm. Eric Washington, BA Tonia Smith, RDN, MCHES, REHS

City of Cincinnati - Planned Events

Washington Park Events 1230 Elm St. Cincinnati, Oh 45202

Fountain Square Events 520 Vine St. Cincinnati, Oh 45202

Ziegler Park 1322 Sycamore St. Cincinnati, Oh 45202

Imagination Alley 1317 Vine St. Cincinnati, Oh 45202

Special Acknowledgements:

Ohio Commissioner on Minority Health Angela Dawson, MS, MRC, PC Executive Director

Geographic Scope

The geographic scope of this project is Cincinnati, Ohio.

Demographic Profile of Cincinnati

Cincinnati is a city in, and the county seat of, Hamilton County, Ohio, United States. Settled in 1788, the city is located north of the Ohio River at the Ohio-Kentucky border, near Indiana. The population within city limits was 296,943 in over 133,000 households according to the 2010 census, making it Ohio's third-largest city. According to the 2010 Census Bureau estimate, the Cincinnati metropolitan area had a population of 298,550 the 27th most populous Metropolitan Statistical Area (MSA) in the United States, and the most populous in Ohio. Cincinnati has a large minority population. The racial demographic breakdown of Cincinnati is as follows:

49.3% are white/Caucasian

44.8% are black/African American

1.8% are Asian/Pacific Islander

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4.1% identified as some other race

The White population continues to decrease as families move to more affluent suburbs, creating a concentration of disparities among minorities living in low-income, urban neighborhoods.

city of CINCINNATI HEALTH DEPARTMENT

Health Disparities in Cincinnati

According to the 2008 Centrum Healthiest Cities Study, Cincinnati is among the least healthy cities nationwide (ranked 48 out of 50). Two-thirds of the 2010 Greater Cincinnati Community Health Status Survey respondents (64%) reported having a chronic condition such as hypertension, high cholesterol and/or triglycerides, diabetes, depression, asthma or history of stroke. Respondents reporting chronic conditions were more likely to be African American, White Appalachian, or over the age of 46. Updated public health data and statistics were not available at the time of print for the 2016 Community Report.

Morbidity and Mortality Burden in Cincinnati: A Health Equity Response

Recent analyses have shown that overall mortality rates are higher in Cincinnati in males and females, blacks and whites, and in all age groups, compared to Ohio rates. In addition, cause-specific mortality rates for the top 10 causes of death in Cincinnati in 2001-2007 are elevated compared to other areas of Ohio, and to United States rates.

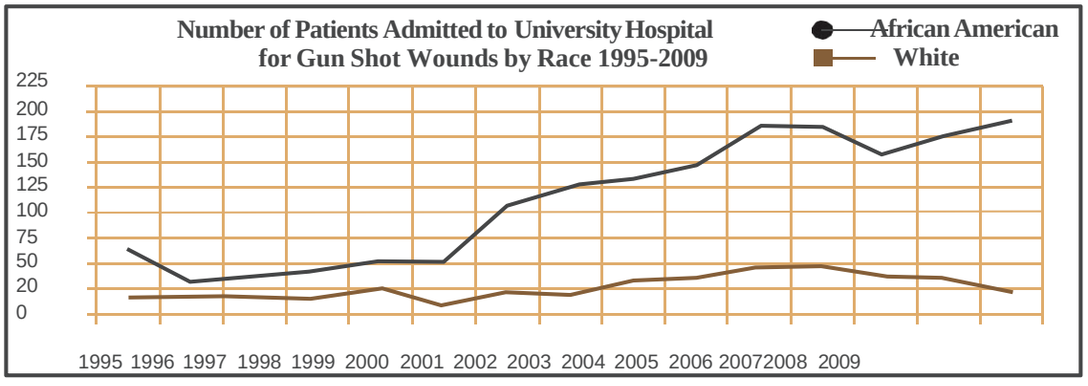
Mortality Rates (per 100,000 population) for the top 10 causes of death in Cincinnati, compared to Ohio Large Metropolitan Areas, and the United States, CDC Wonder Compressed Mortality Files, 2001-2007

Cause of Death	*Cincinnati 2001-2007*	*Ohio Large Metro 2001-2007*	*USA 2004*
1. Heart Disease	265.2	221.1	222.2
2. Malignant Neoplasms (Cancer)	230.8	217.4	188.6
3. Cerebrovascular Diseases (Stroke)	71.1	54.6	51.1
4.Chronic LowerRespiratory Diseases	56.1	44.9	41.5
5.Diabetes Mellitus	44.8	29.7	24.9
6. Accidents	42.6	32.9	38.1
7. Alzheimer's Disease	29.8	25.6	22.5
8.Nephritis / Nephrosis (Kidney Disease)	23.2	18.2	14.5
9.Influenza and Pneumonia	21.9	18.3	20.3
10. Assault(Homicide)	19.1	9.0	5.9

According to the Centers for Disease Control and Prevention (CDC), there are 'pockets of need' areas or populations within each state or major city. Substantial numbers of women with inadequate prenatal care exist in pockets of urban areas with traditionally underserved populations. From 2007-2009, the infant mortality rate (IMR, infant deaths/1000 live births) in Cincinnati's 22 zip codes ranged from 0 to 30.4. In 2010, Cincinnati's overall IMR was nearly 14, more than double the national IMR of 6.

Cincinnati Gun Violence and Homicides

In 2009, the CQ Press ranked Cincinnati the 19th most dangerous city in the United States. To combat the 500% dramatic rise in the incidence of gun violence (frequently due to retaliation) from 2000 - 2006 in Greater Cincinnati, Out of the Crossfire, Inc. (OOTC) was established. OOTC was the region's only hospital-based, violence intervention program and one of only nine in the United States. Hospital-based violence intervention programs have repeatedly been shown to reduce the incidence and severity of criminal activity, decrease the rate of violence recidivism, decrease hospitalizations, and increase employment or self-efficacy. Whereas the medical staff strives to heal the victim physically, these violence intervention programs aid in modifying the social and behavioral factors that may have led to the violent injury and the subsequent (or pre-existing) emotional/mental trauma that usually afflicts the victim and significant others. These programs deliver culturally sensitive interventions aimed at helping the individual through psychological recovery, socioeconomic rehabilitation, re-integration into the community, self-reliance skills development, as well as promoting health and well-being in survivors and other at-risk community members. Updated public health data and statistics were not available at the time of print for the 2016 Community Report.



This graph shows that the total number of adult hospital admissions (in Cincinnati) for gunshot wounds has risen dramatically since 2000, particularly for African-Americans. In 2010, there were 72 reported homicides; in 2011, there were 66. The ratio of survivable gunshot injuries to gunshot deaths is 8:1.

The death rate due to homicide in Cincinnati from 2001-2007 was 19.1/100,000, (more than twice the rate in Ohio large metropolitan regions, and more than three times the homicide rate in the US). Most of these deaths were due to firearms. While the effects of violence and fear of violence were not among the top priority issues identified by Local Conversations participants in initial meetings, many of the concerns raised by Local Conversations participants are impacted by and could impact rates of assault and homicide. Grassroots efforts to address violence are an example of how communities can come together to address high priority issues. The following examples highlight the success of grassroots efforts, but also show the need for sustainability planning to provide ongoing support for these interventions.

Out of the Crossfire, Inc. (OOTC) was established to combat the 500% dramatic rise in the incidence of gun violence (frequently due to retaliation) from 2000 - 2006 in Greater Cincinnati. OOTC was the region's only hospital-based, violence intervention program and one of only nine in the United States. Hospital-based violence intervention programs have repeatedly been shown to reduce the incidence and severity of criminal activity, decrease the rate of violence recidivism, decrease hospitalizations, and increase employment or self-efficacy. Whereas the medical staff strives to heal the victim physically, these violence intervention programs aid in modifying the social and behavioral factors that may have led to the violent injury and the subsequent (or pre- existing) emotional/mental trauma that usually afflicts the victim and significant others. These programs deliver culturally sensitive interventions aimed at helping the individual through psychological recovery, socioeconomic rehabilitation, re-integration into the community, self-reliance skills development, as well as promoting health and well-being in survivors and other, at-risk community members. After its first year of operation (2007), OOTC contributed to an 18% reduction in gunshot wounds treated at the only adult, level one trauma center in Cincinnati. The profile of OOTC clients was as follows: 87% African-American, 83% school dropouts, 85% unemployed, 81% had legal income less than

$10,000/year, 91% male, 80% were from non-traditional families, 80% were from violent neighborhoods, 86% were uninsured, 80% had a history of substance abuse and/or dealing drugs, 82% had a history of incarceration and 54% were within the age range of 14-25 years. Unfortunately, due to budget constraints, this was shut down after five years in April 2011.

Cease Fire Cincinnati is a community effort in Avondale, a predominantly African American community, to reduce gun violence and homicides. Initially, the program was a partnership between the City, the Community Police Partnering Center, the Urban League, the Avondale Community Council, the Cincinnati- Hamilton County Community Action Agency, the Uptown Consortium, the Out of the Crossfire Program, the Cincinnati Human Relation Commission Youth Streetworker Program and others. The program was modeled after Cease Fire Chicago, a program that gained national attention for its effectiveness. Cease Fire Cincinnati organized community rallies within 72 hours of every shooting in the neighborhood. The rallies brought together the community around the common message rejecting gun violence. The program also included a public education campaign to change attitudes toward gun violence and an outreach component to high-risk populations. The overall goal is to change the community by developing a culture of nonviolence. Ceasefire's funding, and its services have been drastically reduced.

The Cincinnati Initiative to Reduce Violence (CIRV) is a multi-agency and community collaborative effort initiated in 2007, designed to quickly and dramatically reduce gun-violence and associated homicides. The initiative is a focused- deterrence strategy which is modeled after the Boston Gun Project from the mid-1990s. A partnership among multiple law enforcement agencies (local, state, and federal), social service providers, and the community has been established to deliver a clear message to violent street groups: "The violence must stop". This message is communicated through a

number of different mechanisms, including call-in sessions with probationers and parolees; direct contact through street workers (street advocates), police, probation, and parole officers; community outreach; and media outlets. Law enforcement agencies have gathered intelligence on violent street group networks, and consequences are delivered to the street groups that continue to engage in violence. Those offenders seeking a more productive lifestyle are provided with streamlined social services, training, education, and employment opportunities. Funding cuts have reduced CIRV's staff and services significantly.

Cincinnati's Local Conversations on Minority Health

First Local Conversation on Minority Health: Saturday, August 23, 2008, at the Community Action Agency located at Jordan's Crossing, Cincinnati, Ohio, 45237.

Second Local Conversation on Minority Health: Thursday, October 28, 2009at the Cincinnati Health Department, 3101
Burnet Avenue, Cincinnati, Ohio, 45229

Third Local Conversation on Minority Health: January 26, 2010, at the Cincinnati Health Department, 3101 Burnet Avenue, Cincinnati, Ohio, 45229

Fourth Local Conversation on Minority Health: May 21, 2016, at the Community Action Agency located at Jordan's Crossing, Cincinnati, Ohio, 45237

At the first three Local Conversations on Minority Health, attendees were asked two key questions:

1. What are the most important health needs in our minority communities?
2. What can we do about them?

At the fourth Local Conversation, attendees were asked the following three questions:

1. What do you think is the most important health issue to you and your family?
2. What do you think is the most important issue in your neighborhood?
3. What services are needed or are your health service needs being met by the Cincinnati Health Department?

At the first conversation, each of four groups had a facilitator and a scribe who helped them identify and reach consensus on critical health needs and strategies to meet those needs in four areas: Resources, Services, Capacity building, and Infra- structure. The following conversations were smaller groups, so each focus area was discussed by the whole group.

To achieve greater community participation and prepare for the Third Local Conversation on Minority Health, a survey was designed and distributed to those that attended the first event, as well as to community leaders and advocates, from January 19 - February 26, 2010. E- mailed invitations to participate in the survey were sent to 125 people, and 78 (62%) completed the web-based questionnaire. The survey was conducted via Survey Monkey, which gave people the opportunity to respond confidentially. Survey participants were asked to update and rank the needs and strategies identified in 2008.

Between the Second and Third Local Conversations, participants were given the opportunity to provide input on how to conduct the survey, then how to interpret and display the survey results.

The following priorities for the most frequently cited needs and strategies are listed in the four categories (Services, Resources, Capacity Building and Infrastructure). The result of this process was the Cincinnati Health Disparity Reduction Plan that follows.

Health Disparity Reduction Plan

Services

		#	%
Need 1	Added services in high need areas	32	49.2%
Need 2	Enhanced positive social environments (in health care facilities, grocery stores, schools, recreation areas, etc.)	28	43.1%
Need 3	Focus on health education	29	43.9%
Need 4	Reduction in infant mortality	27	40.9%
Need 5	Establish prison re-entry programs	28	42.4%
Strategy 1	Raise access to alcohol, drug, & mental health services	23	65.7%
Strategy 2	Provide health education in schools as part of the learning standards	9	64.2%
Strategy 3	Provide pre/postnatal health services for all, especially indigent or high-risk situations	14	60.9%
Strategy 4	Provide peer mentoring for new parents	11	44.9%
Strategy 5	Reduce mental health stigma through education & mental health recovery groups	4	33.3%

Resources

		#	%
Need 1	Increased health literacy for all consumers	45	67.2%
Need 2	More supportive funding for minority health care	37	54.4%
Need 3	Sharing patient information more efficiently (with consumers & providers)	42	62.7%
Need 4	More resources for the homeless, remove obstacles to self-efficacy, respect dignity	37	56.9%
Strategy 1	Mount public awareness campaigns re: needs and new plan/policies	20	45.5%
Strategy 2	Promote health literacy in K-12 schools at all levels	19	54.5%
Strategy 3	Provide training for health providers, e.g., cultural sensitivity, listening, screening	20	48.8%
Strategy 4	Develop and disseminate easy-to-read health information; CDs, videos, PSAs	14	37.9%
Strategy 5	Improve and share data through synchronized electronic systems	10	33.3%

Capacity Building

		#	%
Need 1	Increased collaboration among community sectors	42	70.0%
Need 2	Improved community engagement	38	62.3%
Need 3	Increased resident involvement in politics	43	70.5%
Need 4	Improved cultural competence among all professional and paraprofessional service providers	33	54.1%
Strategy 1	Increase community engagement in health disparity reduction, e.g., Asset-Based Community Development (ABCD)	25	55.6%
Strategy 2	Develop/expand community partnerships with local universities	21	57.4%
Strategy 3	Foster collaborative fund raising	15	60.0%
Strategy 4	Host community forums	12	42.9%
Strategy 5	Broaden base of participants	9	34.6%

Infrastructure

		#	%
Need 1	More free clinics and an urgent care center	32	53.3%
Need 2	Economic development	30	50.0%
Need 3	Increased numbers and improved quality of community health workers	31	51.7%
Need 4	Recruit/develop more community advocates	27	46.5%
Need 5	Increased accountability of service providers e.g. cultural sensitivity, trauma screening, monitoring of medications given	14	23.7%
Strategy 1	Launch urgent care centers & free centers to reduce ER use	24	60.0%
Strategy 2	Collaborate with community & government to stimulate economic development	18	42.9%
Strategy 3	Train and certify community advocates	22	59.4%
Strategy 4	Engage in community health worker outreach	17	41.2%
Strategy 5	Increase awareness of economic development needs	9	27.3%

The Fourth Conversation

The fourth Community Conversation was held in May 2016 to engage stakeholders in a dialogue around the health needs of the community. Since the previous conversation, new priorities emerged. Between 80 and 90 community stakeholders participated in the event. All participants were asked to consider three questions:

1. What do you think is the most important health issue to you and your family?
2. What do you think is the most important issue in your neighborhood?
3. What services are needed or are your health service needs being met by the Cincinnati Health Department?

Thirty-four worksheets reflecting both individual and collective responses to each question were collected from each table at the end of the event. Findings revealed a slight shift in priorities from the previous Conversations. Ranked in order of priority with "1" being most important and "5" being less important, findings are listed below:

A. What do you think is the most important health issue to you and your family?
   1. Mental Health/Chronic Disease Awareness
   2. Healthy Eating
   3. Poverty (childhood)
   4. Finances/Employment
   5. Health Insurance

B. What do you think is the most important issue in your neighborhood?
   1. Safety
   2. Housing/CMHA
   3. Drugs/Violence
   4. Community Friendliness
   5. Food Resources/fresh foods from pantries

C. What services are needed or are your health service needs being met by the Cincinnati Health Department?
   1. Reliable transportation to health appointments
   2. Knowledge of Services CHD provides
   3. Mental Health Services
   4. Food Resources with fresh foods from pantries
   5. Police Trust

As part of the Creating Healthy Community Coalition, monthly meetings are also held at the Cincinnati Health Department. These meetings invite local stakeholders to attend, present, and discuss issues that relate to minority health, the health of the community, and health disparities. Attendance at these meetings is presented in the table below. A diverse analysis was completed to understand if we are reaching a diverse enough audience for these meetings.

COMMUNITY PARTICIPATION

Date(s) of Event(s) (list separately)	# Served	Number served by Ethnic/Racial Group					
Ethnicity/Racial Group Represented	All	African American	Hispanic	Native American	Asian	White	Other
No January meeting							
Creating Healthy Communities Coalition Meeting April 2016	45	15	1		1	28	
Creating Healthy Communities Coalition Meeting May 2016	61	29			1	31	
Creating Healthy Communities Coalition Meeting June 2016	61	27	2			32	
Creating Healthy Communities Coalition Meeting July 2016	52	26			1	25	
Creating Healthy Communities Coalition Meeting August 2016	58	29	1		2	26	
Totals	277	126	4		5	142	

a) Date of event/ Service Provided: Indicate each separate activity/service date on which it occurred.
b) Total# Served: Record the number of people served freesheet/service period.
c) Total #by Ethnic/Racial Group: Record the number of African Americans, Asians, Hispanics and Native American Indians served through each service/ event.

State Agency Partnership

The Ohio Commission on Minority Health received partial funding support for the "**Local Conversation Initiative - Round 3"** 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.

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 Cincinnati Health Disparity Reduction Plan in this document is a result of this process.

The Cincinnati Local Conversations on Minority Health were facilitated by the Cincinnati Health Department (CHD), an agency with a strong history of providing health services to minority and underserved populations.

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.

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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.

Cincinnati Health Department

The Cincinnati Health Department (CHD) has a long and proud tradition of providing primary and preventive health care by operating full-service health centers, functioning as a safety net with on-site medical, dental, and pharmacy services, including five health centers, four dental clinics, and a reproductive health and wellness center. These centers serve more than 35,000 patients, 58% of whom are medically indigent, working poor or homeless, comprising more than 12% of Cincinnati residents.

The CHD also provides a variety of public health services to city residents, including communicable disease prevention and control, environmental services including food and other safety inspections, health status assessments and surveillance, immunizations, and education/prevention programs. More than 400 doctors, nurses, dentists and dental hygienists, pharmacists, dieticians, sanitarians, litter control experts, IT specialists, pest control operators, lead poisoning prevention and control experts and licensed risk assessors, and clerical staff are dedicated to serving the people of Cincinnati. They serve in health centers, school-based nursing programs, in neighborhoods and in the homes and on the streets, and influence policy in public sector settings. The CHD has an Office of Health Equity, located in the Division of Community Health and Environmental Health Services.

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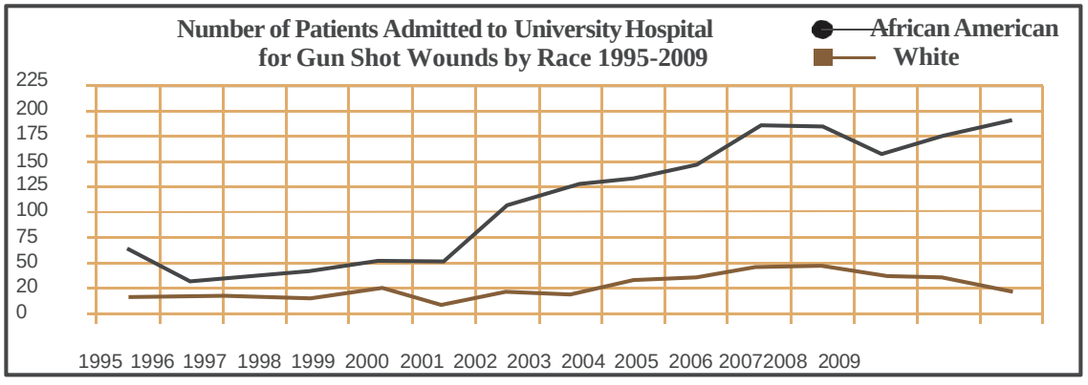

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Geographic Scope

The geographic scope of this project is Cincinnati, Ohio.

Demographic Profile of Cincinnati

Cincinnati is a city in, and the county seat of, Hamilton County, Ohio, United States. Settled in 1788, the city is located north of the Ohio River at the Ohio-Kentucky border, near Indiana. The population within city limits was 296,943 in over 133,000 households according to the 2010 census, making it Ohio's third-largest city. According to the 2010 Census Bureau estimate, the Cincinnati metropolitan area had a population of 298,550 the 27th most populous Metropolitan Statistical Area (MSA) in the United States, and the most populous in Ohio. Cincinnati has a large minority population. The racial demographic breakdown of Cincinnati is as follows:

49.3% are white/Caucasian

44.8% are black/African American

1.8% are Asian/Pacific Islander

2.8% are Hispanic/Latino

4.1% identified as some other race

The White population continues to decrease as families move to more affluent suburbs, creating a concentration of disparities among minorities living in low-income, urban neighborhoods.

Strategies/Comments

The following additional strategies or comments were provided over the course of the conversations and through the survey:

One research project sought to understand the chief health concerns of the Creating Health Communities Coalition. The abstract for the research project is below:

Evaluating the Creating Healthy Communities Coalition Nicholas K. Addo, Rutgers University

Background
The Cincinnati Health Department (CHD) created the Creating Healthy Communities Coalition (CHCC) to promote the health and well-being of people in Cincinnati. The CHCC works with many community partners and policy makers to address healthy eating, tobacco-free living, active living, and chronic disease management or prevention. In May 2016, the CHD in conjunction with the CHCC organized a local conversation about minority health in Cincinnati. Participants in the conversation were from target neighborhoods of the CHD and CHCC. The goal of this research project was to determine the most important health indicators for members of target communities and evaluate the role of CHCC in creating healthy communities in Cincinnati. The objective is to determine the best public health practices for public health communication plans and provide recommendations for future community health planning.

Methodology
The study evaluated two sets of data. The first set came from the CHCC member evaluation survey. Participants (n=50) were members of the coalition. The CHCC evaluation was administered with the online survey platform, SurveyMonkey, and sent to members by email. The second set of data came from a local conversation on minority health with members of Cincinnati CHCC's focus communities in May 2016. Sixty-one community members participated in the discussion. Data from community conversations were collected through an administered health priorities worksheet. Both sets of data were analyzed by descriptive statistics with Microsoft Excel.

Results
Of the 50 CHCC members, n=23 completed the evaluation survey and revealed barriers to participation in the coalition as well as addressing improvement areas. Local conversation data also revealed health gaps and key health indicators in Cincinnati's communities, suggested strategies and identified ways the CHD can address them. The primary community concerns were drugs and violence (n = 23), health education (n=18), mental health services (n=18), food access (n=13), and transportation (n=11). The leading health indicator was poverty.

Conclusion
The results of the study indicate that the intersection of socioeconomic status and the environment shape indicators of health. Furthermore, community-based participatory research is a useful approach to explore issues regarding minority health, communicating intervention plans, and developing programs for maximum impact. Other strategies CHD is taking based on the information gathered at all community conversations are:

- Providing culturally sensitive community education will lead to preventive health care.
- Focus on reproductive health with youth; drug & alcohol, mental health, and safe social interaction education for all.
- Provide interpretation services for limited English speaking or ESL people.
- Promote integrative medicine, e.g., nutrition education, stress management, access to fruits and vegetables.
- Provide transportation for seniors and disabled; provide health care for all, even the undocumented.

Follow-up Action Plan

The final report constitutes a set of needs and strategies that function as a recommended action plan for public health and 10 social services agencies in the region that have been developed through grassroots discussions. The Cincinnati Health Department (CHD) has taken the needs and strategies in this report into consideration as we continue to strive to improve the health of our residents. Specifically:

1. The CHD is investigating the feasibility of establishing a new urgent care center in an underserved neighborhood and plans to submit a proposal to City Council shortly. *[Infrastructure; Need & Strategy 1]*

2. The CHD continues to develop and expand partnership opportunities with local universities. Since the First Local Conversation, a partnership with the Xavier University Master of Health Services Administration program has resulted in the analysis and reporting of the leading causes of death for the City and all its neighborhoods by age, race, and sex. This data provides vital information to help drive public health and social services interventions. *[Capacity Building; Strategy 2]*

3. The CHD continues to play a crucial role in understanding and working to reduce infant mortality through participation in the Cincinnati-Hamilton County Fetal and Infant Mortality Review (FIMR). The FIMR investigates specific cases of infant or fetal loss through comprehensive medical and social service records reviews as well as, where possible, maternal interviews. Through this holistic approach, recommendations for system changes to reduce infant loss are developed and shared with an action team. [*Services; Need 4*]

4. CHD in concert with the University Hospital (UH) Women's Health Center, has implemented an Infant Vitality Surveillance Network, which addresses the root causes of disparities in infant vitality by 1) using data to make decisions; 2) assisting to empower, mobilize and enfranchise communities; 3) monitoring, evaluating and providing feedback that leads to ongoing adaptations and improvements.

5. CHD will continue to address healthy eating, active living, tobacco free living, and chronic disease prevention through the Creating Healthy Communities Program (CHCP). CHCP is a collaborative approach to policy, system and environmental changes that support local population health. The Program includes a **90+** member Coalition whose members work together to create sustainable responses to health disparity by increasing access to nutritious foods, increasing access to safe places for physical activity, increasing access to tobacco-free environments and providing chronic disease prevention and management education. Sectors represented by current members include schools, businesses, transportation, local housing authority, key community stakeholders/residents, local governmental departments, non-profit organizations, faith-based organizations, and other coalitions or agencies. Through a health Lense, members are dedicated to addressing other social determinants of health such as education, housing, transportation, and safety. *[Capacity Building; Strategy 2]*

6. As a result of our fourth conversation, CHD is moving through the Public Health Accreditation process and is using the data from the conversation as part of the overall strategic plan. The department is now putting establishing guidelines and recommendations that address the heroin epidemic and mental health screening and care.

Acknowledgments

In addition to support from the Ohio Commission on Minority Health, the following organizations sponsored the 2008 Local Conversation on Minority Health:

The Cincinnati/Hamilton County Community Action Agency

The Xavier University Women's Center

Xavier University College of Social Sciences, Health and Education

Xavier University Department of Nursing

Xavier University Department of Social

Work Bigg's Department Store

The Coffee Emporium

The Kroger Company

The Cincinnati Local Conversations on Minority Health participants included:

S. Abdullah, Cincinnati/Hamilton County Community Action Agency

James Alexander, T V Producer, Videographer

Janice Alvarado, Health Advocate/Analyst

Tom Bergh, Cincinnati Metro

Anita Brentley, Cincinnati Children's Hospital Center

Jill Byrd, community representative

Tom Chung, Ohio Asian-American Health Coalition

Miriam Crenshaw, CEO, WinMed Clinic

Imelda Castaneda-Emenaker, University of Cincinnati

Debra Dreyfus, RN, Manager of Price Hill & Millvale Health Centers

Nan Gracia, community representative

Judith Harmony, community representative

Kathy Hill, community representative

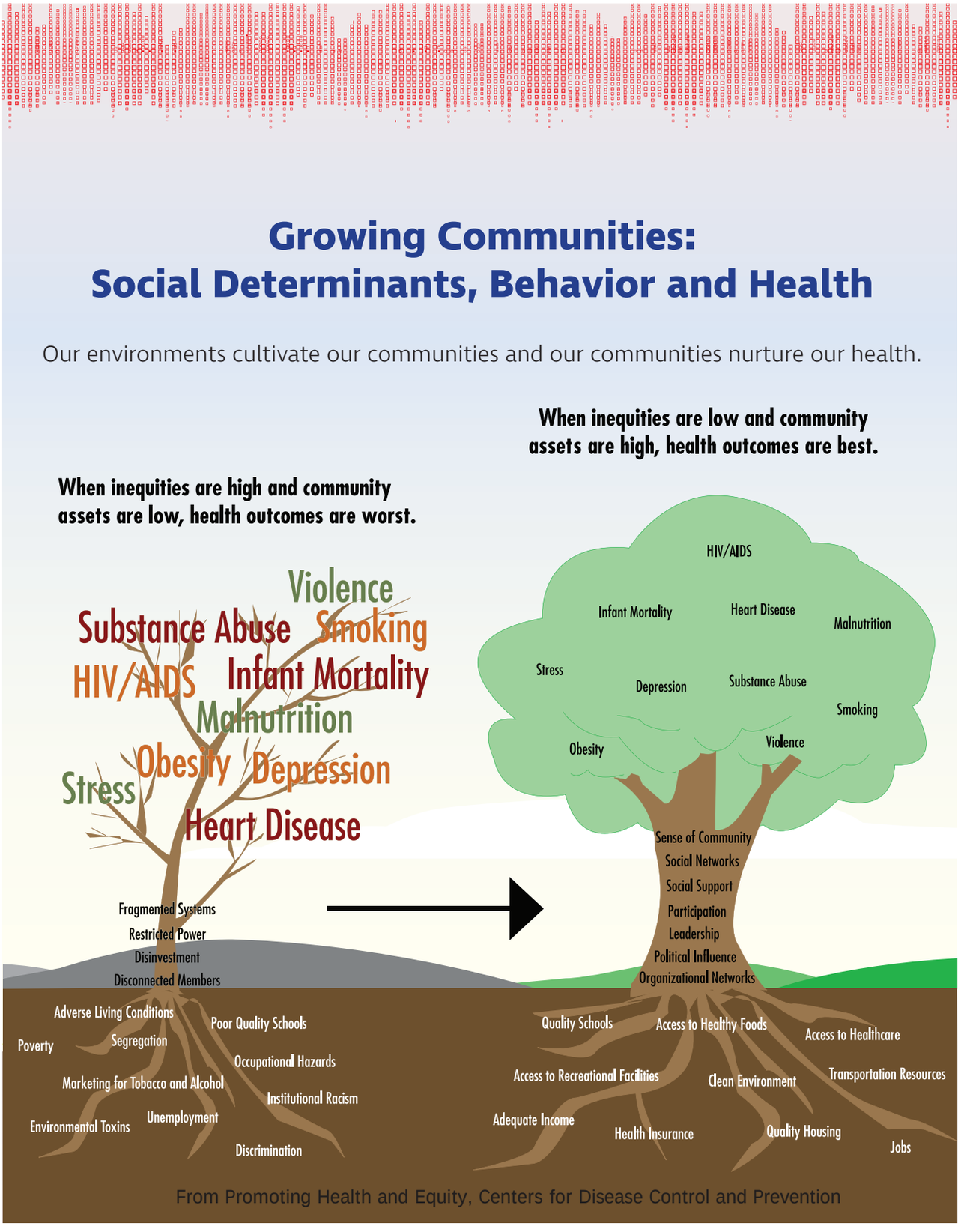
Bo-Kyung Kim Kirby, Asian Community Alliance N.K.U

city of CINCINNATI HEALTH DEPARTMENT

Commission on Minority Health

Growing Communities: Social Determinants, Behavior and Health

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

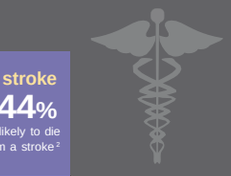


From Promoting Health and Equity, Centers for Disease Control and Prevention

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 AND HOME 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

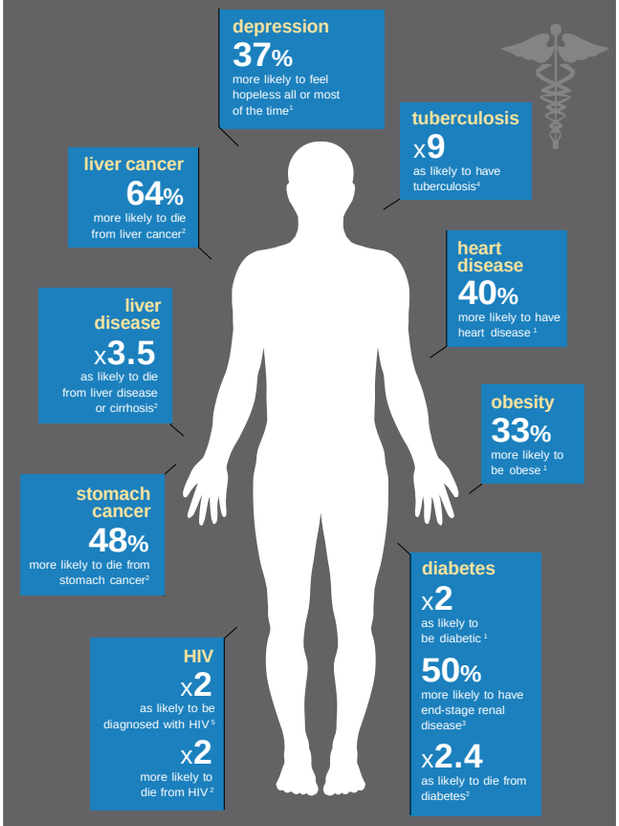
Our common prosperity demands a health system where everyone can attain the best possible health and health care. The roots of health and health care inequities are many, and they run deep in American society--from environmental factors, to living conditions, to lack of access to care, to discrimination,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

FAMILIESUSA HEALTH EQUITY ACTION APIAHF

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)[6]

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.

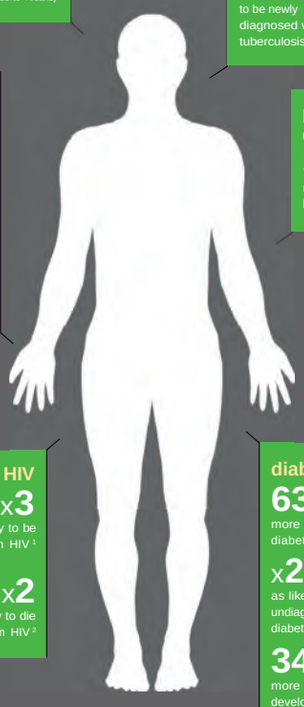
FAMILIESUSA

HEALTH EQUITY ACTION FOR SYSTEM TRANSFORMATION

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

Good Health Begins with You®

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If so join our list serv to receive related information.

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Commission on
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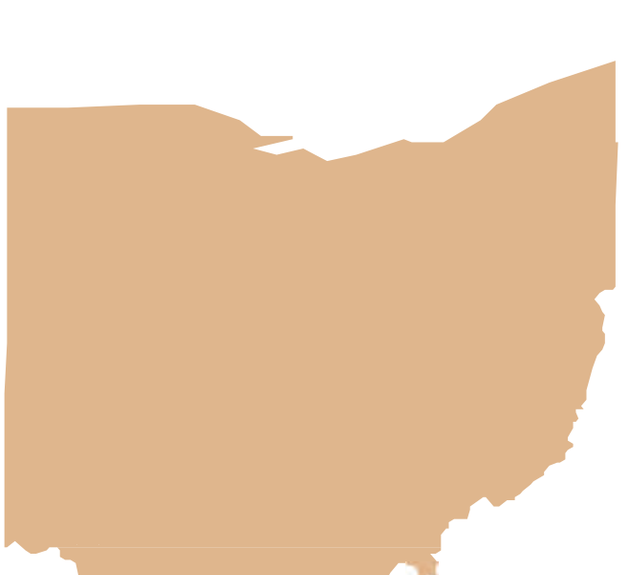

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Local Conversation Report

www.mih.ohio.gov