Ohio Commission on Minority Health

Commission on Minority Health

General Overview

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www.mih.ohio.gov

About Us

In 1987, the Ohio Commission on Minority Health became the first freestanding state agency in the nation to develop a concerted approach to address the disparity that exists between the health status of minority and non-minority populations. Today, there are Offices of Minority Health in 47 states. We provide grants to organizations that design culturally-specific, non-traditional demonstration projects to meet the health needs of Asian Americans, African Americans, Hispanic/Latinos and Native American Indians.

- The national recognition of health disparities in the United States has been extensively documented beginning with the 1985 *Report of the Secretary's Task Force on Black and Minority Health*, and continuing on with more recent reports such as the 2002 report for the Institute of Medicine (IOM) (*Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*), and the yearly *National Healthcare Quality Reports and National Healthcare Disparities Reports* from the U.S. Agency for Healthcare Research and Quality (AHRQ).

- In 1985, The United States Department of Health and Human Services (HHS) released a landmark report documenting the existence of health disparities for minorities in the United States.

The Creation of the Ohio Commission on Minority Health

Former Senator Ray Miller, then Representative Ray Miller envisioned the Ohio Commission on Minority Health after attending a health data conference that presented significant national health disparities experienced by minority populations.

He made a public commitment at the conference to address this issue in Ohio.

He immediately reached out to former Governor Richard Celeste to initiate comprehensive response in Ohio.

Ohio: Governor's Task Force on Black and Minority Health

In 1986, in response to this disparity the State of Ohio created the Governor's Task Force on Black and Minority Health as a special project under the Ohio Department of Health Executive Order 85-69 authorized the task force to:

Examine the conditions under which gaps in the health and health care services for black and minority communities exist and recommend methods by which the gaps could be closed.

In July 1987, then Rep. Ray Miller sponsored and passed an amendment to the State of Ohio's Budget Bill, Amended Substitute House Bill 171, which created the Ohio Commission on Minority Health.

The Commission was the **first concerted efforts in the nation by a state to address** the disparities in health status between majority and minority populations.

The Commission predated the Federal HHS Office on Minority Health and with more than three-times the funding.

In July 1987, the 117th Ohio General Assembly passed amended Substitute House Bill 171, creating the Ohio Commission on Minority Health.

The Commission is an autonomous state agency that began with a biennial appropriation of $3.5 million dollars of general revenue funds.

Visionary and Founder

Former Senator Ray Miller is the Visionary and Founder of the Ohio Commission on Minority Health.

He served as the Board Chair and Board Member of the Ohio Commission on Minority Health providing essential leadership and policy guidance.

During his tenure, he created the Crystal Stair Award to honor Ohioans who have made significant contributions to the efforts to eliminate health disparities and achieve health equity.

This award was named in his honor in 2017 to ensure his notable contributions to the creation of this state agency and the progress toward health equity would be attributed to his efforts.

Executive Director Emeritus

Mrs. Cheryl Boyce, our Executive Director Emeritus, a pioneer in the fight against inequality and injustice.

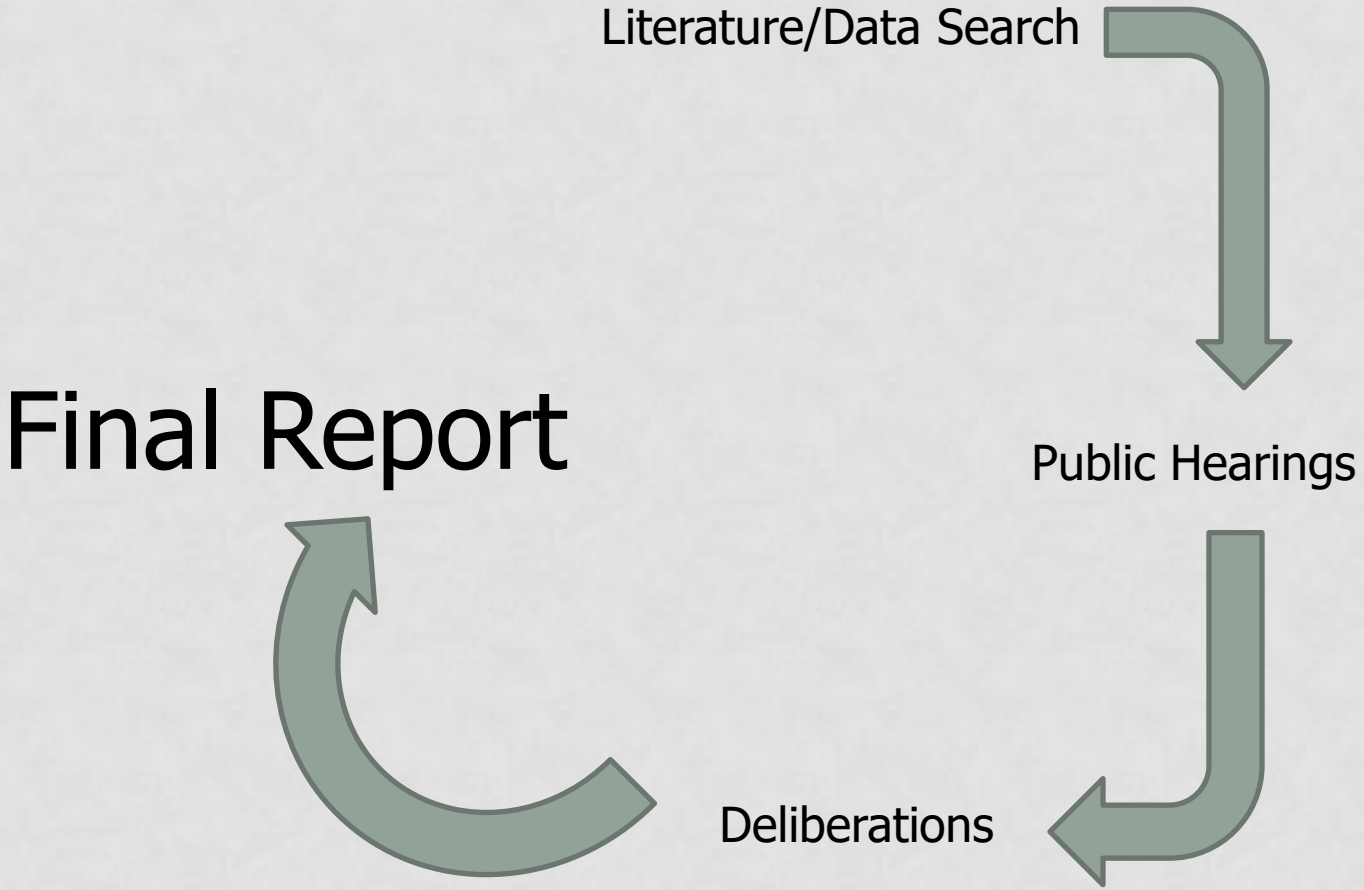
Director Boyce advocated, advanced, adapted and laid an unwearied course for increased awareness of minority health disparities.

She was a leader and a trail blazer in the field of minority health in the state of Ohio and in the nation.

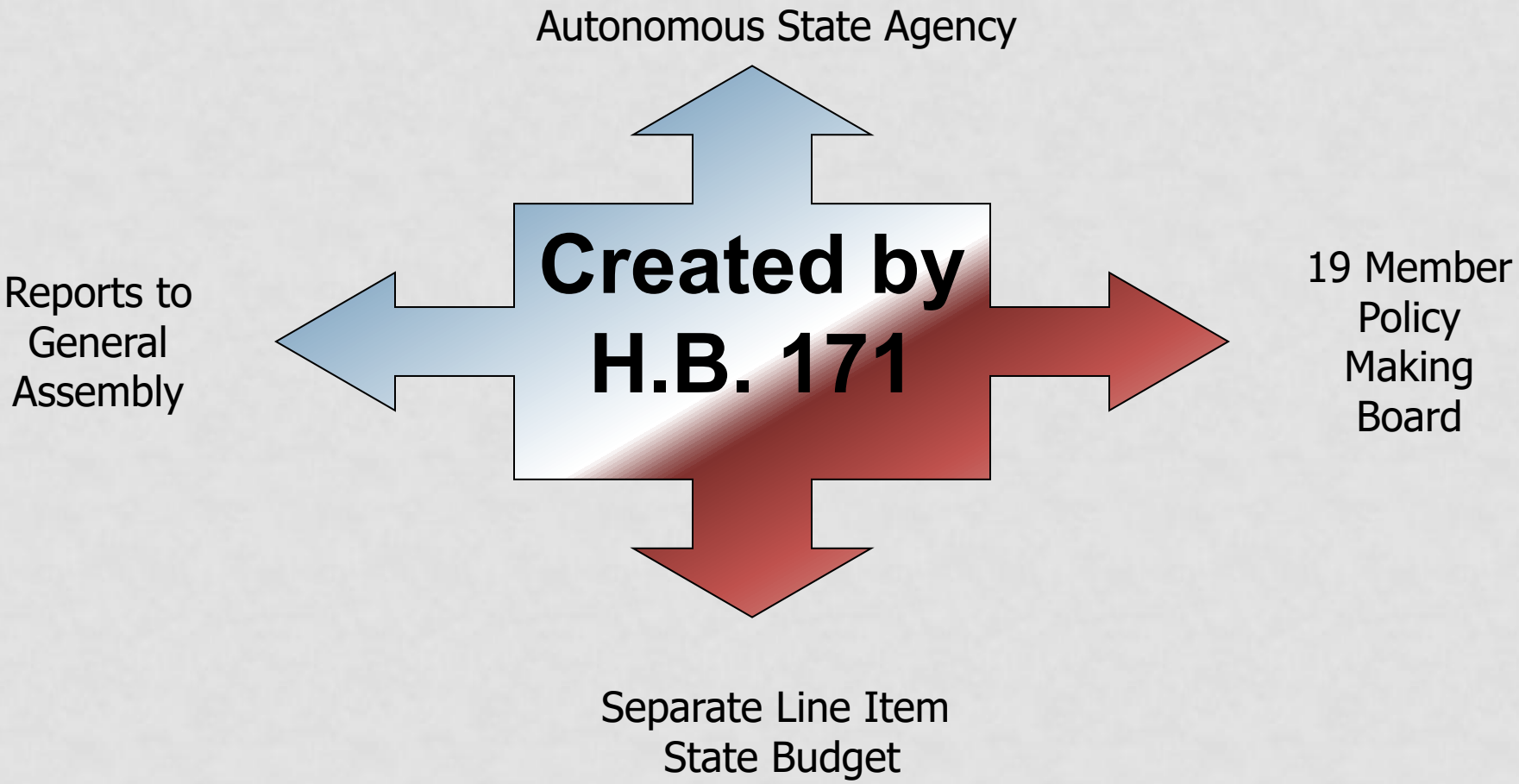
Her national work is reflected in her efforts to replicate the Ohio model and impact the creation of state offices of minority health in the nation as well as the National Association of State Offices of Minority Health.

She is the “Mother of Minority Health in Ohio and in the Nation.

In the Beginning . . .1986



Ohio Commission on Minority Health *1987*



Mission Statement

The Ohio Commission on Minority Health is dedicated to eliminating disparities in minority health through innovative strategies and financial opportunities, public health, promotion, legislative action, public policy and systems change.

Vision Statement

The Ohio Commission on Minority Health's vision is to achieve health parity among Ohio's minority populations.

Guiding Principles

- We involve and empower the community
- Our work is based on the documented needs and interests of the community
- We are culturally competent practitioners who are informed about Minority Health
- We are expected to demonstrate personal and professional integrity
- We prove to be accountable, reliable, and guided by ethical standards
- We make fair and equitable decisions
- We value the formation of strategic partnerships
- We establish performance targets and assess performance regularly
- We promote excellence and innovation

H.B. 171 Provisions

Current Board Structure – 20 members

- Governor appoints 9 from community
- Speaker of the House appoints 2 (one from each party)
- President of the Senate appoints 2 (one from each party)
- Assigned Cabinet Members (7 Directors/Designees)

H.B. 171 Provisions

Assigned Cabinet Members

- Director, Ohio Department of Aging
- Director, Ohio Department of Developmental Disabilities
- Director, Ohio Department of Education and Workforce
- Director, Ohio Department of Health
- Director, Ohio Department of Job and Family Services
- Director, Ohio Department of Medicaid
- Director, Ohio Department of Mental Health and Addiction Services

H.B. 171 Provisions

- The Commission shall promote health and the prevention of disease among members of minority groups

- Each year the Commission shall distribute grants from available funds to community-based health groups to be used to promote health and the prevention of disease among members of minority groups

H.B. 171 Provisions

As used in this division, "Minority Groups" means any of the following economically disadvantaged groups: *African Americans, American Indians, Hispanics/Latinos and Asians*

No group shall qualify to receive a grant from the Commission unless it receives at least (20%) twenty per cent of its funds from sources other than grants distributed under this section

Target Populations

- African Americans
- Hispanic/Latinos
- Asian Americans
- Native American Indians

Grant Programs

Demonstration

Innovative and culturally specific projects are funded up to $200,000, for a two-year period. These projects must address a specific community population with a methodology yielding measurable outcomes for behavior change. Grants must identify one or more of the six diseases and conditions, or risk factors, responsible for excess, premature deaths in the community. They promote behavior change by tapping into the attitudes, values and beliefs of the target populations. A goal of this grant program is the institutionalization of culturally appropriate projects into the healthcare delivery system. Funding for Demonstration grants will be available in December every other year. Funding levels are subject to approved biannual budgets.

Grant Programs

Minority Health Month

Created in April 1989, Minority Health Month is designed to be a 30-day, high visibility, health promotion and disease prevention campaign. This funded initiative is conducted by community-based agencies and organizations. This annual awareness campaign reaches into urban, suburban and rural areas of the State. These initiatives are funded up to $4,000 annually. Funding for Minority Health Month is available every June. Funding levels are subject to annual budgets.

Systemic Lupus Erythematous

This program provides grants for lupus programs for optimal health support groups for persons with Lupus and caregivers and public education which are funded up to $38,000 for a two-year period. In addition, Lupus grants are required to conduct lupus screening and to provide outreach to women of color. Funding for Lupus grants will be available in December every other year. Funding levels are subject to annual budgets.

Grant Programs

Infant Mortality Pathways Community Hub – Expansion Replication Grants

The Commission funds Demonstration grants to develop models that can be self sustainable and replicable. These models are innovative, culturally sensitive and specific in their approach toward reduction of the incidence and severity of those diseases or conditions which are responsible for excess morbidity and mortality in minority populations.

In 2000, the Commission provided seed funding to support the Community Health Access Project who helped to develop the Community Pathways HUB Model.

The Commission continued funding the implementation of this model through our demonstration grant funding program which demonstrated efficacy with racial and ethnic populations and cost effectiveness. This best practice evidenced based model has been endorsed by CMS, CDC, NIH, AHRQ, HRSA and others.

Infant Mortality Pathways Community Hub – Expansion Replication Grants

In 2015, the State of Ohio was ranked 50th in the Nation for African American Infant Mortality. The Commission presented the Community Pathways HUB model as one of the viable solutions to address this significant disparity.

In the FY2016/2017 State of Ohio Biennial Budgets, the Commission was provided an increase in funding to initiate the funding of this Model. This funding was allocated to initiate the Certified Pathways Community HUB Model Expansion and Replication – Infant Mortality funding opportunity.

In 2020, the Commission received additional funding to bring this model to scale in Ohio

Grant awards range from $300,000 - $440,000 annually and award levels are dependent on the approved Biannual Budget and HUB status.

Ohio Commission on Minority Health Local Offices of Minority Health Project

In 1987, the Ohio Commission on Minority Health was the first effort of its kind in the nation with the creation of a state agency focused on addressing the health disparities of Ohio's racial and ethnic populations.

With the increasing growth State Offices of Minority Health, in 2005 the OCMH piloted the creation of the National Association of State office of Minority Health – (NASOMH) to promote and protect the health of racial and ethnic minority communities, tribal organizations and nations, by preventing disease and injury and assuring optimal health and wellbeing.

Having a national strategy established, in 2007 the OCMH moved to create an infrastructure and presence at the local level through the establishment of the Local Offices of Minority Health within urban areas in Ohio. These offices are located in Akron, Cleveland, Columbus, Dayton, Toledo, and Youngstown.

This initiative became the first of its kind by a state agency in the nation. In an effort to develop a model for the nation, the OCMH spearheaded the creation of national performance standards and/or core competencies for Local Offices of Minority Health in collaboration with NASOMH. Grant are funded at $52,500 annually.

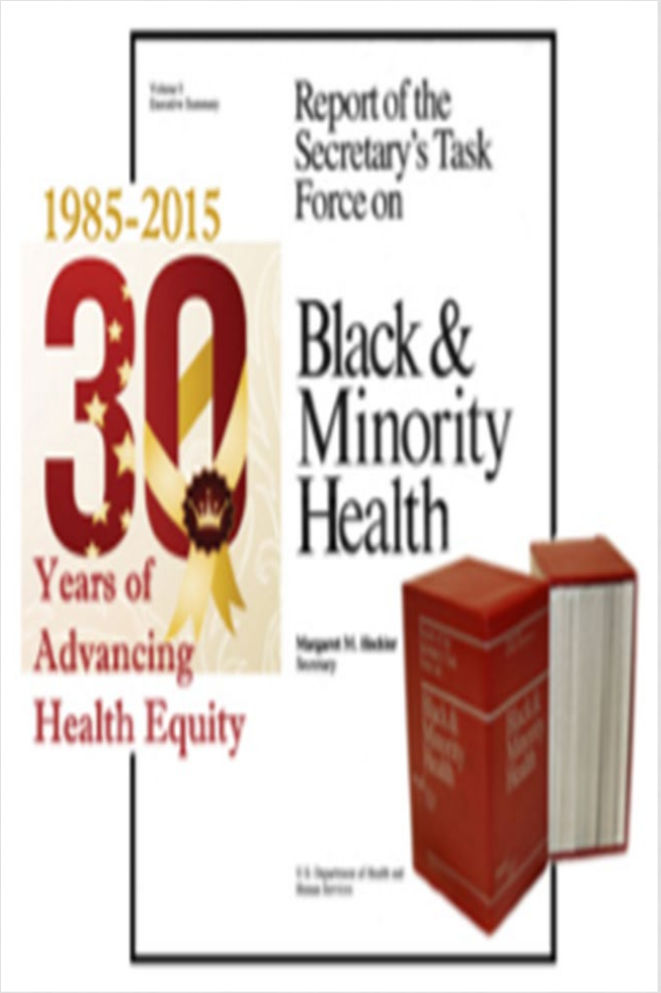
Strategic Plan 2025

The Ohio Commission on Minority Health's Strategic Plan Goals are aligned with the U.S. Department of Health and Human Services Action Plan to Reduce Racial and Ethnic Health Disparities. This strategic plan focuses on core areas of:

1. *Awareness:* To increase awareness of minority health disparities
2. *Leadership:* To broaden leadership to address health disparities at all levels.
3. *Improved healthcare access:* To increase access for racial and ethnic minority populations
4. *Workforce development and Diversity:* To advocate for diversity and cultural and linguistic competency in the healthcare and health related workforce.
5. *Health Data, Research and Evaluation:* To improve availability for all racial and ethnic populations.
6. *Organizational Development:* To improve technological efficiency, expand funding diversification and monitor healthcare cost impact.

1985 REPORT OF THE SECRETARY'S TASK FORCE ON BLACK AND MINORITY HEALTH

"Despite the unprecedented explosion in scientific knowledge and the phenomenal capacity of medicine to diagnose, treat and cure disease, Blacks, Hispanics, Native American Indians and those of Asian/Pacific Islander Heritage have not benefited fully or equitably from the fruits of science or from those systems responsible for translating and using health sciences technology."



Racial and Ethnic Healthcare Disparities are multifactorial and complex

MAJOR FACTORS INCLUDE:

- **Inadequate Access to Care**
- **Poor Utilization of Care**
- **Substandard Quality of Care**
- **Social Economic Status**

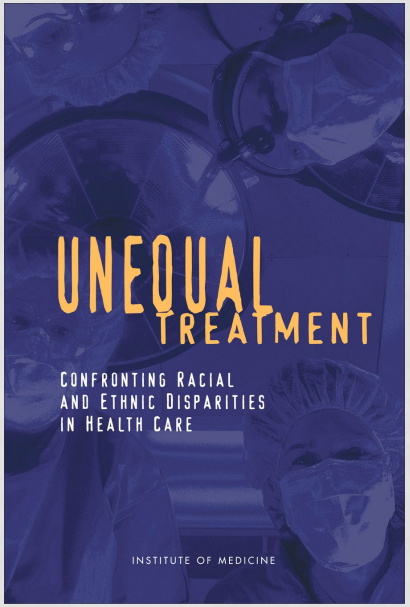
"***The future health of the nation will be determined to a large extent by how effectively we work with communities to reduce and eliminate health disparities between non-minority and minority populations experiencing disproportionate burdens of disease, disability, and premature death.***"

~ Guiding Principle for Improving Minority Health

1999 Institute of Medicine

Congress requested that the IOM:

- Assess the extent of racial and ethnic disparities in healthcare.
- Identify potential sources of these disparities; and
- Suggest intervention strategies.



The study committee was struck by what it found. The research indicated minorities are less likely than whites to receive needed services, including clinically necessary procedures, even after correcting for access-related factors, such as insurance status.

Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care

African Americans and Hispanics tend to receive a lower quality of healthcare across a range of disease areas (including cancer, cardiovascular disease, diabetes, mental health and other chronic and infection disease)

Disparities are found even when clinical factors such as stage of disease presentation, co-morbidities, age and severity of disease are taken into account

Disparities in care are associated with higher mortality among minorities who do not receive the same services as whites

Disparities are found across a range of clinical settings, including public and private hospitals, teaching and non-teaching hospitals

HEALTH CARE DISPARITIES

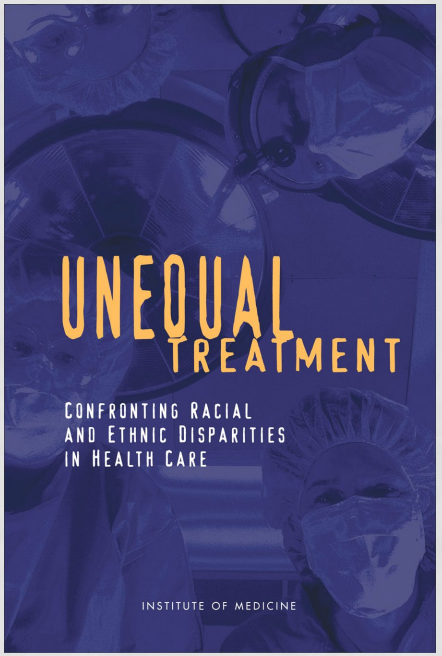
"Racial or Ethnic differences in the QUALITY OF HEALTHCARE that ARE NOT due to access related factors or clinical needs, preferences, and appropriateness of intervention."


HOW THE USE OF RACE IN CLINICAL CARE CAN CONTRIBUTE TO HEALTH CARE DISPARITIES
▸Provider Bias and Discrimination
▸Disease Stereotyping and Nomenclature
▸Clinical Algorithms: Tools and Guidelines
▸Race Based Pharmacological Prescribing

What Healthcare Administrators Need to Know

Racial and Ethnic Disparities in Healthcare

- Base decisions about resource allocation (e.g., which patients should receive particular treatments for specific health conditions) on published clinical guidelines.
- Take steps to improve access to care—including the provision of interpretation and translation services, where community need exists.
- Develop and support a diverse health workforce and promote cultural and linguistic competency training.



2022

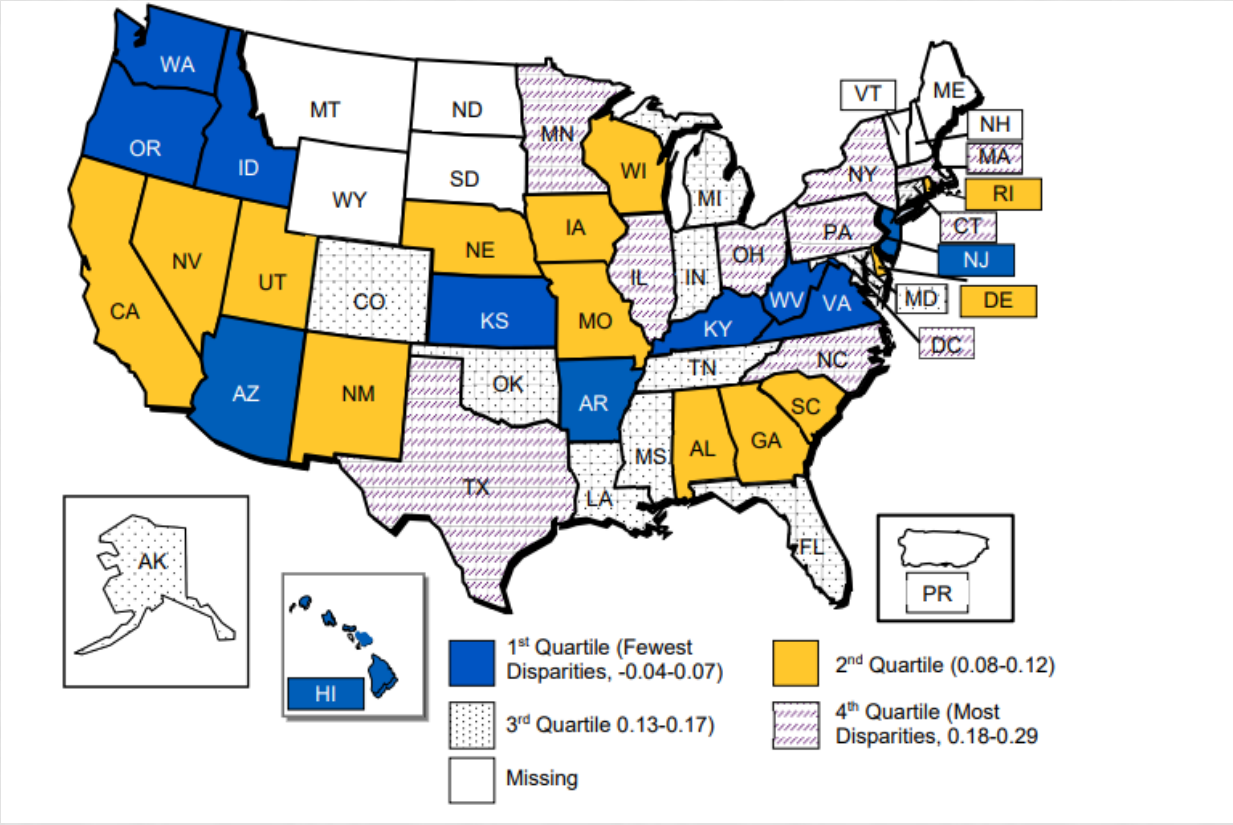
National Healthcare Quality and Disparities Report

AHRQ
Agency for Healthcare Research and Quality

AHRQ DISPARITIES REPORTS

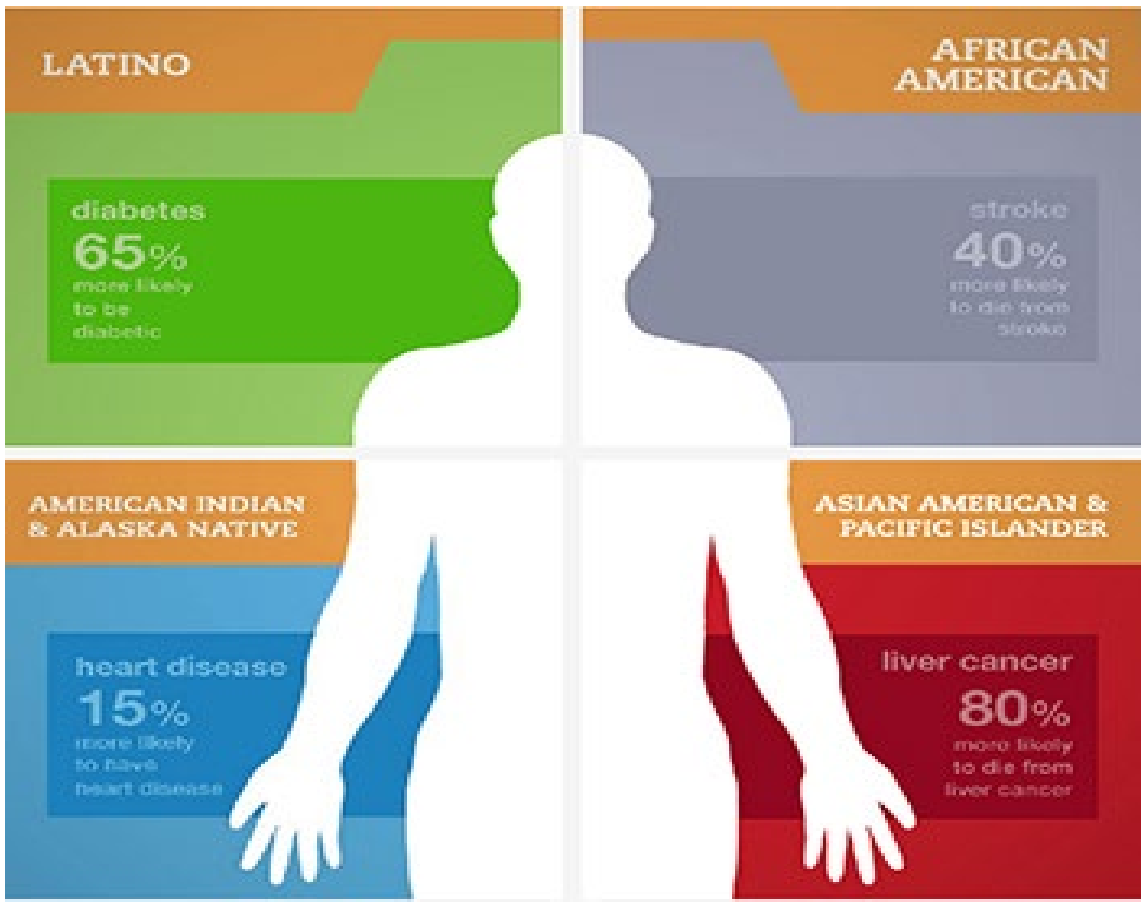
- **Annual report to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129)**
- **Provides a comprehensive overview of:**
  - **Quality of health care received by the general U.S. population**
  - **Disparities in care experienced by different racial and socioeconomic groups**
  - **Contains over 250 health care measures**
  - **Assesses the performance of our health system and identifies areas of strengths and weaknesses, as well as disparities, for access to health care and quality of health care.**

Average Differences in quality of care for American Indian or Alaska Native, Asian, Black, Hispanic, Native Hawaiian/Pacific Islander, compared with non-Hispanic White or White people by state, 2018-2021.



Ohio is in the 4th quartile and is 1 of 10 states with the most racial and ethic disparities overall

National Racial and Ethnic Health Disparities



Source: http://www.familiesusa.org

Ohio Department of Health
2015 – The Impact of Chronic Disease in Ohio

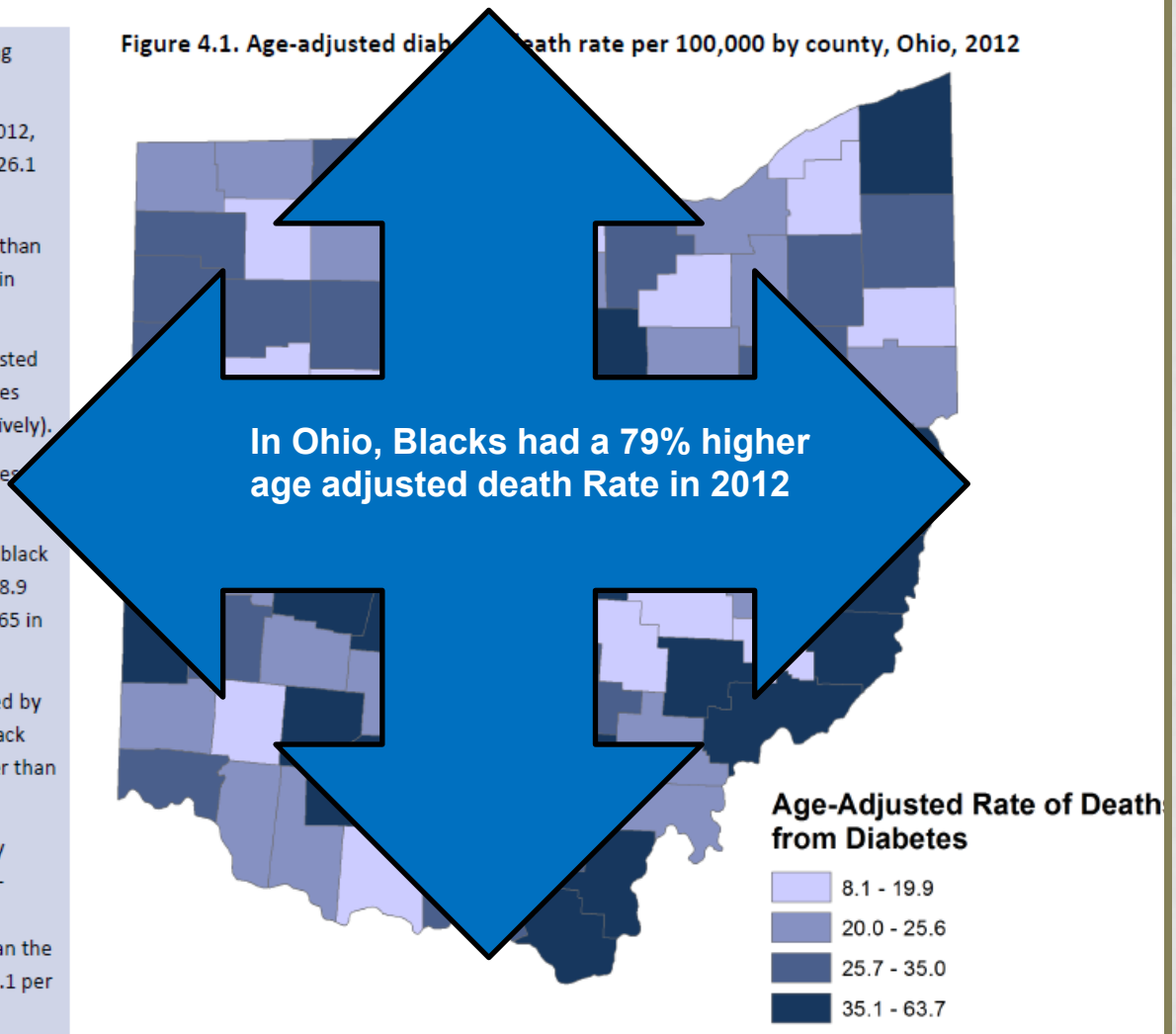
OHIO

Medical costs associated with chronic disease are expected to rise from $25 billion in 2010 to $44 billion in 2020.

Diabetes: Mortality

- In Ohio in 2012, diabetes was the seventh leading cause of death.
- Diabetes claimed the lives of 3,616 Ohioans in 2012, which equates to an age-adjusted death rate of 26.1 per 100,000.
- Men in Ohio were more likely to die of diabetes than women (31.4 per 100,000 and 22.0 per 100,000 in Ohio in 2012, respectively).
- In Ohio, blacks had a 79 percent higher age-adjusted diabetes death rate in 2012 compared with whites (43.4 per 100,000 and 24.3 per 100,000, respectively).
- Black men in Ohio had the highest rate of diabetes deaths in 2012 (52.0 per 100,000).
- In 2012, 43.5 percent of diabetes deaths among black men in Ohio occurred before age 65; whereas, 28.9 percent of diabetes deaths occurred before age 65 in white men.
- Black women in Ohio are also disparately affected by diabetes. In 2012, the diabetes death rate for black women (37.2 per 100,000) was 82 percent higher than that of white women (20.4 per 100,000).
- The diabetes death rate in Ohio varied greatly by county in 2012. The county with the highest age-adjusted death rate (Harrison County, 63.7 per 100,000) had a rate nearly eight times higher than the county with the lowest rate (Wyandot County, 8.1 per 100,000) (Figure 4.1).

Figure 4.1. Age-adjusted diab eath rate per 100,000 by county, Ohio, 2012



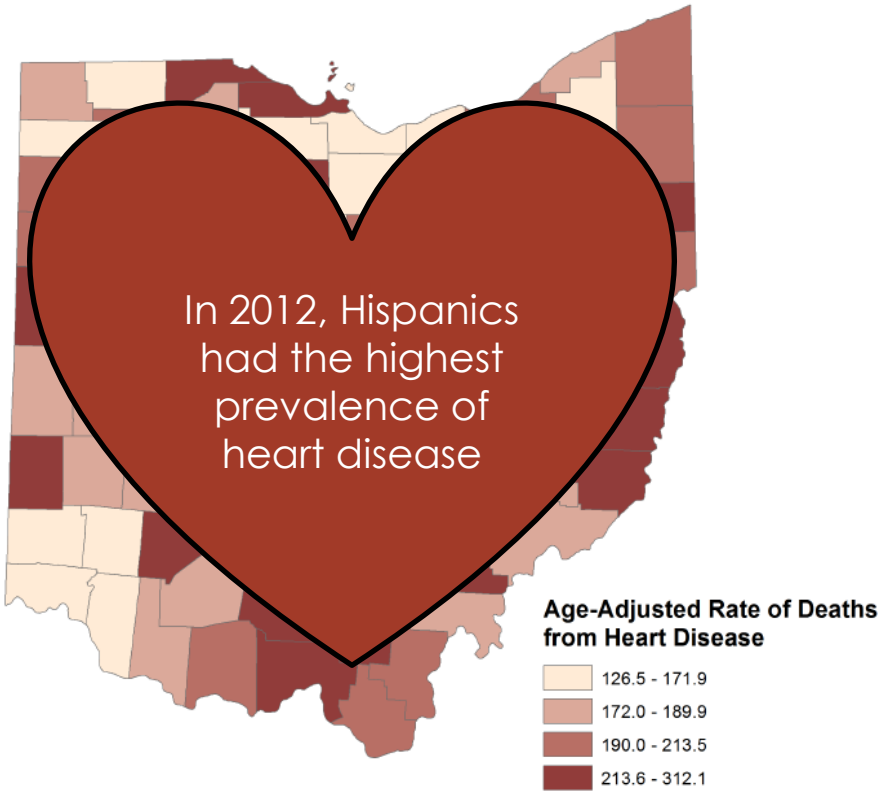
Source: Ohio Bureau of Vital Statistics, Ohio Department of Health, 2014.

ODH 2015 – The Impact of Chronic Disease in Ohio

Heart Disease: Mortality

- In Ohio in 2012, heart disease was the leading cause of death.
- Heart disease killed 26,383 Ohioans in 2012, which equates to an age-adjusted death rate of 187.3 per 100,000.
- Men in Ohio were 57 percent more likely to die from heart disease than women (234.8 per 100,000 and 149.5 per 100,000 in 2012, respectively).
- Black Ohioans had a 13 percent higher age-adjusted heart disease death rate in 2012 compared with whites (209.0 per 100,000 and 184.7 per 100,000, respectively).
- Black men in Ohio had the highest rate of heart disease deaths in 2012 (260.6 per 100,000).
- More than 45 percent of heart disease deaths among black men in Ohio occurred before age 65 in 2012; whereas, approximately 25 percent of heart disease deaths occurred before age 65 in white men.
- In 2012, the heart disease death rate for black women (171.1 per 100,000) was 16 percent higher than that of white women (147.2 per 100,000).
- The heart disease death rate in Ohio varied greatly by county in 2012. The county with the highest age-adjusted death rate (Fayette County, 312.1 per 100,000) had a rate 2.5 times higher than the county with the lowest rate (Delaware County, 126.5 per 100,000) (Figure 2.1).

Figure 2.1. Age-adjusted heart disease death rate per 100,000 by county, Ohio, 2012



Source: Ohio Bureau of Vital Statistics, Ohio Department of Health, 2014.

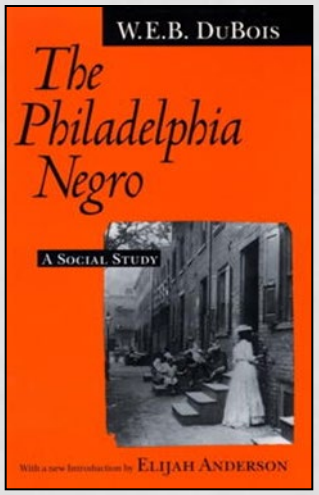
What Are the Root Causes of Health Disparities?

The lack or absence of "life-enhancing resources, such as health care, housing, education, employment, social relationships, transportation, and food supply, whose distribution across populations effectively determines length and quality of life."

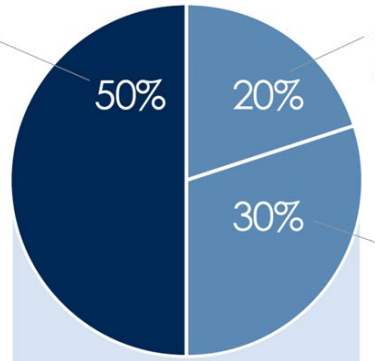
"Social Determinants of Health"

HISTORICAL RESEARCH FOR HEALTH DISPARITIES

- **Published by W.E.B. DuBois in 1899.**
- **First significant scientific study of the social, economic, health, educational and the living conditions among African-Americans.**
- **DuBois research entailed over 5,000 detailed interviews of residents in the 7th Ward in Philadelphia and challenged notion of racial inferiority.**
- **DuBois work is foundational to what we understand today as social determinants of health.**



Modifiable factors that influence health



Social, economic and physical environment
(Community conditions, such as economic stability, food insecurity, housing, education and transportation)

Clinical care
(Such as health care quality and access)

Health behaviors
(Such as physical activity and tobacco use)

Underlying drivers of inequity
Racism and other forms of discrimination (i.e., ableism, ageism), trauma, toxic stress and violence

Source: Health Policy Institute of Ohio, "Unlocking Ohio's economic potential: The impact of eliminating racial disparities on Ohio businesses, governments and communities." July 2023. Based on research from the University of Wisconsin Population Health Institute

WHAT ARE HEALTH INEQUITIES?

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

Figure 1

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	
Medical bills	Playgrounds	Higher education		Stress	Quality of care
Support	Walkability				
	Zip code / geography				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

KFF
HENRY J KAISER FAMILY FOUNDATION

What Are Health Inequities?

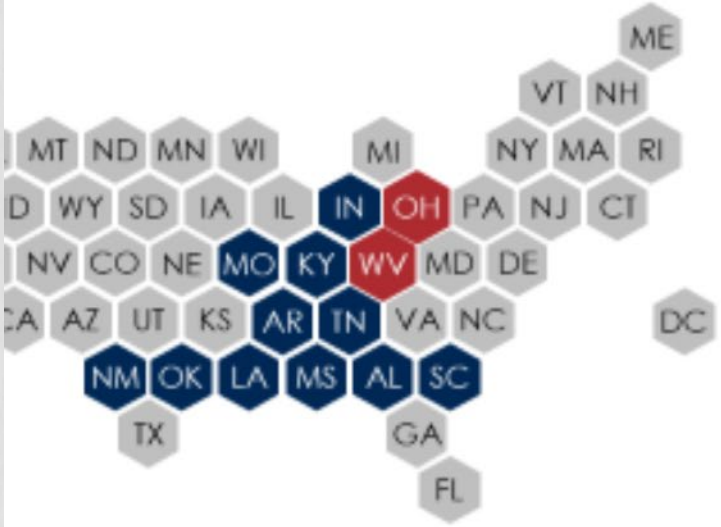
Health disparities are referred to as health inequities when they are the result of the systematic and unjust distribution of these critical conditions (social determinants).

Source: Promoting Health Equity : *A Resource to Help Communities Address Social Determinants of Health*

Ohio's health value rank

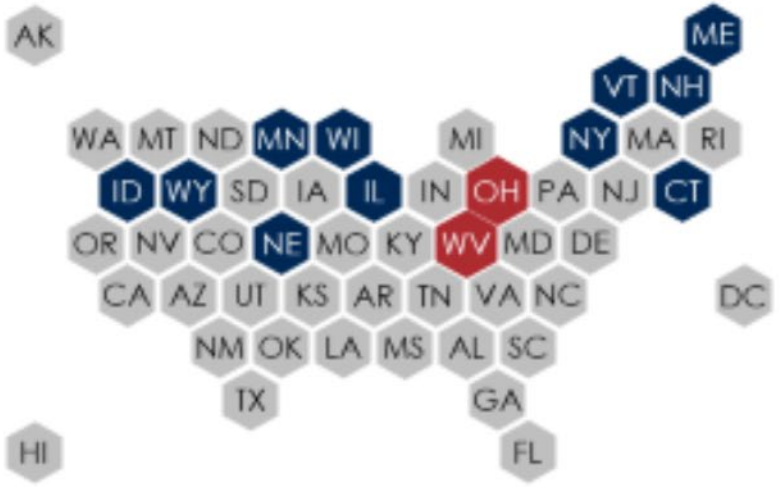
Source: Health Policy Institute of Ohio, 2023 Health Value Dashboard

Bottom quartile population health



Health Policy Institute of Ohio, 2023 Health Value Dashboard

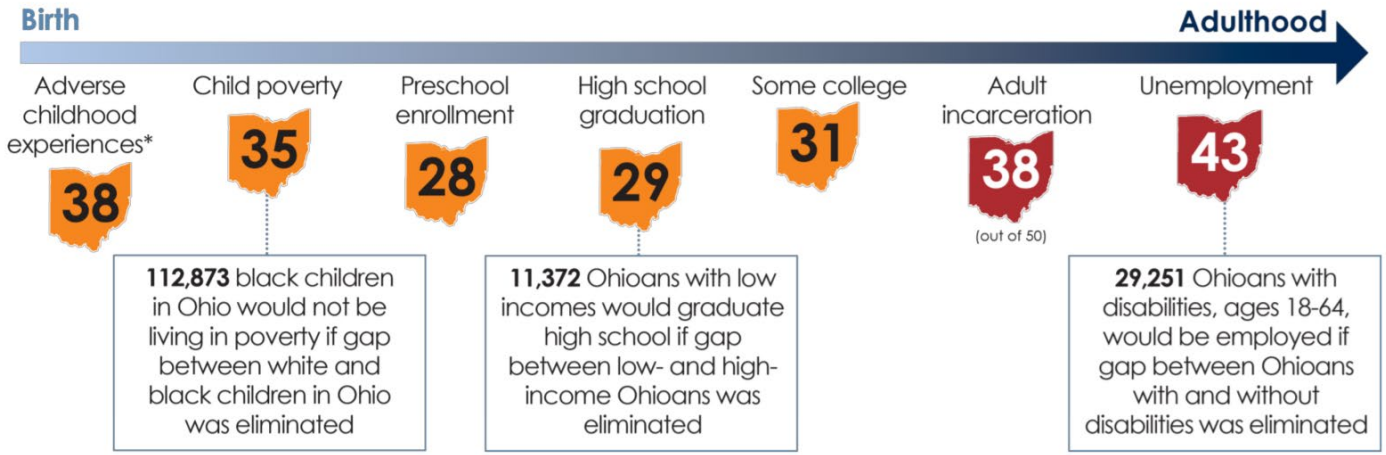
Bottom quartile healthcare spending



hpio
health policy institute of ohio

Too many Ohioans left behind

Without a strong foundation,
not all Ohioans have the same opportunity to be healthy



hpio health policy institute of ohio
Lead. Inform. Improve.

How can policies create barrier to health?

Source: Health Policy Institute of Ohio, 2023 Health Value Dashboard

HOW CAN WE CLOSE OHIO'S HEALTH GAPS?

Why does Ohio rank poorly?

3 Sparse public health workforce leads to missed opportunities for prevention

- **Limited investment in public health.** Only three other states spend less on public health than Ohio, limiting public health workforce and ability to proactively implement comprehensive approaches to our state's greatest health challenges.
- **Patchwork approach to community-based prevention.** Ohio struggles on several outcomes that could be prevented, such as addiction and chronic disease. Stretched thin by the many demands of the COVID-19 pandemic, public health departments now have even fewer resources to devote to these issues.

Going upstream to prevent health problems reduces costly sick care later

State public health funding per capita, 2019

Greatest challenges Ohio in the bottom quartile	Missed opportunities for prevention policy Examples
Adult smoking and youth all-tobacco use	Ohio invests 10.6% of what the CDC recommends for state tobacco prevention and control
Drug overdose deaths	Administrative barriers to naloxone distribution and an overly complex Good Samaritan policy
Excessive drinking	Lack of a sustained, long-term approach to school-based alcohol and drug prevention
Heart disease mortality and food insecurity	Limited reach of programs to increase access to healthy food, such as fruit and vegetable incentives and school breakfast

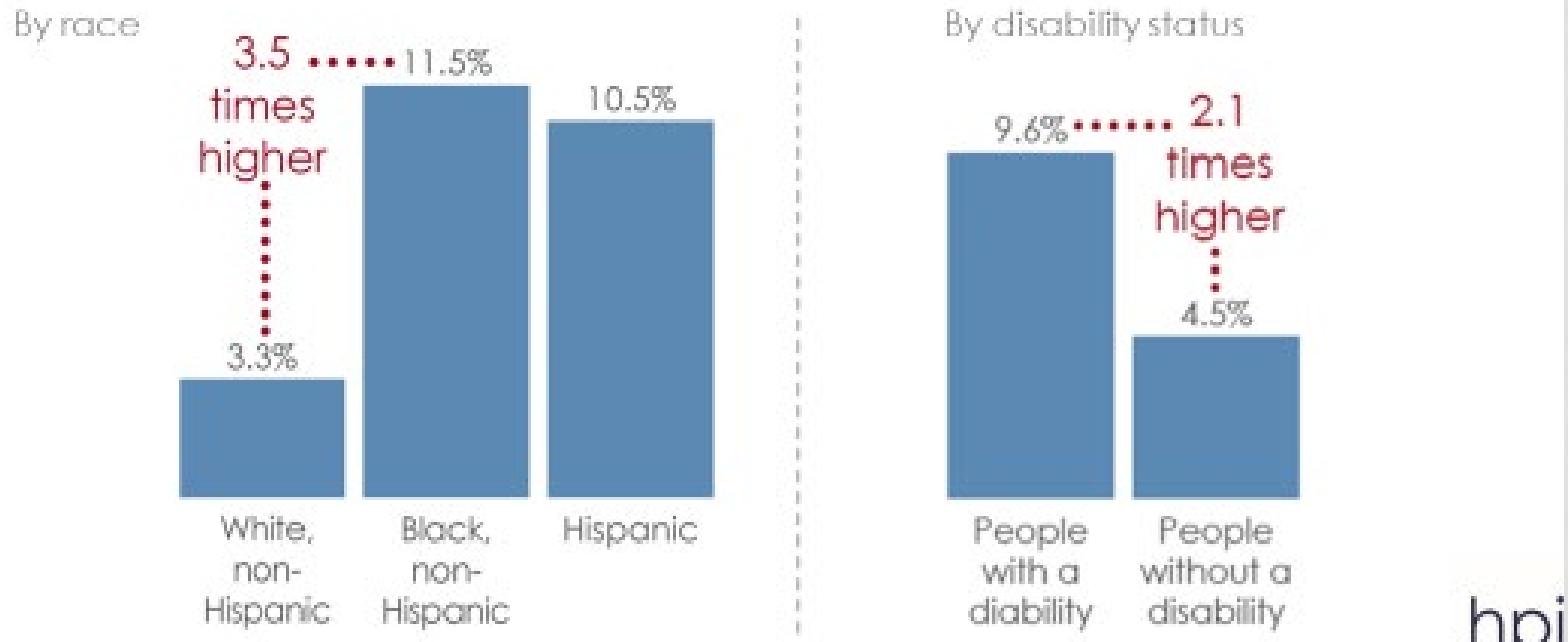
How can we improve through state policy?

- **Strengthen the public health workforce and data systems** by ensuring that the state and local health departments have diverse and adequate staffing for epidemiology, communicable disease control and communications, and by fully implementing the recommendations of the March 2021 Ohio Auditor of State Performance Audit
- **Prevent addiction and overdose deaths** by dedicating a portion of future revenue from tobacco and alcohol taxes, opioid settlements and pandemic relief toward smoking prevention, addiction treatment, recovery supports, harm reduction and overdose reversal
- **Prevent chronic disease through improved access to healthy food** by streamlining access to SNAP and WIC for eligible Ohioans and expanding Produce Perks and Produce Prescriptions

Data sources are available in data appendices posted on the *HPIO Health Value Dashboard web page.*

Food insecurity among Ohio children

2018-2021



Source: Health Policy Institute of Ohio. 2023 Health Value Dashboard. Data from analysis of Health Resources and Services Administration, National Survey of Children's Health by HPIO and The Voinovich School of Leadership & Public Affairs, Ohio University

If disparities were eliminated…

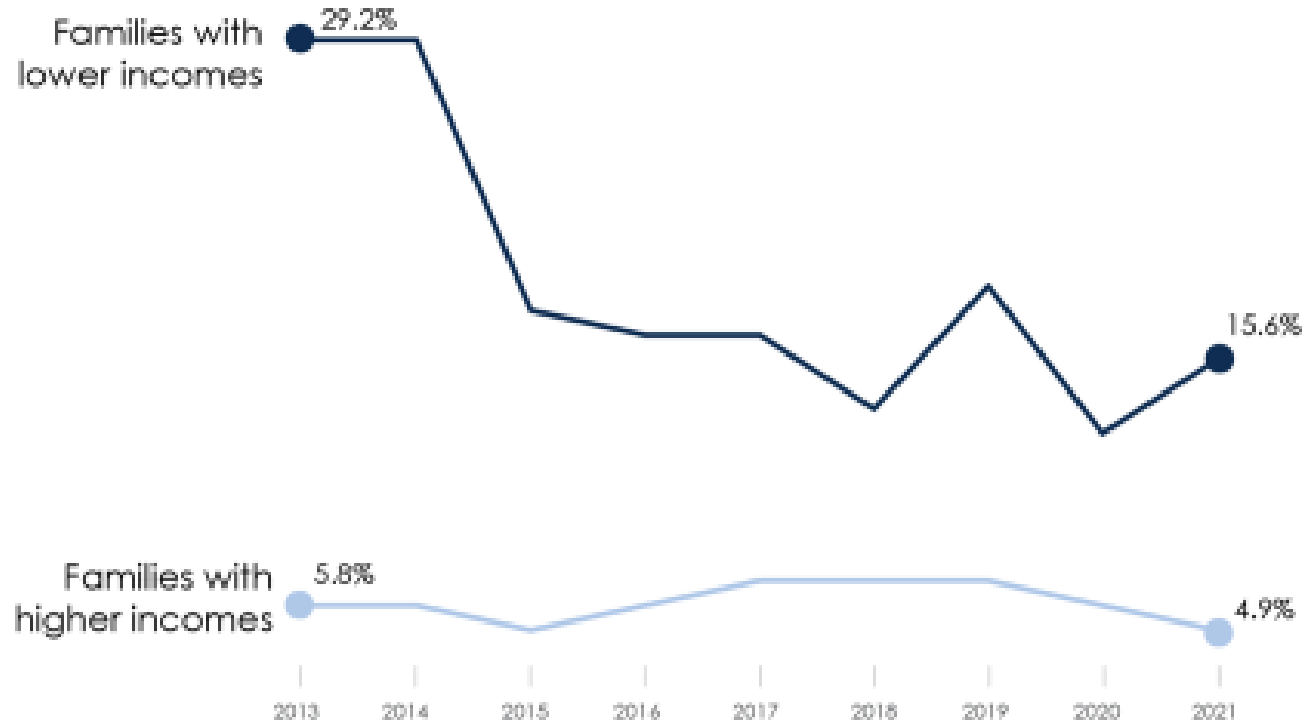
- 30,385 Black children
- 12,512 Hispanic/Latino children
- 7,103 children with disabilities
- 36,972 children from families with low incomes

… in Ohio would not experience food insecurity

Source: Health Policy Institute of Ohio, 2023 Health Value Dashboard

Affordable health care

Unable to see doctor due to cost, Ohio, 2013-2020



Source: Health Policy Insti
Ohio, 2023 Health Value
Dashboard. Data from Ce
for Disease Control and
Prevention, Behavioral Ris
Surveillance Survey

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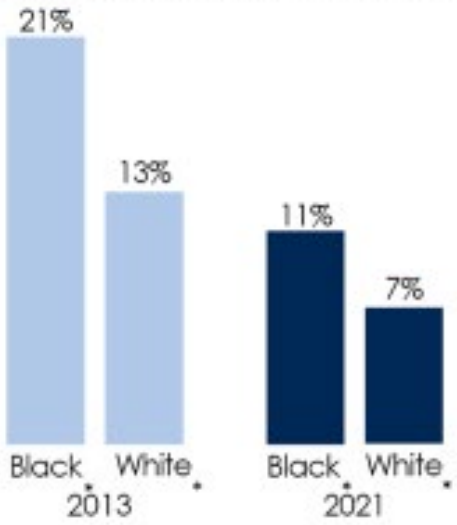
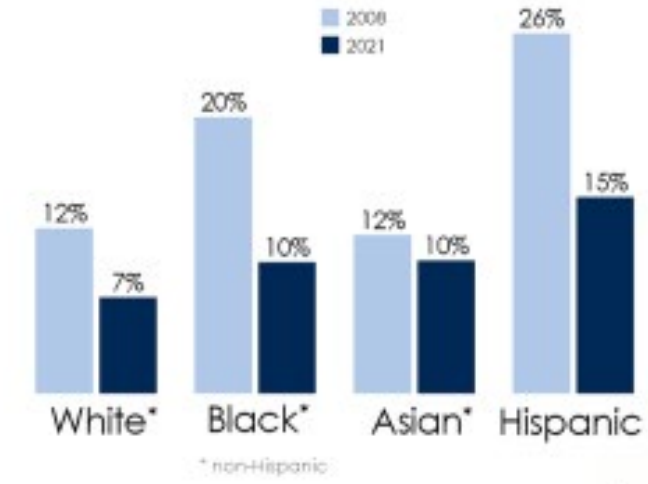
Access and coverage

Percent of adult Ohioans who went without health care because of cost in the past year



Percent of Ohioans who are uninsured, ages 0-64



Source: Health Policy Institute of Ohio, 2023 Health Value Dashboard. Data for "went without care" graphic from Behavioral Risk Factor Surveillance System and data for uninsured from American Community Survey, as compiled by Kaiser Family Foundation State Health Facts

What is Health Equity?

When everyone has the same potential to achieve the best health possible, regardless of who they are or where they live.

Source: Promoting Health Equity : *A Resource to Help Communities Address Social Determinants of Health*

July 2023

Unlocking Ohio's economic potential

If Ohio eliminates disparities...

Researchers estimate that by 2050:

- **Ohio could gain $79 billion in economic output each year**

In addition, Ohio could gain:

- **$40 billion** more in total income
- **$30 billion** more in consumer spending
- **$4 billion** more in state and local tax revenues
- **$3 billion** in reduced healthcare spending
- **$2 billion** in increased employee productivity
- **$821 million** in reduced corrections spending

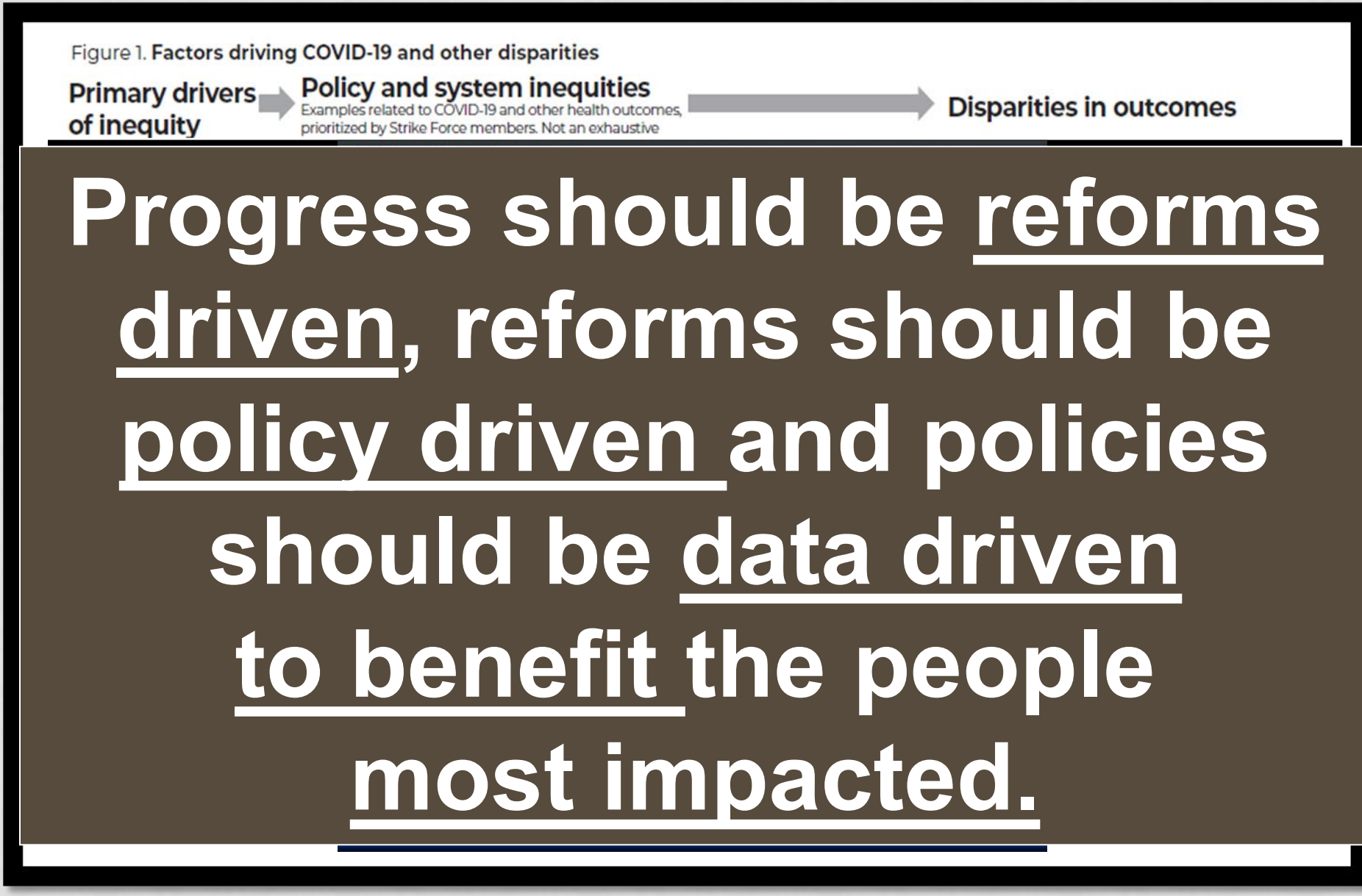
Source: HPIO "Unlocking Ohio's Economic Potential: The Impact of Eliminating Racial Disparities on Ohio Businesses, Governments and Communities" July 2023

Community Input Matters!

Figure 7. **Achieving health equity: Framework for action**

Source: HPIO adaptation of County Health Rankings and Roadmaps Action Cycle

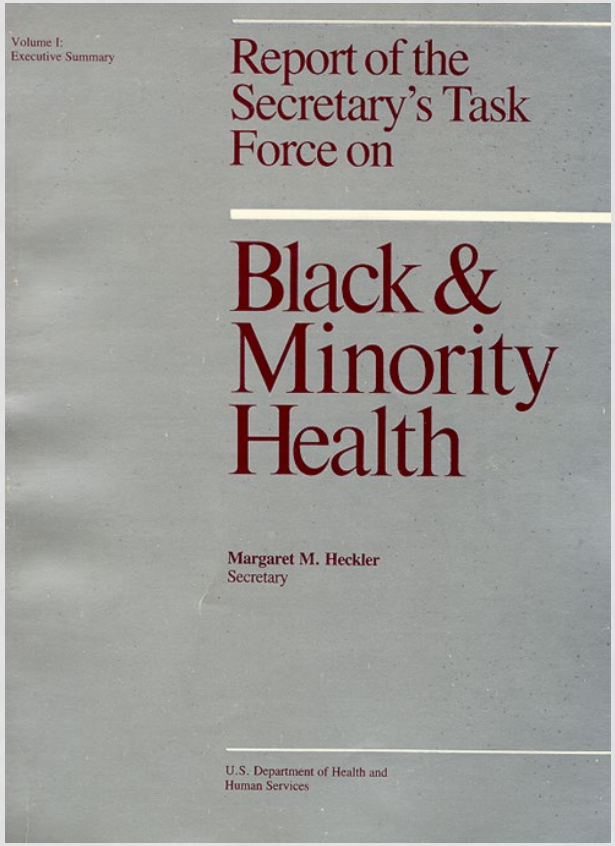
hpio health policy institute of ohio Lead. Inform. Improve.



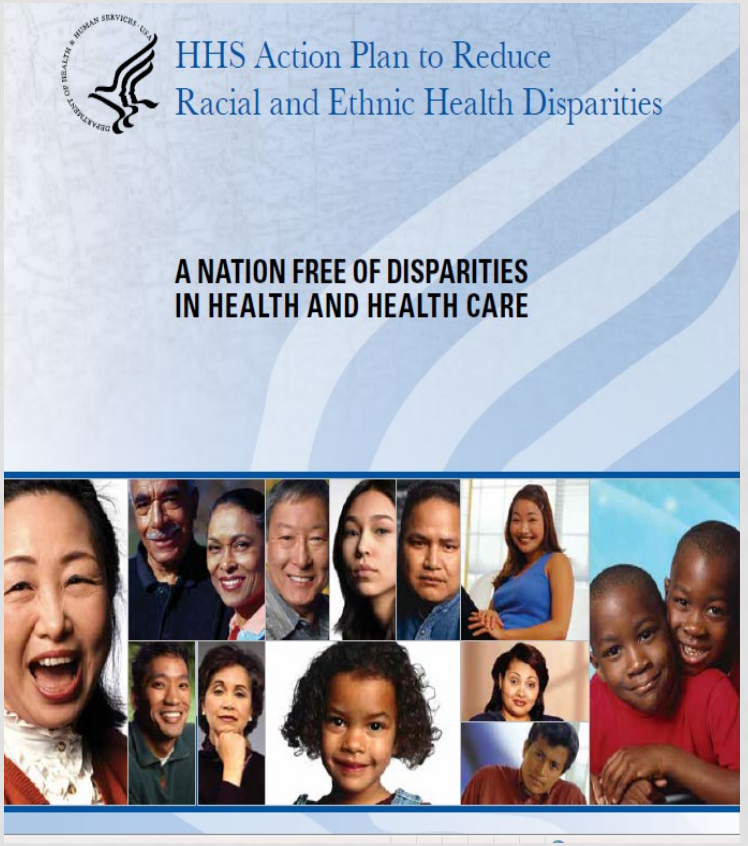
Progress should be reforms driven, reforms should be policy driven and policies should be data driven to benefit the people most impacted.

Progress

1985



2011



National Partnership for Action to End Health Disparities

Purpose: To mobilize a nationwide, comprehensive, and community-driven approach to combating health disparities.

Five Goals of the NPA:

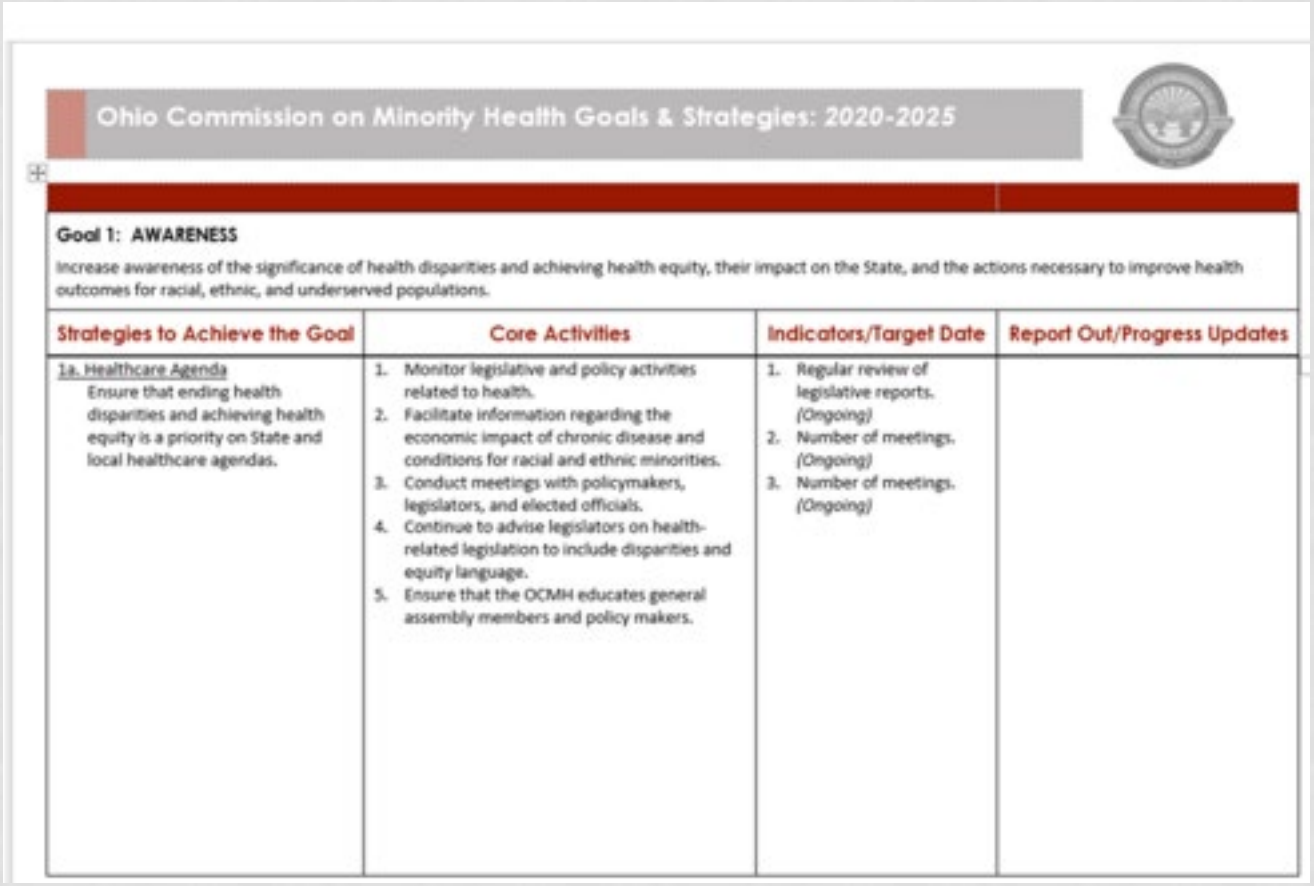
I. Awareness.
II. Leadership.
III. Health System and Life Experience.
IV. Cultural and Linguistic Competency.
V. Data, Research, and Evaluation.

NATIONAL PARTNERSHIP FOR ACTION

National Stakeholder Strategy (NSS):
A product of the NPA that offers 20 specific strategies for reaching NPA goals and assists federal, regional, tribal, state, and local stakeholders in adopting effective strategies for their communities.

http://minorityhealth.hhs.gov/npa/

THE OHIO COMMISSION ON MINORITY HEALTH STRATEGIC PLAN 2020-2025



Ohio Commission on Minority Health Goals & Strategies: 2020-2025

Goal 1: AWARENESS

Increase awareness of the significance of health disparities and achieving health equity, their impact on the State, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations.

Strategies to Achieve the Goal	Core Activities	Indicators/Target Date	Report Out/Progress Updates
1a. Healthcare Agenda Ensure that ending health disparities and achieving health equity is a priority on State and local healthcare agendas.	1. Monitor legislative and policy activities related to health. 2. Facilitate information regarding the economic impact of chronic disease and conditions for racial and ethnic minorities. 3. Conduct meetings with policymakers, legislators, and elected officials. 4. Continue to advise legislators on health-related legislation to include disparities and equity language. 5. Ensure that the OCMH educates general assembly members and policy makers.	1. Regular review of legislative reports. *(Ongoing)* 2. Number of meetings. *(Ongoing)* 3. Number of meetings. *(Ongoing)*	