Ohio 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 existence 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.

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.

The Creation of the Ohio Commission on Minority Health

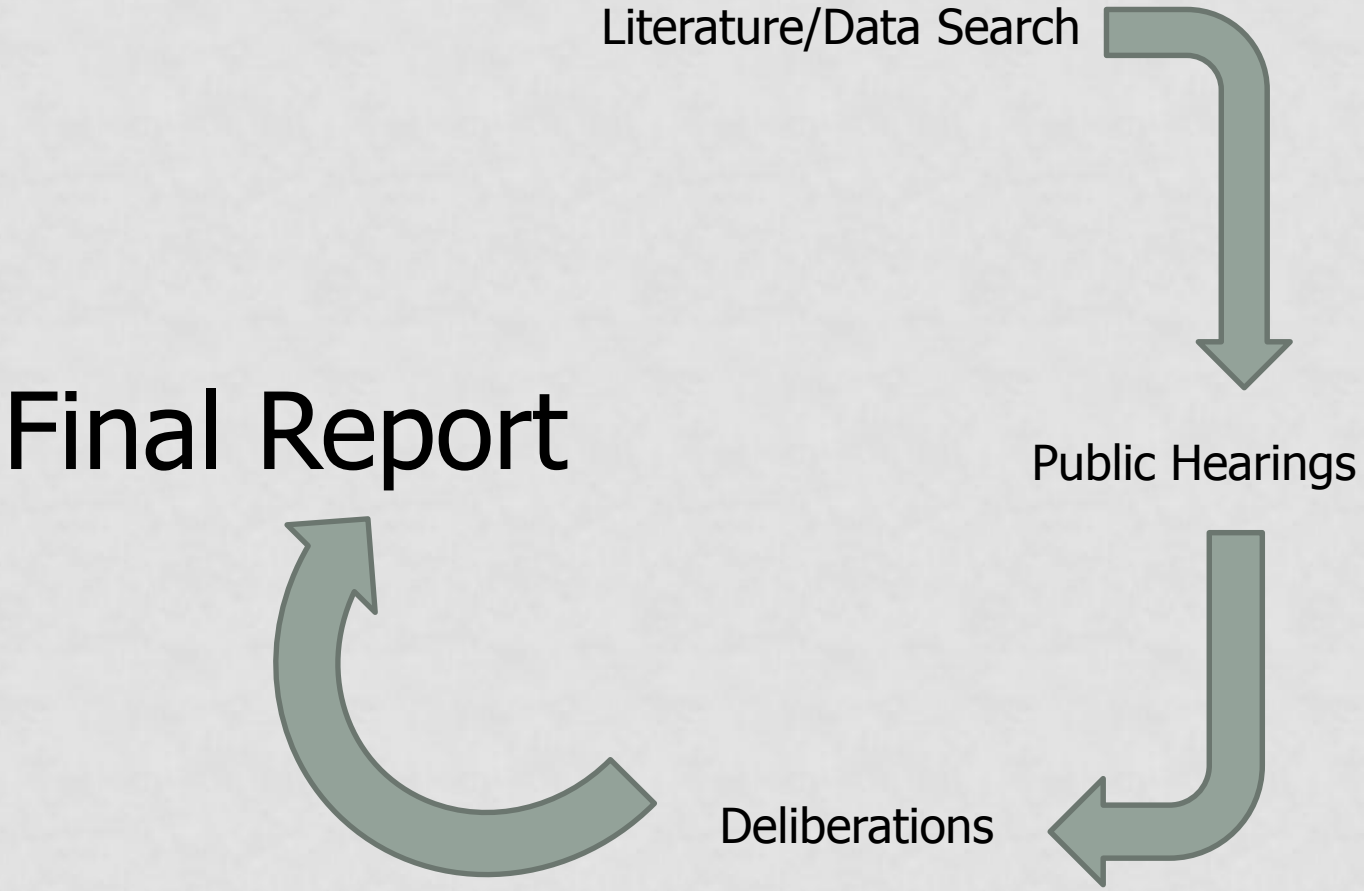
In July 1987, then Rep. Ray Miller sponsored and passed an amendment to the State of Ohio's Budget Bill, Am.Substitute House Bill 171, which created the Ohio Commission on Minority Health.

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.

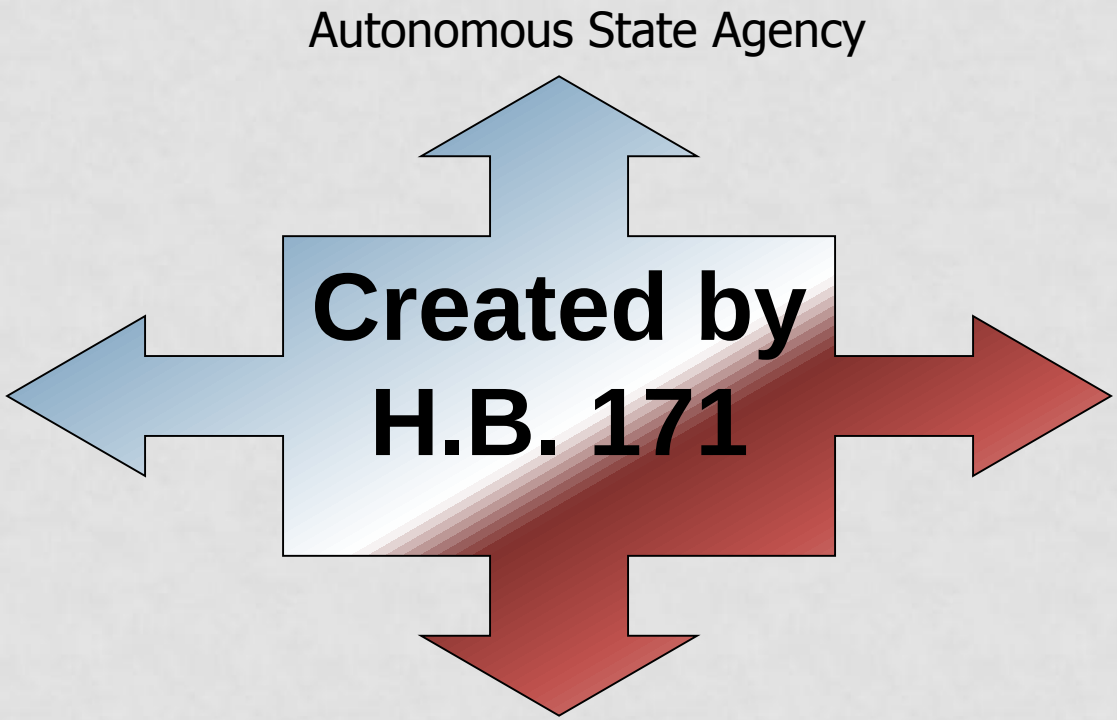
The Commission is an autonomous state agency that began with a biennial appropriation of $3.5 million dollars of general revenue funds. The Commission predated the Federal HHS Office on Minority Health and with more than three-times the funding.

In July 1987, the 117th Ohio General Assembly passed amended Substitute House Bill 171, creating the Ohio Commission on Minority Health. The Commission was the first concerted efforts by a state to address the disparities in health status between majority and minority populations. The Commission is an autonomous state agency that began with a biennial appropriation of $3.5 million dollars of general revenue funds.

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 – 19 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)

H.B. 171 Provisions

Assigned Cabinet Members

- Director, Ohio Department of Developmental Disabilities
- Director, Ohio Department of Mental Health and Addiction Services (revised after merger)
- Director, Ohio Department of Job & Family Services
- Superintendent, Ohio Department of Education
- Director, Ohio Department of Health
- Director, Ohio Department of Medicaid

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 $150,000, for a two-year period. These projects must address a specific community 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 annual 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. Conducted with and by community based agencies and organizations, this celebration reaches into urban, suburban and rural areas of the State. These initiatives are funded up to $3,000 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 patient, public and professional education which are funded up to $32,000 for a two-year period. In addition, Lupus grants can be used to encourage and develop local centers on lupus information gathering and 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 in order 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. Since then the Commission has funded 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, NIH, AHRQ, HRSA and others.

The 2016/2017 and the 200/2021 State of Ohio Biennial Budgets provided an increase in funding to the Ohio Commission on Minority Health to bring this model to scale in Ohio This funding was allocated to initiate the Certified Pathways Community HUB Model Expansion and Replication – Infant Mortality funding opportunity. Grant awards are approximately $280,000 annually and is dependent on the annual 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.

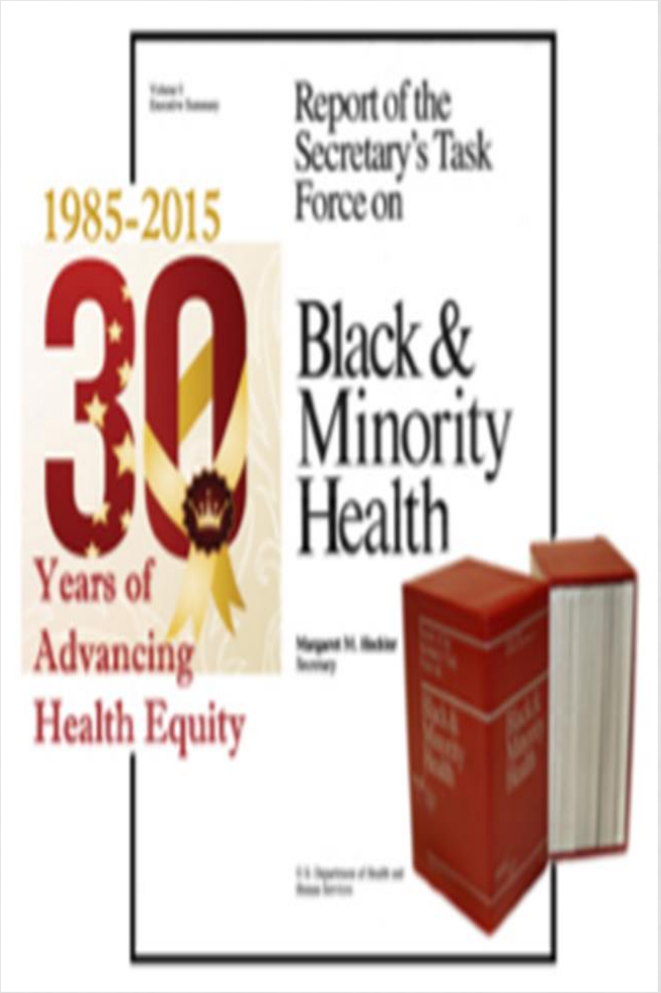
Strategic Plan 2025

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

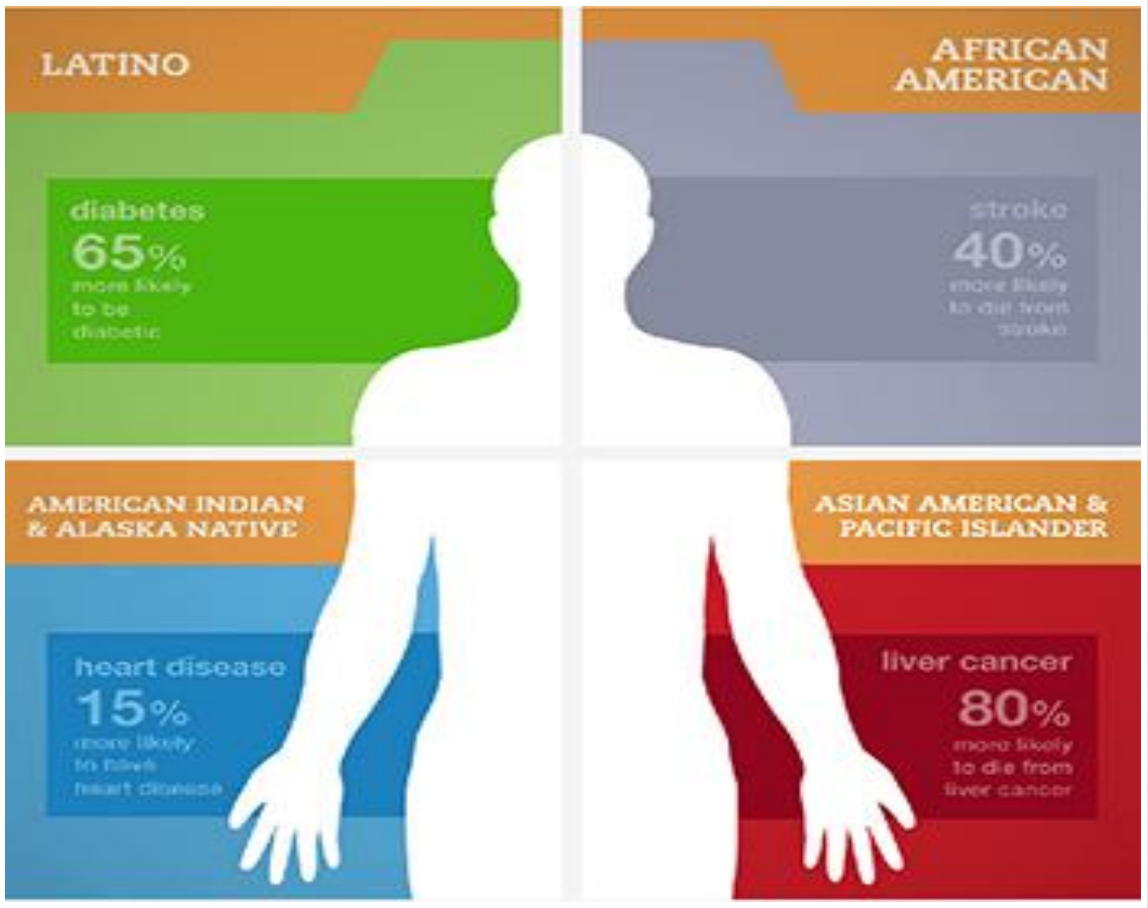
MAJOR FACTORS INCLUDE:

- **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

National Racial and Ethnic Health Disparities



Source: http://www.familiesusa.org

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

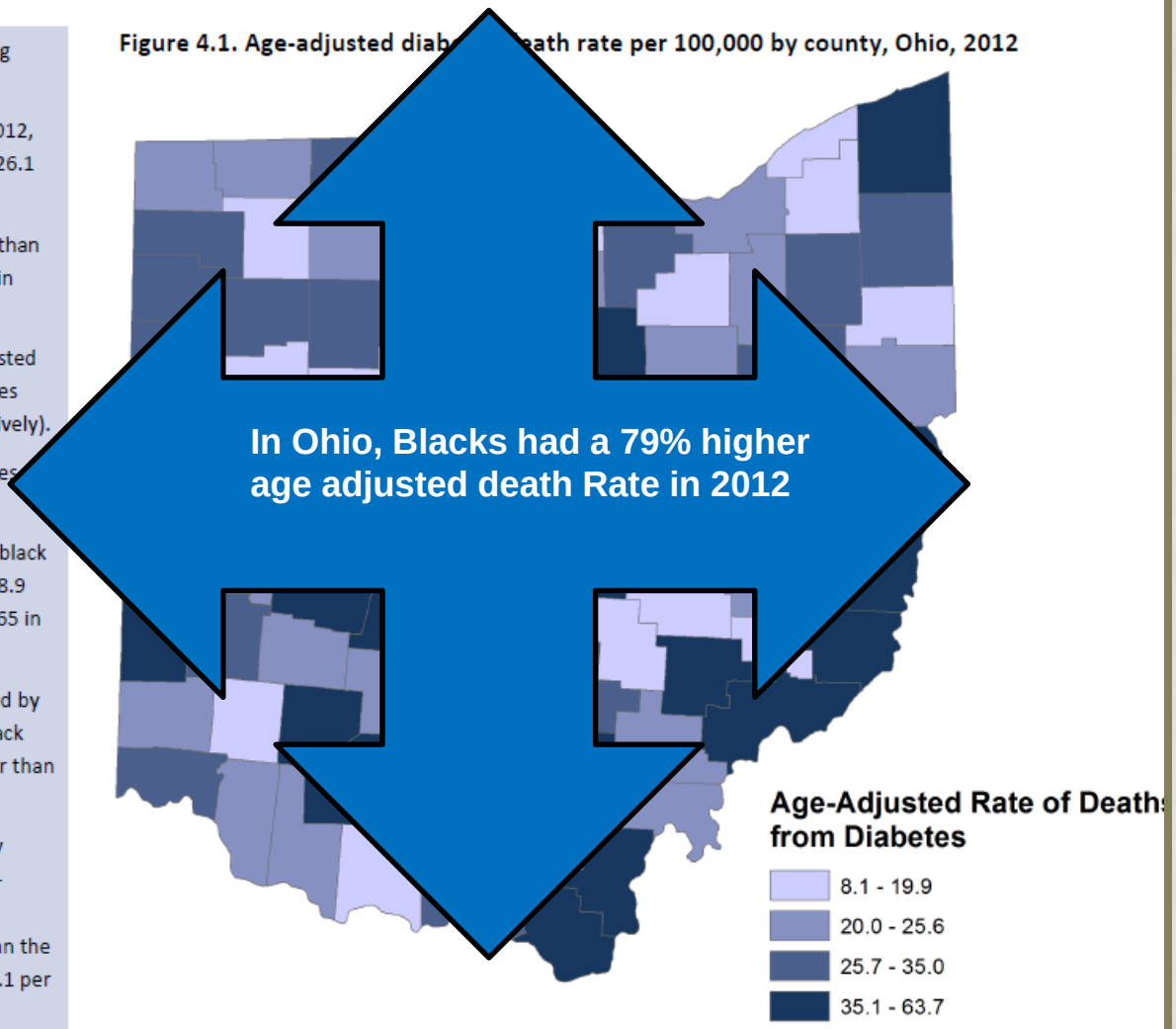
OHIO

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



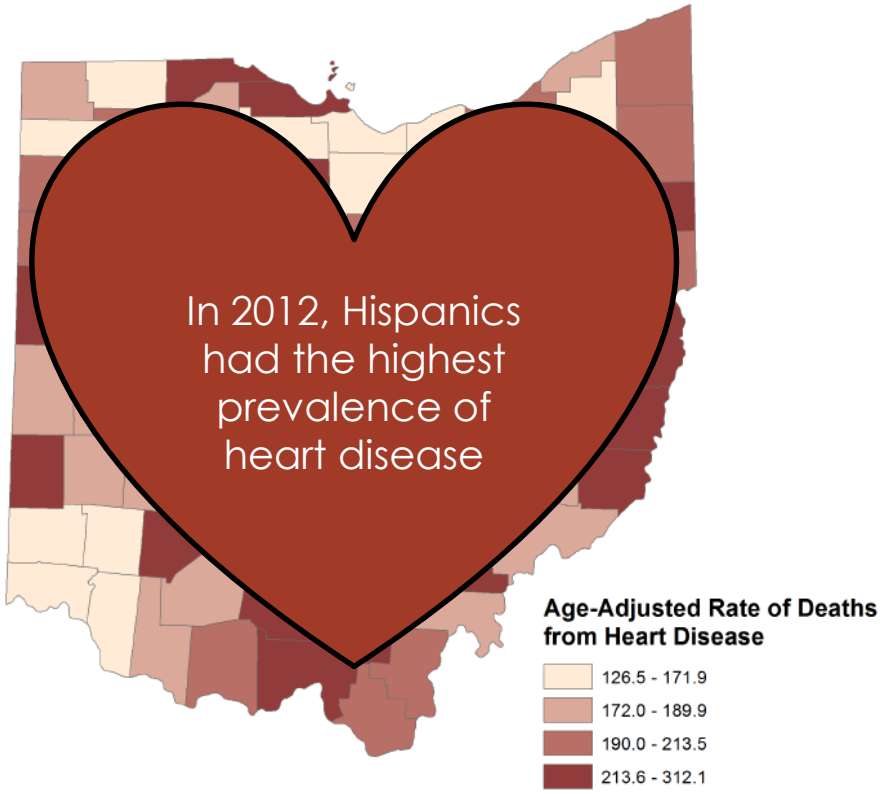
Source: Ohio Bureau of Vital Statistics, Ohio Department of Health, 2014.

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

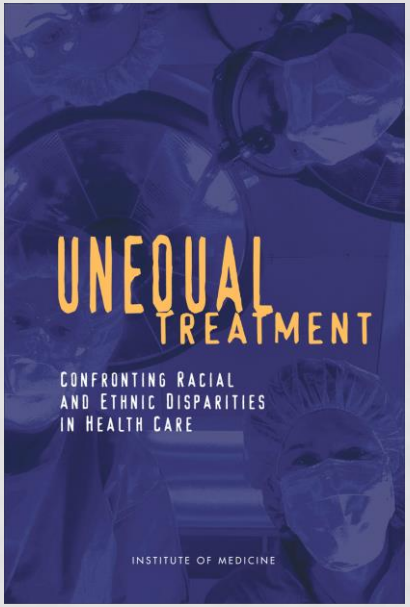


Source: Ohio Bureau of Vital Statistics, Ohio Department of Health, 2014.

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

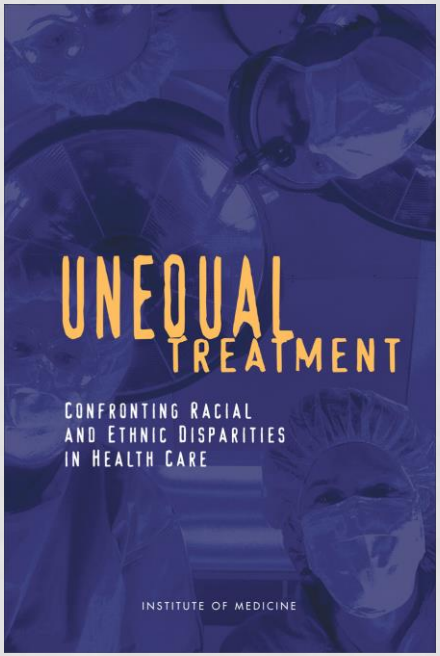
HEALTH CARE DISPARITIES

"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."

What Healthcare Administrators Need to Know

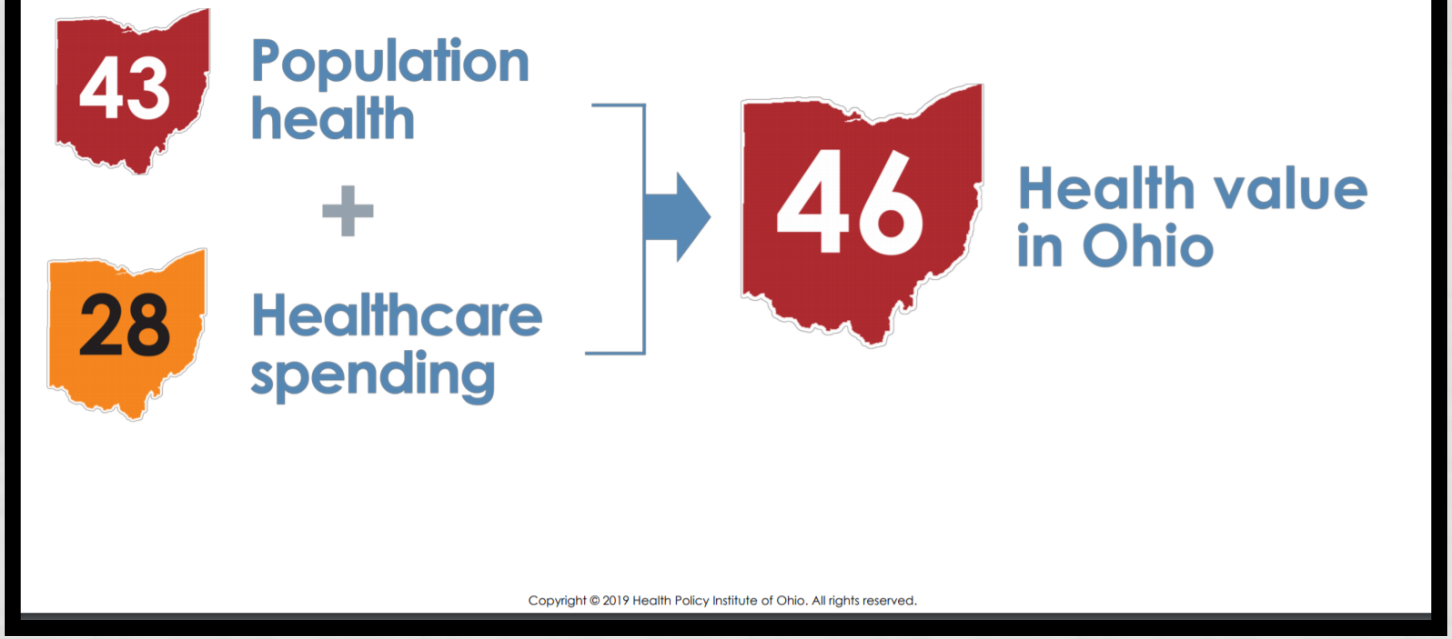
Racial and Ethnic Disparities in Healthcare

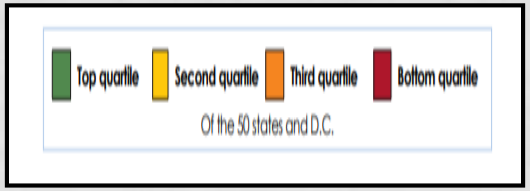
- Base decisions about resource allocation (e.g., which patients should receive particular treatments for specific health conditions) on published clinical guidelines.
- Take steps to improve access to care—including the provision of interpretation and translation services, where community need exists.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




hpio
health policy institute
of ohio
2019
Health
Value
Dashboard

Where does Ohio rank?





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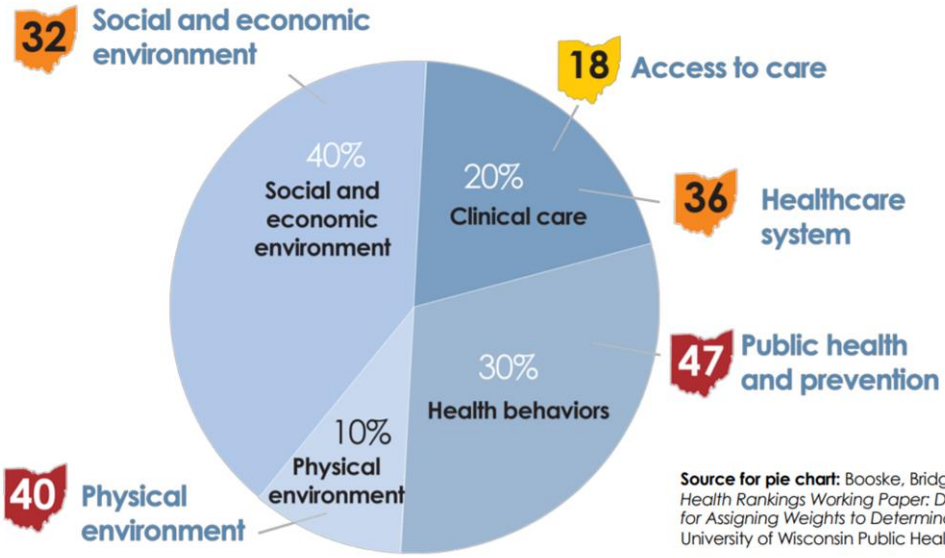
Resources are out of balance

Modifiable factors that influence health



Source for pie chart: Booske, Bridget C. et. Al. *County Health Rankings Working Paper: Different Perspectives for Assigning Weights to Determinants of Health*. University of Wisconsin Public Health Institute, 2010.

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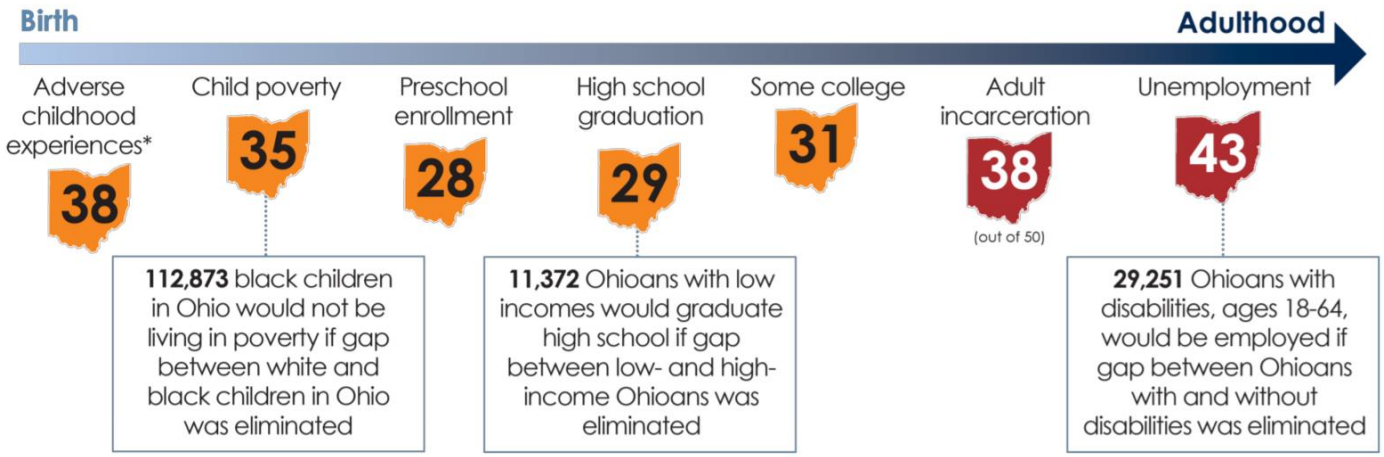
Too many Ohioans left behind

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



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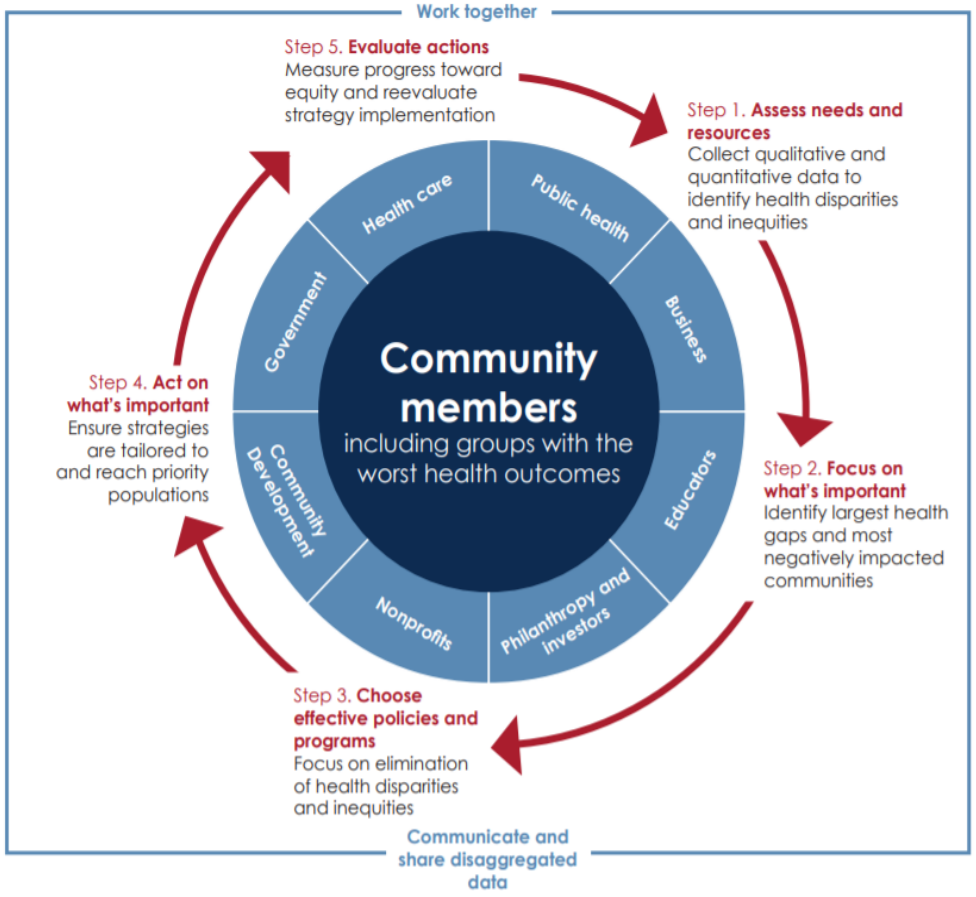
How can we close Ohio's health gaps?

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



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

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NATIONAL HEALTHCARE QUALITY & DISPARITIES REPORT

2018

Introduction and Methods

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.**

DISPARITIES

- Some disparities were getting smaller from 2000 through 2016-2017, but disparities persist, especially for poor and uninsured populations in all priority areas.
- Racial and ethnic disparities vary by group:
  - Blacks, American Indians and Alaska Natives (AI/ANs), and Native Hawaiians/Pacific Islanders (NHPIs) received worse care than Whites for about 40% of quality measures.
  - Disparities were improving for only 4 measures for Blacks, 2 measures for AI/ANs, and 1 measure for NHPIs.

DISPARITIES (CONT'D.)

- Racial and ethnic disparities vary by group:
  - Hispanics received worse care than Whites for about 35% of quality measures.
  - From 2000 to 2017, disparities were improving for 5 measures for Hispanics.
  - Asians received worse care than Whites for 27% of quality measures but better care than Whites for 28% of quality measures.
  - Disparities were improving for only 2 measures for Asians.

What Are the Root Causes of Health Disparities?

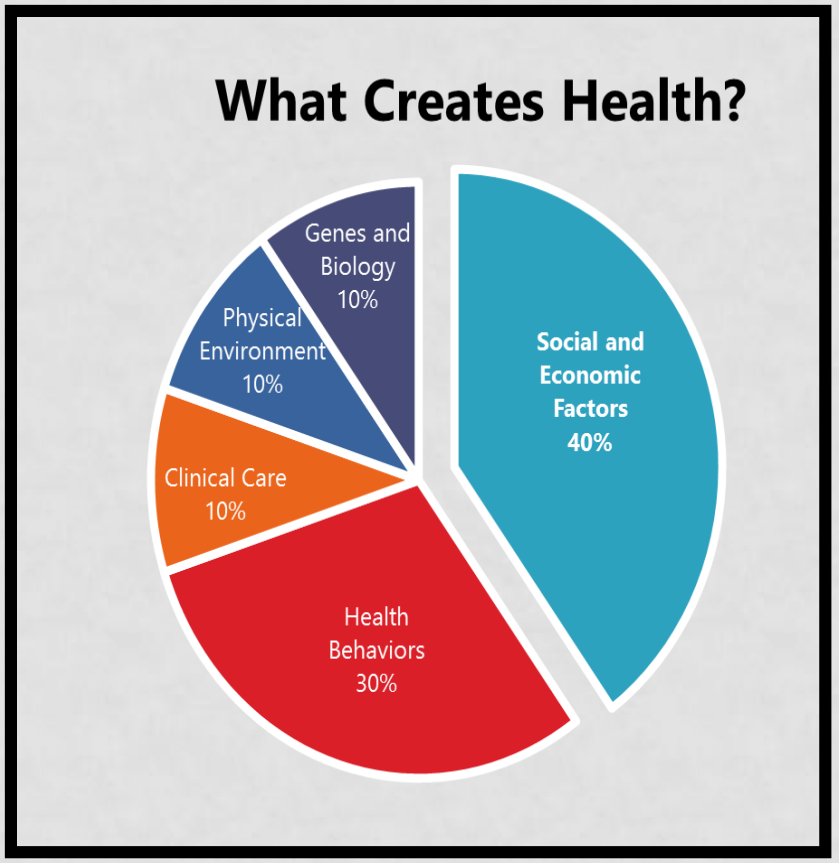
The lack or absence of "life-enhancing resources, such as health care, housing, education, employment, social relationships, transportation, and food supply, whose distribution across populations effectively determines length and quality of life."

"Social Determinants of Health"

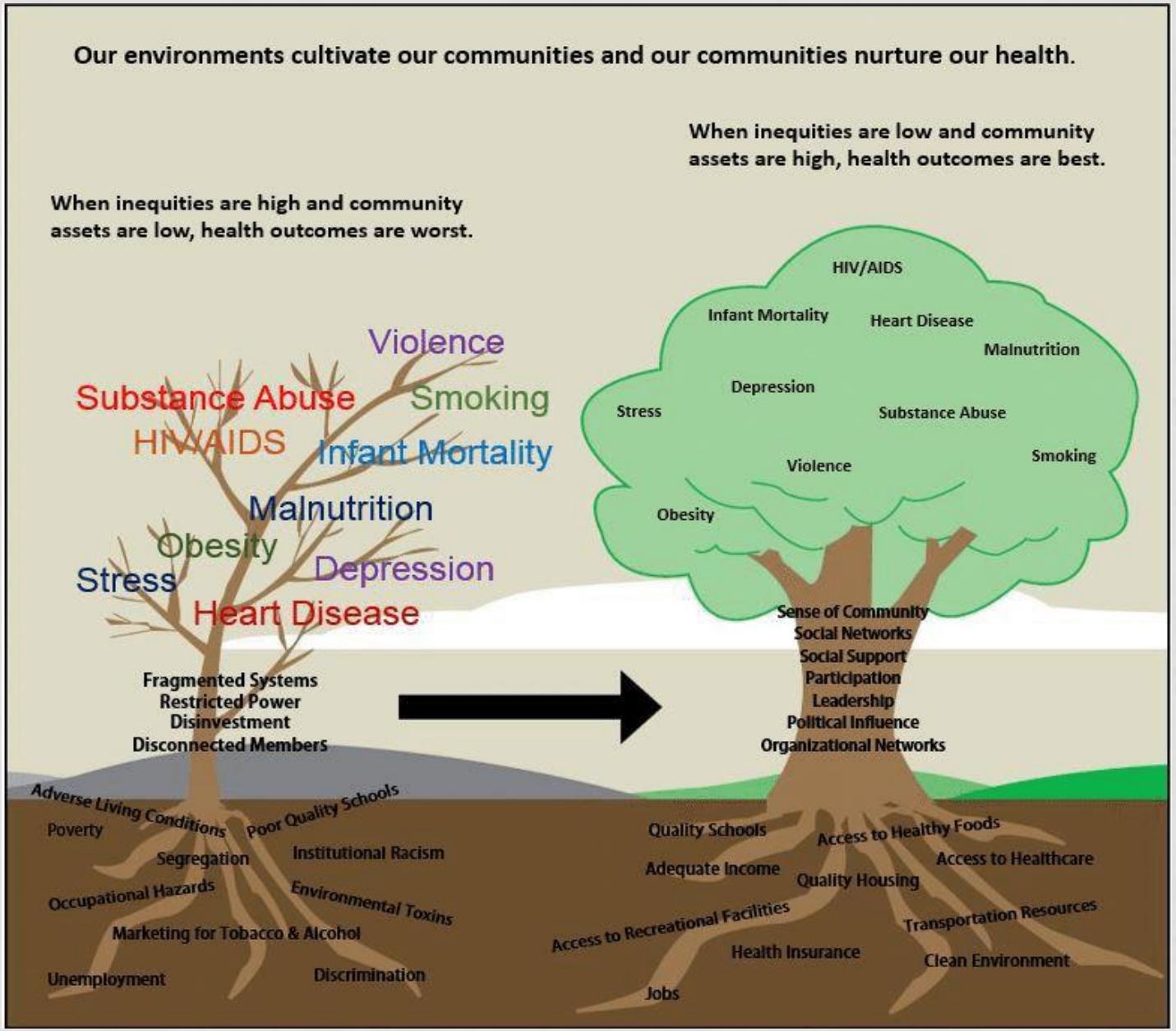
Making the case for Social Determinants of Health

THE SOCIAL CONDITIONS IN WHICH PEOPLE ARE BORN, LIVE AND WORK ARE THE SINGLE MOST IMPORTANT DETERMINANT HEALTH AND LIFE EXPECTANCY.

THE CONDITIONS IN WHICH PEOPLE LIVE AND DIE ARE, IN TURN, SHAPED BY POLITICAL, SOCIAL, AND ECONOMIC FORCES."

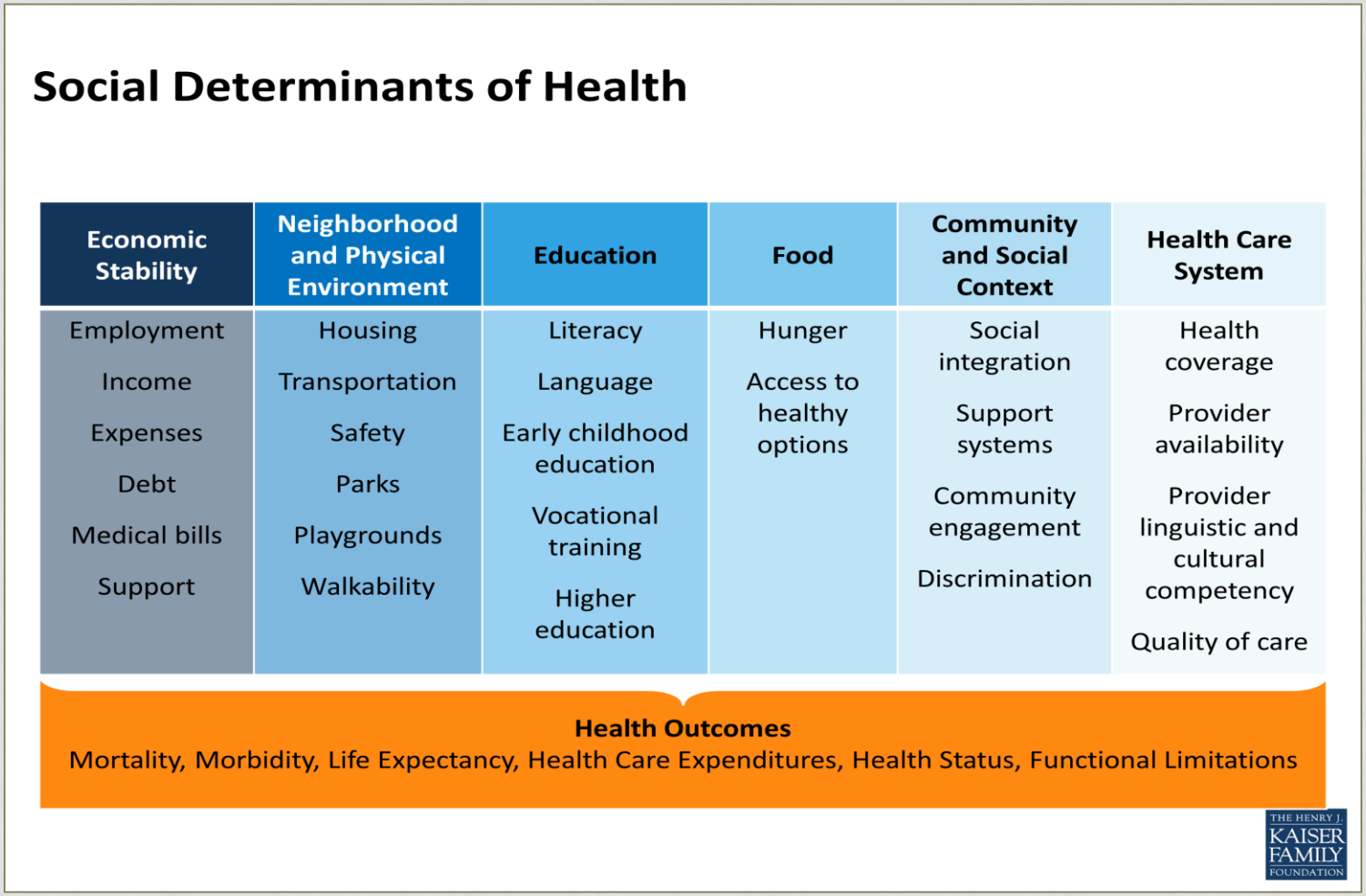


World Health Commission on the Social Determinants of Health (2008)



CENTER FOR DISEASE CONTROL

Kaiser Family Foundation
The Role of Social Determinants of Health



Heiman and Artiga, The Role of Social Determinants in Promoting Health and Health Equity, The Henry J. Kaiser Foundation, Nov. 2015

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*

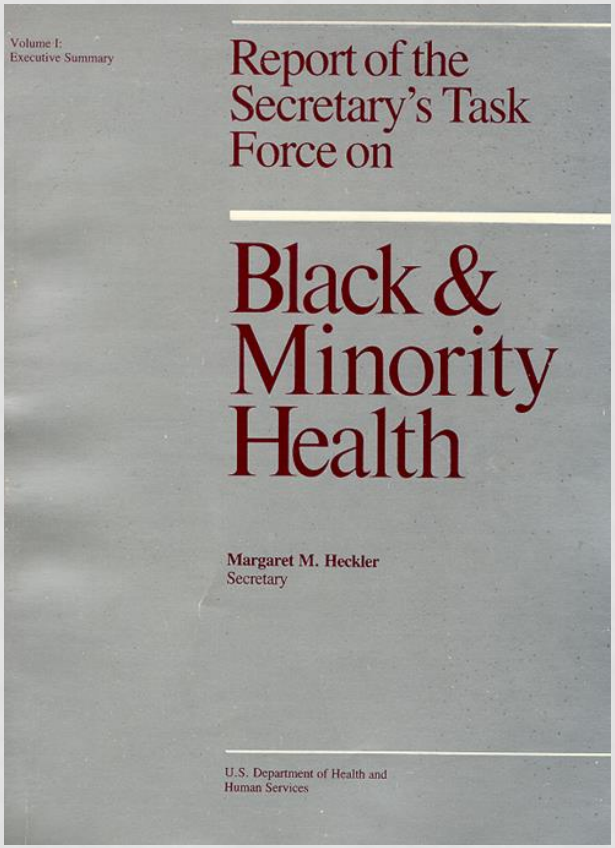
What is Health Equity?

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*

Progress

1985



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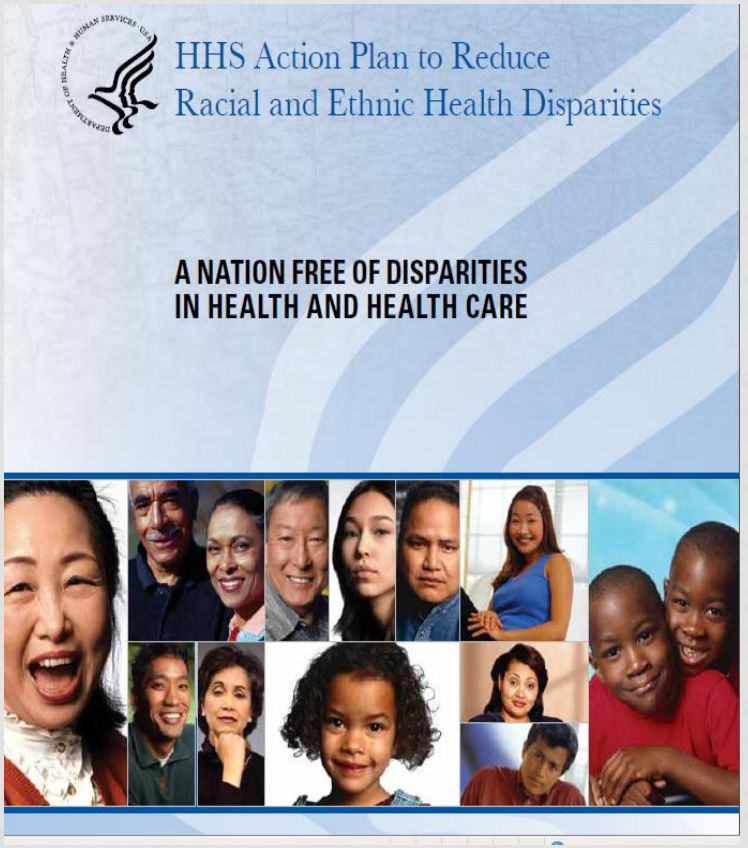


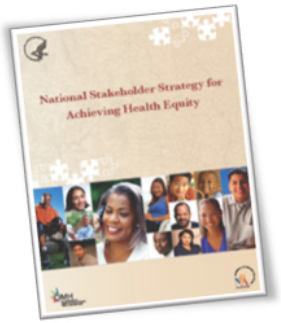
National Partnership for Action to End Health Disparities

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 National Stakeholder Strategy outlines specific goals to achieve Health Equity.

- Establish a Healthcare agenda to ensure ending disparities is a priority on the federal, state and local level.
- Increase the awareness of the significance of health disparities and their impact on the state and healthcare systems.
- Strengthen and expand the leadership to address health disparities at all levels.
- Fund priorities that include coordination, collaboration and opportunities for soliciting community solutions.
- Improve health care access and healthcare outcomes for racial and ethnic and underserved populations.
- Improve cultural and linguistic competency and the diversity of the health related workforce.
- Improve data availability, and coordination and utilization and diffusion of research and evaluation outcomes to include meaningful use of data and knowledge transfer.