



Cleveland Office of Minority Health

Local Conversations on
Minority Health

Report to the
Community 2011



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TABLE OF CONTENTS

National Partnership to End Health Disparities (NPA)	2
Ohio’s Response to the NPA.	2
Cleveland Office of Minority Health (COMH)	3
Cleveland Demographics	3
Cuyahoga County Demographics	3
Cleveland Socioeconomic Profile	3
Health Disparities in Cleveland.	4
a. HIV/AIDS	4
b. Infant Mortality	4
c. Obesity	4
d. Cancer	4
e. Diabetes	4
Cleveland’s Local Conversations on Minority Health	5
a. First Local Conversation	
i. African American	5
ii. Asian American.	5
iii. Hispanic/Latino	5
iv. Special Populations: Youth	
b. Collaborating Agencies	13
c. Community Partners.	13
d. Second Local Conversation: COMH Priority Setting . .	14
COMH Advisory Committee.	15
COMH Staff.	16



The National Partnership for Action to End Health Disparities

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

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

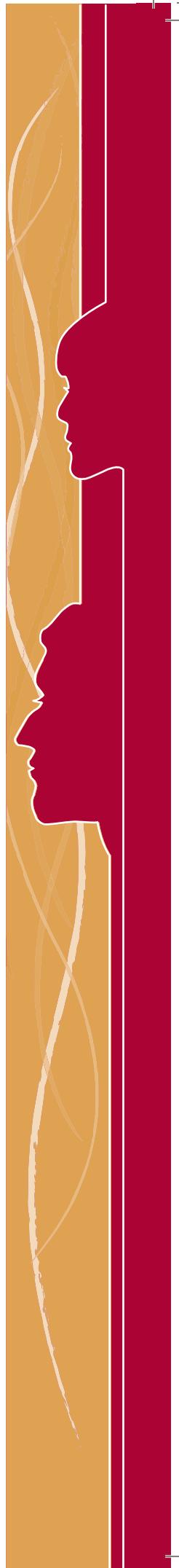
outlines goals, strategies, and actions HHS will take to reduce health disparities among racial and ethnic minorities. Both documents can be found on the Office of Minority Health web page at <http://minorityhealth.hhs.gov/npa/>.

Ohio's Response to the NPA

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

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

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



Cleveland Office of Minority Health

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

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

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

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

Cleveland Demographics

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

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

Cuyahoga County Demographics

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

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

The racial/ethnic composition of Cuyahoga County is:

850,089	(66.7%)	White/ Caucasian
373,782	(29.3%)	Black/African American
3,827	(0.3%)	Asian American /Pacific Islander
30,617	(2.4%)	Hispanic/Latino
1,275	(0.1%)	American Indian/ Alaska Native
5,740	(4.5%)	Two or more races

Cleveland, Ohio Socioeconomic Indicators

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

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

(<http://www.healthpowerforminorities.com>).

Health Disparities in Cleveland

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

Overall Health

Overall, African Americans were 1.77 times more likely to report being in fair or

poor health than Caucasians (21.2.1% compared to 12.0%).

HIV/AIDS Prevalence in Cleveland

As of June 1, 2010, there were 4,176 persons diagnosed with HIV living in Cuyahoga County. Of these, 2,963 (71%) persons were Cleveland residents and 54.4%, or 1,615 of them had AIDS. Nearly 60% of AIDS patients were African American, 24% were Caucasian non-Hispanic, 12% were Hispanic, and less than 1% was of other race. Three in four (74%) were male. Persons with HIV-only were younger, with about 16% being 30 years of age and younger. Eighty-five percent of individuals with AIDS were age 40 and older.

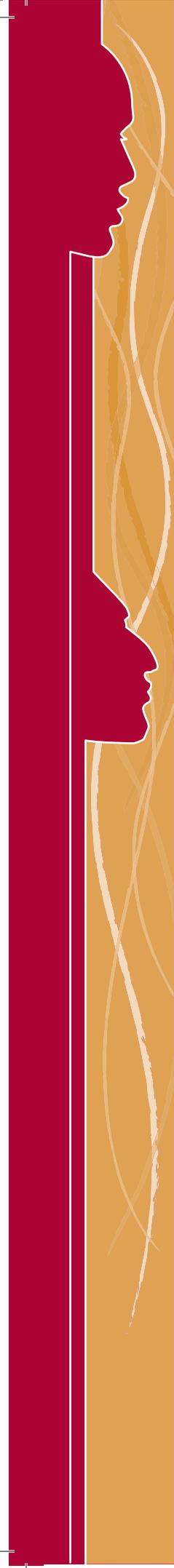
Infant Mortality

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

Obesity

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





Cancer

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

Diabetes

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

Tobacco Use:

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

Sources of demographic and health data:

www.factfindercensus.gov

Cleveland Ohio: A baseline statistical profile 2008, available at:

<http://publichealth.drexel.edu/che/SiteData/docs/Cleveland/81ab5b887147d1752438df4fa0070471/Cleveland.pdf>

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

Cleveland Department of Public Health, www.healthinfo.org

Cleveland's Local Conversations on Minority Health

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

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

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

African American

Approach

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

Individuals/Consumers

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

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

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

Community Stakeholders (service providers, health systems and funders)

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

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

Major resource needs

1. Primary care physicians
2. Culturally competent practitioners

3. Literacy health specialist/educators
4. Everyday role models of people living healthy lifestyles
5. Community care navigators and knowledge workers links

Major strategies for resource needs

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

Major service needs

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

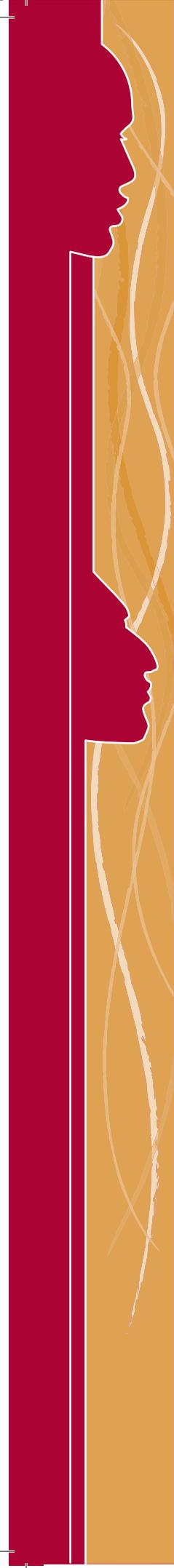
Major strategies for service needs

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

Major capacity building needs

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



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

Major strategies for capacity building

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

Major strategies for infrastructure needs

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

Asian American /Pacific Islander Resource Needs

The participants were very concerned about stereotypes that inhibit their ability to seek resources, e.g., “the Asian

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

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

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

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

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

The group believes that schools should be a major resource for furthering cultural diversity. A heritage/cultural curriculum highlighting the Asian American experience should be developed. Other cultural groups should be prominently added to the school curriculum. Awareness of other ethnic groups through the school setting may help foster an understanding and/or appreciation for other cultures.

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

Major resource needs

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

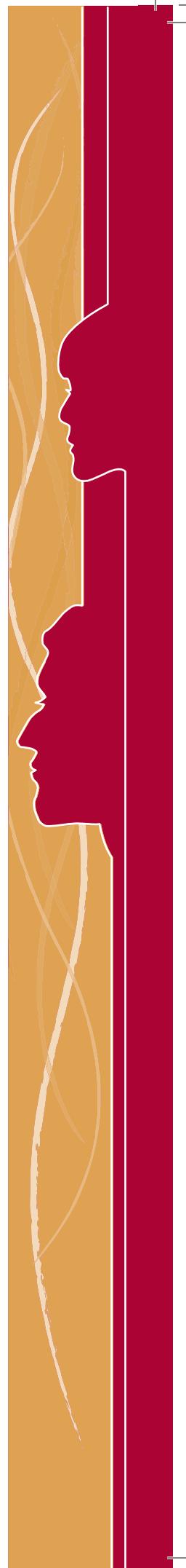
Major strategies for resource needs

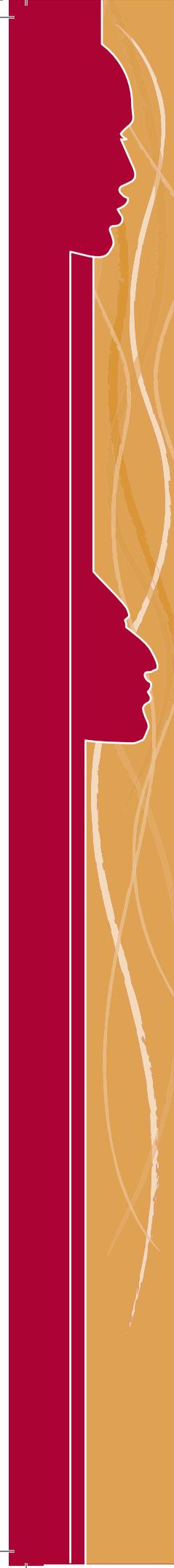
1. Developing a local leadership program
2. Targeting public relations for specific programs for youth and Southeast Asian American populations
3. Working with the statewide Asian American Health Coalition and other partners
4. Being inclusive, planning with all populations in mind, and inviting all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

Service Needs

The participants expressed a need for more health services in Asian American communities. In particular, there is a need for patient navigators. The concept of health disparities is not understood by everyone. This concept goes beyond personal health and impacts the community as a whole. Participants believed that a grass roots approach is needed within communities to help individuals gain a better understanding. Patient navigators could help individuals navigate the health system and connect to other needed services already available to the community. There is an overarching concern that Asian Americans—particularly those dealing with health insurance like Medicare—do not know the intricacies of the system. Within the community, there is a lack of knowledge as to where to find particular services. This problem is compounded by the fact that awareness materials and information sessions are usually offered only in English.

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





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

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

Major service needs

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

Major strategies to address service needs

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

Capacity needs

The needs of the Asian American community should be identified as a foundation for building agency capacity to address

those needs. The results of a recent community wide needs assessment were not disseminated to the Asian American community. Asian American service providers want and need community health assessment information to use in making a case for support with local funders.

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

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

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

Major capacity needs

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

Major capacity strategies

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

Infrastructure Needs

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

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

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

Major infrastructure needs

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

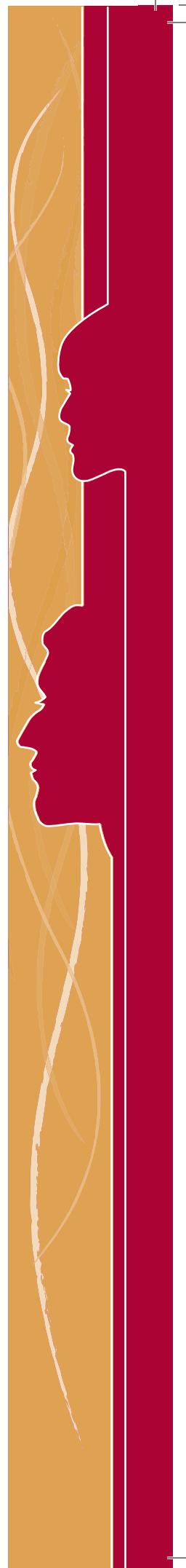
Major strategies for infrastructure needs

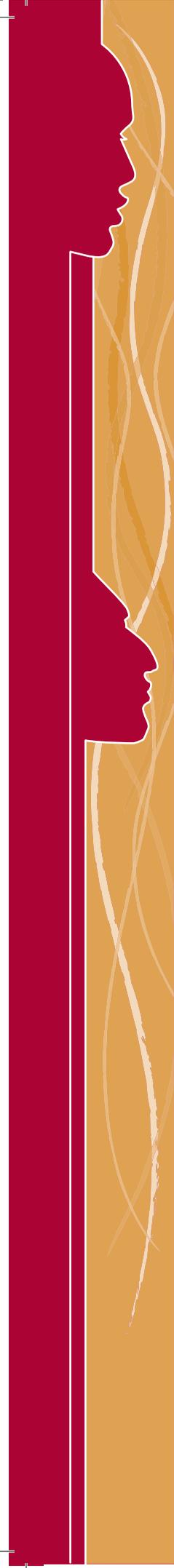
1. Providing training to provide training on health and culture for educational and other organizations
2. Introducing a mandatory diversity curriculum to medical schools.
3. Seeking funding for mobile clinic or work with an existing service provider to expand services to the Asian American community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

Hispanic/Latino Resource Needs

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

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





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

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

Major resource needs

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

Major strategies for resource needs

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

Service needs

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

The participants identified primary care services as a significant need for the Latino community including sexual health education such as prevention of HIV and STDs is

needed. More prenatal, mental health and substance abuse services are also needed in the Latino communities. Healthcare and health education services should be developed for undocumented residents. Early childhood intervention services should be made available in a format and language that the families can understand.

Major service needs

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

Major strategies for service needs

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

Capacity needs

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

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

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

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

Major capacity needs

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

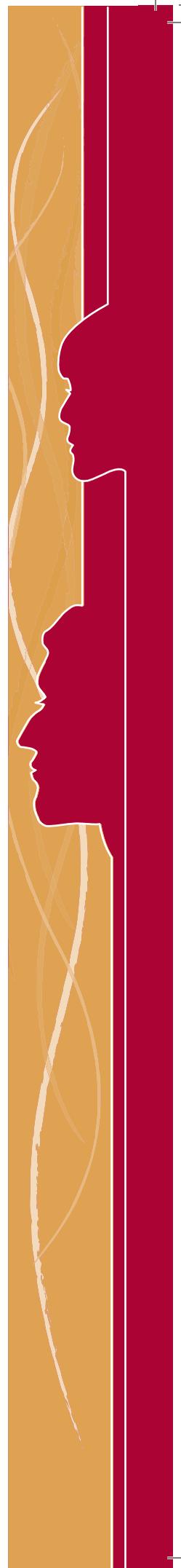
Major strategies for capacity needs

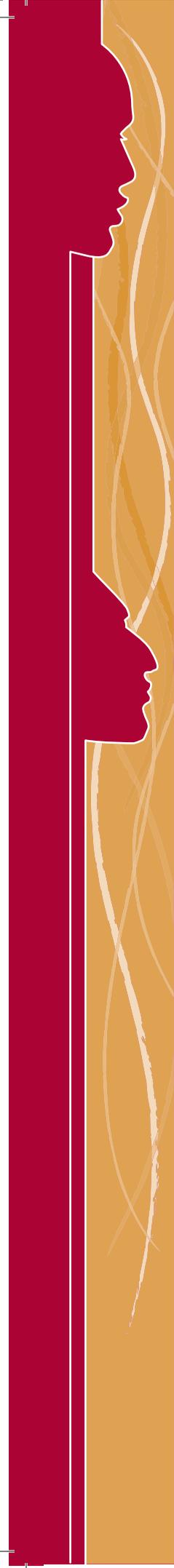
1. Creating youth mentoring programs that will lead to a better qualified workforce
2. Rewarding competence in health professionals
3. Organizing Latin physicians in Cleveland
4. Offering incentives for bilingual/Latin professionals to stay in Cleveland
5. Providing staff training and education in cultural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

Infrastructure needs

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

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





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

Major infrastructure needs

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

Major strategies for infrastructure needs

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

Special Category/Youth

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

Resources and Services

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

Capacity and Infrastructure

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

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

Collaborating Agencies

University Hospitals Case Medical Center
Cleveland Clinic

MetroHealth Medical Center

Partnership to Fight Chronic Disease

Sisters of Charity Foundation of Cleveland

Community Partners

Cleveland Branch NAACP

100 Black Men of Cleveland

Urban League of Greater Cleveland

Policy Bridge

Neighborhood Family Practice

Northeast Ohio Neighborhood Health Services (NEON)

Care Alliance Health Centers

American Cancer Society

Diabetes Association of Greater Cleveland

Partnership to Fight Chronic Disease

Kidney Foundation of Ohio, Inc.

Center for Reducing Health Disparities

Nueva Luz

Asian American Services in Action

Proyecto Luz

Cuyahoga County Community Mental Health Board
 Hispanic Alliance
 Better Health of Greater Cleveland
 Ohio State University Extension
 Children's Defense Fund of Ohio
 Minority Health Alliance
 Children's Hunger Alliance
 Center for Health Promotion Research Case Western Reserve University
 Rx Home Healthcare
 Center for Community Solutions
 Harvard Community Services Center
 Boyd & Son Funeral Home
 Economic Union Consortium of Greater Cleveland
 Neighborhood Connections
 Neighborhood Leadership Institute
 Cuyahoga County Board of Health
 United Church of Christ
 United Pastors in Mission
 Ohio Asian American Health Coalition
 Firm Foundations II
 Council of Economic Opportunities of Greater Cleveland
 Retired Seniors Volunteer Program
 WOIO 19/43
 Hospice and Palliative Care Partners of Ohio
 Cleveland State University College of Urban Affairs
 Zumba Fitness
 Radio One
 Call & Post
 City News

El Sol
 Erie Chinese Journal
 Cleveland Medical Association
 The Gathering Place
 Cleveland Council of Black Nurses

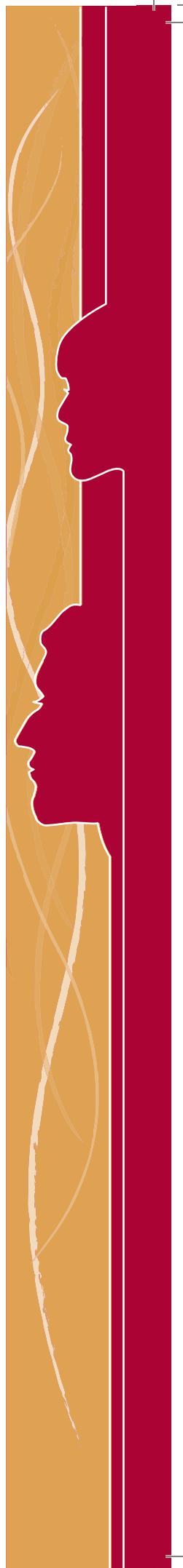
Second Local Conversation on Minority Health: Monday, December 14, 2010

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

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

I. RESOURCE NEEDS

- A. A comprehensive assessment of health needs (which includes access to physical and mental health services) for Cuyahoga County to include the following demographics: zip code, age, gender, race/ethnicity, insurance status, Medicare status, disability status per Social Security, and primary language spoken.
- B. Literacy health specialists/educators – more individuals trained as health educators with specialization in both general literacy (outreach to low-literacy populations) and health literacy for all.



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

II. SERVICE NEEDS

- A. Primary care services for medical, dental, and vision care.
- B. Education – offering education on healthcare issues including health insurance, prevention, mental health, and advocacy (from grassroots to treetops).
- C. Low cost/no cost pharmaceutical services – educating the community about resources for and lobbying for increased access to low cost/no cost pharmaceutical services.

III. CAPACITY NEEDS

- A. Evaluation of the effectiveness of current programs targeting the top five diseases disproportionately affecting minorities in Cuyahoga County and determining and disseminating best practices in these five disease areas.
- B. Collaboration and coordination – increase cross-cultural collaborations and coordination of efforts to reduce health disparities in Cuyahoga County.
- C. Enhanced public visibility of ethnic health issues.

IV. INFRASTRUCTURE NEEDS

- A. Funding – utilizing COMH to learn/ understand fundamental funding resources available to organizations to provide education and community programs.
- B. Coordinated efforts by the healthcare systems – coordinated efforts of all agencies in the sectors where we live, work, and play to eliminate health

disparities.

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

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

COMH Advisory Committee

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

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The accomplishments of the Cleveland
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