city of
CINCINNATI
HEALTH DEPARTMENT

Local Conversations *on* Minority Health

Community Report Update 2016

OHIO COMMISSION ON MINORITY HEALTH
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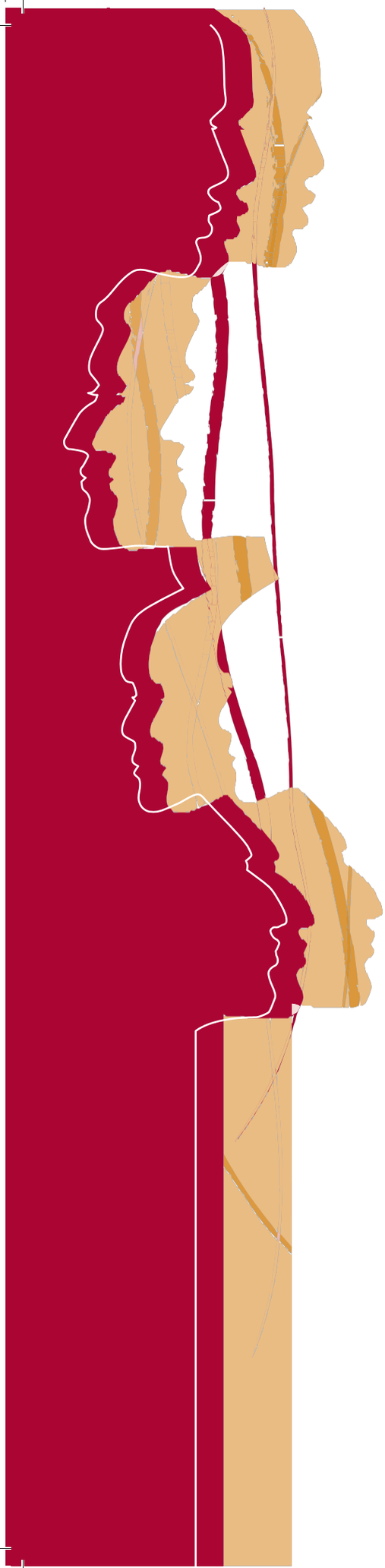


TABLE OF CONTENTS

National Partnership for Action to End Health Disparities (NPA) 4

Ohio's Response to the NPA 4

Cincinnati Health Department 5

Geographic Scope 5

Demographic Profile of Cincinnati 5

Health Disparities in Cincinnati 6

Morbidity and Mortality Burden in Cincinnati: A Health Equity Response 6

Cincinnati Gun Violence and Homicides 7

Cincinnati's Local Conversations on Minority Health 9

Health Disparity Reduction Plan 10

The Fourth Conversation 12

Other Strategies/Comments 13

Follow-up Action Plan 14

Acknowledgements 15

Information contained in this document is based on a series of conversations, and a web-based survey (January 19 – February 26, 2010). These events were scheduled to follow-up the first Local Conversation on Minority Health, which was held on Saturday, August 23, 2008 at the Community Action Agency located at Jordan's Crossing, Cincinnati, OH, 45237. The fourth conversation was held as a follow up on May 21, 2016 at the Cincinnati Community Action Agency Cincinnati, Ohio,

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 in1987 to address health disparities and improve the health of minority populations in Ohio, sponsored a statewide initiative to help guide health equity efforts at the local and state levels.

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

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

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

Cincinnati Health Department

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

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

Geographic Scope

The geographic scope of this project is Cincinnati, Ohio.

Demographic Profile of Cincinnati

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

49.3% are white/Caucasian

44.8% are black/African American

1.8% are Asian/Pacific Islander

2.8% are Hispanic/Latino

4.1% identified as some other race

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

Health Disparities in Cincinnati

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

Morbidity and Mortality Burden in Cincinnati: A Health Equity Response

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

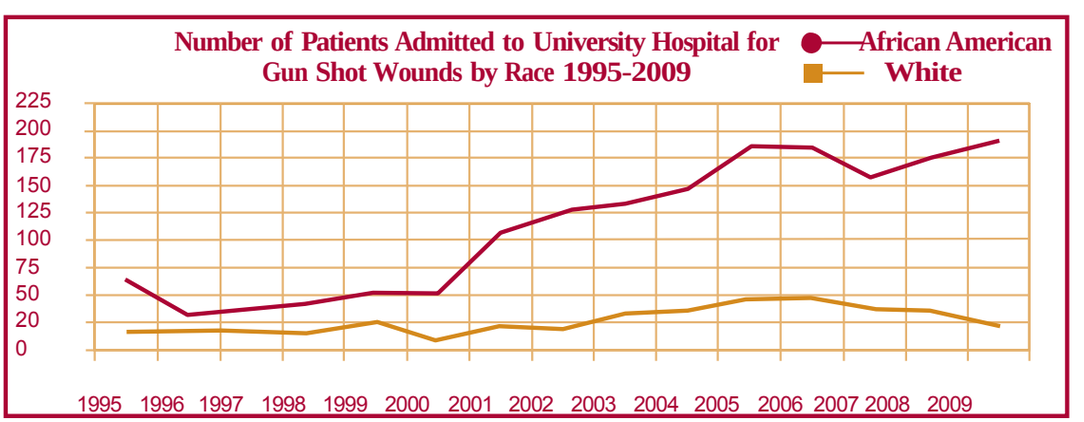
Mortality Rates (per 100,000 population) for the top 10 causes of death in Cincinnati, compared to Ohio Large Metropolitan Areas, and the United States, CDC Wonder Compressed Mortality Files, 2001-2007

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

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

Cincinnati Gun Violence and Homicides

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



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

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

Out of the Crossfire, Inc. (OOTC) was established to combat the 500% dramatic rise in the incidence of gun violence (frequently due to retaliation) from 2000 – 2006 in Greater Cincinnati. OOTC was the region's only hospital-based, violence intervention program and one of only nine in the United States. Hospital-based violence intervention programs have repeatedly been shown to reduce the incidence and severity of criminal activity, decrease the rate of violence recidivism, decrease hospitalizations, and increase employment or self-efficacy. Whereas the medical staff strives to heal the victim physically, these violence intervention programs aid in modifying the social and behavioral factors that may have led to the violent injury and the subsequent (or pre-existing) emotional/mental trauma that usually afflicts the victim and significant others. These programs deliver culturally sensitive interventions aimed at helping the individual through psychological recovery, socioeconomic rehabilitation, re-integration into the community, self reliance skills development, as well as promoting health and well-being in survivors and other, at risk community members. After its first year of operation (2007), OOTC contributed to an 18% reduction in gunshot wounds treated at the only adult, level one trauma center in Cincinnati. The profile of OOTC clients was as follows: 87% African-American, 83% school dropouts, 85% unemployed, 81% had legal income less than $10,000/year, 91% male, 80% were from non-traditional families, 80% were from violent neighborhoods, 86% were uninsured, 80% had a history of substance abuse and/or dealing drugs, 82% had a history of incarceration and 54% were within the age range of 14-25 years. Unfortunately, due to budget constraints, this was shut down after five years in April, 2011.

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

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

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

Cincinnati's Local Conversations on Minority Health

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

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

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

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

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

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

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

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

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

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

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

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

Health Disparity Reduction Plan

Services

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

Resources

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

Capacity Building

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

Infrastructure

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

The Fourth Conversation

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

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

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

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

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

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

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

COMMUNITY PARTICIPATION

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

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

Strategies/Comments

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

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

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

Background
The Cincinnati Health Department (CHD) created the Creating Healthy Communities Coalition (CHCC) to promote the health and well-being of people in Cincinnati. The CHCC works with many community partners and policy makers to address healthy eating, tobacco-free living, active living, and chronic disease management or prevention. In May 2016, the CHD in conjunction with the CHCC organized a local conversation about minority health in Cincinnati. Participants in the conversation were from target neighborhoods of the CHD and CHCC. The goal of this research project was to determine the most important health indicators for members of target communities and evaluate the role of CHCC in creating healthy communities in Cincinnati. The objective is to determine the best public health practices for public health communication plans and provide recommendations for future community health planning.
Methodology
The study evaluated two sets of data. The first set came from the CHCC member evaluation survey. Participants (n=50) were members of the coalition. The CHCC evaluation was administered with the online survey platform, SurveyMonkey, and sent to members by email. The second set of data came from a local conversation on minority health with members of Cincinnati CHCC's focus communities in May 2016. Sixty-one community members participated in the discussion. Data from community conversations were collected through an administered health priorities worksheet. Both sets of data were analyzed by descriptive statistics with Microsoft Excel.
Results
Of the 50 CHCC members, n=23 completed the evaluation survey and revealed barriers to participation in the coalition as well as addressing improvement areas. Local conversation data also revealed health gaps and key health indicators in Cincinnati's communities, suggested strategies and identified ways the CHD can address them. The primary community concerns were drugs and violence (n = 23), health education (n=18), mental health services (n=18), food access (n=13), and transportation (n=11). The leading health indicator was poverty.
Conclusion
The results of the study indicate that the intersection of socioeconomic status and the environment shape indicators of health. Furthermore, community-based participatory research is a useful approach to explore issues regarding minority health, communicating intervention plans, and developing programs for maximum impact. Other strategies CHD is taking based on the information gathered at all community conversations are:

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

Follow-up Action Plan

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

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

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

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

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

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

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

Acknowledgments

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

The Cincinnati/Hamilton County Community Action Agency

The Xavier University Women's Center

Xavier University College of Social Sciences, Health and Education

Xavier University Department of Nursing

Xavier University Department of Social Work

Bigg's Department Store

The Coffee Emporium

The Kroger Company

The Cincinnati Local Conversations on Minority Health participants included:

S. Abdullah, Cincinnati/Hamilton County Community Action Agency

James Alexander, TV Producer, Videographer

Janice Alvarado, Health Advocate/Analyst

Tom Bergh, Cincinnati Metro

Anita Brentley, Cincinnati Children's Hospital Center

Jill Byrd, community representative

Tom Chung, Ohio Asian-American Health Coalition

Miriam Crenshaw, CEO, WinMed Clinic

Imelda Castaneda-Emenaker, University of Cincinnati

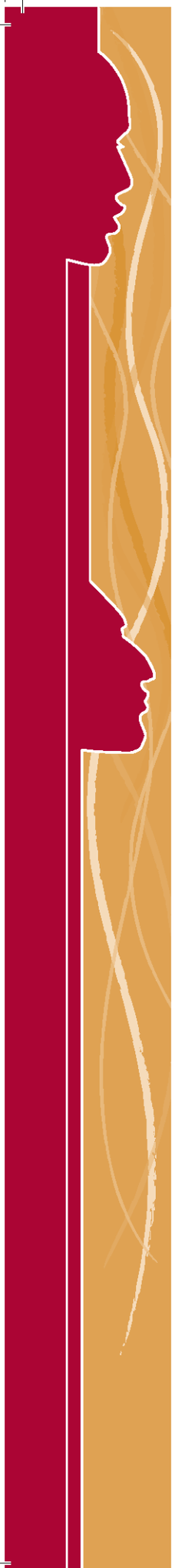
Debra Dreyfus, RN, Manager of Price Hill & Millvale Health Centers

Nan Gracia, community representative

Judith Harmony, community representative

Kathy Hill, community representative

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



Notes

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