Columbus Office of Minority Health

Local Conversations on Minority Health

Report to the Community 2011

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National Partnership for Action to End Health Disparities

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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 Columbus Health Disparity Reduction Plan in this document is a result of this process. The lead agency for the Local Conversations in Columbus was the Columbus Office of Minority Health.

Columbus Office of Minority Health

The Columbus Office of Minority Health (COMH) was established in 2007 as a division of Columbus Public Health. Its mission is to provide leadership to reduce health inequities in minority communities of Columbus and its surrounding areas. The Office of Minority Health has an important role in activating efforts to educate citizens and professionals on critical health care issues through the achievement of four Core Competencies:

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

The Columbus Office of Minority Health was set up to:

- Serve as a mechanism for local governments to produce consistent data sets representative of the diversity in Columbus
- Provide a local presence for issues of minority health in Columbus
- Institutionalize the effort to eliminate health disparities within the city
- Serve as a conduit of information for trends and emerging concerns between the Ohio Commission of Minority Health and local communities.

Columbus Demographics

The geographic scope of this project is Columbus, Ohio, the capital and second largest city in Ohio with an estimated overall 2006 population of 733,203. Columbus has a diverse racial/ethnic population. African Americans make up the largest minority population in the city (about 26%) although the city has experienced rapid growth in Latino and Asian American groups in recent years. Between 2000 and 2005, the Latino population grew 40.8%. Columbus accounts for about two-thirds of the Franklin County population.

Racial and Ethnic Population Composition

COLUMBUS, Ohio 2000 - 2005

Race/Ethnicity	*2000 Population*	*2005 Population*	*% of 2005 Population*	*% Change 2000 - 2005*
White	483,332	454,368	65.5%	- 6.0%
Black or African American	174,065	181,977	26.2%	+ 4.5%
American Indian/AN	2,090	1,674	0.2%	- 8.0%
Asian/NHPI	24,862	27,200	3.9%	+ 9.4%
Some other race	8,292	10,661	1.5%	+ 28.6%
Two or more races	18,829	18,103	2.6%	- 4.0%
Total Columbus	711,470	693,983	100%	- 2.5%
Hispanic or Latino (of any race)	17,471	24,607	3.5%	+ 40.8%

Source: US Census Bureau, American Community Survey, 2000 and 2005
AN=Alaskan Native; NHPI=Native Hawaiian and other Pacific Islanders.

Socioeconomic Profiles of Columbus

Economic conditions are worse for African Americans and Latinos in Franklin County than for their white peers and their prospects are poorer because of lower educational attainment. The median household income for Black or African Americans and Hispanics or Latinos is less than the county median.

Median Household Income by Race, Franklin County, 2005

Race/Ethnicity of Householder	*Median HH Income*	*% Higher/Lower than Franklin County*
White	$50,460	1.10%
Black or African American	$31,223	-31.20%
Asian	$49,796	9.70%
Hispanic or Latino (of any Race)	$35,783	-21.20%
All Franklin County Households	**$45,410**	--

The percentages of Franklin County residents living in poverty are much higher for African Americans and Latinos, particularly for children.

Percent of Persons Living in Poverty in Past 12 Months, Franklin County, 2005

Race/Ethnicity	*All Persons*	*Persons Age 65+*	*Persons Under Age 18*	*Female-Headed Households with Children*
White	10.3%	7.7%	11.7%	26.2%
Black or African American	29.8%	23.9%	44.2%	46.5%
Asian	11.7%	11.3%	6.4%	NA
Hispanic or Latino (of any Race)	15.6%	23.9%	17.0%	NA
Franklin County Total	**14.5%**	**10.2%**	**20.1%**	**36.4%**

The Hispanic or Latino population in Franklin County has the highest percentage of persons ages 25 and over with less than a high school education. African Americans have the highest percentage of individuals with a high school diploma and some college, but no Bachelor's degree, ranking above the county total. Two thirds of the Asians in the county have a Bachelor's degree or higher, almost doubling the total percentage of all persons in Franklin County with these credentials.

Educational Attainment, Percent of Persons Age 25 and Over, Franklin County, 2005

Race/Ethnicity	*Less than High School*	*High School Diploma only*	*Some College no Bachelor's*	*Bachelor's or higher*
White	10.2%	26.6%	26.0%	37.2%
Black or African American	16.7%	36.0%	30.5%	16.8%
Asian	10.9%	10.0%	12.9%	66.2%
Hispanic or Latino (of any Race)	35.6%	27.4%	14.3%	22.7%
Franklin County total	**11.8%**	**27.5%**	**26.2%**	**34.4%**

Source: US Census Bureau, American Community Survey 2005

Health Disparities in Columbus

Racial and ethnic groups in Franklin County and Columbus face persistent health disparities. Most county and city health disparity data provide information on African Americans and Latinos and not on the less populous groups of Native Americans and Asian Americans. Existing data show disparities in mortality due to heart disease, cancer, stroke, diabetes, infant mortality, and homicide. Data from two community health surveys illustrate some of these disparities—the 2004 Franklin County Minority Health Profile published by the Ohio Department of Health and the 2000 Columbus/ Franklin County Community Health Risk Assessment published by the Columbus Health Department.

2004 Franklin County Minority Health Profile

- Poor/fair health status was more likely to be reported by Black and Hispanic adults in Franklin County than White adults.
- White and Black adults in Franklin County were more likely to report they had heart or circulatory disease than Hispanic adults.
- Black adults in Franklin County were more likely to report they had hypertension than any other racial/ethnic group.
- Black and White adults in Franklin County were more likely than Hispanic adults to have been told by a health care professional they had diabetes.
- White adults (54.0%) were more likely than Black (45.3%) and Asian adults (27.7%) to rate the overall quality of their health care "very good – excellent".

2000 Columbus/Franklin County Community Health Risk Assessment

- More Black adults (67.5%) are overweight compared to White adults (55.3%).
- More Black adults (12.3%) report being concerned about having enough food in the past 30 days than white adults (4.5%)
- Diabetes is more prevalent among Black adults (8.5%) than among White adults (5.7%).
- More Black adults with diabetes (58.0%) report not seeing a doctor or nurse for their diabetes in the past year than White adults with diabetes (13.1%).
- More Black adults (37.2%) have high blood pressure than White adults (26.2%).
- More Black adults (17.5%) do not have health care coverage compared to White adults (6.2%).
- More Black adults (12%) were unable to make a needed visit to the doctor in the past 12 months because of the cost compared to White adults (4.6%).
- More Black adults (19.1%) were unable to get prescribed medication due to the cost than White adults (9%).

Leading Causes of Death

Data from the Ohio Department of Health Vital Statistics document disparities by race/ethnicity and gender for most of the leading causes of death.

Selected Leading Causes of Death by Race/Ethnicity, and Gender, Franklin County, 2003-2005

3-Year Totals, Age-Adjusted Rates per 100,000

DISEASE	*Total Franklin County*			*White*			*Black*		
	All	*M*	*F*	*All*	*M*	*F*	*All*	*M*	*F*
Heart Disease	218.8	273.4	179.5	214.4	271.1	174.2	250.7	298.3	212.1
Cancer	209.0	257.4	178.2	203.6	247.0	176.2	257.0	340.2	205.2
Stroke	55.9	53.4	55.7	54.3	51.0	54.7	64.7	65.2	62.3
CLRD	51.8	60.8	46.7	55.8	64.5	50.9	32.9	46.0	25.5
Diabetes	30.2	35.6	26.3	24.1	28.0	21.4	65.4	82.3	53.1
COD-O	*Total Franklin County*			*White*			*Black*		
	All	*M*	*F*	*All*	*M*	*F*	*All*	*M*	*F*
Homicide	9.4	15.8	3.1	4.6	7.3	1.8	29.3	53.1	8.2

Source: Ohio Department of Health, Data Warehouse
CLRD= Chronic Lower Respiratory Disease
*of any race
M = Male; F = Female; PI = Pacific Islander;
NC = Not calculated due to number of deaths <20 per group
COD-O = Cause(s) of Death–Other than from disease.

Death rates for Columbus area African American males and females due to cancer and diabetes exceeded those of African American males and females at the state level. The Franklin County 2003-2005 age-adjusted homicide death rates were highest for African American males followed by Latino males. This represented over half of all homicide deaths in the county during this period, although African American males are only 19.8% of the total Franklin County population. The age-adjusted homicide rate for African American males in Franklin County (53.1/100,000) well exceeded the age adjusted rate for African American males (39.1/100,000) in Ohio as did the homicide rate for Latinos (24.4/100,000 for Franklin County compared to 9/100,000 for Latinos statewide.

Infant mortality rates have been higher for African Americans and Latinos in Franklin County than for White infants.

Infant Mortality by Race/Ethnicity, Franklin County, 2000-2005

3-Year Average Rates Per 1000

Year	*White*	*Black*	*Latino*	*Total*
2000-2002	6.5	14.5	6.1	8.2
2001-2003	6.2	15.0	10.1	8.4
2002-2004	6.3	15.1	9.7	8.5
2003-2005	6.4	10.1	7.8	8.3

Columbus Conversations on Minority Health

Local Conversations Phase I

The first Columbus Local Conversation on Minority Health was held on Friday, October 24, 2008. The event was attended by about 50 individuals who represented a broad range of local leaders, organizations, and sectors, including city and state government, the city health department, health service providers, academic institutions, faith-based agencies, ethnic-specific organizations, and agencies targeting particular diseases or disability groups.

Participants were broken into four groups where they identified and prioritized needs related to *services, resources, capacity building, and infrastructure.*

Resources

- Health communication campaigns using multi-media and offered in multiple venues and targeting young audiences and high risk groups
- Identifying and developing programs to address needs of emerging populations (Latino, Somali, Asian)
- Centralized interpreter services
- Creation of a community toolbox
  - Best practices database
  - Prevention case-building research
- Advocacy for additional funding for health programs and services

Services

- Greater general emphasis on prevention
- More health education and health promotion initiatives in schools
- Holistic health care
- Unmet mental health needs
- HIV education for youth
- More services addressing addictions, including substance abuse and less widely addressed addictions such as gambling
- Improved services for children with MR/DD in public schools
- More outreach for underutilized services

Capacity Building

- Training for youth on how to use the health system

- Assistance with grant seeking for community organizations
- Mandated cultural competency training for practicing health professionals
- Increased collaboration and community partnerships
  - Schools and universities
  - Police and justice systems for neighborhood safety
  - Emerging populations
  - Groups that have not been traditionally involved in health

Infrastructure

- Lack of available health services in certain high needs areas
- Access barriers related to transportation and lack of health insurance or inadequate health insurance
- Greater attention to the social and economic determinants of health
- Greater attention to health in government policy decisions
- Outreach to attract and support minority groups in health professions training

Local Conversations Phase II

Participants were invited back for Phase II to continue health disparity discussions. Utilizing information gathered from Phase I, participants were asked to develop strategies and make recommendations on how to meet the prioritized needs.

RECOMMENDED STRATEGIES

Resources

1. Initiate health communications campaigns using a variety of media that provide consistent positive messages about healthy lifestyles.
2. Target young audiences and high risk groups for health promotion communications campaigns to prevent chronic illness.
3. Identify champions to participate in health communications campaigns for youth and young adults.
4. Create communications campaigns utilizing different outreach strategies for different races, cultures, and age groups.
5. Support the creation of additional resources to address the needs of emerging populations such as Somali, Asian Americans, and Latinos.
6. Conduct demographic analyses and needs assessments of emerging populations in the Columbus area.
7. Explore the feasibility of creating a system of centralized interpreter/translator services.
8. Create a communications toolbox as a general community resource that would include a databank of best practices for health promotion for ethnic communities and research on cost effectiveness of prevention programs.
9. Advocate and provide resources to support greater use of evidence-based practices in mental health services for African Americans and other ethnic consumers.
10. Advocate for more funding to achieve health equity in minority communities.
11. Encourage local community groups to call attention to unmet health needs in their communities.

Services

1. Increase the emphasis on prevention, particularly focusing on modifying lifestyle behaviors related to nutrition and physical activity and in

areas of identified need such as prenatal care.

2. Integrate health education and health promotion through the curriculum in public schools, beginning in preschool years.
3. Encourage a more holistic approach to patient treatment that addresses the full spectrum of their needs.
4. Work to increase the availability of in home health services for ethnic consumers.
5. Increase the availability of mental health services in currently underserved areas.
6. Create public awareness campaigns designed to reduce the stigma associated with seeking mental health services.
7. Advocate for the inclusion of questions on mental health status as a part of routine health screenings.
8. Develop HIV education programs for youth and implement them in diverse community locations, including schools, churches, and recreation centers.
9. Support the expansion of additional addiction treatment services, including treatment programs for addictions (e.g., gambling, shopping, sex) not currently being widely addressed.
10. Advocate for the improvement of education and other services for children with MR/DD attending public schools.
11. Support the expansion of in home support services allowing elderly to remain in their own homes rather than being placed in nursing homes.
12. Carry out outreach programs to increase awareness of health services available to minority consumers.

Capacity Building

1. Expand community partnerships among non-profit organizations, educational institutions, and government agencies to promote information sharing and collaborative planning and to stretch the limited resources available to address ethnic health disparities.
2. Broaden the base of individuals and groups actively participating in planning and implementation of initiatives to reduce minority health disparities to include groups that not traditionally been involved in health care.
3. Identify and involve leaders from emerging populations in discussions and planning on initiatives to address health disparities.
4. Provide training for youth on how to use the health system and be informed consumers of health services.
5. Provide training on grant seeking for community organizations providing health services to ethnic communities.
6. Provide cultural competency training for all levels of practicing health professionals.
7. Develop cultural competency training programs that address developing rapport and trust with minority consumers and generational differences in cultural health beliefs and practices.
8. Advocate for making cultural competency training mandatory (e.g., by making it part of performance evaluations).

Infrastructure

1. Work to increase the availability of health services, including primary care, in underserved, high need areas.

2. Advocate for the establishment of a community mental health center on the west side of the city.
3. Support the development of free health clinics for primary and urgent care to reduce the burden on use of emergency rooms and promote preventive health care.
4. Increase community awareness of the social and economic determinants of health.
5. Advocate for intervention programs to address the social and economic determinants of health; e.g., collaborative work with governmental and community organizations to stimulate economic development in impoverished neighborhoods in order to decrease crime and juvenile delinquency.
6. Encourage that government policies be developed with attention to their impact on community health.
7. Advocate for the creation of policies that make health funding more flexible and responsive to consumer needs.
8. Introduce minority children to health career awareness programs at early ages, beginning in elementary school.
9. Develop initiatives to encourage minority youngsters to pursue health professions training (e.g., job fairs, summer medical camps, service learning programs).
10. Advocate for increased funding to support health professions training for minority students.
11. Advocate for loan forgiveness for going into health practice in high needs areas.
12. Involve representatives from local transportation in health disparity discussions.

Next Steps

The Columbus Office of Minority Health Advisory Committee meets quarterly and is charged with setting up opportunities within the community to address issues surrounding minority health as well as helping facilitate access to racial/ethnic and immigrant/refugee populations and service agencies/organizations. The role of the Advisory Committee is to:

- Advise COMH on its desire to foster and build collaborative relationships with and among agencies/organizations that provide services to racial/ethnic and immigrant/refugee populations resulting in better access to and utilization of services by racial/ethnic and immigrant/refugee populations.
- Advise COMH on what funding and grant opportunities are available to help promote COMH initiatives.
- Provide input into data collection and survey development to facilitate better understanding of racial ethnic and immigrant/refugee populations.
- Help with creating a yearly calendar of events (Columbus, Ohio/Franklin County) as well as recommend speakers to board meetings to speak on issues impacting racial/ethnic and immigrant/refugee populations.

Utilizing the work product from the Local Conversation process, the Columbus Office of Minority Health will be able to work towards achievement of the recommendations that were generated. Measurement of achievement of information gathered from the Local Conversations is ongoing consistent with input from the Advisory Committee and local provider agencies and residents through their service agencies.

Notes

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