SENIORS COOPERATION
GOALS RESEARCH
HEALTHY FOOD SOCIAL PLAN
ASSESSMENT
CUYAHOGA COUNTY STRATEGY
CARE
IMPACT COMMUNICATION SPACE FITNESS EDUCATION
NEIGHBORHOODS
FAMILES
INSPIRATION
COMMUNITY HEALTH

SOLUTIONS
PARTNERSHIP
LEADERSHIP

Cuyahoga County Community Health Improvement Plan

2015

POLICY
EQUALITY
IMPROVEMENT GROWTH COOPERATION VISION
PARTICIPATION
EQUITY
CHILDREN
INNOVATION
RESPECT
IMAGINE
TOGETHER
PLAYGROUNDS
TEENS
FAIRNESS INFORMATION
COLLABORATION
FUTURE

HiP CUYAHOGA
Health Improvement Partnership

Health Improvement Partnership-Cuyahoga (HIP-Cuyahoga) is building opportunities for everyone in Cuyahoga County to have a fair chance to be healthy.

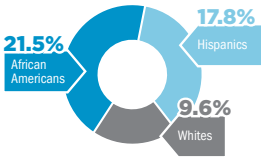
HIP CUYAHOGA
Health Improvement Partnership

UNEQUAL OPPORTUNITIES + POOR HEALTH = SHORTER LIVES

African Americans and Hispanics are three times as likely to live in poverty than whites.

African Americans are more than twice as likely to be unemployed than whites.

UNEMPLOYMENT RATE IN CUYAHOGA COUNTY

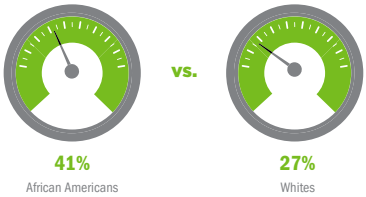


African Americans and Hispanics are less likely to graduate High School than whites.

Half of the people in Cleveland live farther than a half mile from a grocery store. More than 60% of them are people of color.

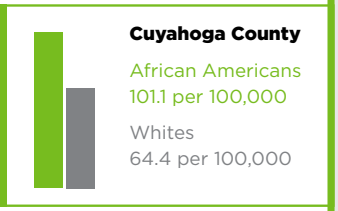
Students of color are more than twice as likely to be obese than white students.

Nationally, African Americans have a higher prevalence of high blood pressure. African Americans are also up to four times more likely to suffer increased risk of complications from high blood pressure than whites.

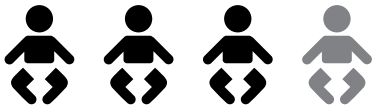


African Americans are more likely to die from a stroke than whites.

STROKE MORTALITY RATES



*2008-2010 Ohio Stroke Mortality Rates



In Cuyahoga County, three times as many African-Americans babies die than white babies.

Depending on where people live, there is up to a 20-year difference in Life Expectancy in Cuyahoga County. City of Cleveland and "inner-ring" suburbs have the lowest life expectancies.

WHY DOES IT MATTER?

In Cuyahoga County, people of color are needlessly suffering and dying before their time.

We all pay for poor health.

>$1 Trillion—the combined cost of health inequities in the U.S.

WHAT ARE WE DOING ABOUT IT?

Public health and health care systems must work together to improve the health of communities.

HIP-Cuyahoga is:

- ✔ Encouraging both systems to work together on shared goals
- ✔ Building public health and health equity training into the curriculum of health profession students
- ✔ Identifying opportunities for combined data collection to better represent community health needs

An increasing number of people of color are at risk of chronic disease and do not get the care they deserve and need.

HIP-Cuyahoga is:

- ✔ Recruiting residents to become trainers or participants in chronic disease self-management programs
- ✔ Training doctors to care for all patients with chronic disease in ways that are proven to work
- ✔ Training doctors to be culturally sensitive and speak in plain language

Structural racism limits opportunities for some but contributes to poor health for all.

HIP-Cuyahoga is:

- ✔ Teaching organizations how to recognize and address structural racism
- ✔ Encouraging organizations to work closely with community members
- ✔ Developing policies to create social and economic opportunities for all people in Cuyahoga County

Everyone should be able to eat healthy and be active if they choose to.

HIP-Cuyahoga is:

- ✔ Making healthy food available in neighborhood stores
- ✔ Making sure that new streets are built to encourage walking and biking
- ✔ Encouraging schools and churches to open their doors for people to be active after hours

TABLE OF CONTENTS

Cuyahoga County Community Health Improvement Plan

HIP-Cuyahoga intends to regularly update this plan to ensure that it accurately represents the most current work of the partnership. All updates will be available at: ***www.hipcuyahoga.org.***

A MESSAGE

From the Co-Chairs of the Health Improvement Partnership-Cuyahoga (HIP-Cuyahoga) Consortium

It is with great pleasure that the Health Improvement Partnership-Cuyahoga consortium presents to our community the Cuyahoga County Community Health Improvement Plan (CHIP). The CHIP is the culmination of a comprehensive and inclusive planning process, including research, collaborative community engagement, collective planning, shared decision making, and meaningful action. Our goal is to increase opportunities for all residing in the county to reach their fullest health potential, especially those who have experienced historical and consistent health disparities.

Since our election as HIP-Cuyahoga co-chairs, we have enjoyed working with a committed, dedicated and innovative group of multidisciplinary professionals, elected and appointed officials, and grassroots community members who have come together to improve opportunities for all people living in Cuyahoga County to live healthy and productive lives. It has been exciting to both observe and actively participate in the evolution of the HIP-Cuyahoga consortium with its members as we worked to develop and implement our mission and vision.

This evolution has created an active level of engagement by consortium members that is based upon our core value of building opportunities for everyone in Cuyahoga County to reach his or her fullest health potential. Our three key approaches are Collective Impact, Community Engagement, and Health and Equity in all Policies. These approaches provide the consortium and its members with a framework that fosters diversity of thought and participation; promotes inclusive and transparent planning, decision making and actions; and highlights equity as a desired outcome as we address and remediate health disparities.

We have marveled at the collaborative spirit that has emerged through our collective impact approach, to align creative and innovative thinking and the pooling of valuable resources. The HIP-Cuyahoga Consortium is focused on four key priorities: (1) Increase access and opportunities for improved nutrition and physical activity; (2) Improve chronic disease management through the engagement of various sectors; (3) Improve coordination between clinical care and public health to improve population health; and (4) Eliminate structural racism.

As we describe above, there are ethical and value propositions that support the creation and sustainability of the consortium's work. It is no less important that we have bonded around the personal reasons that led us to become deeply involved in the mission and vision of the consortium. Each of us has a seminal event or personal developmental story that has led us to embrace the work we are involved in and the ethical and value propositions that support our participation.

GREG'S STORY: As an African American who was born in the 1950s and who came of age in the 1960s and 1970s, two historical events that occurred in my youth and adolescence shaped my life. The two historical events were the civil rights movement and the Vietnam War. These events had such a dominant impact on my development as a person that my future educational and career paths tied directly to these two life-altering events. As a leader in this consortium, I bring who I am as a person and professional, with my values and competencies, as a contribution to build opportunities for all people in Cuyahoga County.

HEIDI'S STORY: HIP-Cuyahoga matters to me because I was born and raised in Northeast Ohio, in a community ravaged by massive economic losses and resultant poverty. I have been afforded a great deal of education that provided the opportunity for me to live in other places where I thought I would be serving vulnerable populations. I was, however, humbled to return to my home as a community member and practicing physician to find marked inequities in the very place I was raised, here in Northeast Ohio. During countless individual patient interactions, I have learned about the realities of inequity for individuals, families, neighborhoods, and local communities, leading to unjust health consequences. However, in the context of my medical training, I often find it overwhelming to consider how I might address these massive issues as only one person with limited time during episodic office visits. Involvement with HIP-Cuyahoga has transformed my understanding of what is possible, as it provides pragmatic solutions to the dilemma of addressing multiple inequities that have real impact on the families I see in my daily work. HIP-Cuyahoga has provided me with a framework for understanding the current conditions, an awareness of the structural contexts that created them, and realistic solutions to move our entire community forward together. HIP-Cuyahoga has transformed me as a physician, educator, parent, and citizen.

The reasons discussed in this letter provide the context for our motivation, participation, and leadership in the Consortium. There is little doubt that each consortium member has a personal story that explains the focus of his or her energy and commitment to the success of our work. We hope that once you have read the report and discussed its content, you too will find a reason to join us in the work to be done to ensure that each and every person in the county has every opportunity to live the life of his or her dreams.

Sincerely,

Gregory L. Brown
Executive Director
PolicyBridge

Heidi Gullett, MD, MPH
Assistant Professor, Case Western Reserve University
School of Medicine,
Department of Family Medicine and Community Health
Population Health Liaison, Cuyahoga County Board of Health

Dear Community Partners,

We are excited to share the official release of the HIP-Cuyahoga Community Health Improvement Plan (CHIP) which many of you have contributed to in ways small and large. As you may know, our CHIP has adopted an important focus on health equity and a strong community engagement component to ensure community input in our effort to create the conditions in which all Cuyahoga County residents can be healthy.

The National Public Health Accreditation Board (PHAB), which accredits state and local health departments, has identified community health improvement planning as a fundamental responsibility of local health departments in the United States. CHIPs serve as an ideal platform for developing shared measurement and collective impact principles focused on public health priorities determined through local consensus. PHAB standards outline the essential components of the CHIP process and provide a roadmap for mobilizing and targeting community resources and evaluating progress toward improvement.

There is a growing understanding of the unfortunate reality that where you live can determine your health, well-being and life expectancy. We also know that the resources which create health, like stable housing, access to good education, availability of healthy food choices, and safe places to exercise are not universally present and, where lacking, are largely responsible for creating these opportunity gaps. Our HIP-Cuyahoga work seeks to illuminate the longstanding and unacceptable gaps in health status that have existed for decades across race and class in Cuyahoga County and to identify sustainable solutions. Evidence suggests that these gaps are a result of historical policies such as redlining which continue to create disadvantages in daily life that influence opportunity and health.

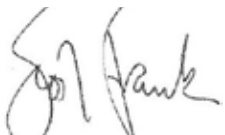
We know that working together works and that well-meaning programs delivered by agencies in isolation will not move the needle on these perennial health inequities in our community. It will take all of us. The interconnectedness of HIP-Cuyahoga, involving more than 50 agencies from government, academic, and nonprofit sectors, as well as community residents, represents a new way of doing business for our community.

We hope that you will connect to the HIP-Cuyahoga health equity movement and join us in ensuring that everyone has a fair shot at being heathy in Cuyahoga County, no matter what your race, income or ZIP code may be.

Sincerely,

Terry Allan
Health Commissioner
Cuyahoga County Board
of Health

CUYAHOGA COUNTY
BOARD OF HEALTH
YOUR TRUSTED SOURCE FOR PUBLIC HEALTH INFORMATION



Scott Frank, MD
Health Commissioner
Shaker Heights Health
Department

SHAKER
HEIGHTS

Toinette Parrilla
Director
Cleveland Department
of Public Health

CDPH
Cleveland Department of Public Health

Thank you to all our partners!

The Health Improvement Partnership-Cuyahoga has partnered with organizations and individuals from many parts of the county to complete the county's first Community Health Improvement Plan and more importantly, to provide ongoing expertise, resources, and time to help make Cuyahoga County a healthier community for all.

CONSORTIUM ORGANIZATIONS

- Academy of Medicine of Cleveland and Northern Ohio
- Advocates for Cleveland Health
- Alcohol, Drug Addiction and Mental Health Services Board of Cuyahoga County
- Alzheimer's Association Cleveland Area Chapter
- Asian Services in Action, Inc.
- Baldwin Wallace University
- Better Health Partnership
- CareSource
- Case Western Reserve University, Prevention Research Center for Healthy Neighborhoods
- Case Western Reserve University, School of Medicine
- Center for Community Solutions
- Center for Families and Children
- City of Cleveland, Office of the Mayor
- City of Cleveland, Office of Minority Health
- Cleveland City Council
- Cleveland City Planning
- Cleveland Clinic
- Cleveland Department of Public Health
- Cleveland Institute of Community Health
- Cleveland Metroparks
- Cleveland Metropolitan Housing Authority
- Cleveland Municipal School District
- Cleveland Neighborhood Progress
- Cleveland Public Library
- Cleveland State University
- Community Partners for Affordable Accessible Healthcare
- Cuyahoga Community College
- Cuyahoga County Board of Developmental Disabilities
- Cuyahoga County Board of Health
- Cuyahoga County Department of Development
- Cuyahoga County Division of Senior and Adult Services
- Cuyahoga County Job and Family Services
- Cuyahoga County, Family and Children First Council
- Cuyahoga County Invest in Children
- Cuyahoga County Office of Health and Human Services
- Cuyahoga County Office of the Executive
- Cuyahoga County Planning Commission
- Cuyahoga County Mayors and City Managers Association
- Cuyahoga Health Access Partnership
- Detroit Shoreway Community Development Corporation
- Diabetes Partnership of Cleveland
- Environmental Health Watch
- Evi-Base
- Federal Reserve Bank of Cleveland
- First Suburbs Consortium
- Greater Cleveland Superintendent's Association
- Hanson Services Inc.
- Hospice of the Western Reserve
- Human Impact Partners
- Hunger Network of Greater Cleveland
- ideastream
- Kent State University, School of Public Health
- Lakewood Community Service Center
- City of Lakewood, Department of Human Services
- Linking Employment, Abilities and Potential
- Merritt Consulting
- MetroHealth System
- Mo and So Grow
- Mount Pleasant Community Zone
- Mt. Sinai Health Care Foundation
- Neighborhood Connections
- Neighborhood Family Practice
- Neighborhood Leadership Institute
- North Coast Health Ministry
- Northeast Ohio Neighborhood Health Services

CONSORTIUM ORGANIZATIONS CONTINUED

- Old Brooklyn Community Development Corporation
- Paramount Advantage
- Parma Community Hospital
- PNC Bank
- Policy Bridge
- Saint Luke's Foundation of Cleveland
- Shaker Heights Health Department
- Sisters of Charity Foundation of Cleveland
- Soil and Water Conservation District
- Strategic Solutions Partners
- Susan G. Komen Northeast Ohio
- The Center for Health Affairs
- The Cutting Board Academy
- The Free Medical Clinic of Greater Cleveland
- The Office of Congresswoman Marcia Fudge
- The Ohio State University, Cuyahoga Extension
- Tremont West Development Corporation
- United Way of Greater Cleveland
- University Healthcare Action Network Ohio
- University Hospitals, Otis Moss Pediatrics
- University Hospitals, Preventive Medicine Residency Program
- University Hospitals, Rainbow Care Connection
- University Hospitals, Seidman Cancer Center
- University Settlement
- Wasserman Consulting
- Western Reserve Area Agency on Aging
- Yinovate
- YMCA of Greater Cleveland

STEERING COMMITTEE ORGANIZATIONS

- *Co-Chair and Co-Anchor, Eliminate Structural Racism Subcommittee*
  - **Greg Brown**, Policy Bridge
- *Co-Chair and Co-Anchor, Clinical and Public Health Subcommittee*
  - **Heidi Gullett, MD**, Case Western Reserve University School of Medicine, Department of Family Medicine and Community Health
- *Co-Anchor, Eliminating Structural Racism Subcommittee*
  - **Evelyn Burnett**, Cleveland Neighborhood Progress
- *Anchor, Healthy Eating and Active Living Subcommittee*
  - **Erika Trapl**, PhD, Case Western Reserve University – Prevention Research Center for Healthy Neighborhoods
- *Anchor, Chronic Disease Management Subcommittee*
  - **Rita Horwitz**, Better Health Partnership
- *Co-Anchor, Clinical and Public Health Subcommittee*
  - **Kim Foreman**, Environmental Health Watch
- *At Large Member**
  - **Marilyn Burns**, Community resident
- *At Large Member*
  - **Joe Cimperman**, Cleveland City Council
- *At Large Member*
  - **Tamiyka Rose**, MetroHealth System
- *At Large Member*
  - **Monique Williams**, Cleveland Institute for Community Health
- *Chair, Shared Measurement and Evaluation Workgroup*
  - **Chris Kippes**, Cuyahoga County Board of Health
- *Chair, Communications and Community Engagement Workgroup*
  - **Romona Brazile and Martha Halko**, Cuyahoga County Board of Health
- *Community resident*
  - **Gail Long**, Community Partners for Affordable Accessible Healthcare
- Elected Official, or designee
  - **Jennifer Scofield**, Cuyahoga County Office of the Executive
- *Public Health Collaborative and Policy Liaison*
  - **Terry Allan**, Cuyahoga County Board of Health

**At Large Member refers to the four HIP-Cuyahoga Steering Committee members who were voted in by the consortium.*

STEERING COMMITTEE ORGANIZATIONS CONTINUED

- *Public Health Collaborative*
  - **Toinette Parilla**, Cleveland Department of Public Health
- *Public Health Collaborative*
  - **Scott Frank**, MD, Shaker Heights Health Department
- *Academia*
  - **Elaine Borawski, PhD**, Case Western Reserve University, Prevention Research Center for Healthy Neighborhoods
- *Philanthropy*
  - **Jodi Mitchell**, Mt. Sinai Health Care Foundation
- *Philanthropy*
  - **Heather Torok**, Saint Luke's Foundation of Cleveland
- *Backbone Organization – Partnership Coordinator*
  - **Martha Halko**, Cuyahoga County Board of Health
- *Backbone Organization – Partnership Manager*
  - **Nichelle Shaw**, Cuyahoga County Board of Health

FUNDERS

- Mt. Sinai Health Care Foundation
- Saint Luke's Foundation of Cleveland
- The George Gund Foundation
- The Centers for Disease Control and Prevention
- National Association of County and City Health Officials

HEALTH EQUITY SUPPORT AND GUIDANCE

- CommonHealth ACTION
- Cuyahoga County PLACE MATTERS team

COMMUNICATIONS SUPPORT AND GUIDANCE

- HIP-Cuyahoga Communications and Community Engagement Workgroup
  Cuyahoga County Board of Health, Workgroup Chair
- Special thanks to Heide Aungst for her assistance with editing the CHIP
- Berkeley Media Studies Group
- Conceptual Geniuses

MEASUREMENT AND EVALUATION SUPPORT AND GUIDANCE

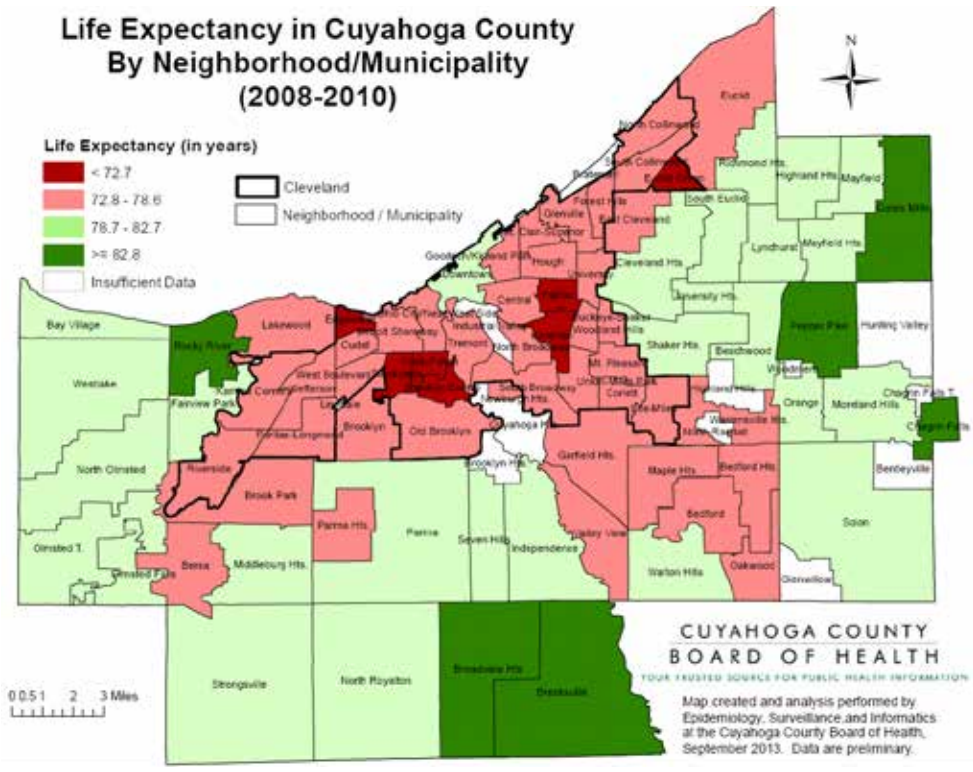
- HIP-Cuyahoga Shared Measurement and Evaluation Workgroup
  Cuyahoga County Board of Health, Workgroup Chair
- Case Western Reserve University, Prevention Research Center for Healthy Neighborhoods

WE BELIEVE THAT ALL PEOPLE IN CUYAHOGA COUNTY HAVE THE RIGHT TO LIVE THEIR HEALTHIEST LIVES, NO MATTER WHERE THEY LIVE OR WORK, HOW MUCH MONEY THEY MAKE, OR WHAT THEIR RACE, RELIGION, SEXUAL ORIENTATION, OR POLITICAL BELIEFS.

INTRODUCTION

According to the 2015 County Health Rankings (University of Wisconsin Population Health Institute), Cuyahoga County ranks in the bottom third of all 88 counties in Ohio for residents' health outcomes. Even though Cuyahoga County ranks consistently in the top 10 in the state for clinical care (measured by access to and quality of care), this has not made our residents healthier. That's because the conditions that shape health are not spread equitably across the county. And, in turn, that causes significant differences in life expectancy, depending on where someone lives (*MAP 1*).

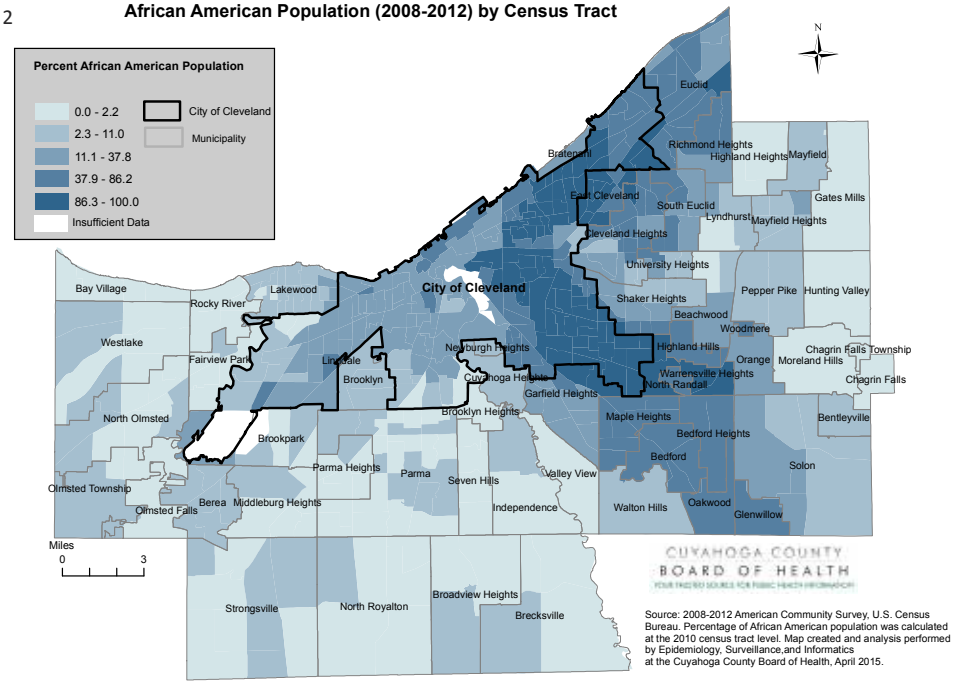
MAP 1



The worst health outcomes are in the urban core—Cleveland and its inner-ring suburbs, such as East Cleveland, Cleveland Heights, and Maple Heights. This is where many people of color live, including African Americans, Asian & Pacific Islanders, and Hispanics (*MAP 2*). In these areas, poverty is high (*MAP 3*) and community conditions can create barriers to good health. For example, many of these areas lack grocery stores that sell fresh fruits and vegetables and many residents have safety concerns about walking or letting their children play outside. This limits their opportunities to be healthy. Too many people in Cuyahoga County are not as healthy as they should be, and because of this, they are living shorter lives. This cannot be explained by differences in genetics or by health care access alone. This is unfair and unjust.

MAP 2

Cuyahoga County:
African American Population (2008-2012) by Census Tract



Source: 2008-2012 American Community Survey, U.S. Census Bureau. Percentage of African American population was calculated at the 2010 census tract level. Map created and analysis performed by Epidemiology, Surveillance,and Informatics at the Cuyahoga County Board of Health, April 2015.

In fact, in Cuyahoga County we know that:

- Three times as many African-American babies die compared to white babies.
- One in four people in Cuyahoga County overall, and one in two people in the City of Cleveland, are living in areas that lack access to healthy food options, referred to as "food deserts."
- Our community experiences two to three times as many poor mental health days as the nation.
- The cancer death rate is 1.5 times higher in the City of Cleveland as the national benchmark.
- Two to three times more African-American and Hispanic residents experience poverty as whites in the City of Cleveland.

KEY TERMS

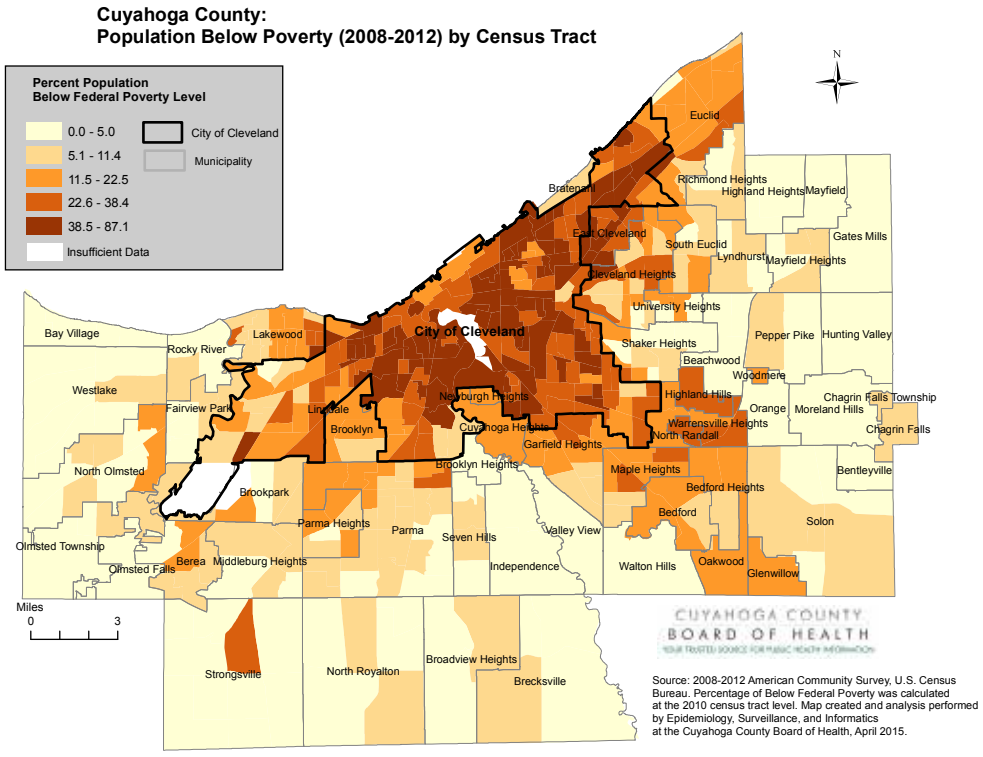
EQUALITY: The quality or state of being equal and refers to the identical distribution of resources, decision making and outcomes regardless of level of need.

EQUITY: Providing all people with fair opportunities to achieve their full potential.

HEALTH OUTCOMES: A change in the health of an individual, group, or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status.

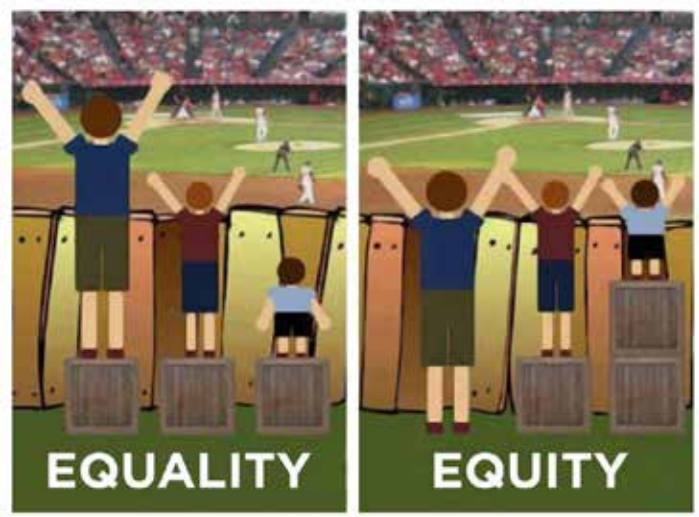
INEQUITY: Differences in well-being between and within communities that are systematic, patterned, unfair, and can be changed. They are not random, as they are caused by our past and current decisions, systems of power and privilege, policies and the implementation of those policies.

MAP 3



WE BELIEVE everyone should have a fair chance to reach his or her fullest health potential. This is equity. Equity is a principle that guides our process and is ultimately what we are trying to achieve. As a principle, it guides who we work with, how we work together, and the goals and strategies of the plan. Using equity as a lens means that we are thinking about the resources we have available and the needs of our population. Our goal is not to make sure that all residents have the same resources or the same health outcomes, rather that everyone has the resources, access, and ability to live their healthiest lives.

FIGURE 1



Source: This image was adapted by the City of Portland Office of Equity and Human Rights from the original graphic: http://indianfunnypicture.com/img/2013/01/Equality-Doesnt-Means-Justice-Facebook-Pics.jpg

Figure 1 illustrates the concept of equality and compares it to equity. Note that with equality everyone gets the same resource (the same crate) but that does not lead to optimal health (being able to view the ball game). However, equity is achieved by distributing the resources (the crates) in a way that acknowledges personal differences (height) and does lead to optimal health for all (everyone being able to view the game).

The inequities that lead to poor health are bad for everyone, not just those who are sick or live in those neighborhoods. Economically, there are major opportunity costs for poor health across the region due to disability and lost years of productive work. We believe that health should not be viewed as something scarce or something that must be rationed or fought over. Instead, we view health as a resource that multiplies the more it is shared. Health is abundant. By improving health for those in need, we will generate better health for everyone who lives and works in Cuyahoga County.

With this perspective, in 2009 Cuyahoga County embarked on a process called Health Improvement Partnership-Cuyahoga (HIP-Cuyahoga). Our goal was to identify the most pressing issues impacting the health of our county's residents and to create a plan for addressing those challenges. This collaborative process builds the foundation for all in Cuyahoga County to be healthy. We do so by using an equity lens to develop a plan that will address traditional public health topics and complex social issues. Our consortium focuses on how we manage individual chronic disease, ensuring access to healthy food and safe places to be active, encouraging collaboration between clinical care and public health organizations, and examining and dismantling the opportunity barriers created by structural racism in our county which lead to stark differences in health outcomes.

Structural racism is racial bias across institutions and society. It's the cumulative and compounded effects of an array of factors such as public policies, institutional practices, cultural representations, and other norms that work in various, and often reinforcing, ways to perpetuate racial inequity. It is a factor in the policies, practices, procedures, and laws across our county and, as such, must be addressed in all parts of our plan.

These are the questions we have asked and will continue to ask throughout this process:

- What are the historical impacts of policies in our community?
- How do these policies impact people's opportunities to be healthy today?
- What resources are at our disposal?
- How do we make sure that we advance the collective understanding of these issues across our community?

KEY TERMS

LIFE EXPECTANCY: The average number of years a population of a certain age is expected to live, given a set of age-specific death rates in a given year.

OPPRESS/ OPPRESSION: The systematic targeting or marginalization of one social group by a more powerful social group for the social, economic, and political benefit of the more powerful social group.

STRUCTURAL RACISM: Racial bias across and within society. It's the cumulative and compounded effects of an array of factors such as public policies, institutional practices, cultural representations, and other norms that work in various, often reinforcing ways to perpetuate racial inequity.

What Creates Health?

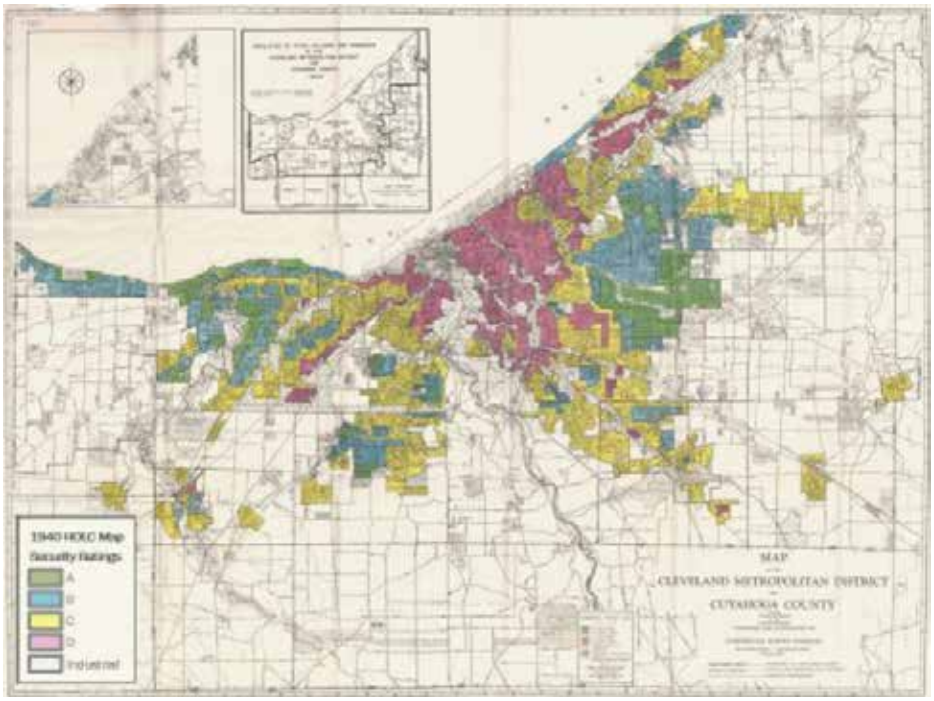
To understand what creates health, it is important to first understand what health is and what it is not. According to the World Health Organization, health is "a state of complete physical, social, and mental well-being, and not merely the absence of disease and illness." Research shows that many people think of health as a personal responsibility or a characteristic of a person. But it is actually a characteristic of communities. Health is not just access to quality and affordable health care. Most of us wait until we're sick to use the health care system. We must change our focus to prevention, because it's critical to prevent sickness to live healthy lives. Health is a product of society. While our genetics and access to health care make a difference, the places we live, work, learn, and play, along with our access to resources and opportunities, shape our health more.

Health, then, is greatly influenced by our surroundings. This includes the policies and systems responsible for creating those surroundings. In our history as a country and a county, these systems and structures have worked to benefit certain populations, while oppressing other populations. Our neighborhoods and communities, and their access to resources and opportunities, are not the result of chance. Decisions have been made, and continue to be made—both intentionally and unintentionally—which oppress certain populations and create extreme disadvantages for health.

One of the most important policies in Cuyahoga County, and our country, is the housing policy that came into existence in the early 1930s. The Federal Housing Administration opened up opportunities for homeownership when they made two changes. They reduced the amount of money necessary for a down payment on a home and created 30-year mortgages. This resulted in more opportunities to buy a home, which is how many Americans generated their wealth. This still holds true today. However, the way in which loans were allocated, especially during the first decades of the program, were not fair or equitable for everyone. The Federal Housing Administration created a handbook that instructed banks on the security of making loans in 239 cities across the country, including Cleveland. This handbook developed maps (*MAP 4*) which color-coded neighborhoods and sections of the city that were "safe" or "unsafe" for giving a loan. Areas that were populated by people of color were almost always designated with red and referred to as "redlined" areas. That meant that banks would not give loans to people in those areas, regardless of the housing stock or their ability to repay the loan.

This history solidified racial segregation in Cleveland, as well as many other cities across the country. This federal policy, carried out at the local level, created opportunities for some people to build wealth and live in neighborhoods with ample resources. These actions forced others to live in communities where they could not build personal wealth in a home or have fair access to resources and opportunities. This legacy of racialized lending and homeownership still exists today. In fact, those same communities that were redlined then had the highest rates of foreclosures and were targets of predatory sub-prime lending that caused a boom, then subsequent crash, of the housing market in the first decade of 2000. If we look at health and life expectancy numbers within those disadvantaged neighborhoods today, we see that those same neighborhoods have some of the worst health outcomes in the county.

By understanding our history and how it continues into present day, we can develop strategies to change the inequities in health outcomes. We can address these issues by using all of the tools at our disposal such as policy making and regulations; hiring and recruitment practices; funding decisions, and more.



MAP 4

Source: History Matters: Understanding the Role of Policy, Race and Real estate in Today's Geography of Health Equity and Opportunity in Cuyahoga County. Kirwan Institute for the Study of Race and Ethnicity and City & Regional Planning Program at the Knowlton School of Architecture at the Ohio State University. February 2015

Because equity is about fairness and justice, we also must have a personal understanding of what these issues mean to us. How do we—as individuals and as a community—interpret fairness and justice? It is by using both our head and our hearts that we will create the type of community that allows all people to achieve their fullest health potential.

As a partnership, HIP–Cuyahoga believes that for our community to make progress, we must transform our approach to health. As a partnership, we believe that the conditions in which many people in our community live are often unsafe, unhealthy, and unacceptable. This did not happen by accident, but is the result of many years of public policy and private actions that created opportunity for some, while oppressing others.

WE MUST ACT NOW

AS A PARTNERSHIP AND A COMMUNITY TO DO THINGS DIFFERENTLY TO CREATE EQUITY AND IMPROVE HEALTH IN OUR COMMUNITY.

> *"This is our county. We are diverse. We are rich and, yes, we are poor. We have magnificent pockets of natural beauty, and unconscionable pockets of poverty. Yet our fortunes are linked, whether we know our neighbors or not. Our lives are connected. We need each other to succeed. We need to use both our head and our hearts to show ourselves and our children what can be done when we dream big, together."*
>
> Cuyahoga County Executive Armond Budish
> January 4, 2015 Inaugural Address

HIP-CUYAHOGA OVERVIEW

The Health Improvement Partnership-Cuyahoga (HIP-Cuyahoga) is a diverse and committed group of people who care about health. HIP-Cuyahoga is building opportunities for everyone in Cuyahoga County to be healthy because we believe everyone should have a fair chance to reach his or her fullest health potential.

What Does HIP-Cuyahoga Address?

HIP-Cuyahoga understands that neighborhoods and communities are not all created equally, and some people are born and live in places where it is difficult to grow up healthy. Decisions our community makes every day impact health, and those decisions can serve as barriers that make it harder for some people to live healthy. Some of these barriers have to do with the conditions in which people live, work, or go to school and what kind of health systems are in place to deal with illness. For example, access to safe and affordable housing, quality transportation, affordable and quality health care, safe places to be active, and healthy food all shape community conditions. In addition, social factors like the availability of jobs that pay a living wage and access to a quality education influence the opportunities people have available to them. The conditions in which people live, and the opportunities they have, form the foundation for health and without them, people are more likely to live shorter, sicker lives, with a greater risk of developing chronic diseases such as high blood pressure, heart disease, and diabetes. When healthy living is easier, we live longer and healthier lives. The good news is that HIP-Cuyahoga has skilled, creative, and dedicated people building a roadmap that will guide us in addressing the most important factors that impact health in our county. We work with community members and residents—from the grassroots level up and with key decision makers—from the policy maker level down to ensure that health and equity are considered in decision-making processes. In addition, we inform and influence the distribution of resources to support healthy living for everyone in the county.

OUR VISION

"Cuyahoga County is a place where all residents live, work, learn, and play in safe, healthy, sustainable, and prosperous communities."

OUR MISSION

HIP-Cuyahoga's mission is to inspire, influence, and advance policy, environmental, and lifestyle changes that foster health and wellness for everyone who lives, works, learns, and plays in Cuyahoga County.

Our Core Value and Key Approaches

» HIP-Cuyahoga's core value is to build opportunities for everyone in Cuyahoga County to be healthy. This core value underlies our work, how we interact with each other, and which strategies and approaches we employ to fulfill our mission.

» To advance our vision, mission, and core value we employ, three key approaches including:

» Collective Impact: Coordination of partnerships, alignment of priorities and actions, and mobilization of resources.
» Community Engagement: Involving community members in planning, decision making, and actions.
» Health and Equity in All Policies: Collaborating to improve the health of all people in Cuyahoga County by incorporating health and equity into decision making across sectors, systems, and policy areas.

As part of our roadmap, our group picked four important health issues to work on:

» Eliminate structural racism as a social determinant of health.
» Increase access and opportunity for improved nutrition and physical activity.
» Improve coordination between clinical care and public health to improve population health.
» Improve chronic disease management through the engagement of various sectors.

HIP-Cuyahoga Partnership and Structure

Change takes time, and we know it won't be easy to address these health issues. We believe that if we partner with the community and decision makers, together we can improve the conditions in our community that create opportunities for everyone in Cuyahoga County to achieve his or her fullest health potential.

The HIP-Cuyahoga Consortium includes over 100 diverse and engaged partners from all different areas of our community. For example, we have community advocates, people from public health, health care, mental health, academics and education, transportation, community and social services, planning, community and economic development, philanthropy (funders), and others. HIP-Cuyahoga works in partnership with community members to define and address critical health issues. More importantly, we seek to build trusting relationships that lead to lasting changes which community members start and direct.

HIP-Cuyahoga partners are committed to a shared vision and a common agenda. We understand that there is no "silver bullet" solution to address the complex factors that shape opportunities for people in our community to be healthy. No single organization alone can create such a large-scale and lasting change. To have the greatest impact on the health and well-being of our community, we need to coordinate our work and our resources around well-defined priorities and goals.

A highly committed steering committee, led by two co-chairs and directed by by-laws (a copy of the bylaws can be found at: http://ccbh.info/hipcuyahoga/wp-content/uploads/2011/06/Final-3-Health-Improvement-Partnership-Bylaws-November-2014.pdf), guides the work of HIP-Cuyahoga. Each member brings important knowledge, skills, and experience to inform our work. The steering committee offers guidance and ongoing oversight on the consortium's goals and objectives. The HIP-Cuyahoga co-chairs ensure that the steering committee maintains its commitment to engaging the consortium and the community, in following the Community Health Improvement Plan.

Four active subcommittees convene regularly to shape and carry out strategies to address our four priority health issues. In support of HIP-Cuyahoga's vision, mission, and core value, anchor organizations, selected by subcommittee members, ensure completion of each subcommittee's plans of action in a collective manner.

In collaboration with the subcommittees, two workgroups support the HIP-Cuyahoga vision through expert guidance:

- The Communications and Community Engagement Workgroup maintains effective communication within the consortium and with the public, key policy makers, and organizational leaders.
- The Shared Measurement and Evaluation Workgroup is a technical advisory group to the HIP-Cuyahoga subcommittees to promote ways to effectively measure the work and share information across agencies.

Creating and managing this collective impact approach requires an organization with staff and a specific set of skills to serve as the backbone organization for the entire initiative. The backbone organization works closely with partners to guide vision and strategy, build public will, advance policy, and mobilize funding. It serves as a coordinator for the day-to-day operations and implementation of work.

For more information on the Health Improvement Partnership–Cuyahoga, please visit www.hipcuyahoga.org

Image: Cracking the nut of health equity: top down and bottom up pressure for action...Fran Baum. Promotion & Education; 2007; 14, 2; Academic Research Library

COMMUNITY HEALTH IMPROVEMENT PLANNING PROCESS OVERVIEW

HIP-Cuyahoga's Community Health Improvement Planning (CHIP) process was launched in 2009 by the Cuyahoga County Board of Health (CCBH). CCBH initiated this important planning process for four main reasons:

- To improve the health and well-being of all who live, work, learn, and play in Cuyahoga County.
- To identify and create a plan for addressing the most pressing issues impacting the health of our county's residents.
- To guide the development of our county's first and only Community Health Improvement Plan. The lack of a plan has limited our county's ability to align partnerships, expertise, data, and resources around key issues impacting the health and well-being of our residents.
- To become an accredited local public health agency. The CHIP and the Community Health Status Assessment are required for accreditation.

HIP-Cuyahoga used the Mobilizing for Action through Planning and Partnerships (MAPP) strategic planning framework to guide the creation of our county's first Community Health Improvement Plan. The Centers for Disease Control and Prevention (CDC) and the National Association of County and City Health Officials (NACCHO) developed the MAPP framework that consists of six (6) phases:

- ORGANIZING
- VISIONING
- ASSESSMENTS
- IDENTIFYING STRATEGIC ISSUES & KEY PRIORITIES
- FORMULATING GOALS AND STRATEGIES
- MOVING TO ACTION

CHIP PROCESS TIMELINE

2015 (June)
CHIP COMPLETED AND RELEASED
- Communications strategy in development
- Implementation underway

2014
MOVING TO ACTION
- Action phase infrastructure established
- Bylaws adopted
- Key priority action plans completed
- Racial and Ethnic Approaches to Community Health (REACH) Grant awarded

2013
IDENTIFYING STRATEGIC ISSUES & KEY PRIORITIES
Formulating goals and strategies
- Engaged CommonHealth ACTION
- Hosted health equity workshop for consortium
- Hosted community conversations with residents
- Community Health Status Assessment report published
- Two strategic issues selected
- Four key priorities selected

2012
DATA COLLECTION THROUGH ASSESSMENTS
- Community Health Status Assessment data collected and analyzed
- Youth photovoice project completed
- Quality of Life Survey results shared
- Forces of Change Assessment completed
- Key informant interviews completed

2011
DATA COLLECTION THROUGH ASSESSMENTS
- Quality of Life Survey completed
- Community Health Status Assessment indicators selected

2010
ORGANIZING AND VISIONING
- Planning committee established (consortium)
- Planning committee creates vision and mission

2009 (November)
LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

The planning process, supported by a comprehensive partnership, spanned over five years and included all six phases of the MAPP framework (see *CHIP Process Timeline, page 17*). To support the partnership's commitment to equity and community involvement, the process, structure, and timeline was enhanced and modified along the way.

To complete the CHIP, the organizational and resident members of HIP-Cuyahoga jointly reviewed locally collected health and social data, identified and ranked top issues impacting health, and voted on key priorities. Subcommittees then were formed to develop action plans addressing selected key priorities. The CHIP includes local data, meaningful input from community residents, and describes plans for action with measureable outcomes.

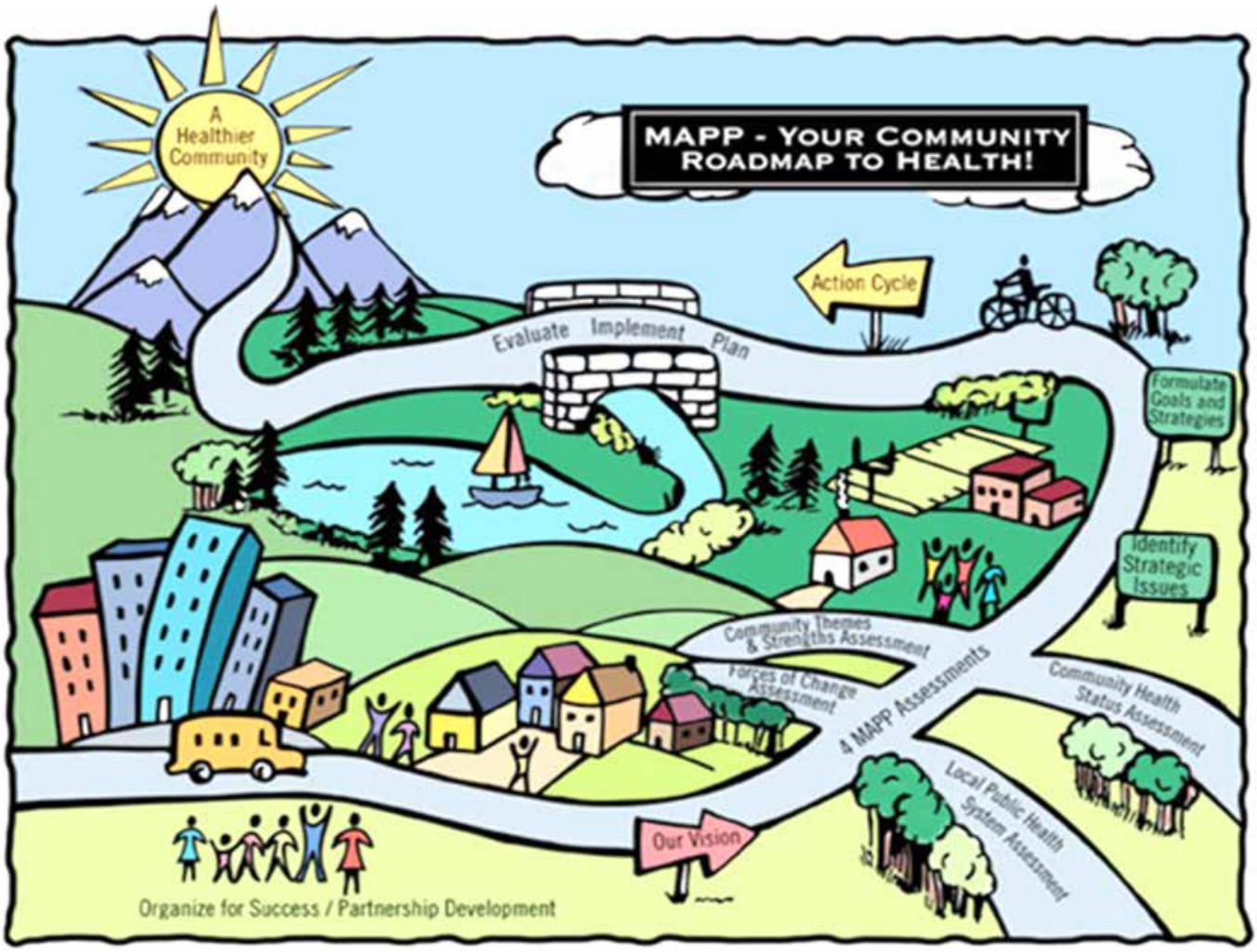


Image courtesy of National Association of County and City Health Officials (NACCHO)

The completion of this plan is not the end of our process; rather it marks our transition to the action phase of the process. We intend to update this plan to ensure that it accurately represents our most current work as we move forward in the action phase of our process. All updates will be made available on our website www.hipcuyahoga.org.

CHIP Process Highlights

BUILDING THE CASE FOR EQUITY

When HIP-Cuyahoga launched the health improvement planning process, planning partners were keenly aware of local disparities and inequities in Cuyahoga County. The county's first analysis of life expectancy in 2009 revealed a staggering 24.5 year gap between those who live the longest in our county and those who live the shortest lives. This unacceptable difference in life expectancy served as a spark for the partners to gain a deeper understand of how and why "where you live, work, learn, and play impacts your health and ultimately how long you will live." In response to this growing understanding of how place impacts health, HIP-Cuyahoga made a commitment early in the CHIP process to shape this plan in a way that engages the community and addresses both traditional public health issues and complex social issues that impact the health status of disadvantaged members of our community.

An understanding of, and commitment to, equity and community engagement emerged from active involvement in the Cuyahoga County PLACE MATTERS team. PLACE MATTERS, an initiative of the National Collaborative for Health Equity, works to build the capacity of leaders and communities around the country to identify and address the social, economic, and environmental factors that shape health and health inequities. The Cuyahoga County PLACE MATTERS team has several members actively participating in HIP-Cuyahoga who have contributed to shaping the equity frame for HIP-Cuyahoga and to the selection of "Eliminating Structural Racism as a Social Determinant of Health" as one of the four key priorities.

PLACE MATTERS reinforces the importance of beginning any equity focused effort with capacity building. Before developing solutions, everyone working together to address inequities should have at least a base knowledge and understanding of the concept of equity. It is through this foundational understanding of how our historical policies and practices continue to shape our current inequities that we begin to value the need to do our work differently. This approach offers everyone in our county the opportunity to reach his or her fullest health potential.

KEY TERMS

CONTINUOUS QUALITY IMPROVEMENT: an approach to quality management that builds upon traditional quality assurance methods by emphasizing the organization and systems: it focuses on "process" rather than the individual; it recognizes both internal and external "customers;" it promotes the need for objective data to analyze and improve processes.

KEY PRIORITIES: HIP-Cuyahoga refers to key priorities as serious threats to health and/ or determinants of health which if addressed, improve health and wellness and reduce inequities.

LIFE EXPECTANCY: the average number of years a population of a certain age is expected to live, given a set of age-specific death rates in a given year.

POPULATION FOCUS: the geographic area and population on which interventions will focus.

STRATEGIC ISSUES: fundamental policy choices or critical challenges that must be addressed in order for a community to achieve its vision. It is important and forward thinking and seizes current opportunities. It can either stand alone, or it can guide actions that will improve health.

KEY TERMS

QUALITY OF LIFE: an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships, personal beliefs, and their relationship to important features of their environment.

As the HIP-Cuyahoga partnership grew to more than 100 individuals and participating organizations, the different levels of knowledge and understanding around equity became evident. This equity knowledge gap became an important issue as the process approached the selection of strategic issues and key priorities.

At this stage, the partnership engaged CommonHealth ACTION, a national public health organization from Washington DC. Through its work, CommonHealth ACTION aligns people, strategies, and resources to create community-generated solutions to health and policy challenges. CommonHealth ACTION served as a consultant and facilitator to HIP-Cuyahoga for over three years of the planning process (2012-2015), providing health equity training and education, facilitating group input and voting processes, and supporting collaborative strategic planning. CommonHealth ACTION's team was instrumental in building a foundational knowledge and understanding around equity for HIP-Cuyahoga partners. More importantly, they informed, influenced, and inspired the partnership to build and maintain an equity frame throughout the planning process into action and implementation. As a result, HIP-Cuyahoga has a strong shared value and commitment for addressing inequities and has improved its collective capacity around strategies to address equity and structural racism.

> *"At CommonHealth ACTION, we have worked with groups that approach this work using just their "heads," collecting and analyzing data, engaging in strategic planning, and designing meaningful group processes, or their "hearts," developing a personal connection to concepts such as fairness, justice, and equity. Working with the HIP-Cuyahoga team gave us the opportunity to marry these two elements that are essential for the development of a plan that is sustainable, focused on equity, and is something that people can rally around."*
>
> Mark Cervero, MPH, CPH, Program Manager
> CommonHealth ACTION

Organizing and Visioning

The organizing and visioning phase of the planning process involved convening partners from all different areas of Cuyahoga County to begin developing the Community Health Improvement Plan. In addition to community advocates, people working in public health, health care, mental health, education, transportation, community and social services, community development, philanthropy, and other sectors participated in the process and established a leadership structure and planning committee to guide the work.

[Figure 2] **HIP-Cuyahoga Structure**

INITIAL STRUCTURE	STRUCTURE AFTER SELECTING KEY PRIORITIES	STRUCTURE MOVING TO ACTION
Leadership Team	Leadership Team	Steering Committee
Planning Committee	Planning Committee	HIP-Cuyahoga Consortium
Community Health Status Assessment Subcommittee	Shared Measurement and Evaluation Subcommittee	Shared Measurement and Evaluation Workgroup
Community Themes and Strengths Subcommittee	Communication Subcommittee	Communications and Community Engagement Workgroup
	Eliminating Racism as a Social Determinant of Health Subcommittee	Eliminating Structural Racism Subcommittee
	Nutrition and Physical Activity Subcommittee	Healthy Eating/ Active Living Subcommittee
	Clinical Care and Public Health Subcommittee	Clinical and Public Health Subcommittee
	Chronic Disease Management Subcommittee	Chronic Disease Management Subcommittee

Early planning committee meetings focused on building support for the development of the county's first Community Health Improvement Plan, establishing a commitment to a community-driven process, building the case for equity, and creating a vision and mission to guide the work. As the process moved closer to the action phase, the partnership recognized that the initial structure would not meet its needs, so HIP-Cuyahoga modified its structure to include additional important partners to better reflect the collective impact approach. CCBH took on the role of backbone organization to facilitate the work and two co-chairs were selected to reinforce the collaborative nature of the community-driven process, (*see Figure 2–HIP-Cuyahoga Structure*). A continuous quality improvement approach was adopted to better represent how the partnership would move forward as a consortium into action.

ASSESSMENTS

The assessment phase of the MAPP planning process focused on data collection to help understand the community's needs. HIP-Cuyahoga completed four assessments between 2009 and 2012 including:

- **Local Public Health System Assessment**—This stakeholder assessment resulted in a better understanding of the resources, strengths, and limitations of the local public health system.
- **Community Health Status Assessment (CHSA)**—The CHSA presents data on health outcomes to inform the Community Health Improvement Plan (CHIP) and describes: who residents are and where they live (demographics); education and poverty levels (socioeconomic status); access to health care; health-related behaviors; environment; illnesses and their causes; health at birth and causes of death. Improving health begins by understanding these measures known as determinants of health. Findings can be reviewed at: http://ccbh.info/hipcuyahoga/?page_id=1175
- **Community Themes and Strengths Assessment (CTSA)**—The CTSA answered the following questions: "What is important to our community?" "How is quality of life perceived in our community?" and "What assets do we have that can be used to improve community health?"

  To gain an understanding of these issues, the partnership gathered community input through:
  - A county-wide Quality of Life survey (*see sidebar*) Results can be reviewed at: http://ccbh.info/hipcuyahoga/?tag=quality-of-life-survey
  - A photovoice project that involved youth who took pictures as a way to describe their community
  - Key stakeholder interviews

  The CTSA assessment resulted in a much clearer understanding of the community's issues, concerns, and perceptions about quality of life, all important considerations in the priority setting process.

- **Forces of Change Assessment**—This brainstorming session identified existing or emerging forces (trends, factors, events) that influence health and quality of life in the community.

The results from these assessments informed the partnership's selection of strategic issues and key priorities. HIP-Cuyahoga will complete all four of these assessments every five years to ensure that the partnership is being responsive to the community's most pressing health issues.

More than 5,500 Cuyahoga County residents responded to the HIP-Cuyahoga *Quality of Life* Survey. The top three responses to the strengths, improvements, and health issues for Cuyahoga County are:

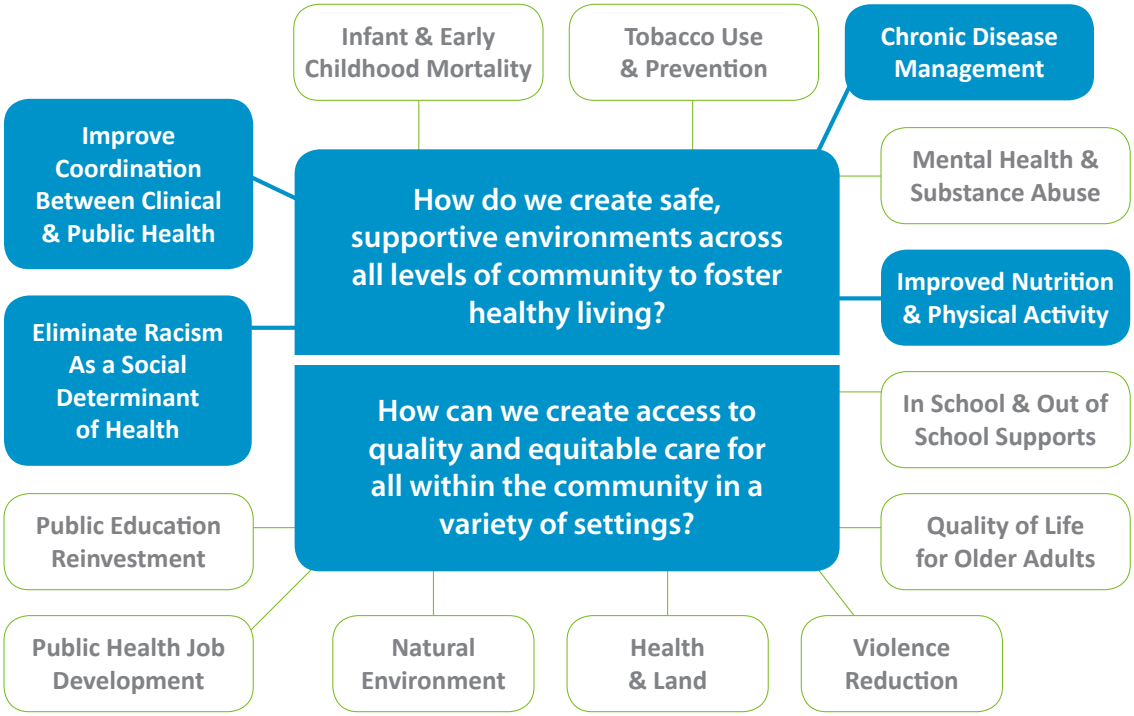
1) Strengths of your community
- Access to parks and recreation
- Responsive police, fire, and rescue
- Walkable, bikeable community

2) Improvements needed
- Good job opportunities
- Quality education and schools
- Programs, activities, and support for youth and teens during non-school hours

3) Health related issues that most affect your community
- Alcohol and drug abuse (both illegal and prescription)
- Overweight and obesity
- Mental health issues (depression, anxiety, stress)

IDENTIFYING STRATEGIC ISSUES AND KEY PRIORITIES FORMULATING GOALS AND STRATEGIES

[Figure 3] **Health Priorities**



The selection of strategic issues and key priorities, and the development of goals and strategies to address the key priorities, were important milestones in the planning process. Several years of data collection and community input culminated with the partners selecting two overarching strategic issues and four key priorities *(see Figure 3—Health Priorities)*.

As anticipated, the group process leading up to the selection of the priorities resulted in a range of views on potential priority health issues. The group generated 14 priority health issues based on the four assessments *(see Figure 3—Health Priorities)*.

Recognizing that there would not be capacity or resources to successfully address all 14 priorities, the steering committee invested much time and energy in further reviewing the assessment data, establishing criteria to aid in the prioritization of issues, ensuring alignment with the National Prevention Strategy and Ohio State Health Improvement Plan, and gathering input from the planning committee and community. To ensure that equity was a primary consideration in the selection of the top priorities and in the creation of goals and strategies, CommonHealth ACTION successfully moved the planning committee through an equity-focused process to define each issue, apply criteria for prioritization, and ultimately, a group vote that yielded four key prioritie. HIP-Cuyahoga has not limited itself to addressing only the top four priorities over the next five years. The remaining 10 priorities have local efforts to address them underway and HIP-Cuyahoga remains open to connecting one or more of these priorities to its body of work if the collective will, capacity, and resources exist to do so.

To inform the development of goals and strategies that address the four identified key priorities, HIP-Cuyahoga used these approaches:

- **Community conversations** —to complement the responses provided through the quality of life surveys, 60 residents shared their thoughts and ideas on what should be done to address the priority issues. In addition, 19 signed up to become engaged in HIP-Cuyahoga.
- **Environmental scan survey**—HIP-Cuyahoga partners shared how the mission of their agencies aligned with the four key priorities to maintain momentum in moving from the planning to the action phase.
- **Health equity workshop**—HIP-Cuyahoga partners participated in a day long health equity workshop conducted by CommonHealth ACTION to ensure that equity was a primary consideration in goal and strategy development.

MOVING TO ACTION

HIP-Cuyahoga launched the action phase of the process by finalizing its structure, formally adopting consortium bylaws, and completing action plans for the four key priorities. Anchor organization representatives guided action plan development with their subcommittee members. Each plan included goals, population focus, health equity focus (impacts on social, economic, and environmental factors), approaches to community engagement, two-year objectives, major activities, and performance measures.

With a solid structure and partnership in place, and action plans complete, the partnership was well positioned to explore funding opportunities to support the implementation of the plan. In 2015, HIP-Cuyahoga received the Racial and Ethnic Approaches to Community Health (REACH) grant to implement the Healthy Eating/Active Living and Chronic Disease Management subcommittee action plans *(Visit www.hipcuyahoga.org for more information on REACH)*. The development and success of this proposal was a testament to the strength of the collaborative.

Two other local organizations received REACH funding to support local efforts to reduce chronic diseases, promote healthier lifestyles, reduce health disparities and inequities, and control health care spending.

- **The YMCA of Greater Cleveland** is working to transform streets into safe places to walk, run, and bike and to expand Healthy Eating/Active Living and chronic disease prevention efforts in the City of Cleveland. (http://www.clevelandymca.org)
- **Asian Services in Action, Inc. (ASIA)** is working with Asian-American and Pacific Islander communities, especially those who are newly arriving to the United States, to increase access to healthy food options, nutrition education, and physical activity opportunities. (http://www.asiaohio.org/programs/community-health-evaluation-and-research-institute/raise/)

Local foundation funding was instrumental in the development of HIP-Cuyahoga's solid infrastructure through support for the backbone organization which guides the day-to-day operations and management of the partnership. Local funding also supported consortium meetings and events, communications and marketing activities, shared measurement and evaluation, and the completion and release of this written plan.

> *"Because HIP-Cuyahoga is a large, complex, collaborative initiative with many moving parts, it is important that the communications strategy clearly articulate the problems that will be addressed, why it matters (values), and the solutions to the priority health issues."*
>
> Julieta Kusnir, MPH
> Berkeley Media Studies Group

Where are we going from here?

» WE ARE COMMITTED to continuing to cultivate our partnerships and grow our movement so everyone in Cuyahoga County has a fair chance to reach his or her fullest health potential.

» WE WILL CONTINUE to build knowledge and capacity on health and equity ensuring that our partnership and community are equipped to address the complex factors that shape opportunities for people in our county to be healthy.

» WE WILL INCREASE community engagement in our efforts, especially among those directly impacted by inequities.

» WE WILL CONTINUE to align partnerships, expertise, data, and resources around the key issues impacting the health and well-being of our residents.

» AS WE IMPLEMENT OUR ACTION PLANS, we will measure our impact; share successes and lessons learned; and refine our work to best meet the needs of our community.

» AS OUR WORK ADVANCES, we will use the HIP-Cuyahoga website and other communication vehicles to update the community on our progress.

KEY PRIORITY
ELIMINATING STRUCTURAL RACISM

What is the problem?

Equal opportunity is a basic American value that most people strive for and residents of Cuyahoga County are no exception. However, despite progress we have made in our county, opportunities are not the same for everyone, and we remain largely divided by factors such as community conditions, income, skin color, and ethnicity. Many racial and ethnic groups face steep obstacles and barriers to living healthy and prosperous lives. This is because decisions that have been made and continue to be made—both intentionally and unintentionally—oppress certain racial and ethnic groups, limiting their opportunities, and creating extreme disadvantages for health. As a result, many people in our county are not as healthy as they should be and, because of this, they are living shorter lives.

Research shows that improving the conditions where people live, work, learn, and play, will improve their health. Healthy people need healthy places, so place matters. Place is not the only aspect of health that matters. Race also matters to health. People of color, especially those with the lowest incomes, have some of the worst health outcomes of anyone in Cuyahoga County. The statistical portrait of our county, broken down by race, clearly reveals the stark inequities between people of color and their white counterparts.

For example:

- The poverty rate is 11% for whites, 31.1% for blacks, and 36.7% for Hispanics.
- The unemployment rate is 9.6% for whites, 21.5% for blacks, and 17.8% for Hispanics.
- 90% of whites have a high school diploma, compared with 81.8% of blacks, and 69.6% of Hispanics.
- Three times as many black babies die compared to white babies.

Many racial and ethnic groups face barriers to healthy living that must be addressed to make a real and sustainable difference in the health of Cuyahoga County residents. Institutional and structural racism is at the root of such barriers.

The threads of structural and institutional racism are deeply woven in society. Racial differences in power, status, and access to opportunities are just a few examples. This type of racism also impacts people's views of themselves, their interpersonal relationships, their health, and quality of life. The pathways connecting structural racism to health are complex and multidimensional. Structural racism often is a barrier to economic opportunities, leads to social isolation and exclusion, and becomes a powerful stressor in people's lives leading to negative health effects. In addition, it plays a role in who gets jobs, how schools treat students, and even the availability of transportation in a neighborhood. It's compounding factors like these that lead to racial health disparities, including increased rates of chronic disease and disability, higher rates of infant death, and shorter life expectancy.

Structural and institutional racism are not new issues in Cuyahoga County. In fact, this type of racism is often unintentional, resulting from years of governmental policies and organizational practices that have limited

opportunities for certain people, living in particular neighborhoods. Like other cities nationally, Cleveland, and even some of its inner-ring suburbs, has dealt with this challenge over the course of decades, and it continues today.

Recent research, commissioned by the Cuyahoga County PLACE MATTERS team and conducted by the Kirwan Institute for the Study of Race and Ethnicity at The Ohio State University, uncovered data showing that past housing, real estate, and planning policies disadvantaged communities of color and immigrant groups in our county. It also revealed how these groups could not take advantage of critical opportunities, such as a fair loan toward home ownership in a community of their choice. Discriminatory housing policies, created after the turn of the 20th Century, resulted in a lending system that provided loans to white individuals and families, while denying them to people of color, creating areas in cities where some people could not receive home loans. The color-coded maps, created by the lending system at that time, showed these disadvantaged areas in red and became known as "redlined" areas. *(See Map 4 on page 13)* At the same time, people in areas where they could receive loans (indicated in blue and green) often worked to keep people of color out of their neighborhoods to protect their investments.

As a result, people living in these redlined communities were unable to build personal wealth through homeownership. In what became a vicious cycle, employers denied them access to employment, and banks denied them loans. Today, these redlined communities still have a higher concentration of poverty, fewer resources, more environmental risk factors, lack of access to healthy foods, and few safe places for physical activity—all leading to long-term, elevated stress levels and poor health outcomes.

This is just one important example of how structural racism creates barriers for entire communities. These practices are not limited to the past. Structural racism is still influencing our systems and policies today.

What are the solutions?

To make sustainable improvements in the health of all people in Cuyahoga County, HIP-Cuyahoga understands it must address the root causes of poor health and health inequities, including structural and institutional racism. Structural racism is prevalent and embedded in every system, institution, and policy. Individuals and organizations need to become critically aware of how and why personal and group assumptions can negatively affect thinking, feeling, and actions towards racial and ethnic groups. This concept, known as perspective transformation, is the way to start to understand things differently and, as a result, act in new and different ways.

HIP-Cuyahoga and PLACE MATTERS are examples of two partnerships using perspective transformation as a tool to think differently and act differently to improve opportunities, and in turn, health in Cuyahoga County. Perspective transformation starts with learning about the historical forces and using health equity data to understand the policies and practices involved in creating the current inequities, such as redlining discussed

KEY TERMS

INSTITUTIONAL RACISM: discriminatory treatment, unfair policies and practices, and inequitable opportunities and influence within organizations and institutions, based on race.

LIFE EXPECTANCY: the average number of years a population of a certain age is expected to live, given a set of age-specific death rates in a given year.

OPPRESS/ OPPRESSION: the systematic targeting or marginalization of one social group for the social, economic, and political benefit of a more powerful social group.

PEOPLE OF COLOR: refers to groups of African Americans, Asian & Pacific Islanders, Native Americans, and Hispanics.

PERSPECTIVE TRANSFORMATION: the process of becoming critically aware of how and why people's assumptions limit the way they perceive, understand, and feel about the world and how they act on this understanding.

KEY TERMS

PLACE MATTERS: an initiative of the National Collaborative for Health Equity focused on building the capacity of leaders and communities around the country to identify and address the social, economic, and environmental factors that shape health and health inequities. Cuyahoga County has a local PLACE MATTERS team (http://cuyahogaplacematters.com).

PRIVILEGE: when one group has something of value that is denied to others simply because of the group they belong to, rather than because of anything they have done or failed to do.

SOCIAL DETERMINANTS OF HEALTH: the circumstances, in which people are born, grow up, live, work, and age. These circumstances are, in turn, shaped by a wider set of forces: economics, social policies, and politics.

STRUCTURAL RACISM: racial bias across and within society. It's the cumulative and compounded effects of an array of factors such as public policies, institutional practices, cultural representations, and other norms that work in various, often reinforcing, ways to perpetuate racial inequity.

previously. With this understanding, organizations, institutions, and community leaders must work to address the structural and institutional racism that exists within our organizations and systems by examining current practices and policies, and making the right changes to significantly improve conditions for all people living in Cuyahoga County.

The Eliminating Structural Racism subcommittee understands that perspective transformation must begin with the members of HIP-Cuyahoga. In response, subcommittee members are working with CommonHealth ACTION to develop a tool that will assess the characteristics and capacities of HIP-Cuyahoga to address structural racism as individual HIP-Cuyahoga members and within their organizations. This assessment will become the basis for HIP-Cuyahoga's capacity building efforts related to structural and institutional racism over the next several years. The Eliminating Structural Racism subcommittee hopes that HIP-Cuyahoga member organizations will review their existing values, policies, and practices, and work to transform their organizations by adopting an overarching value system based on equity for racial and ethnic minorities. In short, HIP-Cuyahoga's partners must set goals focused on changing all policies that are not based on values of inclusion and fairness.

The subcommittee's goals include:

- developing a community-level understanding of the historical forces involved in creating current inequities;
- using health equity data to illuminate how race-based policies and practices created opportunities for some and restricted possibilities for others;
- supporting organizational, institutional, and community leaders to work closely with community members to create an awareness of how and why assumptions about racial and ethnic populations can impact their thinking, feeling, and actions; and
- using an equity-focused approach to develop policies that increase social and economic opportunities for racial and ethnic minorities, change individual and organizational behaviors, and significantly improve conditions for all people living in Cuyahoga County.

Why does it matter?

In Cuyahoga County, we believe that all people should have the opportunity to live

To show people that you will find love no matter what color! – Photograph and Comment from Boys and Girls Club member, 2012 Youth Photovoice Project

healthy and prosperous lives. We understand that our values shape the policies and systems that either create barriers and disadvantages for some or promote prosperity for all. Our current policies and systems create barriers for certain populations that lead to unfair differences in health outcomes; differences that impact us all in Cuyahoga County. By addressing the unfair policies and systems in Cuyahoga County, we will be able to uphold values that we all believe in. We will be able to eliminate structural barriers for communities of color and create a Cuyahoga County where all people are healthy and thriving.

Summary of Goals and Intended Outcomes:

SHORT-TERM (1-2 YEARS)

- We will have improved knowledge, awareness, and understanding of the role structural and institutional racism plays as a social determinant of health.
- We will achieve perspective transformation and apply this concept in our organizations to create a change in culture, policies, and organizational practices.
- We will develop and use clear and intentional messaging about the impact of structural and institutional racism on opportunities for health.
- There will be a shift in the way local media reports on health topics by using the frame of equity and the social determinants of health.
- The HIP-Cuyahoga priority subcommittees that are not directly focused on structural and institutional racism will include strategies that address it.

MID-TERM (3-5 YEARS)

- More organizations will improve their individual and organizational competencies around structural and institutional racism, as well as racial inclusion and cultural competence.
- More organizations will have an explicit focus on structural and institutional racism and how to address it.
- More individuals and organizations will acknowledge and discuss the role that structural and institutional racism plays in creating opportunities for healthy people and communities in our county.
- HIP-Cuyahoga member organizations will begin to create identifiable policies and practices that address structural racism, racial inclusion, and cultural competence. Work will be underway to document these changes, develop incentives, create metrics, and conduct evaluations to ensure accountability.

LONG-TERM (5+ YEARS)

- After five years, we will start to see an improvement in community conditions and the ability of people in all communities to have fair opportunity to improve their health.
- Structural and institutional racism will be addressed explicitly in decisions, policies, and organizational and community practices.

Subcommittee Structure

The anchor organizations and individuals responsible for this subcommittee are:

PolicyBridge
Greg Brown, Executive Director

PolicyBridge is a research and advocacy think tank that prompts and sustains high quality dialogue about public policy issues affecting African Americans and other underserved communities to enlighten community members and catalyze action.

Cleveland Neighborhood Progress
Evelyn Burnett, Vice President of Economic Opportunity

Cleveland Neighborhood Progress is a local community development-funding intermediary with more than 25 years of experience investing in community revitalization work in Greater Cleveland.

For more information on this subcommittee or to get involved, please contact:
Greg Brown, gbrown@policy-bridge.org
Evelyn Burnett, Eburnett@ClevelandNP.org

Photograph from Boys and Girls Club member, 2012 Youth Photovoice Project

KEY PRIORITY
HEALTHY EATING AND ACTIVE LIVING (HEAL)

What is the problem?

While access and opportunity for improved nutrition and physical activity is important for everyone in Cuyahoga County, there is an unfair burden of poor health among our low-income, under-resourced communities, specifically communities of color, youth, and older adults.

In Cuyahoga County:

- One in four adults is obese.
- Residents named obesity as a top five health issue on the HIP-Cuyahoga Quality of Life survey (http://ccbh.info/hipcuyahoga/?tag=quality-of-life-survey).
- Residents lack access to transportation, safe places for physical activity, and places to purchase fresh meats and produce.
- Only 25% of adults reported meeting the recommended fruit and vegetable consumption.
- About 50% all Cleveland residents live in a "food desert" area compared to 25% for Cuyahoga County as a whole.

Environments that support a healthy diet and physical activity are not spread equally throughout Cuyahoga County due to patterns of sprawl and population shifts. Over the past few decades, many people have moved away from the city and inner-ring suburbs, known as the urban core. As more people have moved away from these places, many of the businesses and services once available to support healthy eating and acting living moved as well. Those residents who remain in the urban core often find themselves living without grocery stores, green spaces, and other places to exercise safely.

KEY TERMS

FOOD DESERTS: Urban neighborhoods and rural towns without ready access to fresh, healthy, and affordable food. Instead of supermarkets and grocery stores, these communities may have no food access or access only to fast food restaurants and convenience stores that offer few healthy, affordable food options.

GREEN SPACE: An area of grass, trees, or other vegetation set apart for recreational or aesthetic purposes in an otherwise urban environment.

NUTRITION: The intake of food, considered in relation to the body's dietary needs.

PHYSICAL ACTIVITY: Any body movement that works muscles and requires more energy than resting. Physical activity generally refers to movement that enhances health.

SOCIOECONOMIC: Relating to, or concerned with, the interaction of social and economic factors.

URBAN OR SUBURBAN SPRAWL: The expansion of human populations away from central urban areas into areas with less population density; car-dependent communities.

Crime and different neighborhood characteristics impact people's perceptions of safety and, as a result, impact their use of spaces for physical activity. Although these issues are most prevalent in Cuyahoga County's urban core, it is not limited to that area. Areas in the county that range across the socioeconomic spectrum share similar concerns on issues including lack of sidewalks, bike lanes, parks, and healthy food retail options.

Residents want to improve their health and, given opportunities to do so, will make healthier choices. Although many people have a desire to make healthier choices, their environment and availability of resources often limits them. Improved nutrition and physical activity in schools, worksites, neighborhoods, and institutions can help address the limited access to healthy, affordable foods and safe places to be active. A focus on nutrition and physical activity policies and systems has the potential to shape opportunities and impact the health and well-being of all residents in Cuyahoga County.

What are the solutions?

Through policy implementation, evidence-based strategies, and community engagement, HIP-Cuyahoga partners will work together to create equitable access to healthy food and safe and engaging places for recreation and physical activity for everyone who lives, works, learns, and plays in Cuyahoga County. The Healthy Eating Active Living subcommittee has identified three evidence-based strategies to support this vision: healthy food retail, complete streets, and shared use agreements. These three strategies will help create the environments that make the healthy choice the easy choice for everyone in Cuyahoga County.

» **Healthy retail goals**—In neighborhoods without full-service grocery stores, corner stores provide a vital resource to the community. Subcommittee members will work with residents to identify local corner stores that could serve as a reliable source of healthy produce and food within their neighborhoods. A Healthy Corner Store Certification initiative will encourage and support stores to offer healthy items in a sustainable way. Recruited store owners will need to meet the requirements for certification through an in-depth evaluation of current corner store offerings, resident food preferences, and training on the new initiative.

» **Complete streets goals**—Communities need streets that provide safe places to walk, run, and ride bikes, and allow access to public transportation. Complete streets are places that allow for the safe travel of all people, whether on foot or bikes or in cars or buses.

- Subcommittee members will work to ensure that communities with complete streets policies remain committed to developing roadways that are safe for bicycle and pedestrian traffic.

- Subcommittee members also will develop a plan for a countywide network of protected bikeways and obtain funding for at least 10 miles of protected bike boulevards in this network outside of the City of Cleveland.

» **Shared use agreement goals**—Facilities in communities such as schools and businesses have resources that often sit empty and could be used for physical activity. Shared use agreements create the opportunity for these public and private places to increase community members' access to facilities and opportunities for physical activity.

- Subcommittee members will increase the number of facilities with formal shared use agreements in order to increase resident access to facilities and opportunities for physical activity.

AN EXAMPLE

HIP-Cuyahoga is deeply committed to collaboration.

But what does that look like in practice?

A good example of people coming together for a common goal is the Healthy Eating and Active Living subcommittee, which has worked hard to help HIP-Cuyahoga collaborate with other initiatives in the county such as the Cuyahoga County Board of Health's Creating Healthy Communities and the Cleveland Department of Public Health's Healthy Cleveland initiatives. These initiatives and their diverse organizational partners are all working together to increase opportunities for residents to be physically active.

"We are now able to be more coordinated across a broader geography than we were able to before," says Dr. Erika Trapl, PhD, a subcommittee anchor.

In addition to coming up with creative ways to leverage resources, the collaboration also has saved time by streamlining meetings and data collection in more effective ways. These changes in data collection will facilitate efforts to open up schools after hours to give whole neighborhoods more places to play and exercise.

"With a shared vision and a deepened collaboration, we can now leverage resources and have a bigger impact. We can use one group's resources like training opportunities to serve all," says Dr. Trapl.

And although this level of integration is new, it is likely to shape how people working to improve health in Cuyahoga County interact in the future. "One of the reasons it is really important is that if we didn't work together, we'd be stepping on each other's toes," says Dr. Trapl. "If we weren't in step, we'd be sending too many messages to our community. But, by coming together, we can send one stronger message in a more consistent way."

Why does it Matter?

Everyone in Cuyahoga County deserves equitable access to fresh food resources and safe places to be active. Where people live should not dictate their ability to eat healthy or to be physically active. Consuming healthy foods and increasing physical activity are essential for good health. A focus on nutrition and physical activity has the potential to impact all residents in Cuyahoga County, especially those who currently face barriers to being healthy.

Summary of Goals and Intended Outcomes:

HEALTHY RETAIL

SHORT-TERM (1-2 YEARS)

- We will survey corner stores in Cuyahoga County about current healthy food offerings, and survey residents about their food preferences, with attention to cultural differences. We will emphasize neighborhoods and communities with a strong link between food desert status and poverty.
- We will use this information to develop and refine healthy corner store policies, guidelines, and training.

MID-TERM (3-5 YEARS)

- We will recruit corner store owners to participate in a "How to Become a Healthy Corner Store" training.
- We will advocate for the adoption of model healthy retail ordinances in communities with food deserts.
- We will certify at least 20 stores as healthy corner stores.

LONG-TERM (5+ YEARS)

- There will be at least one certified healthy corner store within a half-mile of census tracts designated as food deserts.
- Eighty percent of participating corner stores will be in compliance with healthy corner store policies and guidelines.
- Legislation is passed supporting healthy options in corner stores in the inner-ring suburbs.

COMPLETE STREETS

SHORT-TERM (1-2 YEARS)

- The Cuyahoga County Planning Commission's complete streets tool kit will be distributed to 100% of communities within Cuyahoga County.
- We will host a series of complete streets trainings targeting municipal engineers and planners.
- We will determine the number of miles of roads in Cuyahoga County that currently incorporate complete streets principles.

MID-TERM (3-5 YEARS)

- All of Cuyahoga County's inner-ring suburbs will adopt complete streets ordinances or resolutions.
- At least half of Cuyahoga County's outer-ring suburbs will adopt complete streets ordinances or resolutions.
- We will adopt a plan for a network of protected bike boulevards within the City of Cleveland.
- We will align safe routes to school plans with complete streets tool kit guidelines.

LONG-TERM (5+ YEARS)

» Cuyahoga County will develop a plan for a network of protected bike boulevards for Cuyahoga County.
» We will pursue funds to implement a pilot network of at least 10 miles of protected bike boulevards within Cuyahoga County, outside of the City of Cleveland.

SHARED USE AGREEMENT

SHORT-TERM (1-2 YEARS)

» We will build capacity among community-serving governmental and non-governmental institutions on how to develop, implement, and evaluate shared use agreements.
» We will collect, map, and share data to identify potential shared use facilities and gather community feedback on physical activity opportunity needs.
» We will develop and disseminate a shared use local resource guide.

MID-TERM (3-5 YEARS)

» We will formalize a community-based process for ongoing identification of resident physical activity opportunity needs.
» We will create a process for linking individuals or organizations interested in providing physical activity (or other) programming with organizations that have facilities available for shared use.
» We will identify ways to publicize opportunities at shared use sites to members of the community to increase utilization of program and/or facilities.

LONG-TERM (5+ YEARS)

» There will be an increased number of facilities with formal shared use agreement policies.
» There will be an increased number of residents who feel that they have easy access to opportunities for physical activity.
» There will be increased physical activity among those who previously had limited access to opportunities for physical activity.

Subcommittee Structure

The anchor organization and individual responsible for this subcommittee is:

The Prevention Research Center for Healthy Neighborhoods at Case Western Reserve University (PRCHN)
Erika Trapl, PhD
Assistant Professor, Epidemiology and Biostatistics
Associate Director, CWRU Prevention Research Center for Healthy Neighborhoods

The PRCHN, initially funded in 2009, is one of 26 Prevention Research Centers funded by the Centers for Disease Control and Prevention. The PRCHN has been an active member of HIP-Cuyahoga serving on the steering committee since its inception and now serving as the HEAL anchor organization. The PRCHN was selected to serve as the anchor due to its ongoing involvement in food access and youth physical activity projects.

For more information on this subcommittee or to get involved, please contact:
Erika Trapl, erika.trapl@case.edu, (216) 368-0098

> **"Health disparities have grown even as medical capabilities have become more sophisticated."**
>
> *Brandt, et al. Am J Public Health. 2000; 90:707–715*

KEY PRIORITY
CLINICAL AND PUBLIC HEALTH

What is the problem?

Despite having multiple first class and highly ranked health care institutions and high quality public health organizations in our county, according to the 2015 County Health Rankings (University of Wisconsin Population Health Institute) Cuyahoga County ranks in the bottom third (65th) of all 88 counties in Ohio for residents' health outcomes. In addition, even though Cuyahoga County consistently ranks in the top 10 in the state for clinical care (measured by access to and quality of care), our residents are not getting healthier. This is because health is more than just health care. Health is the result of our surroundings, including the policies and systems responsible for creating those surroundings.

Our larger health system, is one of the groups that contributes to the health of our community. It includes both clinical care (health care institutions in our county) and local public health (three local health departments in our county).

Traditionally, clinical care institutions think about health and causes of death in terms of diseases and illnesses, as well as individual risk factors such as genetics and personal behavior (*see page 38, Figure 4, Top Causes of Death, MEDICINE*). These institutions also consider access to quality and affordable health care as one of the primary reasons for poor health outcomes and growing health disparities. Their solutions focus on providing quality and accessible health care, and often do not include addressing the underlying structural and policy issues that shape the opportunities our residents have to be healthy. In contrast, public health has begun to focus more on the social, environmental, economic, and structural causes of illness and death addressing what has been referred to as the "Actual, Actual Causes of Death"—those issues at the root of poor health outcomes and disparities (*see page 38, Figure 4, Top Causes of Death, NEW Public Health*).

KEY TERMS

ACCREDITATION: a process of review for health care organizations to show their ability to meet standards set by a professional accrediting agency. Accreditation is a way for organizations to demonstrate accountability to the individuals and communities they serve. Accreditation forms the foundation for policies and procedures.

CLINICAL CARE/ CLINICAL MEDICINE: High quality and coordinated health care provided by health professionals such as physicians, nurse practitioners, physician assistants, and clinical pharmacists.

COMMUNITY BENEFIT PLAN: A document usually created with the nonprofit health care organization's annual strategic plan that describes how an organization plans to fulfill both its mission of community service and its charitable, tax-exempt purpose. It includes a description of community benefit priorities, projects, staffing, resources, evaluation procedures and expected outcomes, and a description of community involvement.

COMMUNITY HEALTH ASSESSMENT: The ongoing process of regular and organized collection, analysis, and distribution of information on the health needs of the community. This information includes statistics on health status, community health needs, gaps, problems, and assets.

KEY TERMS

DISTRIBUTION OF HEALTH OUTCOMES: variation in health outcomes by gender or geographic area, or for different groups, such as socioeconomic, racial/ethnic, or age groups.

HEALTH CARE INSTITUTION: Every place, institution, building, or agency, whether for profit or nonprofit, which provides facilities with medical, nursing, screening, and other related health services.

INTERNAL REVENUE SERVICE (IRS): Federal governmental body that requires nonprofit health systems to complete a community health needs assessment and community benefit plan.

LARGER HEALTH SYSTEM: An organization of people, institutions, and resources that deliver health care services to meet the health needs of target populations. This includes both clinical care (comprised of many health care systems in Cuyahoga County) and local public health (three local health departments in our county – Cuyahoga County Board of Health, Cleveland Department of Public Health, and Shaker Heights Health Department).

[Figure 4] Top Causes of Death in the U.S. in 2000

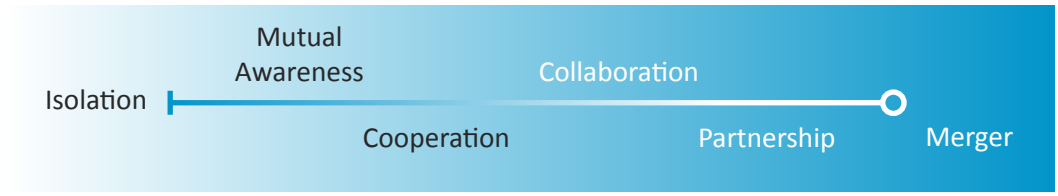
MEDICINE		TRADITIONAL PUBLIC HEALTH		NEW PUBLIC HEALTH	
Cause of Death	**Percent**	**Actual Cause of Death**	**Percent**	**Actual Actual Cause of Death**	**Percent**
Diseases of the Heart	29.6	Tobacco	18.1	Low Education	10.2
Malignant Neoplasms	23.0	Poor Diet and Physical Inactivity	16.6	Racial Segregation	7.3
Cerebrovascular Diseases	7.0	Alcohol Consumption	3.5	Low Social Support	6.7
Chronic Lower Respiratory Diseases	5.0	Microbial Agents	3.1	Individual Poverty	5.5
Accidents	4.0	Toxic Agents	2.3	Income Inequality	5.0
Diabetes Mellitus	2.9	Motor Vehicles	1.8	Area Level Poverty	1.6

Minino, et al, 2002 Natl Vital Stat Rep *Mokdad, et al, 2004, JAMA* *Galea, et al, 2011, AJPH*

Historically, both nationally and locally, each part of the larger health system has worked separate from the other, and health professionals often suggest that "clinical care and public health were separated at birth." While our health care and public health organizations provide excellent programs and services in each of their own fields, strengthening the partnership between these two groups will have an even greater impact on the health of our community.

According to the Institute of Medicine, there is a critical need for improved collaboration between public health and clinical care as the institute describes in its landmark report published in 2012: *Primary Care and Public Health: Exploring Integration to Improve Population Health*. **Figure 5** *(see page 39)* shows the process of improved collaboration from working separately or in isolation, toward true partnership. Population health is a concept that both clinical care and public health organizations can use to work toward common community health goals.

[Figure 5] **Primary Care Integration**



Source: Institute of Medicine. Primary Care and Public Health: Exploring Integration to Improve Population Health, March 2012.

At the national level, there are a number of groups working toward better coordination between clinical care and public health. For example, both local public health departments and nonprofit hospital systems are required to conduct a community health assessment to meet accreditation and regulatory requirements. For local public health, this is known as the Community Health Status Assessment (CHSA). HIP-Cuyahoga completed a CHSA in 2013, as part of this Community Health Improvement Planning process (http://ccbh.info/hipcuyahoga/?page_id=1175). The Internal Revenue Service (IRS) requires nonprofit hospital systems to conduct a Community Health Needs Assessment (CHNA) that serves as the foundation for a community benefit plan and includes collaboration between clinical care and public health.

What are the solutions?

The clinical care and public health organizations in our larger health system must move from working in isolation to working in partnership in order to improve the health of our community. This will require a new way of thinking and a new approach by both clinical care and public health leaders and providers. This new thinking begins with the basic willingness to work together on shared goals, while continually showing mutual respect for each other in words and actions. A collaborative approach that builds on the strengths of both clinical care and public health offers new and exciting partnership opportunities that will lead to a healthier community.

Clinical care and public health share a common focus on improved population health and health equity, but each takes a different approach to addressing the populations they serve. Both groups must shift their approaches and funding processes to focus on prevention as the primary means of improving population health. Clinical care must join the current public health movement to broaden its focus from the treatment of illness and disease to include prevention efforts that address complex social issues like education, racial segregation, poverty and inequality—the "Actual, Actual Causes of Death" (*see Figure 4, page 38*). Clinical care leaders and providers must not only change how they value public health, but they also must commit to training and educating a new generation of health care providers who value population health, health equity, and collaboration with public health as a foundational component of their medical practices. Similarly, public health can learn from the experience of clinical medicine in the areas of evaluation and adoption of quality improvement principles.

KEY TERMS

LOCAL PUBLIC HEALTH DEPARTMENT: a government agency on the front lines of public health. The three public health departments in Northeast Ohio are the Cuyahoga County Board of Health, the Cleveland Department of Public Health and the Shaker Heights Health Department.

POPULATION HEALTH: The health outcomes of a group of individuals and the distribution of outcomes within the group.

POPULATION HEALTH OUTCOMES: the result of many factors that combine together to affect the health of individuals and communities, including clinical/medical care, public health, genetics, behaviors, social factors, and environmental factors. Population health is now a well-defined term that is an accepted and valid measure of outcomes for both health care and public health.

INSTITUTE OF MEDICINE: An independent, nonprofit organization that works outside of government to help those in government and the private sector make informed health decisions by providing evidence about important health-related issues across the country.

White Coats for Black Lives

Countless studies show that racism—experienced interpersonally through ill treatment, or structurally by whole families and neighborhoods—dramatically impacts the health of a community. Addressing health disparities sounds good on paper, but what does it mean in practice? Members of HIP-Cuyahoga's Clinical and Public Health subcommittee are not only learning from one another, but also from the caring medical students at Case Western Reserve University School of Medicine.

After medical students attended sessions about medicine, public health, and institutional racism in their required first course of medical school, these students used their voices to raise the level of discourse over a growing national movement reminding us all that Black Lives Matter.

The students held a "die in" outside the university's Biomedical Research Building to coincide with other protests around the country following the deaths of Michael Brown, Eric Garner and, here in Cleveland, Tamir Rice, at the hands of police.

"This is the community that we serve, and one of our own was affected…These are the people we're trying to protect," medical student Madhuri Nishtala told The Cleveland Plain Dealer, (http://www.cleveland.com/metro/index.ssf/2014/12/case_western_medical_students_1.html).

"The students are acting on what they are learning, and our community will be healthier for it," says Heidi Gullett, MD, MPH, who leads the course and serves as the anchor of the Clinical and Public Health subcommittee. "The School of Medicine's curriculum intentionally focuses on health equity, population health, and health impact assessments, so students get a more complete picture of the many factors that impact their patients' lives and ability to be healthy."

HIP-Cuyahoga members contributed to the course by giving lectures that used maps, data, and examples taken directly from Cuyahoga County. Lectures focused on topics like implicit bias and the health impacts of the redlining process in the county.

Dr. Gullett says she believes that student actions such as the "die-in" illustrate how medical students are expanding their role in the community and opting to take a stand. "It showcases that it's not just about their role as direct health care providers, but that understanding the larger context is critical when working with patients and communities," she adds.

School of Medicine professors, like Dr. Gullett, support students as they take risks to ensure the infusion of HIP-Cuyahoga's core values in their work, in the county's health centers, and neighborhoods. "Our unique emphasis on public health, patient advocacy, and eliminating institutionalized racism and structural inequality from the medical field have inspired and empowered many of us to be agents of change," says medical student Vanessa Van Doren.

"After they graduate, these young health professionals not only will treat patients, but they will also understand the importance of linking medicine and public health, so we can heal our entire community and ensure everyone can enjoy healthy lives and safe communities," says Dr. Gullett. "We can't afford not to train the next generation of health professionals this way. The vast majority of things that cause our patients to be sick cannot be treated in the exam room. We have to train our students to understand and address the true drivers of illness and disease."

In response to Cuyahoga County's segmented health system, as well as the growing health disparities and inequities, the Clinical Care and Public Health subcommittee developed an action plan focused on policy change and a demonstration of partnership. In general, these efforts include:

» County level policy change that would combine our local Community Health Status Assessment process, led by our local public health organizations, with the Community Health Needs Assessment process, led by our local hospital systems. The coordination of these two assessments builds on the strengths of both groups by allowing for data collection that better represents the needs of everyone in our county. It also will help identify opportunities where clinical care and public health can partner to address important health issues for a much greater community impact.

» Practical demonstration of partnership between clinical care (a hospital system), public health (local public health departments), a community nonprofit organization, and a Medicaid managed care company (insurer), focused on improving health outcomes related to pediatric asthma. Asthma is a major health issue in our county affecting about 48,500 children. African-American children are the most likely to have asthma. Furthermore, this chronic disease is highly influenced by environmental breathing triggers that can be controlled. Public health and community organizations have reduced these environmental causes effectively in many cases. But when integrated as part of a medical plan of care for affected children, it will lead to marked improvements in their health outcomes and financial savings to the families and health care system.

Why does it matter?

Sustainable changes in population health and reductions in inequities in our community cannot and will not be realized without improved cooperation and collaboration between public health and clinical care organizations on policy development and health outcomes. The health and economic vitality of our community and our residents is at stake. Now is the time to act on the many opportunities that clinical care and public health have to work together because everyone in our county should have the opportunity to reach his or her fullest health potential.

Summary of Goals and Intended Outcomes

SHORT-TERM (1-2 YEARS)

- Northeast Ohio hospitals will include HIP-Cuyahoga representatives in planning their next CHNA.
- Local hospital leadership will participate in HIP-Cuyahoga.
- We will create and implement a demonstration project on pediatric asthma with a defined Medicaid population.
- Ohio Medicaid leadership will be engaged in discussing the cost effectiveness of financially reimbursing clinical care and public health partnership efforts around improved asthma outcomes. We will secure external funding to support and sustain our subcommittee's work.

MID-TERM (3-5 YEARS)

- We will create a clear plan to coordinate the next CHSA and CHNA in Cuyahoga County.
- We will work collaboratively on the next CHSA and CHNA during every stage of the process—from planning through implementation and development of community benefit plans.
- Ohio Medicaid consistently will fund public health efforts around asthma home interventions and consider funding for other collaborative initiatives that address other chronic conditions.

LONG-TERM (5+ YEARS)

- Health equity will serve as a foundation for the work of both public health and clinical care organizations.
- Collaboration between local public health and clinical care organizations will be a standard business practice.
- State-level policies will reflect the importance of collaboration for CHSA and CHNA. We will secure funding to support clinical care and public health working together to write community benefit and community health improvement plans.
- The health and quality of life of our community will improve.

Subcommittee Structure

The anchor organization and individuals responsible for this subcommittee are:

Environmental Health Watch (EHW)
Kim Foreman, Interim Executive Director

EHW is a healthy homes movement pioneer. It has worked locally for 35 years to address environmental health with hospital and health department partners through nationally recognized research and direct service. EHW has built a strong grassroots network of residents and community stakeholders genuinely engaged in environmental health. HIP-Cuyahoga selected EHW as an anchor organization based on its vast experience in the Healthy Homes program that has demonstrated a true collaborative approach to improving asthma outcomes following home remediation.

Case Western Reserve University School of Medicine
Heidi Gullett, MD, MPH
Assistant Professor, Case Western Reserve University School of Medicine,
Department of Family Medicine and Community Health
Population Health Liaison, Cuyahoga County Board of Health
Co-chair, HIP-Cuyahoga Consortium

The School of Medicine serves as the second anchor organization based on its partnership with the Cuyahoga County Board of Health which created the population health liaison position. This position, currently held by Heidi Gullett, MD, MPH, provides dedicated time toward further developing the partnership and shared initiatives between the two organizations. The School of Medicine's most recent strategic plan makes community health a priority, further strengthening this formal partnership.

For more information on this subcommittee or to get involved, please contact:
Kim Foreman, Kim.Foreman@ehw.org, (216) 961-4646, Ext. 104
Heidi Gullett, Heidi.Gullett@case.edu, (216) 368-0776

KEY PRIORITY
IMPROVE CHRONIC DISEASE MANAGEMENT

What is the problem?

In today's society, diseases like diabetes, high blood pressure, heart disease, asthma, and mental health illnesses touch everyone. These illnesses are known as chronic conditions or chronic diseases. You or one of your family or friends might be experiencing one of these conditions. One in four Americans has heart disease, which is the number-one leading cause of death in Cuyahoga County, the state of Ohio, and in the nation. Similarly, one in three Americans has high blood pressure, which leads to heart disease and stroke. The burden and costs of these diseases are high. Many studies report that, at the current pace, half the country will be diabetic or pre-diabetic by 2020. Over three trillion dollars now are spent every year on health care and 75% of this total goes toward treating chronic diseases.

Chronic diseases, or illnesses, either keep coming back or never go away and often send you to the doctor or hospital, can prevent you from enjoying your life, and can even cut your life short. For example, Ohioans die from stroke at nearly two times the rate of the average American. In Cuyahoga County, African Americans die from stroke at about one-and-a-half times higher rate than whites. Contributing to this is the fact that African Americans have more high blood pressure (41% vs. 27%), have worse blood pressure control (48% vs. 56%), and have a one-and-a-half to four times increased chance of having high blood pressure complications compared to their white counterparts. Those with fewer resources, like access to healthy food, good health care, and family support systems, have more complications and more deaths. **Figure 6**, based on 2014 data collected by Better Health Partnership, formerly known as Better Health Greater Cleveland, shows that those with fewer resources have poorer blood pressure control.

[Figure 6] **Blood Pressure Chart**

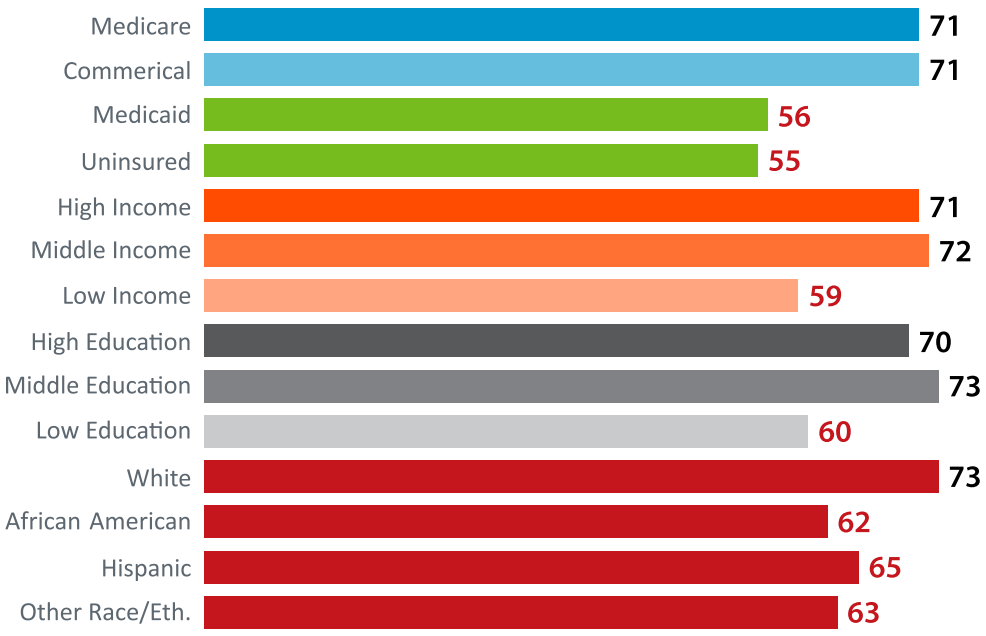


Figure 6: Percent of 141,534 patients with high blood pressure in Cleveland with good blood pressure control: by race, insurance type, household education, and income. Source: Better Health Partnership, formerly known as Better Health Greater Cleveland, 2014

Environmental factors like stress, financial problems, and unemployment prevent vulnerable populations from having better control of their blood pressure. Certain behaviors, like smoking, not exercising, and eating unhealthy food, contribute to getting and controlling high blood pressure and other chronic diseases *(see Figure 7)*. It is harder to practice healthy behaviors when you live in a vulnerable community where you can't get healthy food, where you don't have safe places to play or exercise, and where companies spend a lot of money marketing fast food and tobacco products.

Individuals of color and poorer individuals live in the City of Cleveland; thus they get chronic diseases more often and are more likely to have problems with controlling their chronic diseases. All of this leads to groups of individuals, in vulnerable communities, living sicker and dying earlier.

[Figure 7] Percent of Adults with Factors that Contribute to Getting and Managing Chronic Diseases by Location

LOCATION	SMOKING	PHYSICAL INACTIVITY	OBESITY	BELOW FEDERAL POVERTY LEVEL	UNINSURED
Cleveland	31.3	58.1	35.0	34.0	18.5
Cuyahoga County	20.5	51.2	26.2	17.9	12.5
Ohio	22.5	56.4	29.2	11.8	12.3
Nation	17.3	49.0	27.5	11.3	15.5

Source: Health Improvement Partnership- Cuyahoga, Community Health Status Assessment for Cuyahoga County, Ohio, 2013

What are the solutions?

While we can't totally expect to stop high blood pressure and chronic diseases, we can work together as a community to manage, or lessen, the burden that chronic diseases have on individuals, families, and Cuyahoga County, as a whole. The solutions fall into two different categories: chronic disease clinical management and chronic disease self-management.

Clinical management refers to making sure that all people have the same access to the health care system and skilled members of a health care team to manage their high blood pressure and/or chronic diseases. This is especially true for low-income populations of color, because studies clearly show that lowering blood pressure strongly reduces complications, like stroke and heart attack, by 20% to 50% among these groups. For clinical management to be effective, health care providers must understand and respect their patients and ensure that the care they receive is safe and easy to access.

KEY TERMS

CHRONIC DISEASE: conditions that keep coming back, or persistent conditions, that are the nation's leading causes of death and disability (i.e., high blood pressure, diabetes, asthma, heart problems, and mental illness). Most of the time, these conditions could have been prevented. They can lead to lifelong disability. They negatively impact an individual's quality of life, and they lead to high health care costs.

CHRONIC DISEASE CLINICAL MANAGEMENT: medical treatment of chronic disease that creates a partnership between the patient and the clinician to improve the patient's health.

CHRONIC DISEASE SELF-MANAGEMENT: nonmedical treatment of chronic disease that gives patients the tools they need to improve their health. These interventions can reduce symptoms, build patient confidence to manage their condition, and improve their quality of life.

AN EXAMPLE

Controlling High Blood Pressue

One in three Americans has high blood pressure, which leads to heart disease and stroke, the leading cause of death in the United States–and over half don't have it under good control.

Better Health Partnership, a regional health improvement collaborative, has long documented disparities in high blood pressure control in the health quality data it reports, with rates of good control among African Americans lagging. In 2012, its routine data analyses found that one health care system had achieved a dramatic rise in its rate of control of patients' blood pressure. At HealthSpan, then Kaiser Permanente Ohio, up to 90 percent of patients with high blood pressure had it under control–including African Americans.

HealthSpan's success was no accident. It had adopted a deliberate strategy that drove its results: new protocols to ensure accurate blood pressure readings, simplified medication instructions, stepped-up blood pressure checks and cultural sensitivity training for physicians and staff to help build trusting relationships with patients. Now, Better Health is helping primary care safety-net practices adopt the methodology across Northeast Ohio.

Thanks to Better Health and its collaborators, which include HIP-Cuyahoga members, data that regional health care systems provide for performance measurement and public reporting are uncovering best practices like HealthSpan's–and spreading them across the community to improve health.

Why are publicly reported health care quality data such an important part of improving community health?

"It motivates providers, who want to do their best for their patients and for their community," says Diane Solov, director of Communications and Foundation Relations. "If you know what the gaps are, you can develop a plan to improve. You can't manage what you don't measure."

The public reports are just one of the ways that Better Health pursues its vision to make northeast Ohio a better place to live and to do business. "By providing a safe place for competitors to collaborate, we're working together with employers, health care providers, and community efforts like HIP-Cuyahoga to transform health and health care across the region," Solov says.

The Chronic Disease Management subcommittee members will use the following clinical management methods (based on Kaiser Model Best Practices) to improve the quality of life for those who have high blood pressure:

- train clinicians and staff to communicate well with their patients from different backgrounds;
- train clinicians and staff on how to build trusting relationships with their patients;
- make sure that clinicians measure blood pressure correctly;
- encourage the use of low-cost medication that is only taken once a day;
- communicate regularly with patients who have high blood pressure; and
- have a nurse or medical assistant visit patients until their blood pressure is controlled.

Chronic disease self-management refers to the actions that an individual takes to control his or her chronic illnesses or the risk factors or behaviors that can make the condition worse. For example, unhealthy food choices, smoking, and not exercising can lead to the development of a chronic disease. There is growing evidence showing a strong relationship between patient self-management and improved health outcomes. The Chronic Disease Management subcommittee will use the following self-management methods:

- train community members with Stanford University's Chronic Disease Self-Management and Diabetes Self-Management programs;
- have community residents assist with developing an easy-to-understand message to motivate and encourage residents in vulnerable populations to take care of their chronic diseases or to practice healthy behaviors that will reduce the chances of developing chronic diseases; and
- help to link patients with services in both health care and community settings that promote healthy eating, physical activity, and other chronic disease self-management programs.

The ultimate goal of both clinical and self-management care is to ensure that all in Cuyahoga County have the opportunity to achieve their best possible health.

Why does it matter?

It matters because our entire community is impacted by the multiple costs of chronic diseases. People are dying before their time and suffering needlessly. Families are burdened, and everyone, including businesses, pays a price, both in time and in money. It doesn't have to be this way. Vulnerable citizens in our community lack health care tailored to their specific needs; lack affordable access to healthy food; and lack safe and affordable places to play and exercise. Since the choices we make are based on the choices we have, many environmental factors also make it difficult for people living in low-income and communities of color to live healthy lives.

KEY TERMS

ENVIRONMENTAL FACTORS: conditions that impact the health of people and communities. The amount of money, power, and resources that people have in their daily lives shapes these conditions. Examples include access to healthy food, as well as safe places to play and exercise; levels of stress; financial instability; insufficient or lack of employment; lack of quality education; unstable housing; and substandard health care.

VULNERABLE COMMUNITIES: neighborhoods or places at risk for experiencing societal injustices based on such factors as race/ethnicity; income level; gender; age; sexual orientation; and physical or learning disability.

Summary of Goals and Intended Outcomes

SHORT-TERM (1-2 YEARS)

- We will determine and communicate community resources available to individuals with high blood pressure and related conditions.
- We will use surveys and conduct community focus groups to develop a message campaign that encourages individuals to engage in healthy behaviors and to manage their chronic diseases.
- We will conduct a review of high blood pressure interventions being used in health care settings for vulnerable communities.
- A quality high blood pressure clinical care program will be implemented in target communities.
- Community residents will be trained in chronic disease and diabetes self-management programs.

MID-TERM (3-5 YEARS)

- We will develop a relevant, appropriate, simple, and understandable chronic disease self-management campaign message for vulnerable populations.
- The number of individuals from vulnerable communities participating in quality high blood pressure clinical care programs will be increased.
- The number of individuals from vulnerable communities participating in chronic disease self-management and diabetes self-management programs will be increased.

LONG-TERM (5+ YEARS)

- High quality high blood pressure clinical care programs will be practiced across the county.
- Communities will have the resources to sustain, or continue, the chronic disease and diabetes self-management programs.
- We will create and maintain a database of community resources to aid in chronic disease self-management and to aid providers in clinical settings with referrals to these resources for their patients.
- We will use ZIP codes to track impact of high blood pressure clinical care programs and chronic disease and diabetes self-management programs.
- Results will be shared widely through various communication channels, including an education summit.

Subcommittee Structure

The anchor organization and individual responsible for this subcommittee is:

Better Health Partnership (BHP)
Rita Horwitz, Director of Business Development and Operations

Better Health Partnership
Transforming Health Care, Together

BHP, a nonprofit regional health improvement organization, is strategically leading the continuous growth, financial stability, and achievement of the organization's vision, mission and goals for improving the health of the population in Northeast Ohio.

For more information on this subcommittee or to get involved, please contact:
Rita Horwitz, rhorwitz@metrohealth.org, (216) 778-8546

SHARED MEASUREMENT & EVALUATION

Shared measurement and evaluation is part of HIP-Cuyahoga's collective impact approach to address traditional public health issues and complex social problems. Shared measurement is a way for our partners to work together to achieve shared goals, through common measures for our work.

The Shared Measurement and Evaluation workgroup serves as an advisory group to assist HIP-Cuyahoga with:

- identifying potential measures and data collection tools;
- proposing strategies and tools to collect information; and
- proposing ways to track progress of subcommittee goals and objectives.

The following are examples of outcomes and related performance measures for each of the HIP-Cuyahoga key priority areas.

Improve Nutrition and Physical Activity

OUTCOME MEASURE: Increase the percentage of census tracts that have at least one healthy food retail option located within the tract (or within half mile of the tract).

PERFORMANCE MEASURES: Determine the number of existing healthy retail establishments.

Improve Chronic Disease Management

OUTCOME MEASURE: Increase the number of people participating in chronic disease self-monitoring and management practice(s).

PERFORMANCE MEASURES: Identify and train health leaders.

Eliminate Structural Racism as a Social Determinant of Health

OUTCOME MEASURE: Increase the number of HIP-Cuyahoga affiliated organizations that support and follow racial inclusion and culturally competent work.

PERFORMANCE MEASURES: Equity impact tools adopted for cataloging changes to policies and practices.

Link Public Health and Clinical Care

OUTCOME MEASURE: Create an integrated system to conduct countywide community and clinical health assessments.

PERFORMANCE MEASURES: Identify key decision makers within each health care system and establish agreements for coordinated work.

OUR COLLECTIVE CALL TO ACTION

The HIP-Cuyahoga partnership believes that we must transform our approach to create the conditions for all Cuyahoga County residents to be healthy. Years of public policy and private actions have created opportunity for some, while oppressing others. We know that these opportunity gaps among low-income and minority populations have, in turn, created living conditions for these citizens that are unsafe, unhealthy, and unacceptable.

WE MUST ACT NOW AS A PARTNERSHIP AND A COMMUNITY TO CREATE EQUITY AND IMPROVE HEALTH FOR EVERYONE IN OUR COMMUNITY. THIS WILL REQUIRE US TO APPROACH OUR WORK DIFFERENTLY. WE WOULD LIKE OUR RESIDENTS, PARTNERS, AND POLICY MAKERS TO JOIN HIP-CUYAHOGA IN BUILDING OPPORTUNITIES FOR EVERYONE IN OUR COUNTY TO BE HEALTHY.

> *During our Community Health Improvement Planning process, we recognized that for our plan to truly impact inequities, we needed to build the case for equity among all our partners. We moved beyond a data-driven approach that appeals to the mind only, to a community-driven approach guided by shared values—moving both hearts and minds towards improved health for all in Cuyahoga County.*
>
> Martha Halko, HIP-Cuyahoga Partnership Coordinator
> Cuyahoga County Board of Health

Here is how you can be involved!

» JOIN OUR PARTNERSHIP to help us address the complex factors that shape opportunities for people in our county to be healthy. No single person or organization alone can create such a large-scale and lasting change as we can together.

» HELP US TELL A DIFFERENT STORY about the most pressing issues impacting health in our county. How we communicate about our partnership and our work is critical to our success. The story that people are most familiar with is that health is a product of personal responsibility. The reality is that the conditions in which people live, and the opportunities they have, form the foundation for health. This supports why we must address the policies, systems, and structures that shape the conditions in which people live and the opportunities that they have.

» BEGIN BY UNDERSTANDING how your organizations' and/or your personal values and vision align with the goals of HIP-Cuyahoga. Then build knowledge and capacity on health and equity through open and honest discussion about how social, economic, and environmental factors such as racism, poverty, poor education, unsafe housing, and poor food access contribute to differences in health outcomes that have negative impacts for our entire society.

» WORK WITH US to increase community engagement. Commit to including community members, especially those impacted by inequities, in all aspects of planning, implementation, and evaluation of your programs and services. The data we collect is always important to measuring needs, progress, and ultimately our impact; however, gaining community buy-in and input is critical to achieving sustainable change. Building trusting relationships and community ownership can lead to lasting changes.

» ASSIST US WITH INCREASING UNDERSTANDING of how historical policies and practices have shaped our present day inequities. Work with us to inform and influence policy and decision makers to ensure that everyone achieves the same benefit from the policies and practices within our county, our communities, and our organizations. We can do this by using the many tools at our disposal, such as policy making, creating regulations; hiring and recruitment practices; and, funding and resource allocation.

» SUPPORT US in addressing both traditional public health issues and the increasingly complex social issues present in our evolving community which can bring about lasting change. To do this well, we must enhance our evaluation and measurement approaches and practices to document our progress by strengthening the collection, reporting, and sharing of data. It is only through measurement that we can clearly understand how successful we are in addressing our most pressing health issues and reducing inequities.

To learn more or to get involved in HIP-Cuyahoga, go to www.hipcuyahoga.org.

DOCUMENT REFERENCES

Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, PhD, MSc; Julie L. Gerberding, MD, MPH Actual causes of death in the United States. JAMA. 2004;291(10):1238-1245.

Appel LJ, Wright JT, Jr., Greene T et al. Intensive blood-pressure control in hypertensive chronic kidney disease. N Engl J Med 2010;363(10):918-929.

Brandt and Gardner. Antagonism and Accommodation: Interpreting the Relationship Between Public Health and Medicine in the United States During the 20th Century, Am J Pub Health, 2000; 90: 707-715.

County Health Rankings. A Collaboration between the Robert Woods Johnson Foundation and The University of Wisconsin Population Health Institute. Available at: http://www.countyhealthrankings.org/app/ohio/2015/compare/snapshot?counties=035

Community Health Status Assessment for Cuyahoga County, Ohio (March 2013). Available at: http://ccbh.info/hipcuyahoga/?page_id=1175

High Blood Pressure Fact Sheet, 2011. Centers for Disease Control and Prevention. Division for Heart Disease and Stroke Prevention. Accessed 09/01/2013.

History Matters: Understanding the Role of Policy, Race and Real Estate in Today's Geography of Health Equity and Opportunity in Cuyahoga County. Kirwan Institute for the Study of Race and Ethnicity and City and Regional Planning Program at the Kowlton School of Architecture at The Ohio State University. Feb 2015. http://cuyahogaplacematters.com/resources/publications/

Institute of Medicine. Primary Care and Public Health: Exploring Integration to Improve Population Health, March 2012. This PDF is available from The National Academies Press at: http://www.nap.edu/catalog.php?record_id=13381

Quality of Life Survey: A Community Themes and Strengths Assessment for Cuyahoga County, Ohio (March 2012). Available at: http://ccbh.info/hipcuyahoga/?tag=quality-of-life-survey)

Mensah GA, Mokdad AH, Ford ES, Greenlund KJ, Croft JB. State of disparities in cardiovascular health in the United States. Circulation 2005;111(10):1233-1241.

Miniño AM, Arias E, Kochanek KD, et al. Deaths: Final data for 2000. National vital statistics reports; vol 50 no 15. Hyattsville, MD: National Center for Health Statistics. 2002. Available from: http://www.cdc.gov/nchs/data/nvsr/nvsr50/nvsr50_15.pdf

Paulsen MS, Andersen M, Munck AP et al. Socio-economic status influences blood pressure control despite equal access to care. Fam Pract 2012;29(5):503-510.

Partners who care enough to measure quality. Available at http://www.betterhealthcleveland.org/. 2010. Accessed 7-10-2013.

Ogden LG, He J, Lydick E, Whelton PK. Long-term absolute benefit of lowering blood pressure in hypertensive patients according to the JNC VI risk stratification. Hypertension 2000;35(2):539-543.

Sandro Galea, Peter C. Rockers, and Margaret E. Kruk. Galea et al. Respond. American Journal of Public Health: April 2011, Vol. 101, No. 4, pp. 582-582.

Turnbull F, Neal B, Algert C et al. Effects of different blood pressure-lowering regimens on major cardiovascular events in individuals with and without diabetes mellitus: results of prospectively designed overviews of randomized trials. Arch Intern Med 2005;165(12):1410-1419.

Lv J, Neal B, Ehteshami P et al. Effects of intensive blood pressure lowering on cardiovascular and renal outcomes: a systematic review and meta-analysis. PLoS Med 2012;9(8):e1001293.

Wright JT, Jr., Dunn JK, Cutler JA et al. Outcomes in hypertensive black and nonblack patients treated with chlorthalidone, amlodipine, and lisinopril. JAMA 2005;293(13):1595-1608.

List of Supportive Resources

ASTHO—Health Equity
http://www.astho.org/Programs/Health-Equity/

Center for Disease Control and Prevention—Attaining Health Equity
http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/overview/healthequity.htm

Center for Disease Control and Prevention—Meaningful Community Engagement for Health and Equity
http://www.cdc.gov/nccdphp/dch/pdfs/health-equity-guide/health-equity-guide-sect-1-2.pdf

Center for Disease Control and Prevention—A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease
http://www.cdc.gov/NCCDPHP/dch/health-equity-guide/index.htm

Community Engagement in Public Health
http://cchealth.org/public-health/pdf/community_engagement_in_ph.pdf
FSG Reimagining Social Change – Collective Impact - http://www.fsg.org/OurApproach/CollectiveImpact.aspx

Health in All Policies—Health in All Policies: A Guide for State and Local Government
http://www.phi.org/resources/?resource=hiapguide

Iton, Anthony. Tackling the Root Causes of Health Disparities through Community Capacity Building. Tackling Health Inequities through Public Health Practice: A Handbook for Action.

National Association of County and City Health Officials (NACCHO)—Health Equity and Social Justice
http://www.naccho.org/topics/justice/

National Collaborative for Health Equity—http://nationalcollaborative.org/

Prevention Institute—New Health Equity Guide for Public Health Practitioners
http://www.preventioninstitute.org/press/highlights/1098-new-health-equity-guide-for-public-health-practitioners.html

What can public health programs do to improve health equity?
http://www.publichealthreports.org/issueopen.cfm?articleID=3042

World Health Organization—Equity
http://www.who.int/healthsystems/topics/equity/en/

NOTES

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